TUBERCULOSIS CONTROL ASSISTANCE PROGRAM (TB CAP)

PROGRAM YEAR 1

Annual Progress Report I
October 1, 2005 – September 30, 2006

15 November, 2006

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: The Dead Mother and Child, 1897, Edvard Munch. Norway's most popular artist Edvard Munch was born in 1863. His mother died of Tuberculosis at the age of 30 when Munch was five. His sister Sophie died of Tuberculosis at the age of 15 when Munch was 14.

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Executive Summary

Introduction

This is the first annual progress report of the Tuberculosis Control Assistance Program (TB CAP), carried out by the Tuberculosis Coalition for Technical Assistance (TBCTA) a coalition of KNCV Tuberculosis foundation (prime contractor), 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).

After TB CAP was awarded to TBCTA, core-funded projects were prioritized for strategic importance during a start-up meeting in Washington DC (October 5th to 7th, 2005). The first annual workplan was submitted to USAID on December 2nd, 2005, five weeks following the award. Project implementation started after final approval from January 2006 onwards, some projects and country work plans were approved in April or later. This report covers 37 projects during the period October 1, 2005 till September 30, 2006.

Background

TBCTA was founded in 2000 comprising of the American Lung Association (ALA), ATS, CDC, The Union, KNCV Tuberculosis Foundation and the WHO. In 2004 ALA withdrew from the coalition. During 2000-2005, with USAID guidance and funding, TBCTA played a prominent role in global TB control in 20 countries. Its significant success and wide recognition led to the development of TB CAP which was awarded to TBCTA on October 1st 2005. Three partner organizations have been added to the coalition in recognition of the new and emerging challenges of TB CAP; FHI, JATA and MSH. With these new partners the current coalition comprises of 8 organizations: ATS, CDC, FHI, KNCV, MSH, RIT/JATA, The Union and WHO. In addition, close collaboration exists with the Stop TB Partnership, and with a number of other international and national collaborating agencies.

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).
- 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).

Project initiation

A Cooperative Agreement was signed between USAID and KNCV Tuberculosis Foundation, and sub-agreements were signed with all coalition partners. During the first year, based on the experiences gained from the TBCTA period, TB CAP partners developed a **Strategic Framework** and **Monitoring & Evaluation Plan**, forming the basis for project development and management. A stronger Program Management Unit was established to improve communication, increase performance, to ensure appropriate technical and financial monitoring and timely reporting. Main management tools developed were;

- An Operational Manual for administrative and technical guidance
- A revised quarterly technical progress reporting system
- Web-based platform (TB CAP eRoom) to improve document management and communication

Main achievements

During the first year TB CAP's main achievements were:

- 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.

    - **In Mozambique** community-based (CB) DOTS has been introduced. Since this is the first time that a CB DOTS approach will be implemented in Mozambique, the TB CAP project has just developed CB DOTS &TB-HIV Guidelines, training and educational materials as well as monitoring tools. TB CAP has also supported the establishment of a TB/HIV Task Force in Mozambique to improve coordination between the two programs.

    - **In Namibia** treatment success rate increased from 70% (2004 cohort) to 74% (mid-year report 2005 cohort). Percent of all registered TB patients who are tested for HIV rose from 16% to 24% (mid-year report 2006). TB CAP conducted national TB course for a total of 51 officers (18 men

and 33 women) and also trained 40 volunteers (out of 100 targeted) who are now engaged in providing DOT at various clinics in Erongo region. The project provides transport and lunch allowance to the volunteers. TB CAP is purchasing low cost containers which will be converted into DOTS points located closer to the communities. This will allow for decentralization of additional DOT centers.

- **In Zambia** 70% of TB patients are co-infected with HIV. TB CAP is supporting TB staff training in HIV counseling and testing for TB suspects/patients. In total 26 Provincial and District focal point persons were trained as trainers in the Diagnostic Counseling and Testing (DCT) and Clinical Training Skills (CTS) courses.

- 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. This year, missions to Romania and Uzbekistan were successfully completed, a Lesotho mission is in progress and plans for Georgia, DR Congo and Vietnam have been made for next year.

Main challenges

- So far, **three TB CAP outputs have not been addressed,** that need to be addressed 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) .

- **HRD** remains a challenge. A broader HRD approach is needed to address the expected outputs from IR5, particularly that of **institutional capacity building**.

- To date, TB CAP has succeeded only in Namibia ($1 M) in receiving funds from PEPFAR for TB/HIV activities. Securing **PEPFAR funds** in other countries for TB/HIV collaborative activities remains a continuing challenge.

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

- **Preparing timely workplans** for the TB CAP countries continues to be a challenge. It is important ensure that baseline assessments are used in the development of country workplans. It is equally important to provide for the multi-lateral planning that is now required for each workplan and ensure timelines are followed, all stakeholders are involved, and appropriate NTP/MOH and USAID consultations held to reach the mandated deadlines.

1. Introduction

TBCTA partners are pleased to submit the first TB CAP Annual Progress Report covering the October 1, 2005 and September 30, 2006 period. The purpose of this report is to give an overview of it's first year activities, accomplishments and challenges.

This report covers 37 (23 core funded, 4 regional and 10 field supported) projects. All coordinating partners have submitted final annual reports for all projects. While each project was coordinated by one coalition partner, others also joined as collaborating partners as needed. Table 1 below summarizes the involvement of partners with Year 1;

Table 1: Involvement of partners with APA1 projects

Partners & Projects	Core (23)	Regional (4)	Field (10)	Total (37)
ATS	7	0	0	**7**
FHI	6	0	4	**10**
JATA	6	0	1	**7**
KNCV	10	1	7	**18**
MSH	9	1	5	**15**
PMU	3	2	0	**5**
The Union	10	2	2	**14**
WHO	22	2	5	**29**
Total	**73**	**8**	**24**	**105**
Average number of partners	**3.2**	**2.0**	**2.4**	**2.8**

On average three TBCTA partners are involved the planning, communication, coordination, execution, monitoring, and reporting related to a project. During the first year of implementation TB CAP has found that this level of collaboration contributed to the success of the workplan by creating and maintaining synergy between coalition partners.

The following sections provide information on TB CAP major accomplishments, as well as challenges experienced during the first program year. Annex 1 provides detailed information on each project. Annex 2 provides baseline and end of year 1 results of TB CAP's Monitoring and Evaluation Plan indicators.

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.

Launch of TBCTA
In 2000, six organizations (ALA, ATS, CDC, KNCV, The Union and WHO) actively involved in global TB control came together to form the TBCTA, submitting an unsolicited proposal to USAID. The proposal was approved by USAID in September 2000. The TBCTA then established its formal and operational structures to manage USAID-funded programs.

Launch of TB CAP
During the past five years, with USAID guidance and funding, TBCTA played a prominent and increasing role in global TB control efforts in 20 countries. TBCTA's significant success and wide recognition led to the development of TB CAP which was awarded to TBCTA on October 1st 2005. TBCTA has been expanded for TB CAP to include three new partners; Family Health International (FHI), the Japanese Anti-Tuberculosis Association (JATA) and Management Sciences for Health (MSH). TB CAP is USAID's chief mechanism contributing to the global targets of TB control. 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):
- 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:

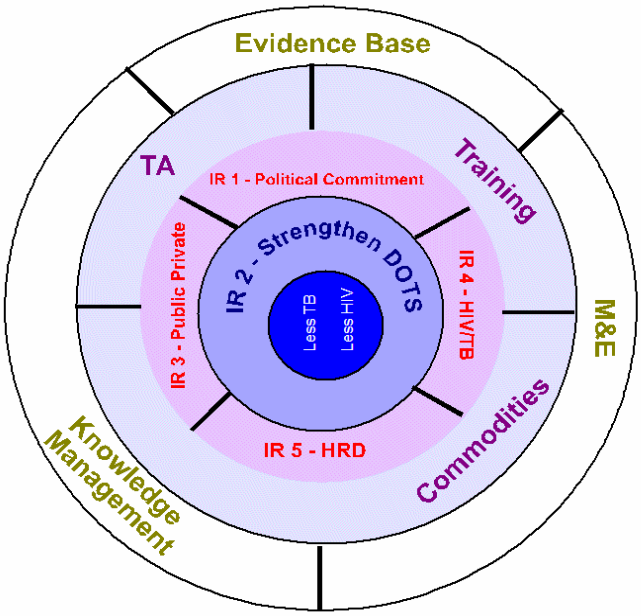
1. Address the needs and priorities of USAID missions and regional bureaus to scale up country programs by adapting TBCTA's successful model to individual needs.

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 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 CAPs vision towards achieving the goals and IRs.

Figure 1: TB CAP Conceptual Framework



After TB CAP was awarded to TBCTA, all projects were discussed, selected and prioritized for strategic importance during the Start-Up meeting with TBCTA partners and USAID Global Health Bureau Staff in Washington DC, October 5th to 7th , 2005. The TBCTA first annual workplan was submitted to USAID on December 2nd, 2005, just five weeks following the award.

The Board of Directors, the PMU, and USAID held a strategic planning meeting in The Hague to reach consensus on 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 and expected outputs for each IR were discussed in detail. Based on the expected outputs participants also discussed and agreed on a set of performance indicators. Table 2 below illustrates the expected outputs.

Table 2: 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

All core funded projects implemented in APA1 contribute to at least one of the expected outputs organized under each IR. Table 3 below illustrates the APA1 projects related to expected outputs of each IR.

Table 3: APA1 projects related to the expected outputs of each IR

IR	Expected Outputs	APA 1 Projects
IR1	Sustained appropriate level of government funding	Developing Financial Assessment and Budgeting Tool
IR1	Ensured political legal framework	No project
IR2	Strengthened TB program leadership and management	Improved health systems mapping and organization
		Developing management tool- MOST
IR2	Strengthened integration of DOTS services in general health services	No project
IR2	Improved diagnostic capacity	Improved diagnosis capacity – laboratory networks
		Promotion of rational use of TB diagnostic process
IR2	Improved prevention and management of MDR TB	International MDR-TB Course Mexico
IR2	Improved equitable access to quality TB care for vulnerable populations	No project
IR3	Increased NTP coordination and collaboration with public and private sectors	Preparing a strategic coordination plan for developing PPP in USAID priority countries
		Developing tools for situational analysis
		Promotion of PPP through sharing of PPP experiences among TB CAP and other countries
		Dissemination and implementation of *ISTC*
IR4	Improved national policies and coordination between National TB and HIV programs	Lessons learned for scaling up
		Validation of revised recording and reporting system
IR4	Improved access of HIV positive TB patients to HIV services	Assessment role and potential of comm. based TB/HIV care in scaling-up
IR4	Improved access of persons living with HIV to TB services	Accurate and faster diagnosis of sputum-neg. patients for TB/HIV
IR5	Improved competence and availability of staff at different levels of the health system	Task Force on HRD
		Development of a guide on "How to develop an HRD plan for comprehensive TB control"
		Support to CORE workshop in India for US PVOs
		Institutional capacity building
		Regional workshop for HRD focal points
		Training course for TB/HIV consultants and support for field experience
		Training PPP consultants
		Field experience for laboratory consultant trainees
		Generic advanced course on supervision of TB management at sub-national level

Table 3 also shows that some of the outputs are not addressed by specific projects. In principle, the outputs not addressed in APA1 will be addressed in APA2 and beyond. Designing and submitting project proposals based on the expected results has helped to identify specific, measurable, attainable, realistic and timely outputs for each project thus increasing the likelihood of success and helping to establish clearer links between the annual projects and overall expected TB CAP five year outputs.

Although TBCTA has a history of over five years with the TBCTA program USAID strategic framework and the five IRs require a new approach in developing workplans. The first version of the Year 1 workplan submitted did not fully address the needed coherent strategic approach for each of the IRs. Adjusting the project proposals took more time than anticipated. Several workplans were only approved after the second quarter. IR 5 Core funded projects were affected the most from the delays. Most of those projects had to be re-written and re-submitted for approval during the second quarter. Also, the three regional projects were delayed due to similar reasons.
A few TB CAP partners experienced problems with administrative issues, delaying the signing of the sub-agreements and project implementation. This has led to late completion of projects.

The new partners in TBCTA have added value to the coalition including FHI for their expertise in TB/HIV, MSH for their expertise in management and capacity building, and JATA for their expertise in training. On the other hand, it has been a challenge for all partners to learn each others' work cultures and align our administrative procedures.

3. Program Year 1 Achievements

3.1 Project management

Based on the experiences gained from the TBCTA period, TB CAP developed systems and project management practices to improve communication, increase performance, ensure appropriate technical and financial monitoring and timely reporting.

- **Expanded Project Management Unit (PMU):**
  As prime contractor KNCV hosts the PMU which is responsible for the day-to-day management of all projects. Currently PMU is comprised of three key personnel: the Project Director, the Deputy Project Director and the Monitoring & Evaluation Officer, complemented by a Financial Controller, two Senior Staff Officers and the Human Resource Development (HRD) Officer. In addition there are two secretaries and two financial and administrative support staff. It should be noted that several of the PMU staff are also involved in TBCTA program, and thus work on two projects.

- **Operational Manual:**
  In order to establish effective project management PMU, in collaboration with partner organizations prepared an Operational Manual. This document explains and defines the basic project management components, such as organization, planning, communication, reporting as well as relevant USAID rules and regulations. The document is continuously updated, as required.

- **Sub-agreements between coalition partners and KNCV:**
  Sub-agreements were signed with all TB CAP partners to cover the entire project period (October 2005 – September 2010) and are legally binding documents. Sub-

agreements are updated through amendments with the approval of annual plans and country plans and changes in rules and regulations.

- **Strategic planning meeting:**
  A strategic planning meeting was conducted in May 2006 to develop a clear framework and set of objectively verifiable performance measures.

- **Board meetings:**
  Board Meetings were held in February 2006 in Washington DC to review the project progress and in August 2006 in The Hague to discuss, prioritize and agree on the APA2 projects. The strategic planning meeting conducted in May 2006 had a very big impact on agreement of a clear framework, a set of objectively verifiable performance measures, and selection of projects for APA2.

- **TB CAP project officers and field officers training workshop:**
  The purpose of the two-day workshop for project and field officers was training on TB CAP rules and regulations as well as technical and financial reporting requirements. It was held in August 2006 in The Hague.

- **TB CAP Monitoring and Evaluation Plan:**
  An M&E plan with a framework was developed to conceptualize the project inputs, processes and outputs as well as desired outcomes and impact of TB CAP over the five-year project period.

- **Quarterly technical progress reporting system:**
  A quarterly technical progress reporting system was adopted in order to effectively and timely monitor project activities. PMU has worked with all partners to gradually improve the timeliness and completeness of quarterly reporting. Timeliness of reporting has improved from 88.6% in the first two quarters to 100% in the last two quarters.

- **Revised financial monitoring and reporting system:**
  It was decided to shift from activity level to project level financial monitoring and reporting. This important change has not only helped to simplify the reporting between partners and PMU, but has also reduced the burden of monitoring and record keeping at the PMU.

- **Launched TB CAP eRoom:**
  PMU, in collaboration with MSH, designed and introduced TB CAP eRoom as an electronic platform for management of communication between partners and for effective document management. TB CAP eRoom is hosted at the MSH server and managed by PMU staff.

3.2 Contribution of Year 1 core funded projects to the five IRs

The core funded projects are organized according to the five IRs, as mentioned above. TB CAP assumes that improved competence and availability of staff at different levels of the health system is the key success factor for TB control. The importance given by TB CAP to improved human and institutional capacity (IR5), is clearly demonstrated both by the level of funding through core (around 40%) and number of projects (10 out of 23). The levels of effort for the other four intermediate results (IR1 – IR4) for the first year were approximately 10%, 10%, 20%, and 20%, respectively.

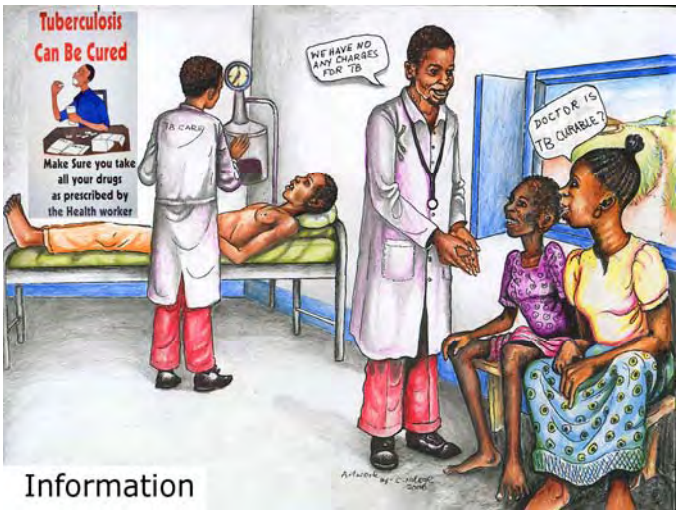
In this document, contribution of Program Year 1 core funded projects is organized under each IR and each expected output, facilitating an assessment of TB CAP performance in each IR.

IR 1: 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.

Developing Financial Assessment and Budgeting Tool: In APA 1, the Financial Assessment and Budgeting Tool was designed and developed for planning and budgeting at national and sub-national level within the framework of the Global Plan and the Stop TB Strategy. It will be posted on the WHO and Stop TB Department websites for download. The tool has two components; the first component (financing) shows users how to assess budgets and expenditures related to TB control for a particular year, at a particular administrative level. This includes a standard framework for a) compiling budget and expenditure data and b) for analyzing the data to calculate useful indicators.

The second component is for prospective budgeting for TB control at national and local level, based on the framework provided by the Global Plan and the Stop TB Strategy. The tool helps users to develop annual and medium-term budgets for TB control.



The tool has been successfully field-tested in 10 Latin American countries as well as Kenya, Indonesia and Malawi, and is currently being used in South Africa. During the last quarter field-testing in Indonesia (August, 20-29) and Kenya (September, 15-20) was completed, with very positive feedback.

Follow-up work to promote and use the tool will be conducted through the project approved under IR1, APA2.

IR 2: Strengthened and Expanded DOTS programs

DOTS expansion to improve access to timely and quality assured diagnosis and treatment is a strategic approach of TB CAP. This will be achieved by improving laboratory systems, community-based DOT, PPM, and DOTS+. Year 1 projects have focused on strengthened TB program leadership and management, improved diagnostic capacity and improved prevention and management of MDR TB. In total, five core projects (four IR2 and one cross-cutting IR2 & IR5) and one regional project have contributed to achieving expected results of TB CAP as described below:

Laboratory Standard Operating Procedures (SOP): A written SOP is essential to ensure standardization of laboratory practice and a uniform level of quality throughout a country or region. As such they are a pre-requisite for quality assurance. This SOP provides information on all laboratory procedures, including test methods, operation of equipment, laboratory organization, quality control, safety practices and record keeping. The draft SOP has been completed and the final version will be available in early Year 2.

MOST TB for use in African settings: MOST (Management Organizational Sustainability) TB assessment and planning tool 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 Kampala, Uganda from August 9-11, 2006 attended by 17 participants from 5 countries. All five countries believe that conducting MOST for TB would be of value for their NTPs and have requested MOST for TB workshop to be conducted in their countries. The tool will be finalized and published in Year 2.

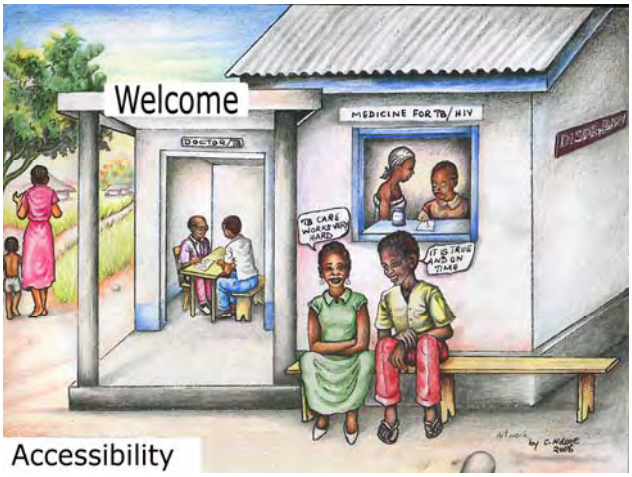
QUOTE tool to measure and improve the quality of TB care and control: In the previous TBCTA project, NTP staff of Malawi, Kenya and Uganda participated in developing a QUOTE TB tool (Quality of Care as seen Through the Eyes of the TB patient). However, the tool has not yet been tested in the field for validation and psychometric characteristics. For that purpose, during APA 1, a regionally funded project was implemented to field test and finalize the tool. The project has successfully completed the field testing of the tool. The final product will be ready in early Year 2. 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. The artwork was designed by Charles Ndege, a Tanzanian artist and illustrated in this report.

Guidelines to improve quality of conventional radiology: Draft Guidelines to provide information on interpretation and use of CXR for either the diagnosis of smear-negative TB or for the screening of TB suspects in resource poor and high HIV prevalent settings are under development. A first version will be available in early Year 2.

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 will provide 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 projects complement and significantly advance the global efforts for increased public and private participation and collaboration in DOTS implementation. Five core funded projects (four IR 4 and one IR 5) have produced important results as described below:

***International Standards of Tuberculosis Care*:** 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 XRD-TB. The ISTC has been translated English, French and Russian, Indonesian, Vietnamese and Chinese.

As of end APA1, a total of 27 organizations (9 international and 18 national) have endorsed *ISTC*. Pilot studies of *ISTC* implementation were initiated in Indonesia, Kenya and Tanzania in Year 1. Two additional countries, India and Mexico will undertake implementation pilot projects in Year 2.

Twenty-two high burden countries (HBC) responded to WHO's 2006 NTP survey on the *ISTC* and Patient Charter. Sixteen HBCs (76%) were already familiar with ISTC and 12 HBCs (57%) were familiar with Patient Charter. Below is a summary of TB CAP countries that propose to undertake *ISTC* promotional activities in the current/future fiscal year (2006);

Brazil	First implement in 315 priority municipalities then implement nationwide.
Cambodia	Introduce and disseminate *ISTC* through TB-CAP. Adapt, translate and print *ISTC* in Khmer.

	Conduct meetings with medical and pharmaceutical associations to sensitize health providers on *ISTC*.
Indonesia	Five professional organizations have officially endorsed ISTC on World TB Day 2006. *ISTC* has been translated and produced into a pocket book for easy use at the health facility level. Sensitization workshops with pulmonologists and hospital staff for roll out of *ISTC*.
Nigeria	DOT expansion to all remaining LGAs to bring DOTS closer to patients. Involvement of the community in TB suspects, diagnosis and treatment. Use of treatment supporters and TB treatment groups for ensuring DOTS.
Philippines	Revision of the manual of procedures (Single Drug Formulations were changed to Fixed Dose Combination drugs (FDCs). Development of a project proposal in line with *ISTC*.
Vietnam	Translation and distribution of the *ISTC*.

Global PPP coordination plan: This global strategic plan will guide the use of TB CAP resources in the most efficient manner for scaling-up PPPs. This plan and the related country-activity-partner matrix provide the baseline information for future reference and for measuring progress during the TB CAP project period.

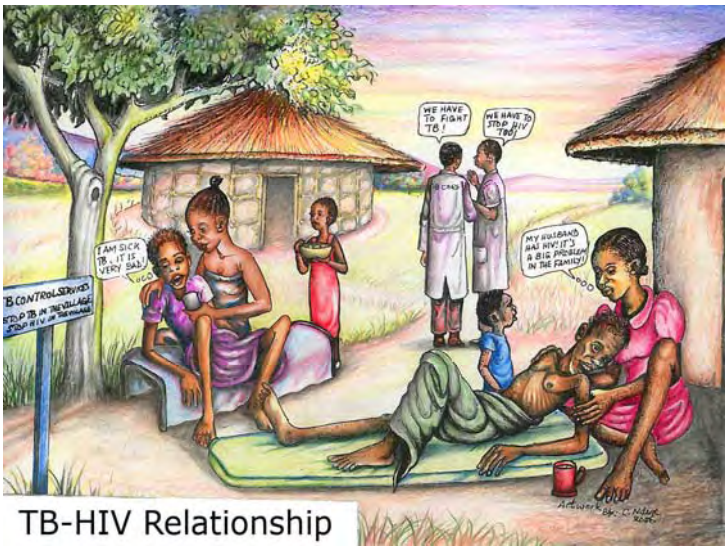
Participation of TB CAP countries in the 4th meeting of the PPM Subgroup: During the PPM Subgroup meeting, countries benefited from the analysis of global progress on PPP, understanding of regional PPP activities, knowledge of experiences of countries in Africa and Asia on PPP implementation, and a first-hand field exposure to working PPP models in Kenya. The Subgroup meeting was held in Nairobi, 12-14 September 2006.

Standardized country assessment tool: Private providers either already participate or could participate in TB control and care activities in different ways. A systematic assessment using a standardized approach enables this information to be collected. This tool assists NTPs to assess the complete picture of the magnitude and types of involvement of the private sector in TB control. The data collection and analysis tool is under development and will be available in Year 2.

Training of PPP consultants: TB CAP conducted a PPP consultants training on March 27-31, 2006 in Geneva, Switzerland. In total, 19 participants from 12 countries (Bangladesh, Cambodia, Egypt, France, India, Italy, Lebanon, Myanmar, Netherlands, Philippines, Switzerland, US) successfully completed the course. Five of the trained consultants have already participated in country missions and assessed PPM plans and implementation status. Field visits are being organized for 3-5 additional consultants during October-December 2006.

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

TB CAP aims 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 for achieving these expected results is to work with national governments and partners to improve the policy environment for coordinated TB and HIV/AIDS activities. TBCTA sees its role as a catalyst acting in a complementary manner to influence policy and practice through promotion and training, while leveraging resources for funding the HIV/AIDS care services required for TB patients.



In its first year TB CAP planned for the implementation of five projects (four IR 4 and one IR5) that addressed the need for rapid scale-up of TB/HIV, through TB/HIV consultancy training, documentation and dissemination of best practices on TB/HIV scale-up, improved reporting and recording, accurate and faster diagnosis of HIV-positive patients with smear-negative and extra-pulmonary tuberculosis**,** and community involvement in scaling-up of TB/HIV care.

TB/HIV Consultancy Training: On June 8-15, 2006, TB CAP conducted a TB/HIV consultancy training course attended by 22 participants from 17 countries (Azerbaijan, Dominican Republic, Ghana, Japan, Kenya, Nepal, Nigeria, Peru, Somalia, Tanzania, Thailand, Turkey, Uganda, USA, UK, Zambia, Zimbabwe) in Sondalo, Italy. Newly trained consultants will be assisted by "mentored consultancies" to six countries (Burundi, Angola, Dominican Republic, Sudan, Moldova and Papua New Guinea) during Year 2.

Validation of Stop TB TB/HIV recording and reporting system: The final version of the new TB/HIV reporting and recording system was piloted in five countries, revised, finalized and posted on the web in October 2006. Country programs have started adopting the new system. Kenya is one of the first country reporting national TB/HIV indicators to use the new reporting and recording system.

Flow diagrams to improve the accuracy and expediency of diagnosis of sputum-negative/ EPTB patients: TB CAP conducted a three day meeting on March 21-22, 2006 in Geneva, Switzerland for the expert group members to discuss and finalize recommendations for flow diagrams on smear-negative and extra-pulmonary tuberculosis. Draft algorithms for the diagnosis of smear negative TB and the clinical guidelines were designed and published for consultation on the web. These were presented to STAG, endorsed, revised and published on the WHO website (http://www.who.int/tb/hiv/en/) in November 2006.

IR 5: Improved human and institutional capacity

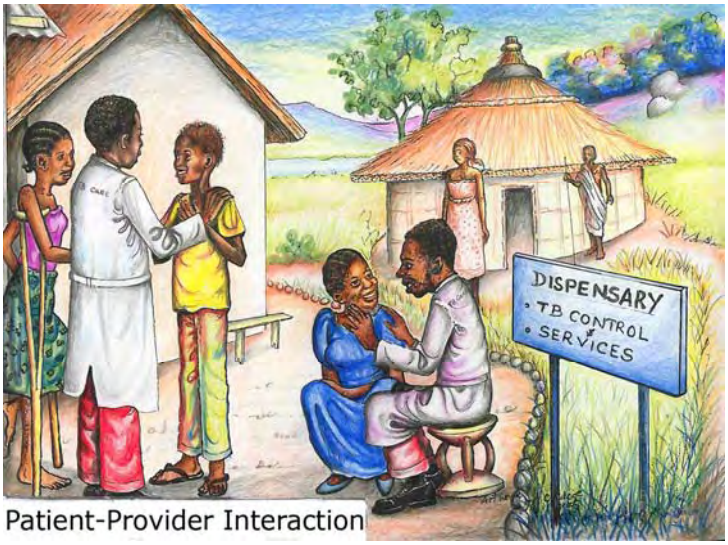
TB CAP views Human Resource Development (HRD) as an essential component of any comprehensive TB control strategy to achieve and sustain the global TB control targets and reach the Millennium Development Goals (MDGs). TB CAP aims to improve competence and availability of staff in countries at different levels of the health system and will focus both on improving human resource capacity and improving institutional capacity. The ultimate goal of HRD for comprehensive TB control is to ensure that:

- Staff at different levels of the health system has the skills, knowledge, attitudes (professional competence) and motivation, necessary to successfully plan, implement, evaluate and sustain comprehensive TB control services including the implementation of new and revised strategies and tools and in relation to HIV and MDR TB management.

- There is a sufficient number (relative to the overall human resources available in a country) 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 staff to use their competencies to provide quality preventive and curative services for all aspects of comprehensive TB control to the entire population according to their needs.

IR 5 projects also contribute to the objectives of other IRs. Specific areas include the following:

- Improved management skills and competence building in health service delivery systems (including laboratory services, supervision, monitoring & evaluation) (IR2),
- Improved compliance of all providers with standard approaches for tuberculosis diagnosis and treatment, in line with *International Standards for TB Care* developed by TBCTA (IR3),
- Improved competence in development, implementation and scaling-up of TB/HIV collaborative program activities (IR4).



Patient-Provider Interaction

Several IR5 core funded projects' achievements under TB CAP Year 1 are already mentioned in the related IR sections above. However, there are additional project contributions that are mentioned below;

Task Force on Human Resource Development: During APA1 a Task Force was formed to provide strategic guidance, advice and policy development on areas concerning human resource development. During APA1 Task Force drafted the Terms of Reference, conducted two meetings and formulated the strategic approach for IR5, discussed the project proposals for IR5 APA 1 and 2 and provided the Board with feedback. Also a small working group was assigned to revisit the role and function of the TFH. Later it was decided to continue with a IR 5 working group

that will function like the other IR working groups. The IR5 working group for TB CAP will advise as necessary on the development and review of the annual workplan for IR5 core projects in line with the strategic approach and intervention areas. The IR5 working group TB CAP serves as an informal technical advisory body to the Board of Directors.

Generic guide on "How to develop an HRD plan for comprehensive TB control": The management of human resources for TB Control needs consolidation and strengthening including strategic medium and long term planning. One of the key issues is the lack of comprehensive plans for Human Resource Development for TB control as well as practical tools to assist NTPs in developing such plans. This product provides guidance on how to plan for on-going in-service training, monitoring and supervision, strengthening pre-service curricula, coordinating and collaborating with other programs and institutions. The draft guide is under review and the final version will be available in early Year 2.

Training in the clinical and operational management of MDR TB: An international MDR-TB Course was conducted in Mexico City, Mexico on July 3-7, 2006. In total, 41 participants from 11 countries (Bolivia, Colombia, Costa Rica, El Salvador, Equator, Guatemala, Nicaragua, Paraguay, Peru, US, Venezuela) successfully completed the course An email network was developed to build and support institutional capacity among the participants and course instructors. This network will help to communicate problems and discuss solutions at the country level and will also be used to regularly send news and publications to participants.

Increase TB Control capacity among CORE members PVOs: TB CAP supported two instructors to conduct a “TB Programming for PVO Program Managers” course in Chennai, India on February 20-24, 2006. In total, 21 Program Managers representing 11 PVOs working throughout Southeast Asia completed the course.

3.3 Support to Global Fund (GF) projects

TB CAP supported countries for GF Round 6 proposal development: TB CAP supported seven countries for the preparation and submission of Global Fund Round 6 proposals for TB grants. PMU worked in close collaboration with WHO to identify the countries, contact consultants and set the appropriate dates for missions. High burden and/or TB CAP countries were given priority. All planned missions were completed on schedule and all seven countries submitted TB proposals to the GF. In early November 2006, the Technical Review Panel of Global Fund reviewed a total of 55 TB proposals and recommended 34 (62%) of TB proposals for funding. Among those proposals supported by TB CAP 43% were funded, providing a total grant amount of $15,180,998. Table 4 below summarizes the countries supported by TB CAP and the outcomes.

Table 4: TB CAP countries supported for Global Fund Round 6 proposal development

Supported	Component		TB CAP Budget Spent for Grant Proposal	Approved Grant Amount
Country	TB	ACSM		
Botswana	$4,486		$4,486	Not funded
Cambodia	$6,757		$6,757	Not funded
DR Congo	$4,797	$11,336	$16,133	**$8,532,576**
Lesotho	$4,970		$4,970	**$3,829,664**
Pakistan	$3,830	$10,610	$14,440	Not funded
Togo	$5,560		$5,560	**$2,818,758**
Zambia		$8,649	$8,649	Not funded
Total	**$30,400**	**$30,595**	**$60,995**	**$15,180,998**

TA to countries for better management of Global Fund projects: The U.S. Government has provided short-term, rapid assistance to Global Fund 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 Romania, Uzbekistan and Lesotho. While Romania and Uzbekistan missions were successfully completed, the Lesotho mission is in progress. Additional missions to Georgia and Vietnam will be conducted in Year 2. TB CAP is also expecting additional country requests in the near future. The following table summarizes the current situation.

Table 5: Global Fund TA projects

Supported Country	Key Issues Addressed	Status and Timetable	Partners Involved	Estimated Budget
Romania	Effective functioning of CCM and roles and responsibilities regarding M&E	**Completed** June 2006	MSH	$22,000
Lesotho	M&E	**In progress** September – December 2006	KNCV, PMU, The Union	$98,000
Uzbekistan	Financial management, M&E, OR & multi-sectoral coordination	**Completed** September – October 2006	MSH, PMU, WHO	$150,000
Georgia	Collaboration of TB & HIV/AIDS programs, M&E	**In progress** November 2006 – January 2007	KNCV, PMU	$111,000
Vietnam	Financial management, M&E, commodity management	**Under planning** February – July 2007	KNCV, Measure Evaluation	$213,000
DRC	Financial management, procurement planning, M&E	**Waiting for approval of SOW**	The Union	$111,000
Training	Training of three TB CAP staff on Global Fund project management	**Completed** April 2006	PMU, FHI, The Union	$11,000
			Total	**$716,000**

3.4 Year 1 TB CAP Countries

During Program Year 1, TB CAP partners worked in countries described below for assessment, proposal workplan preparation and actual project implementation.

Brazil: TB CAP hired a full-time resident consultant to assist Brazil's NTP in reaching the goals outlined in the new tuberculosis strategy. During APA1 the consultant assisted Brazilian NTP to implement Drug Resistance and HIV Prevalence Surveys in 3 additional Brazilian states. The consultant also helped to develop and distribute a software program for data entry, train health care workers for data entry and enroll over 1,000 patients in the survey.

DR Congo: DR Congo is one of the 22 high-burden countries targeted by Stop-TB Partnership for achieving the 70% case-detection rate and 85% treatment success rate. The burden of tuberculosis in DR Congo in the year 2004 was 94,000 cases (all forms) which reflects a case-detection rate of just over 70% - using the WHO criterion. In the same year NTP reported a treatment success rate of 83% for new ss- patients registered in 2003. Given the vast size of the country and the extremely difficult infra-structure conditions this is an enormous achievement for one of the poorest countries in the world.

The political situation is currently volatile in this USAID declared fragile state which poses a great challenge to NTP and its partners. In spite of almost achieving the global targets for TB control, the NTP is faced with significant 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 TB CAP Year 1 project focused on the following components:

1. Reinforcing NTP coordination in South-Kivu and Maniema provinces,
2. Printing and distribution of the NTP Manual 4th edition,
3. Training of health workers and provincial coordinators in TB/HIV collaborative activities in the cities Bukavu, Kindu and Kanaga,
4. Strengthening of the laboratory network, including decentralization of culture capacity to two regional laboratories in Lubumbashi and Kisangani,
5. Support to the national level in coordination and supervision,
6. Strengthening of drugs management and particularly distribution, and
7. Strengthening of the NTP management capacity (program coordination, reporting, budgeting and accounting).

The approval of DR Congo workplan did not occur until August 2006, so the implementation of above components will begin in Year 2.

Kenya: This country is among the 22 Global High Burden Countries for TB. It diagnosed and notified 95,310 cases of tuberculosis in 2003, which is a 16% increase compared to 2002. The annual increase of TB has been constant (16%) over the last decade and is attributed to the HIV epidemic and improved case finding. It is estimated that 6.7% of the adult population is infected with HIV and 40-60% of all TB cases is HIV positive. The incidence of all forms of TB is estimated by WHO to be 540/100,000 population, which means that Kenya's current CDR for infectious cases is 45%, well below from the 2005 WHO target of 70% of all cases (population 32.3 million).

TB CAP Kenya project aimed at providing TA to Kenya as defined under the Intensified Support and Action Country (ISAC) initiative. All three TA visits have been completed successfully. The technical assistance on the first mission focused on the establishment of ISAC, joint TB/HIV activities, drug management, routine TB reference laboratory support and monitoring and evaluation. The second visit addressed the joint development of the new 5 year strategic plan 2006-2010. The third visit addressed case detection, treatment results, laboratory, drug management, TB/HIV, technical partner coordination, donor coordination, and DOTS expansion activities.

TB CAP has helped the NTP to improve TB/HIV collaborative activities and introduced the revised recording and reporting system. Kenya is one of the few countries world-wide, reporting national TB/HIV indicators that are collected through the revised recording and reporting system. By June 2006, 59% of all TB patients had been counseled and tested of which 53% tested HIV positive. Over 80% of the HIV positive TB patients were

commenced on CPT. On the downside, less than 5% of HIV positive TB patients was able to start ART.

Mozambique: Mozambique is one of the 22 countries with a high burden of tuberculosis. One of the main challenges facing the TB control program in Mozambique is a low case-detection rate, estimated by WHO (2005 Report) at 33% and 45% (all and new ss+ cases). Treatment success rate for new smear positive patients is around 77% with a 10% case-fatality rate. During 6-12 December, 2005 a TB CAP mission visited Mozambique to develop the first annual work plan. The following four areas were identified for assistance by TB CAP:

- Laboratory strengthening
- TB/HIV Collaborative Program Activities and
- Community-based DOTS

Due to delays in approval of the workplan by the Mozambique MOH, activities not requiring MOH approval were developed and submitted to KNCV, FHI and USAID in a "mini-workplan". TB CAP introduced community based (CB) DOTS approach in Mozambique. Since this is the first time that a CB DOTS approach will be implemented in Mozambique, TB CAP program developed CB DOTS &TB-HIV Guidelines, training and educational materials as well as monitoring tools. In order to increase access for TB patients to Provider Initiated Counseling and Testing (PICT), TB CAP developed a curriculum for training of health workers and counselors on PICT. TB CAP also started improving the competence of TB/HIV/AIDS health workers in TB/HIV activities. A baseline rapid assessment was completed and a training package prepared that includes all aspects of TB/HIV, including PICT, medical management of patients with both diseases, and recording and reporting.

Namibia: Namibia suffers from one of the severest TB epidemic in the world, ranking no.1 in 2005 and number 3 in the 2006 Global TB report, after Swaziland and Botswana in notification rate. A total of 16,156 patients with all forms of TB were notified in 2004, corresponding to an average case detection rate of 822/100,000. Approximately 60 % of the reported TB patients are HIV sero-positive. A low treatment success of 70% was reported in the 2004 cohort of smear positive patients.

TB CAP in Namibia is rapidly scaling-up DOT. Treatment success rate increased from 70% (2004 cohort) to 74% (mid-year report 2005 cohort). The percent of all registered TB patients who are tested for HIV rose from 16% to 24% (mid-year report 2006). During APA1, TB CAP offered national TB courses for 51 officers (18 men and 33 women). Forty volunteers (out of 100 targeted) trained on CB DOTS and are now engaged in providing DOT at various clinics. Five thousand copies of the NTCP guidelines printed and distributed to all regions and districts. Two medical officers were trained in MDR TB in Latvia.

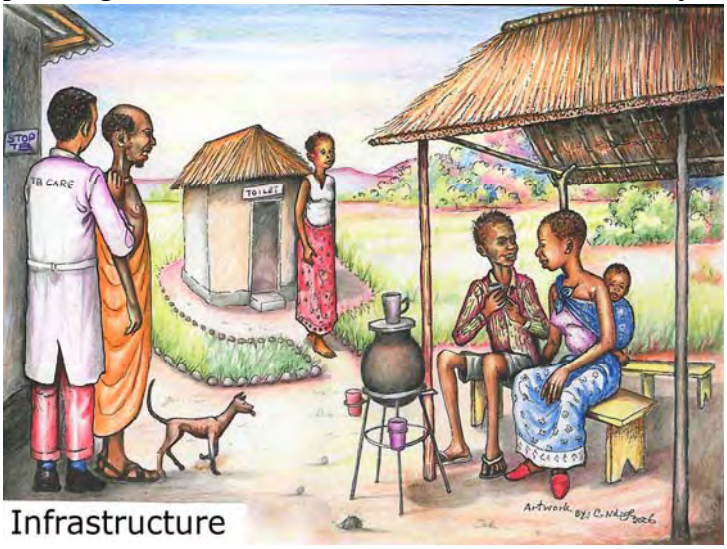
Philippines: TB is the sixth most common cause of death in the Philippines. TB causes 75 deaths per day (289,904 total deaths, 1999) in the Philippines, having the 8th highest burden in the world. The number of new cases in 2003 was 72,200. The country has achieved 70% case detection and 77% cure rate.

USAID/Philippines has been a leading partner in supporting the strengthening of private sector TB control. They are currently funding the 4-year, $11.5 million Philippines TIPS

project. The project will be coming to an end in August 2006 and a new project is anticipated to be awarded in September 2006. TB CAP is expected to help design the follow-up to Philippine TIPS, provide the Mission with TB M&E assistance, and provide periodic technical assistance. During Program 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. A workplan has been approved and will be implemented beginning in Year 2.

South Africa: The NTCP has received support for the past 4 years through TBCTA for various activities including the development of a Medium-Term Development Plan at the national and provincial levels (2002-2006), human resource development and follow-up and monitoring visits. A new workplan will be prepared by TB CAP to continue support to the NTCP.

South Sudan: Over twenty years of war in South Sudan came to an end by the signing of a peace agreement on 9th Jan 2005 and was followed by the installation of a formal government for South Sudan which will govern the geographical southern part of Sudan. The newly formed MoH, installed in October 2005, has yet to fully establish itself and faces the challenge of establishing health policies and services almost from scratch. TB control in South Sudan, after years of total collapse, re-started with treatment of individual cases by some NGO's in the early 1990's. Today, case detection and treatment in South Sudan still relies entirely on the work of NGOs with technical assistance by WHO. Coordination and monitoring of TB activities is done by WHO as a joint effort with South Sudan MoH.



In 2004, the South Sudan NTP reported a total of 2539 cases, of which 1064 were smear positive. However, even with the most conservative estimates of incidence (200/100,000 for all TB cases and 100/100,000 for SM+ cases) and the lowest population estimates (7 million people), these figures correspond to a case detection rate of only 15% for SM+ cases. Despite low case detection rates and low coverage, outcomes of treatment are very promising, with reasonable cure rates and default rates that in most cases remain below 5-10%. Prevalence of HIV is believed to be relatively low in most areas, but has reached endemic levels of over 1% (up to 8% in some places) and has a potential for rapid increase in the coming years.

TB CAP in South Sudan is strengthening national capacity. The construction of a TB reference laboratory has begun and is projected to be completed in 3 months time. Delay in formation of the Government in Southern Sudan impacted negatively on the project because these institutions are pivotal in policy decisions and actual implementation of the program.

Zambia: Zambia nearly misses to be one of WHO's 22 high burden countries. HIV/AIDS has clearly fueled the TB epidemic in Zambia. The estimated incidence of all forms of TB cases is 680/100,000 (2004) and sputum smear positive (ss+) incidence is 280/100,000. With 53,932 TB cases, 2003 data shows a case detection rate of 65%, a cure rate 67%, a treatment success rate of 75%, a default rate of 2%, and a mortality rate of 8%. The case detection rate and treatment success rate are approaching the global targets of 70% (case detection) and 85% (treatment success) respectively.

A TB CAP mission was carried out on 7-11 November 2005 to identify the technical areas for support and develop a work plan of activities in full collaboration with the CBOH/MOH in Zambia and in line with the new Zambian TB strategic plan for 2006-2011. Four areas of support to TB control in Zambia were identified:

- DOTS strengthening,
- Collaborative TB/HIV activities,,
- Community mobilization and involvement in TB and TB/HIV care, and
- Involvement of all providers in TB control (TB/HIV in the workplace, public/private and public/public mix DOTS).

Program operations started in 2006 after the staff recruitment process was completed. TB CAP in Zambia has started improving the collaboration between TB and HIV Programs. Routine HIV counseling and voluntary HIV testing has become an important component of care for symptomatic patients that present to health facilities. TB CAP is supporting TB staff training in HIV counseling and testing. During APA1, 26 Provincial and District TB focal point persons were trained as trainers in the newly introduced HIV counseling and testing in a clinical setting (DCT). TB CAP also printed national revised TB laboratory registers and laboratory request forms for sputum examination and also supported the revision and printing of National TB manual. A car was procured for program staff to carry out training, TA and monitoring.

3.5 Other TB CAP fieldwork

During Year 1 TB CAP also conducted assessment and workplan preparation visits to the following countries;

Cambodia: TB CAP conducted a field mission and prepared a workplan for implementing targeted interventions to address to enhance and strengthen quality DOTS and TB/HIV collaborative activities. TB CAP will initiate the implementation as soon as the workplan is approved.

Djibouti: TB CAP consultants conducted an assessment visit to Djibouti during the third quarter of Year 1 and prepared a workplan for Year 2 implementation. The workplan includes two strategic activities:

1. Development of a new NTP management structure based on a network of peripheral centers coordinated by an independent central management unit, and
2. Development of a quality-assured laboratory network.

Ghana: Consultants supported TB CAP and KNCV conducted an initial assessment mission in March 2006. A budget and workplan were developed and submitted to the Ghana mission. It was decided to conduct an NTP program review as the first intervention given the various areas to be considered for TA in Ghana, the new players involved in TB control, and the need to provide support to the New 5 year strategic plan. However just

prior to undertaking the review planned for September, the USAID mission confirmed the embargo on all in-coming missions until mid November 2006. The review will be rescheduled.

Indonesia: TBCTA project ended in September 2006. TB CAP will continue to implement the Mission's TB program and a new workplan will be prepared for Year 2.

Malawi: In June and August 2006, a TB CAP mission was organized to Malawi and a draft workplan prepared. In collaboration with the NTP, the USAID/Malawi Mission and TB CAP implementing partners, the following areas of intervention are defined:

1) Developing and implementing model of integrated TB/HIV care and support ("Zones to Homes") model,
2) Improving the diagnostic capacity at all levels,
3) Improving the Public / Private Mix especially with regards to the private sector implementing TB/HIV, and
4) Human Resource Development.

The Mission will provide the funding and TB CAP will initiate the implementation in Year 2 once the workplan is approved.

4. Status of Year 1 Projects

4.1 Technical status:

Table 6 below summarizes the status of all 37 approved projects as of the end of APA1. Twelve of the 37 projects (32.4%) were fully completed, 20 projects (54.1%) are still in progress and 5 projects (13.5%) have not started implementation. It is expected that all projects that are in progress or have not started will be completed in early Year 2.

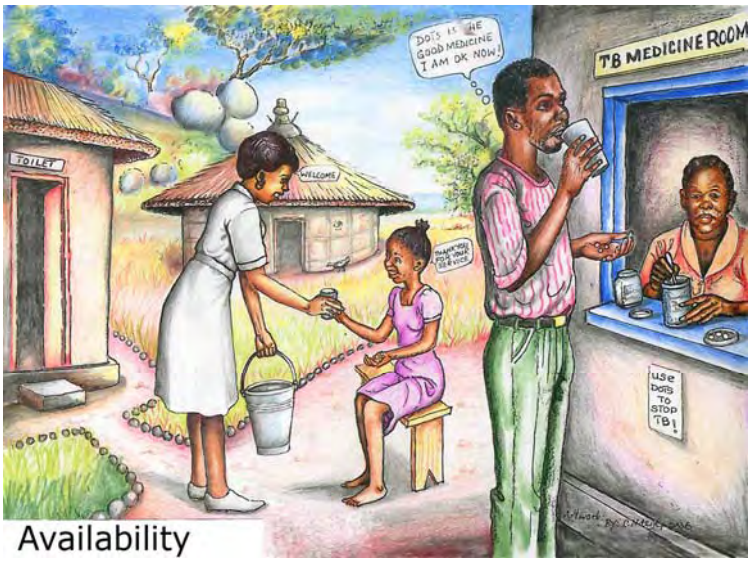


Table 6 also provides the ***level of completion*** for each project. A simple methodology was developed for this purpose. During the planning period, each TB CAP project identified a number of main activities. Each main activity was then equally weighted and the number of activities was divided by 100% to measure their contribution towards the completion of a project. Based on the quarterly project progress reports, the main activities have been categorized as ***fully completed, in progress*** or ***not started.*** While a ***fully completed*** activity contributes its full percentage share, a main activity ***in progress*** contributes half of its percentage share and a main activity which has not started yet contributes nothing towards completion of the project. Although this is a quite robust measurement with too many weaknesses, it still provides valuable information on the overall project monitoring and evaluation.

Table 6 reveals that overall level of completion for 37 projects is 60.0%. Given the fact that most of the projects started in the second quarter and in some cases in third quarter, this level of completion should be interpreted as a quite successful for Program Year 1.

Table 6: APA1 Projects, technical and financial status, end of Program Year 1

APA1 Projects		Leading Partner	Level of Completion (%)											Budget		Expenditures			Level of Spending
Code	Name		0	10	20	30	40	50	60	70	80	90	100	Obligated	Approved	Declared	Accrued	Total	
C1.01	Developing Financial Assessment and Budgeting Tool	WHO												$127,440	$127,440	$77,119	$50,321	$127,440	100.0%
C2.01	Improved diagnostic capacity	MSH												$85,431	$85,431	$82,593	$0	$82,593	96.7%
C2.02	Improved health systems mapping and organization	MSH												$12,929	$12,929	$12,929	$0	$12,929	100.0%
C2.03	Promotion of rational use of TB diagnostic process	JATA												$79,076	$79,076	$6,330	$3,000	$9,330	11.8%
C2.04	Improved TB program management – MOST	MSH												$81,323	$81,323	$45,020	$36,303	$81,323	100.0%
C3.01	Preparing a strategic coordination plan for developing PPP in USAID priority countries	WHO												$18,097	$18,097	$14,054	$4,043	$18,097	100.0%
C3.02	Developing tools for situational analysis	WHO												$39,550	$39,550	$39,550	$0	$39,550	100.0%
C3.03	Promotion of PPP through sharing of PPP experiences among TB CAP and other countries	WHO												$122,364	$122,364	$104,284	$18,080	$122,364	100.0%
C3.04	Dissemination and implementation of *ISTC*	ATS												$16,000	$16,000	$0	$16,000	$16,000	100.0%
C4.01	Lessons learned for scaling up	FHI												$81,259	$81,259	$0	$8,000	$8,000	9.8%
C4.02	Validation of revised recording and reporting system	WHO												$75,025	$75,025	$23,893	$0	$23,893	31.8%
C4.03	Accurate and faster diagnosis of sputum-negative EPTB patients for TB/HIV	WHO												$60,010	$60,010	$31,075	$0	$31,075	51.8%
C4.04	Assessment of role and potential of community based TB/HIV care in scaling-up	FHI	Project is rescheduled for Year 2											$93,872	$93,872	$0	$0	$0	0.0%
C5.01	Task Force on HRD	PMU												$144,298	$144,298	$54,744	$89,554	$144,298	100.0%
C5.02	Development of a guide on "How to develop an HRD plan for comprehensive TB control"	WHO												$15,255	$15,255	$15,255	$0	$15,255	100.0%
C5.03	Support to CORE workshop in India for US PVOs	PMU												$7,742	$7,742	$7,658	$0	$7,658	98.9%
C5.05	Institutional capacity building	PMU												$35,347	$35,347	$0	$0	$0	0.0%
C5.06	Regional workshop for HRD focal points	KNCV	Project has been cancelled											$62,660	$62,660	$1,858	$0	$1,858	3.0%
C5.07	Training course for TB/HIV consultants and support for field experience	WHO												$99,994	$99,994	$69,258	$30,736	$99,994	100.0%
C5.08	Training PPP consultants	WHO												$92,765	$92,765	$27,745	$65,020	$92,765	100.0%
C5.09	Field experience for laboratory consultant trainees	WHO												$29,663	$29,663	$0	$29,663	$29,663	100.0%
C5.10	International MDR-TB Course Mexico	The Union												$49,365	$49,365	$45,067	$0	$45,067	91.3%
C5.12	Generic advanced course on supervision of TB management at sub-national level	WHO												$20,001	$20,001	$0	$10,000	$10,000	50.0%
Core	Support to GF Round 6 proposal development	WHO												$60,995	$60,995	$60,995	$0	$60,995	100.0%
	Management	All												$1,141,386	$1,141,386	$906,518	$0	$906,518	79.4%

APA1 Projects		Leading Partner	Level of Completion (%)											Budget		Expenditures			Level of Spending
Code	Name		0	10	20	30	40	50	60	70	80	90	100	Obligated	Approved	Declared	Accrued	Total	
													Total	**$2,651,847**	**$2,651,847**	**$1,625,945**	**$360,720**	**$1,986,665**	**74.9%**
R1.01	Africa QUOTE TB instrument development, Phase 2	KNCV												$179,582	$179,582	$48,923	$15,000	$63,923	35.6%
R1.02	Africa TB CAP Assessment in Djibouti and one follow-up visit: HRD focal point	WHO												$20,418	$20,418	$14,940	$0	$14,940	73.2%
R2.01	LAC TB nursing curriculum translation and adaptation to LAC countries	WHO	Project is rescheduled for Year 2											$100,000	$100,000	$7,101	$0	$7,101	7.1%
R3.01	G-CAP TB/HIV collaborative activities in El Salvador, Guatemala, Nicaragua & Panama	PMU												$300,000	$300,000	$21,180	$186,051	$207,231	69.1%
													Total	**$600,000**	**$600,000**	**$92,144**	**$201,051**	**$293,195**	**48.9%**
F01	Brazil	The Union												$170,000	$170,000	$152,150	$17,850	$170,000	100.0%
F02	DR Congo	The Union	Project is rescheduled for Year 2											$800,000	$800,000	$208,044	$84,000	$292,044	36.5%
F03	Ghana	MSH												$60,000	$0	$3,264	$15,000	$18,264	#DIV/0!
F04	Mozambique	FHI												$1,080,000	$277,845	$181,752	$0	$181,752	65.4%
F05	Namibia	KNCV												$580,000	$580,000	$84,242	$495,758	$580,000	100.0%
F06	Philippines	KNCV												$200,000	$200,000	$44,610	$0	$44,610	22.3%
F07	South Africa	KNCV	Project is rescheduled for Year 2											$300,000	$0	$0	$0	$0	#DIV/0!
F08	South Sudan	WHO												$150,000	$150,000	$0	$15,750	$15,750	10.5%
F09	Zambia	FHI												$1,000,000	$1,000,000	$279,742	$105,000	$384,742	38.5%
F10	Kenya	KNCV												$55,000	$55,000	$0	$55,000	$55,000	100.0%
													Total	**$4,395,000**	**$3,232,845**	**$953,804**	**$788,358**	**$1,742,162**	**53.9%**
GF	TA to Global Fund projects	PMU												$250,000	$250,000	$14,063	$235,937	$250,000	100.0%
													Total	**$250,000**	**$250,000**	**$14,063**	**$235,937**	**$250,000**	**100.0%**
													Grand Total	**$7,896,847**	**$6,734,692**	**$2,685,956**	**$1,586,066**	**$4,272,022**	**63.4%**

4.2 Financial status:

As seen from Table 7, the total approved budget for 37 projects is $6.7 million including management. As of 30 September 2006, the total expenditures, excluding management, declared by partners through the quarterly reports was $3.4 million, 60.2% of the total project budget. This figure is consistent with the 60% completion level mentioned above.

Table 7: APA1 Projects, financial status, as of end of APA1

APA1 Projects	Total Budget		Expenditures			Level of Spending*
	Obligated	Approved	Declared	Accrued	Total	
Core	$1,510,461	$1,510,461	$719,427	$360,720	$1,080,147	**71.5%**
Regional	$600,000	$600,000	$92,144	$201,051	$293,195	**48.9%**
Country	$4,395,000	$3,232,845	$953,804	$788,358	$1,742,162	**53.9%**
Global Fund TA	$250,000	$250,000	$14,063	$235,937	$250,000	**100.0%**
Total projects	**$6,755,461**	**$5,593,306**	**$1,779,438**	**$1,586,066**	**$3,365,504**	**60.2%**
+						
Management	$1,141,386	$1,141,386	$906,518	$0	$906,518	**79.4%**
Grand Total	**$7,896,847**	**$6,734,692**	**$2,685,956**	**$1,586,066**	**$4,272,022**	**63.4%**

*** Total Expenditures vs. Approved**

Cost Share

As defined for TB CAP, the "Cost share includes all non-federal expenditures made by a partner outside of the scope of TB CAP, provided these costs are in line with TB CAP strategic objectives aimed at: "Decreasing morbidity and mortality by increasing case detection and treatment success of pulmonary TB patients in USAID priority countries". This also includes in-kind contributions and voluntary work. Cost share contributions are limited to USAID priority countries (Tier 1 and 2). The standard provisions also indicate that for volunteer services the services can be counted if the service is an integral and necessary part of an approved program".

The cooperative agreement mentions that a minimum of 17.8% need to be cost shared over the course of the project. For Year 1 we received a cost share totaling US $ 9,881,640 (See table 8 below), which corresponds with a cost share of 147.0% of the approved budget.

Table 8: Cost Share Year 1 of TB CAP as of 15th of November 2006:

Partner	Amount	Status
JATA	$2,381,514	Info received
KNCV		No info yet
MSH		No info yet
ATS		No info yet
The Union	$5,247,092	Info received
WHO	$2,253,034	Info received
FHI		No info yet
Total	**$9,881,640**	
Approved Budget Year # 1	**$6,734,692**	
Percentage Cost share	**147.0%**	

Throughout the duration of the project cost share will be reported cumulatively.

5. Challenges for future

Addressing all expected outputs

As mentioned before (Table 3) three expected TB CAP outputs have not been addressed by the Program Year 1. These are; "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. As of writing this report no projects were developed or selected to address these outputs in the Program Year 2 either. 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. During the Program Year 1, the HRD Task Force spent a lot of energy with agreeing on approaches, definitions and finalizing the terms of reference to develop regional institutional capacity for training, which delayed real implementation. Institutional capacity building remains key challenge for the coming years.

TB/HIV

Leveraging resources for TB/HIV is also a challenge for TB CAP. To date, TB CAP has succeeded only in Namibia ($1 M) in receiving funds from PEPFAR for TB/HIV activities. Securing PEPFAR funds in other countries for TB/HIV collaborative activities remains a continuing 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. It is expected that during the next board meeting in February 2006, XDR TB will be extensively discussed and a response will be prepared.

Workplan preparation

Preparing timely workplans for the TB CAP countries continues to be a challenge. It is important ensure that baseline assessments are used in the development of country workplans. It is equally important to provide for the multi-lateral planning that is now required for each workplan and ensure timelines are followed, all stakeholders are involved, and appropriate NTP/MOH and USAID consultations held to reach the mandated deadlines.

Global Fund support

The TB CAP supported Global Fund Round 6 proposals should have performed better. A closer analysis of the current situations at country level for those countries TB CAP provided TA and longer preparation times could have yielded better outcomes in terms of approved funding.

Annex 1
TB CAP Year 1
Annual Project Progress Report
October 2005 – September 2006

Core funded projects

C1.01 Developing Financial Assessment and Budgeting Tool	Funding Source	Approved Budget	Total Expenses	Coordinating Partner
	Core	$127,440	$127,440	WHO

Project Completed

The **Developing Financial Assessment and Budgeting Tool** has been developed and will be posted on the WHO and Stop TB Department websites so that it can be downloaded from there.

To date, the **Developing Financial Assessment and Budgeting Tool** has been successfully field-tested in 10 Latin American countries as well as Kenya, Indonesia and Malawi, and is currently being used in South Africa. During the last quarter field-testing in Indonesia (20-29 August) and Kenya (15-20 September) was successfully completed, with very positive feedback.

WHO, KNCV and NTP staff in Indonesia are now working on adaptation of the tool for use in provincial and district level planning in Indonesia. A costing study in Free State, South Africa, which is using the tool for collection and analysis of data, started in mid-September and is due to be completed by mid-November. Considerable additional work to refine the tool based on the results of field-testing in Indonesia and Kenya, as well as discussions with staff including IT experts in WHO, has been done. A short (3-page) user guide that provides tips for trouble-shooting when using the tool and for using Excel has been written.

Feedback about the value/usefulness of the tool has been extremely positive, which has likely facilitated all aspects of the work. The project is regarded as a priority output and considerable time and effort have been devoted to it. IT staff in WHO have been very supportive and have provided valuable expertise and advice. There has been very good collaboration among all teams in the Stop TB Department and with all WHO regional and country offices, which has facilitated field-testing and subsequent follow-up.

The momentum around the launch of the Global Plan and the Stop TB Strategy means that there is considerable interest and recognition of the value/importance of the tool. In Africa in particular, this has been reinforced by the declaration of TB as an emergency in 2005 and the call for all countries to develop Emergency plans.

The major challenge has been compressing work that is demanding of time, such as field-visits to test the tool and further revisions based on the earlier rounds of field-testing, into a short period of time when this has to be balanced with other work commitments. There were some initial delays to data collection using the tool in the Free State, South Africa (related to availability of local staff) as well as difficulties in accessing some data at national level.

Intended Project Output 1/1	A Financial Assessment and Budgeting Tool developed to be used in TB CAP activities on political commitment and advocacy	
Main	**Progress To Date**	**Outstanding Issues & Achievements**

Activities		
1.1 Financial and budgeting assessment tools (Modules 1 and 2 of an Advocacy Toolkit)	All planned activities were completed. Following the development of first draft the tool was field tested in 14 countries and finalized during the last quarter. A users guide was developed and the tool will be posted on the WHO and Stop TB Department websites.	Only a few relatively minor design issues remain to be addressed soon. Follow-up work to promote and use the tool will be conducted through the project approved under IR1, APA2.

C2.01 Improved diagnostic capacity	Funding Source	Approved Budget	Total Expenses	Coordinating Partner
	Core	$85,431	$82,593	MSH

Project will be completed in Year 2

The laboratory meeting, with representatives from CDC, WHO, The UNION, JATA, MSH, KNCV, KIT and FIND, was held in Geneva from 4-6 July 2006. The aim of the meeting was to assist TBCAP to improve TB diagnostic laboratory capacity in resource-poor settings through the development of generic tools and procedures that can be adapted and modified for use by individual countries. Recommendations on priorities for the APA2 workplan were sent to the TBCAP Project Director immediately following the meeting. The following topics and issues were discussed:

- Proposed format and international standard and focus of SOPs – 1st draft has been developed by WHO,
- Implementation guidelines for the SOPs – 1st draft prepared by MSH,
- Laboratory information management tools – coordinated by The UNION, and
- TBCAP Laboratory activity plan for APA1 and APA2.

The list of global priority areas for laboratories, suggested at the Geneva laboratory meeting, was sent to the TBCAP Project Director on 7 July 2006 for consideration by the TBCAP Board for funding under the APA2 Workplan.

The following factors have a positive effect on the progress:

- Recognition by TBCAP of the key role of laboratories in TB Control and financial support to hold the laboratory meeting, and
- Common understanding and agreement on pressing global needs and priorities for laboratories by laboratory representatives from the TBCAP partner organizations.

The SOPs, implementation guidelines and laboratory information management tools will require more work to have a draft suitable for piloting. The developed tools, particularly the SOPs, all require further work and editing in APA2. Country sites for piloting need to be identified.

The importance of having an annual meeting of laboratory representatives from the TBCAP partner organization is considered very important and productive. It is recommended that this be formally established as a TBCAP Laboratory Working Group.

Intended Project Output 1/1	Improved diagnosis capacity – laboratory networks	
Main Activities	**Progress To Date**	**Outstanding Issues &**

		Achievements
1.1 Generic laboratory Standard Operating Procedures (SOPs)	**Completed** Draft SOPs have been prepared, circulated and reviewed by experts. Expert meeting to provide recommendations was conducted.	1st drafts of tools need more work and refining in line with recommendations from the Geneva laboratory meeting.
1.2 Guidelines for adapting and implementing laboratory SOPs	**Completed** Consensus meeting to orient guideline development has been conducted and the guidelines prepared. Experts have reviewed and commented on draft	These will be included as a Chapter in the SOP manual in the next draft.
1.3 Guidelines to generate laboratory data reports in resource-poor settings	**In progress** The Union (Armand van Deun) has worked on and collated the information management tools. These were presented and discussed at the laboratory meeting.	Further work is required to refine the tools for piloting and use.
1.4 Draft management tools adapted for field testing	**Rescheduled for Year 2**	Not yet addressed due to lack of budget.

C2.02 Improved health systems mapping and organization	Funding Source	Approved Budget	Total Expenses	Coordinating Partner
	Core	$12,929	$12,929	MSH

Project completed
This activity produced a report designed to help countries make decisions about using mapping software in their projects. The collaboration with colleagues at WHO and KNCV were very helpful in the completion of this report. Below is a summary of the findings:

National TB control programs have several options for mapping their programs using computer-based applications. While this report focused on computer-based applications available to create maps, it is important to note that hand-drawn maps can also be an important, appropriate method to present information, especially at the community level. This reports attempts to gather relevant information from a variety of sources to give decision makers information so they can make informed choices about using mapping in their program. The three most relevant mapping programs for health are ArcView, HealthMapper and Epi Map.

There are many ways in which tuberculosis control programs could use mapping to strengthen their program. Some examples include mapping:

- the geographical distribution of TB cases,
- the location of defaulters,
- the distribution of resources (facilities, health personnel, equipment such as microscopes), and
- the trends over time.

This report finds that ArcView, HealthMapper and Epi Map would be appropriate in

different settings. If a TB program was already making use of Epi Info for all of its data management, it could make sense to start by using Epi Map. However, of the three applications, Epi Map has the least amount of functionalities. If the TB program wanted to do more than was capable in Epi Map, it could switch to ArcView and would be able to use the same data files, since they are all compatible. For those TB programs new to GIS and not using Epi Info, HealthMapper would be a very good place to start. The application is easy to use and very importantly, already contains key country data. As mentioned above, obtaining accurate data can be one of the biggest challenges to mapping. As with Epi Map, switching to ArcView at a later point in time would always be possible as different needs arise. ArcView appears to be the leading for-purchase GIS software used in health programs. Countries with previous experience with mapping and who need a broader range of capabilities may want to invest in ArcView and arrange for training of the users.		
Intended Project Output 1/1	TB programs select mapping tools that meet their needs and will conduct mapping exercises that will identify gaps and areas to be addressed.	
Main Activities	**Progress To Date**	**Outstanding Issues & Achievements**
1.1 A plan for gathering information on mapping tools	**Completed** Preliminary research conducted on who has created and used mapping tools; and Questionnaires sent and a brief report on findings prepared	
1.2 A questionnaire to collect information about mapping tools and a framework for analyzing the tools	Deemed not necessary given the limited amount of software packages typically used in health programs	
1.3 Analysis report of mapping tools	**Completed** An analysis report produced	

C2.03 Promotion of rational use of TB diagnostic process	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Core	**$79,076**	**$9,330**	**JATA**

Project will be completed in Year 2

The first meeting between partners to set a direction was held in KNCV on 1-2 June immediately after the TBCAP Board Meeting / Strategic Planning Workshop.

Following on review of field experience gathered over many years of working in X-Ray quality initiatives, JATA outlined a Quality Assurance system for chest x-ray in the TB program. Elements of this system include an evaluation sheet/format, questionnaires/inventories of X-Ray equipment, and an evaluation system for chest X-Ray films. JATA designed a 3-day training curriculum on quality assurance, which it implemented in Cambodia during the fourth quarter. JATA also collected and scanned a variety of low quality films, to be used for training on quality X-Ray (demonstrating what can go wrong in the process). JATA hopes to develop these into a CD-Rom to be used for in-country trainings. The Outline of this X-Ray QA system, as well as sample forms and

examples of bad X-Rays, will be shared in the Consensus Meeting which follows one day after the Paris Conference. Among the questions to be posed at this meeting, is whether or not to promote the use of auto-processors in district hospitals, now that they are less expensive than they were in the past and are more reliable than manual processing.

KNCV started with an inventory of observed and perceived problems with interpreting X-rays within the context of TB programs in developing countries. The inventory was based on experiences of KNCV consultants within >30 countries. In addition a literature search was done including a PhD thesis on the subject. Existing materials and initiatives in the field of X-ray reading in general and related to TB in particular were identified. During phone-conferences (KNCV and IUATLD) the potential collaboration with partners in South Africa was explored. This Cape Town based initiative (a chest radiology review system intensive training course) may be used within the context of this IR2 C2.03 project. Results of above activities clearly show that 4 potential areas need to be distinguished: 1) adequate *description* of X-rays, 2) interpretation of lesions on X-ray, 3) supervision of smear negative X-ray diagnosis in TB programs and 4) rational use of X-ray under different epidemiological and programmatic situations.

Final priority setting will take place during the consensus meeting on November 5th in Paris. Both JATA and KNCV look forward to input and feedback from the other collaborating partners during this meeting. This will be used to complete/revise the drafts and move forward into in-country field testing.

Language barriers posed a significant challenge during the process. As it turns out, none of JATA's staff radiographers speak English; neither do their in-country counterparts. Thus everything was done through interpreters between the local language and Japanese, and the final results must be translated into English for use internationally.

Intended Project Output 1/1	Improved detection of smear negative TB cases with the appropriate use of chest x-ray	
Main Activities	**Progress To Date**	**Outstanding Issues & Achievements**
1.1 Guidelines to improved quality of conventional radiology together with a quality assurance system	**In progress** Experience of RIT/JATA project in Cambodia was made available in English, and WHO published documents were reviewed. Outline of QA system was designed for X-Ray Quality in the TB Program. A 3-day curriculum was designed and implemented in Cambodia (by cost share) on X-Ray Quality Assurance. A variety of "bad X-rays" were collected and scanned for use in teaching (and possible incorporation into CD-Rom).	Guidelines will be finalized during APA2.
1.2 Improved protocols for	**In progress** The Union and South Africa were	Protocols will be finalized during APA2.

diagnosis of smear negative TB cases	contacted to coordinate ongoing current work. The first meeting between partners to set a direction was held in on 1-2 June.	

C2.04 Improved TB program management	Funding Source	Approved Budget	Total Expenses	Coordinating Partner
	Core	$81,323	$81,323	MSH

Project completed

MSH and WHO successfully organized a three-day workshop in Kampala, Uganda from August 9-11 to discuss management challenges facing national TB programs and to introduce a new approach for improving the management of TB programs to achieve results meeting health needs. Before the workshop, coordination meetings were held with the directors and teams of invited NTPs, WHO advisors and the MSH consultants to gain a deeper understanding of the TB context that the NTPs are working in, for the participants to gain an orientation on MOST/TB methodology and tool, and to discuss the proposed agenda for the workshop and coordinate logistical support.

The workshop was attended by 17 participants from five countries (Uganda, Pakistan, Mozambique, Zambia and Namibia) including three WHO medical officers from Uganda and Mozambique, and one WHO Stop TB Geneva representative. The diverse country teams included national TB program managers, regional and provincial TB managers, and TB laboratory personnel.

Most participants were complimentary with the workshop and MOST for TB process. Almost 65 % of participants said in their evaluation that the workshop objectives were achieved*(see below for workshop objectives) and more than 85% of participants said that the organization, methodology, facilitation and applicability were excellent or very good. The participatory methodology was quoted by almost all participants as what they liked most from the workshop. Seventy one percent of participants thought the workshop time was reasonable and 29% said it was too short.

Most importantly, all five countries believe that conducting MOST for TB would be of value for their NTPs and have requested MOST for TB workshop to be conducted in their countries.

Dr. Pedro Suarez is the technical lead and had facilitated two TB MOST workshops prior to this one. Barbara Tobin is one of the original creators of the MOST process. While this is not a traditional TB MOST workshop, the facilitators' knowledge of the MOST process greatly contributed to the success of the workshop. Additionally, having a pharmacist as a facilitator greatly complemented the facilitation team.

As a major challenge it was very difficult to get responses from the NTP teams of the invited countries. MSH is grateful for all of the logistical and administrative support that WHO Uganda office provided the facilitators and participants prior to and during the workshop.

The lack of clarity regarding roles and responsibilities for this activity increased the amount

of LOE and concern for both partners. These issues were eventually resolved and the lessons learned have proved useful for future opportunities where two partners (or more) are organizing a workshop.

RPM Plus contributed to some funds to make sure the facilitation team had enough funds to get together and finalize the design before traveling to Uganda. They also paid for additional shipping of materials needed for the workshop.

The next steps are as follows:

- MSH will coordinate with four countries (Uganda, Zambia, Mozambique and Namibia) to include MOST for TB workshops in their TBCAP workplans for 2007. MSH has already identified potential source of funding to conduct a MOST for TB workshop in Pakistan through RPM Plus program. The tentative date for the workshop is scheduled for first week in December 2006
- Follow-up on MOST for TB: Follow-up field visits will be carried out to selected countries usually six months to one year after the workshop. MSH will develop these visits in collaboration with TBCAP partners. The goal is to encourage NTP and change leaders to accomplish targets on action plan
- MSH will finalize and update the MOST for TB assessment instrument based on recommendations from workshop participants, and
- MSH, in collaboration with TBCAP partners, will finalize, publish and disseminate a MOST for TB guide and instrument

One of the lessons learned is to specify the roles and responsibilities so there is little room for ambiguity or misunderstanding.

Intended Project Output 1/1	MOST TB revised and adapted for use in African setting
Main Activities	**Progress To Date**
1.1 MOST workshop in an African country (3 days workshop for 10-15 participants from 5 Tier 1 countries)	**All planned activities were completed** MSH and WHO successfully organized a three-day workshop in Kampala, Uganda from August 9-11, 2006 attended by 17 participants from 5 countries.

C3.01 Preparing a strategic coordination plan for developing PPP in USAID priority countries	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Core	**$18,097**	**$18,097**	**WHO**

Project Completed

A strategic coordination meeting of TB CAP partners was held in The Hague. All TB CAP partners assigned a IR3 PPP focal point. The ongoing global PPM work was overviewed and ways to strategically use TBCAP expertise and resources were discussed. PPP projects for APA1 were reviewed and the ones for APA2 were identified. Soon after the meeting a Project-Partner Matrix was prepared to guide APA2 projects development. Based on that matrix APA2 IR3 proposals were submitted.

Intended Project Output 1/1	TB CAP has a global PPP coordination plan.
Main Activities	**Progress To Date**

1.1 A global coordination plan for TB CAP	**All planned activities were completed** A planning meeting was held in The Hague on May 29th, 2006 prior to TB CAP strategic meeting. A global PPP coordination plan has been developed and APA2 IR3 proposals were submitted.

C3.02 Developing tools for situational analysis	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Core	**$39,550**	**$39,550**	**WHO**

Project Completed
A draft situation analysis tool has been developed. The draft tool was sent for review and comments by experts and a revised version was presented in the September PPM Subgroup meeting in Nairobi. The draft tool will be used in situational analyses in selected countries that will participate in the PPM planning workshop for EMR and AFR countries in January 2007 (project under APA2). PPM consultants trained under APA1 IR5 will be recruited to for assist countries in conducting the situational analyses.

Intended Project Output 1/1	A tool that enables standardized country assessments was developed
Main Activities	**Progress To Date**
1.1 Assessment tool(s) available	**All planned activities were completed** Draft tool developed, sent to experts for review, revised and presented in the 4th PPM Subgroup meeting.

C3.03 Promotion of PPP through sharing of PPP experiences among TB CAP and other countries	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Core	**$122,364**	**$122,364**	**WHO**

Project Completed
The PPM Subgroup meeting was successfully organized in Nairobi 12-14 September. All TB CAP partners were represented except CDC and The Union. Regional and country experiences of PPP were shared, with a special focus on African countries, through plenary sessions, a poster session and group work. A special working group developed a generic country plan for PPM for TB CAP countries in Africa, and plans for the PPM planning workshop for EMR and AFR countries (APA2 project) were fine-tuned. Field visits were conducted to working PPM models in Nairobi.

Intended Project Output 1/1	Promotion of PPP and strengthening partnership	
Main Activities	**Progress To Date**	**Outstanding Issues & Achievements**
1.1 Support participation of TB CAP countries in the 4th meeting of the PPM Subgroup	**All planned activities were completed** DR Congo, Ethiopia, Ghana, Malawi, Nigeria, Tanzania, Uganda, and Zambia participated in a special working group to develop generic PPP plans for TB CAP countries. A full meeting report is being prepared and will be disseminated to all participants and all TBCAP partners.	Selected countries will participate in PPP planning workshop for AFR and EMR in Cairo, quarter 1 2007 (APA2 IR3), preceded by in-depth situational analysis using the PPP Situational Analysis Tool (APA IR3.02), aided by PPP consultants (APA1 IR5).

C3.04 Dissemination and implementation of ISTC	Funding Source	Approved Budget	Total Expenses	Coordinating Partner
	Core	$16,000	$16,000	ATS

Project completed
As of August 2nd, 2006 a total of 27 organizations (9 international and 18 national) had endorsed the *ISTC*. Print and CD versions of the *ISTC* were completed in time for a launch on World TB Day on March 24. Translations into Spanish, French, Russian, Chinese, Vietnamese and Indonesian were completed. Pilot studies of *ISTC* country-level implementation were initiated in Indonesia, Kenya and Tanzania. A workplan for the coming year, to be funded from country money, was developed in a visit to Indonesia.

A part of this project is an exploration of the optimum ways in which the *ISTC* can be used at country level. With each country visit the experience base grows and influences the strategies pursued in subsequent visits to other countries.

Intended Project Output 1/1	ISTC is available in multiple languages
Main Activities	**Progress To Date**
1.1 Develop final version with presentation copies	**Completed** Final print-ready version of ISTC was completed.
1.2 Translation into Spanish and French	**Completed** Both translations were completed and the print-ready versions are in production. Translations into Russian, Chinese, Vietnamese and Indonesian are also completed.
1.3 Initiation of dissemination and implementation activities in selected countries	**Completed** Visits to Kenya, Tanzania and Indonesia were completed and workplans for the coming year to be proposed for support by country missions were developed.

C4.01 Lessons learned for scaling up	Funding Source	Approved Budget	Total Expenses	Coordinating Partner
	Core	$81,259	$8,000	FHI

Project will be completed in Year 2
After months of delay in the signing of the amendment to the sub-agreement, the activities on this project started in July 2006. A conference call was held with all the partners involved in this project to discuss the implementation of the projects. It was agreed during the conference call to draft an outline of the final document, which will serve as the data collection tool and to develop a scope of work for the consultants. Partners were asked to provide the name of the countries where the project will be implemented. A draft outline of the final document and a scope of work for the consultants have been developed and shared with partners for their inputs. Selected partners have already identified countries where the project will be implemented.

The major challenge was maintaining the momentum on this project in view of multiple other activities (including TBCAP activities) and following a long period of inactivity due to delay in signing the amendment to the sub-agreement**.**

Next steps to complete the project in Year 2 are as follows:

1. Finalize the data collection tool based on inputs from partners, 2. Finalize the scope of work for consultants based on inputs from partners, 3. Hire consultants and conduct evaluation in the country, and 4. Review consultant report and publish the report	
Intended Project Output 1/1	All stakeholders adopt best practices on TB/HIV scale-up, and make use of country assessment report.
Main Activities	**Progress To Date**
1.1 A standardized tool for country assessment	**In progress** Draft questionnaire and assessment tool ready.
1.2 Disseminated country assessment report	Scheduled for APA2.

C4.02 Validation of revised recording and reporting system	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Core	**$75,025**	**$23,893**	**WHO**
Project completed WHO finalized its field testing survey on revision of the TB R&R and report was prepared. The final version of the forms is now posted on the web. **(http://www.who.int/tb/err/en/index.html)**				
Intended Project Output 1/1	Validated Stop-TB TB/HIV recording and reporting system is widely adopted by country programs.			
Main Activities	**Progress To Date**			
1.1 A standardized tool for R&R assessment	**Completed** Assessment tool has been finalized.			
1.2 Select countries that will be included in the assessment	**Completed** WHO sent the questionnaires to all countries and received response from 105 countries.			
1.3 Conduct country assessment in 3 countries	**Completed** 4th meeting on revision of TB R&R was held in Geneva with participation of Cambodia, Kenya, Estonia, Korea and India.			
1.4 Implement 2 country pilots	**Completed** In June 2006, during the expert group meeting on R&R new formats were reviewed with NTP managers from Cambodia and Latvia.			
1.5 Final report	**Completed** Final version of the revised forms posted on the web in October 2006.			

C4.03 Accurate and faster diagnosis of sputum-negative EPTB patients for TB/HIV	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Core	**$60,010**	**$31,075**	**WHO**
Project will be completed in Year 2 The revised recommendations and the generic protocol to evaluate the algorithms and recommendations have been endorsed by Strategic and Technical Advisory Group on TB of WHO in June 2006. The document is now being edited for web-publishing and printing.				

National programs and interested research parties have been contacted for sensitization. Collaboration with the Foundation for Innovative and New Diagnosis (FIND) to evaluate these revised recommendations is ongoing. The problem of smear negative TB particularly in HIV prevalent settings and the associated morbidity and mortality stirred strong global activist movement. The revised recommendations will be published as WHO recommended policy. Following the implementation, evaluation will be done based on the recommended generic protocol and technical assistance will be provided for selected sites. Evaluations and implementation of the revised recommendations may require revision of national guidelines, logistical and technical arrangements, including human resources, training, and infrastructure development depending on country specific factors. Due to these issues, the project will be completed in Year 2.	
Intended Project Output 1/1	Accurate and faster diagnosis of sputum-negative EPTB patients.
Main Activities	**Progress To Date**
1.1 A three day meeting for the expert group members to discuss and finalize recommendations for flow diagrams on smear-negative and extra-pulmonary tuberculosis	**Completed** Expert Group Meeting on smear-negative TB was held on March 21-22, 2006 in Geneva, Switzerland and the draft algorithms for the diagnosis of smear negative TB and the clinical guidelines revised.
1.2 Monitoring missions to 4 validation sites	**Scheduled for Year 2** The monitoring missions are all pending.

C4.04 Assessment of role and potential of community based TB/HIV care in scaling-up	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Core	**$93,872**	**$0**	**FHI**

Project is rescheduled for Year 2

After months of delay in the signing of the amendment to the sub-agreement, the activities on this project started in July 2006. A meeting was held with the partners involved in this project during the AIDS conference in Toronto to discuss the implementation of the projects. It was agreed during the meeting to share with the partners the scope of work of the consultants. Partners were asked to provide the name of the countries where the project will be implemented. A draft scope of work for the consultants has been developed and shared with partners for their inputs. Partners have identified sites in five countries where the project will be implemented

Next steps to complete the project in APA2 are as follows:

1. Develop questionnaire and assessment tool,
2. Finalize SOW and recruit consultants,
3. Conduct assessment and develop report by consultants, and
4. Review, finalize and publish the report.

Intended Project Output 1/1	Better understanding of community involvement in TB/HIV for scale-up.
Main Activities	**Progress To Date**
1.1 A publication on best practices and lessons learned	**Scheduled for Year 2**

C5.01 Task Force on HRD	Funding Source	Approved Budget	Total Expenses	Coordinating Partner
	Core	$144,298	$144,298	PMU

Project will be completed in Year 2
Two meetings were conducted in The Hague in January (24-26) and July (18-20). The strategic approach and areas of interventions for IR5 were developed and are now the basis for new project proposals for IR5. The TFH discussed the project proposals for IR5 APA 1 and 2 and provided the Board with feedback. Two representatives from the Asian and African region joined the July meeting and their input from country perspectives was very much appreciated. Individual members in their capacity as HRD focal point within their respective organizations supported the adjustment and implementation of the project proposals.

The TFH was able to build on accomplishments of the TFT (Task Force Training) and able to develop the main tools for HRH. A positive factor of the TFH is that all partner organizations have an HRD expert as representative in the TFH. The new partners in the coalition of TBCTA have an additional value because of their expertise in TB/HIV (FHI), management and capacity building (MSH), training (JATA).

The implementation of the projects for APA 1 started late because of the late approval of the annual workplan. Adjusting the project proposals took more time than anticipated. Another challenge for the TFH was the Terms of Reference and approval of the Board. The major challenge was to make the relationship between the TFH and the Board explicit as a sub working group of the board. A small committee of the Board is now working on the final ToR.

Intended Project Output 1/1	The TFH will have provided strategic guidance, advice and policy development concerning IR5 and initiated project proposals under IR5.	
Main Activities	**Progress To Date**	**Outstanding Issues & Achievements**
1.1 Task force on HRD is established and operational	**Completed** Two TFH meetings were conducted in The Hague.	Agreement on Terms of Reference has not been achieved.
1.2 Course standards and guidelines for strengthening curricula are developed	**In progress** A draft course standards for training of consultants (including criteria for selection, institutional attachment, follow up and monitoring) prepared.	
1.3 Agreement on TOR for Institutional	**In progress** A draft TOR for institutional capacity building was prepared.	Agreement on Terms of Reference has not been achieved.

Capacity Building		
1.4 Incorporated HRD into international and regional meetings and conferences	**In progress** A draft inventory of meetings and conferences that "should" have HRD as a topic on the agenda was prepared.	
1.5 Information about training courses is available on the website	**In progress** The inventory of training courses was prepared and kept updated.	The website of TBCTA is under development and will be operational in APA2.

C5.02 Development of a guide on "How to develop an HRD plan for comprehensive TB control"	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Core	**$15,255**	**$15,255**	**WHO**
Project will be completed in Year 2 Due to limited availability of staff involved in the implementation, the work has been ongoing.				
Intended Project Output 1/1	Increased capacity at national level (NTP) to prepare HRD plans for comprehensive TB control			
Main Activities	**Progress To Date**		**Outstanding Issues & Achievements**	
1.1 A generic guide on "How to develop an HRD plan for comprehensive TB control"	**In progress** A comprehensive outline of the guide was prepared.		Editing, layout and dissemination will be completed in APA2.	

C5.03 Support to CORE workshop in India for US PVOs	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Core	**$7,742**	**$7,658**	**PMU**
Project completed Twenty-one Program Managers representing 11 PVOs working throughout Southeast Asia attended the course, "TB Programming for PVO Program Managers" on February 20-24th in Chennai, India. The purpose of this workshop was to offer an overview of TB programming to PVO/NGO program managers, or supervisors of program managers, interested in getting their organization involved in TB programming for the first time, or improving/expanding their current TB work. Overall, the course was successful. Participants reported increased knowledge in TB control programming after completing the course and generally felt the course met their training needs and was relevant to their work. Increased knowledge was demonstrated objectively by a 32% increase between the average pre-test score (46%) and the average post-test score (61%). The course culminated in the participants' presentations of potential new TB control projects or expansions of current program work in TB control. Working in small groups, participants presented nine project designs that incorporated key concepts they had learned during the week. Immediate feedback was provided to the groups from the course facilitators and their peers. TB CAP supported two participants for attending this course.				

This training provided critical information and guidance in developing TB program plans. The course was well received and succeeded in alerting partners to the importance of PVO led activities. The CORE TB working group would like to replicate the course in Africa and include information for program managers working in high HIV prevalent settings. For PMU the lesson learned is that is important to keep supporting collaborative partners in their initiatives and to have an open attitude for collaboration in future projects.	
Intended Project Output 1/1	Increased capacity among CORE members PVOs
Main Activities	**Progress To Date**
1.1 A PVO Course conducted for 21 participants	**All planned activities were completed** 21 participants completed the course while TBCAP supported two participants.

C5.05 Institutional capacity building	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Core	**$35,347**	**$0**	**PMU**
Project will be completed in Year 2 The Terms of Reference were prepared and the topic was discussed in the TFH meeting in July. A strategic approach was discussed in more detail and agreed upon. The major challenge is to come to an agreement with all partners on the strategic direction to achieve the desired objectives of institutional capacity building. The project was delayed first due to late approval of the annual workplan and second because of disagreement on the strategic direction of this project. The steps in coming to a consensus are now agreed by all partners. Next steps will be taken in APA 2. The most important lesson is that it is very important first to agree on the definitions and strategic direction of the project. Without mutual agreement on the content and way forward the foundation of the project is missing.				
Intended Project Output 1/1	One regional institute is competent to develop and organize regional training courses, meeting international technical and educational quality standards.			
Main Activities	**Progress To Date**			
1.1 TOR is developed and specifies in detail the expected outcome and the process to arrive at the outcome	**In progress** A potential training institute was identified in South Africa.			
1.2 Potential training institutions have been visited	**Rescheduled for Year 2**			
1.3 Goals, objectives and workplan is developed for one	**Rescheduled for Year 2**			

selected pilot institution	
1.4 Two other potential institutions are identified for the second year	**Rescheduled for Year 2**

C5.06 Regional workshop for HRD focal points	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Core	**$62,660**	**$1,858**	**KNCV**
Project cancelled				
Intended Project Output 1/1	Increased HRD leadership and capacity at NTP level.			
Main Activities	**Progress To Date**			
1.1 A workshop is conducted for 16 persons from 7 NTPs in the African region	**Cancelled**			
1.2 Participants start developing comprehensive HRD plans for their countries	**Cancelled**			

C5.07 Training course for TB/HIV consultants and support for field experience	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Core	**$99,994**	**$99,994**	**WHO**
Project will be completed in Year 2 During Q2, the Second Global TB/HIV course for Consultants was conducted in Sondalo, Italy (8-15 June). Twenty-two participants from 18 countries attended. During Q4, in coordination with WHO Regions, countries were selected needing consultancies on TB/HIV and the availability of the newly trained consultants was determined for the period September to December 2006. A total of six countries were selected (Burundi, Angola, Dominican Republic, Sudan, Moldova and Papua New Guinea). Final dates for consultancies are being coordinated. It has taken more time than initially planned due to tight agendas of the national TB and HIV/AIDS program managers involved. For future similar projects, it is important to take into consideration the time and effort this coordination for "mentored consultancies" takes.				
Intended Project Output 1/1	Consulting capacity on TB/HIV increased and strengthened.			
Main Activities	**Progress To Date**		**Outstanding Issues & Achievements**	
1.1 A course for 20 TB/HIV consultants	**In progress** 22 TB/HIV consultants (7 women and		The field visits will take place in APA2.	

conducted	15 men) trained.	

5.08 Training PPP consultants	Funding Source	Approved Budget	Total Expenses	Coordinating Partner
	Core	$92,765	$92,765	WHO

Project will be completed in Year 2
This activity was accomplished during the second quarter. The first PPP consultant training workshop was held in Geneva in March 2006. There were 21 participants out of which 6, including 2 facilitators, belonged to TB CAP partners (ATS, CDC, KNCV, Union, WHO).

During 3rd and 4th quarter, 5 of the trained consultants participated in country missions and assessed PPM plans and implementation status.

Field visits are being organized for 3-5 additional consultants during October-December 2006. The main focus for these field visits will be to assist selected AFR and EMR countries to conduct a PPP situational analysis using the tool that was developed under APA1-IR3. This analysis is in preparation for the PPP planning workshop in February 2007 (APA2-IR3 activity).

Intended Project Output 1/1	A nucleus of PPP consultants developed.	
Main Activities	**Progress To Date**	**Outstanding Issues & Achievements**
1.1 20 consultants trained in PPP	**In progress** 19 consultants trained in PPP. Mentored field visit conducted for five consultants.	Field visits are being organized for 3-5 additional consultants during APA2.

C5.09 Field experience for laboratory consultant trainees	Funding Source	Approved Budget	Total Expenses	Coordinating Partner
	Core	$29,663	$29,663	WHO

Project will be completed in Year 2
Following the laboratory consultant training, six graduates were identified to further develop their consultancy skills via participation in the laboratory assessment missions along with the experienced international laboratory experts. The experienced laboratory experts and WHO regional and country offices were contacted to define list of missions with the laboratory component. EURO and EMRO has confirmed the proposed inclusions of the training graduates in selected missions.

In general, the importance of laboratory support in TB control efforts has been recognized. The need of laboratory performance improvement and capacity building has been underlined in the STOP TB Strategy and the Global Plan to Stop TB.

Intended Project Output 1/1	Improved consulting capacity of laboratory experts.	
Main Activities	**Progress To Date**	**Outstanding Issues & Achievements**
1.1 Five laboratory consultants acquired field	**In progress** Six promising laboratory consultants will join the planned missions.	Consultancy missions will take place in APA2.

experience		

C5.10 International MDR-TB Course Mexico, clinical and operational manual	Funding Source	Approved Budget	Total Expenses	Coordinating Partner
	Core	$49,365	$45,067	The Union

Project Completed
The course was successfully conducted in Mexico on July 3-7, 2006. In total 41 participants (18 female and 23 male and19 from Mexico, 5 from Equator, 3 from Paraguay, 3 from Guatemala, 2 from Bolivia, 2 from Costa Rica, 2 from Peru, 1 from Colombia, 1 from Venezuela, 1 from Nicaragua, 1 from El Salvador and 1 from US) completed the course.

In order to build and support institutional capacity an e-mail network was developed among the participants and course instructors. This network will be used to communicate problems and discuss solutions at the country level and also to regularly send recent news and publications to participants.

The plan is to conduct such a course every year, gradually transferring the methodology of the course to the National Institute of Respiratory Diseases (INER, Instituto Nacional de Enfermedades Respiratorias) of Mexico City and to the NTP of Mexico. In 2007, it is expected that the third part of the clinical management can be conducted by Mexican facilitators. In the 2007, the following Mexican instructors will take part in the course; Dr. Elizabeth Ferreira (NTP), Dr. Andres Hernandez (NTP), Dr. Ivonne Reyes (NTP), Dr. Miguel A. Salazar (INER), Dr. Rafael Valdez (INER), Lic. Susana Balandrano (INDRE).

In 2008, Mexican facilitators of the previous courses (identified by The Union) will conduct half of the course. And, finally, in the fourth and fifth year of the course, the Mexican instructors will be able to conduct all the course, but with the supervision of The Union, trying to improve the methodology year by year.

Intended Project Output 1/1	Specialized health care providers trained in the clinical and operational management of complex MDR TB patients.
Main Activities	**Progress To Date**
1.1 Conduct and international MDR-TB course in Mexico	**All planned activities were completed** The course was conducted and 41 participants attended.

C5.12 Development of a generic advanced course on supervision of TB management at sub-national level	Funding Source	Approved Budget	Total Expenses	Coordinating Partner
	Core	$20,001	$10,000	WHO

Project will be completed in Year 2
Comprehensive draft of the course was prepared. Editing, layout, printing and preparation of the CD will be completed in APA2.

Intended Project Output 1/1	Increased capacity at sub-national level to manage the implementation of the Stop TB Strategy.	
Main Activities	**Progress To Date**	**Outstanding Issues & Achievements**
1.1 A generic	**In progress**	It will be completed in

advanced course on supervision of TB management at sub-national level	The draft course was prepared and reviewed by TFH members.	APA2.

Regional projects

R1.01 Africa QUOTE TB instrument development, Phase 2	Funding Source	Approved Budget	Total Expenses	Coordinating Partner
	Regional	$179,582	$63,923	KNCV

Project will be completed in Year 2
Majority of the activities have been completed in Year 1. There was excellent collaboration with and commitment to this project of NTPs of Malawi, Kenya and Uganda. We foresee sustained interest and commitment to implement the tools.

The next steps that to be completed in Year 2 are as follows:

- Conduct SPSS analysis workshop, for psychometric testing and validation of the tools,
- Develop final version of the QUOTE-TB tool,
- Develop the Guide, after inputs from key persons (Board members TBCTA, Stop TB Partnership) on a draft version,
- Develop publications from the three countries and overall publications of the QUOTE-TB tool,
- Develop dissemination plan, including linking of the performance tool with the PIA exit interview,
- Present and practically use the draft Guide during the IUATLD Paris Conference, both in a postgraduate workshop as in a symposium about quality of TB care,
- Introduce the final Guide in December, during a SOTA meeting of the RCQHC,
- Conduct three dissemination workshops in Malawi, Kenya and Uganda, and
- Encourage NTPs from other countries to take this new tool on board in supervision, M&E and HRD approaches.

Intended Project Output 1	Guide to PIA/QUOTE TB tool and mainstreaming PIA/QUOTE in NTPs produced	
Main Activities	**Progress To Date**	**Outstanding Issues & Achievements**
Conduct workshop for QUOTE TB instrument development	**Completed** The Quote TB instrument development instruction workshop was held, with social scientists and NTP staff, including one program manager, from Malawi, Kenya and Uganda. The Importance and Performance questionnaires were adjusted agreed upon by all parties. Excel sheets were disseminated to assist with and ensure consistency in data entry.	

Produce picture cards for ranking and scoring	**Completed** Picture cards were designed, field-tested and produced. Tools for ranking of importance were picture cards, denoting the nine abstract importance concepts of TB care, which were established during phase 1 of the QUOTE-TB tool development, were field tested during the workshop. The artwork was designed by a Tanzanian artist and after field testing the cards adjusted to accommodate observations from the field and remarks from other experts.	
Conduct fieldwork for testing the instruments	**Completed** MoUs for fieldwork, ethical clearance, etc. with three countries were signed and funds disbursed. All three countries have done fieldwork, entered data in spreadsheets and returned these to KNCV/KIT/NIVEL, in preparation for the data analysis workshop in APA2.	
Conduct PIA workshop in Zambia	**Completed** A PIA workshop of RCQHC in Zambia for managerial staff from 6 countries (Malawi, Kenya, Uganda, Tanzania, Somalia, Uganda) was co-facilitated, to improve performance of health teams and to introduce the QUOTE tool for quality improvement.	
Conduct PIA workshop in Lesotho	**Completed** A PIA workshop of RCQHC in Lesotho, for central and district NTP staff, was co-facilitated, to improve performance of health teams and to introduce the concept of the QUOTE tool for quality improvement.	
Conduct SPSS workshop in NL	**Rescheduled for Year 2**	The organization of the fieldwork took longer than expected, and as a result the analysis workshop, planned in Q4, will take place in Year 2.
Prepare draft guideline	**Rescheduled for Year 2**	The draft guide will be ready early November (Paris Conference) and the final early December, before the SOTA meeting

		of the RCQHC, where the Guide will be officially introduced.

R1.02 Africa TB CAP Assessment in Djibouti and one follow-up visit: HRD focal point	Funding Source	Approved Budget	Total Expenses	Coordinating Partner
	Regional	$20,418	$14,940	PMU

Project will be completed in Year 2
An assessment mission was planned and completed in June, 2006. A work plan was developed for approximately US$ 225,000. Major activities of the work plan included: Development of central management team, development of infrastructure at peripheral centers, development of laboratory network, staff development, and development of decentralized DOTS network. During the fourth quarter, the budget and work plan for Djibouti were finalized and approved by USAID Djibouti. The next step is to finish the revisions as suggested by PMU and have final approval by CTO.

Follow-up visit to NTP/HRD focal point could not take place because the workshop it is supposed to support was postponed due to a need to revise the workplan. This activity will be moved to APA2 and joined with the HRD focal point workshop proposal to be submitted to the African Region Bureau and CTO for approval. However, planning is dependent on when the workshop will take place after it is approved.

Intended Project Output 1	Development of a work plan focusing on improvement of the NTP in Djibouti
Main Activities	**Progress To Date**
Conduct assessment of TB program in Djibouti by two consultants—lab expert and general TB consultant.	**Completed**
Conduct one follow-up visit to NTP/HRD Focal Point who participated in training	**Rescheduled for Year 2**

R2.01 LAC TB nursing curriculum translation and adaptation to LAC countries	Funding Source	Approved Budget	Total Expenses	Coordinating Partner
	Regional	$100,000	$7,101	PMU

Project will be implemented in Year 2
The project and budget were officially approved by USAID in August 2nd. The approved proposal considered a new time frame (September 2006 – August 2007). The next steps are summarized below:

- An expert meeting will be organized in Washington DC, December 15th. The purpose of the meeting is to:
  - Select the countries to perform the comparison between nurses´ tasks and

curriculum, and

- Designate one focal person to analyze the tasks and curriculum in order to find discrepancies at the selected countries.

After these steps, a "competence statement" for nurses can be developed.

- Review the workplan and discuss next steps to prepare the proposal for the nurses' curriculum, using the bibliographic review, the results from the questionnaires and task analysis.

- Organize the subsequent project's activities (expert consultation in Mexico and pilot in El Salvador), involving all the partners and experts. The mentioned countries could change following expert criteria and/or budgetary constraints.

The change in the decision about the coordinating partner from the UNION to PAHO/WHO affected the preparation of the workplan and budget, since activities, budget and time frame had to be adjusted consequently. Frequent communication among involved partners and consultant helped to adequately define roles, responsibilities and to confront challenges.

Intended Project Output 1	Increased competence for newly qualified nurses and health workers in the LAC region.	
Main Activities	**Progress To Date**	**Outstanding Issues & Achievements**
1.1 Desk review of available literature on TB training in nursing programs	**Completed** Review already prepared by the Union.	The results will be shared before the expert consultation by December 15th.
1.2. Preparation of a compiled curriculum	**Rescheduled for Year 2**	
1.3 Workshop in Mexico	**Rescheduled for Year 2**	
1.4 Pilot study in El Salvador	**Rescheduled for Year 2**	
1.5 Final curriculum prepared to be printed	**Rescheduled for Year 2**	

R3.01 G-CAP TB/HIV collaborative activities in El Salvador, Guatemala, Nicaragua and Panama	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Regional	**$300,000**	**$20,813**	**PMU**

Project will be implemented in Year 2

A proposal and a budget were developed in partnership with PAHO/WHO, CDC-GAP/CAP and the UNION after planning mission to assess the needs on TB/HIV control in El Salvador, Guatemala and Panama.

Nicaragua's visit was postponed because of the medical strike. Report of the mission is available (Spanish). The draft proposal was shared and discussed with the four countries during the III Regional TB/HIV Meeting in San Salvador (April 24-26). NTP and NAP

managers were prioritizing the TB/HIV activities to be implemented in each respective country, taking into account the results of the performed assessment.

Upon request from the PMU, the assessment mission was organized in less than 4 weeks, coordinating the participation of the UNION, CDC-GAP/CAP and PAHO/WHO. Concurrence and meetings with the national authorities suffered from this short time notice.

Communication among partners was centralized by the PMU, maintaining separate discussion with each partner. Decisions about coordination partner or the approval of the workplan were not communicated opportunely from the PMU. The Project was approved in late June, however funds have yet to arrive to the partners/countries for implementation of activities.

During Q4 of APA1 a contract was signed between KNCV Tuberculosis Foundation and the Universidad del Valle de Guatemala who will hire a full time consultant for this project.

In October 2006, the PMU will visit Guatemala in order to facilitate job interviews/ consultant hiring so that implementation of activities can start.

Intended Project Output	NTPs in three countries receive continuous and high quality technical assistance from TB CAP.	
Main Activities	**Progress To Date**	**Outstanding Issues & Achievements**
Hiring of resident TB CAP consultant stationed in Guatemala City	**In progress** A full time consultant will be hired for this project. A Scope of Work for the consultant was prepared and a Spanish advertisement was published in several newspapers in Guatemala.	The Universidad will offer office space, and take care of all administrative issues.

Country projects

F1 Technical support to NTP Brazil	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Field	**$170,000**	**$170,000**	**The Union**

Project completed

The following activities were successfully completed during APA1:

- Expansion of the implementation of the Drug Resistance and HIV prevalence Surveys in 3 additional Brazilian states,
- Site visits to Rio de Janeiro, Rio Grande do Sul, São Paulo, Rio de Janeiro and Minas Gerais,
- Hiring of 6 lab technicians for laboratorial support to state laboratories,
- Development and distribution of software program for data entry,
- Training of health care workers for survey's data entry,
- Enrollment of patients: to date, over 1,000 patients have been enrolled in the survey, and
- Supervisory visit from WHO (Drs Lucia Barrera and Adalbert Laszlo) with development of report about the visit, including recommendations.

Major challenges experienced were as follows:

- Setting up logistics for transportation of sputum samples from health units to

laboratories,

- Setting up mechanisms for disbursement of funds, such as payment of health professionals, transportation of samples, etc. and,
- Working with HIV programs for availability of HIV testing kits.

The following two factors contributed negatively on the project implementation:

- Difficulties on setting up funding disbursement mechanisms, and
- Political instability due to national country elections.

Intended Project Output 1/1	Improve the central level National TB Control Program (NTP) and assist NTP to reach goals outlined in the new tuberculosis program.
Main Activities	**Progress To Date**
1.1 Support to Brazil's NTP	Consultant was contracted and has started working.

F2 Technical support to NTP DRC	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Field	**$0**	**$292,044**	**The Union**
Workplan was approved in August 2006 and the project implementation will start in Year 2.				

F3 Technical support to NTP Ghana	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Field	**$0**	**$18,264**	**MSH**

Project will be implemented in Year 2

Following the initial assessment mission in the second quarter of this year (March, 2006), a budget and workplan were developed and submitted to the Ghana mission. It was decided to conduct an NTP program review as the first intervention given the various areas to be considered for TA in Ghana, the new players involved in TB control, and the need to provide support to the new 5 year strategic plan.

The overarching organization of this review was determined with the support of the CTO – Ghana. It was indicated that a WHO representative would be tasked with taking the lead for the design of the mission review, together with the NTP Manager, while the organization and logistics were to be provided by the QAP project. TB CAP would support two technical experts that would address both general and laboratory networks for review. Other experts who would participate would be from the country itself. The review outline would be consistent with the new global Stop TB Strategy and would include TB/HIV, HRD and PPM among other areas.

The dates for the review were scheduled for the month of September, 2006. WHO/Geneva had made arrangements with the NTP and the CTO of the Ghana mission to conduct the PPM part of the review in advance of the rest of the mission. (report attached)

In August, just prior to undertaking the review, the USAID mission confirmed the embargo on all in-coming missions until mid November. Communications with the HPN director and the NTP manager suggested that this will need to be deferred for a future date. No date – has yet to be determined.

TB CAP has received additional funds and these needs to be taken into consideration when planning for future activities according to needs outlined by the review mission. The next step is to re-program the NTP review, communicate with QAP and the USAID/Ghana mission and coordinate with the WHO representative who will be leading the review.			
Intended Project Output 1	Strengthened TB management team with regard to planning and evaluation, TB/HIV collaborative activities, community based DOTS, & PPM DOTS.		
Main Activities	**Progress This Quarter**	**Progress To Date**	**Outstanding Issues & Achievements**
TBD			

F4 DOTS expansion in Mozambique	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Field	**$277,845**	**$181,752**	**FHI**

The project will continue in Year 2
FY2006 has been a challenging year for the implementation of the Tuberculosis Control Assistance Program through TB CAP/Mozambique due to delays in approval by the Mozambique Ministry of Health [MOH]. While awaiting the authorization of the full Mozambique TB CAP workplan, activities not requiring MOH approval were developed and submitted to KNCV, FHI and USAID in a "mini-workplan". These activities, along with others requested by the National Tuberculosis and Leprosy Program, form the bulk of the reportable achievements. During this time period, other administrative and systems development work was conducted, including the development of key Memoranda of Understanding [MOU] and sub-agreement documents, networking with other stakeholders and developing further expertise in TB/HIV management and CB DOTS approach.

The major accomplishments of APA1 are as follows:
1. Development of TB CAP Work Plan
In early December 2005, a team of experts on TB/HIV worked together in country to develop a nine-month workplan and budget [Year One]. The team included international representatives from PMU, USAID/Washington, MSH and CDC/Atlanta and local stakeholders including: representatives from the National Tuberculosis and Leprosy Program (NTLP), WHO/Mozambique and FHI/Mozambique. Over the course of these activities, the team met with the Vice Minister of Health, Dr Aida Libombo and the Mission Director of USAID/Mozambique.

In January 2006, the workplan and budget underwent technical reviews by FHI/Arlington and PMU. The final version of the workplan and budget was submitted to the National Director of Health, MOH in early February 2006. The MOH conducted a review process over several months, asking for further information and detail resulting in a final workplan being approved in October 2006.

2. TB CAP Mini Work Plan
While awaiting the authorization of the full Mozambique TB CAP workplan, activities not requiring MOH approval were developed and submitted to KNCV, FHI and USAID in a "mini-workplan". The final version of the mini-workplan (June to August 2006) was approved by the TB CAP CTO at USAID-Mozambique, FHI-Home Office and PMU and

included the following main activities:

- A CB DOTS pilot in Chôkwe Region through a sub-agreement with World Relief as the selected Implementing Agency. Under the sub-agreement, World Relief will work together with the local Carmelite Order of Nuns,
- Revision, update and/or development of materials, guidelines and training modules, forms and leaflets for CB DOTS and TB-HIV, and
- Assessment of Beira Laboratory to identify renovation needs.

3. Support for the TB CAP Project Director

The position of Director of the National Tuberculosis and Leprosy Program (NTLP) was vacant from September 2005 through late February 2006, which slowed consensus building on activities and implementation of the TB CAP program. Upon nomination of the new National Director (Dr. Paula Samo Gudo), the TB CAP Project Director immediately sought to work with her regarding the pending program. Meetings were held in order to provide her a with detailed briefing on the TB CAP workplan and the interlinked TB-HIVAIDS situation in Mozambique, including challenges, constraints and opportunities that had been developed in then initial months. The TB CAP Project provided support to activities as requested by the Head of National TB Program (NTP), such as:

- Support in:
  - Revision of Provincial TB Control Workplans,
  - Upgrade of guidelines for supervision visits, and
  - Participation in the National Supervision visits to the Provinces.
- Development of the National TB Operational Plan for 2007, and
- Development of the MDR-TB Plan in response to the outbreak in neighboring South Africa.

3. Study tour to Zambia in CB DOTS

In April 2006, TB CAP Project Director in Mozambique, Dr. Dário Sacur, and a counterpart who will play a key role for TB and TB-HIV activities in Gaza Province, Dr. Jorge Sixpence, participated in a study tour of the CB DOTS program in Zambia implemented by FHI. The main objective of the study tour was to learn best practices of a successful CB DOTS program in order to support the provision of assistance to the MoH in the introduction of CB DOTS in Gaza as outlined in the TB CAP workplan.

The study tour provided a valuable opportunity to observe firsthand Zambia's progress in the implementation of CB DOTS where health facilities are providing integrated high-quality services. The Zambian MoH has developed strong partnerships with local NGOs in which they have been given support in training, supervision, monitoring and evaluation of activities at the community level and the coordination of meetings between technical staff and community volunteers in rural areas. The strong commitment of all actors has been a key factor in the improvement of care and prevention activities at the community level despite the lack of resources; as a result, the program is achieving significant progress in reaching its targets.

4. Participation in WHO Training Course in Global DOTS and TB HIV Management

The TB CAP Project Director attended an international advanced training course on DOTS and TB-HIV management organized by WHO in Sondalo, Italy, from May 17-30, 2006. The course enabled the TB CAP Director to refresh his knowledge of and learn strategies to improve access to and quality of TB and TB-HIV care for patients based on techniques for community mobilization and to strengthen existing institutional health facilities, e.g.

laboratory capacity and drug management. Through the course, the TB CAP Director improved his knowledge and understanding of TB and TB-HIV within the framework of the WHO/Stop TB strategy and became more confident in providing technical assistance to the NTLP to reinforce the MoH's efforts to reduce TB in Mozambique. The training also provided an excellent opportunity to exchange experiences with TB professionals from other countries. TB CAP Mozambique has strongly recommended to NTLP seeking opportunities to replicate this training course for Portuguese TB professionals who are not able to attend a International course due the lack of financial resources as well as lack of English language skills.

5. Development of sub-agreement for CB DOTS pilot

A sub-agreement with World Relief and the Carmelite Order of Sisters as the implementing agencies was developed for the implementation of a pilot of CB DOTS in Gaza. The sub-agreement has been included in the approved TB CAP mini-workplan and is pending implementation. The proposed Training of Trainers (TOT) workshop on CB DOTS/HIV (supported by KNCV/WHO remaining funds) will be conducted in November 2006, followed by the training of the volunteers at community level.

6.Assessment of Beira Laboratory

One of the main challenges of the TB CAP project is strengthening laboratory capacity to improve access to *M. tuberculosis* culture through decentralization and dissemination of TB culture to Beira and Nampula regional laboratories. To achieve those goals, TB CAP Director, together with a team of two engineers, visited Beira in September 2006 to conduct a needs assessment and develop a technical design for the renovation of the laboratories. The design has been finalized by a local company. The next steps agreed by the Sofala Provincial Director of Heath, the Director of the Beira Central Hospital and the Head of the NTLP are to:

a) Submit the design to the Ministry of Health for approval through NTLP and the National Laboratory Program (NTLP) (in process),

b) Make a public announcement for bid selection,

c) Start the renovation of the laboratory, and

d) Initiate the procurement of all laboratory equipment, including furniture.

7. Development of CB DOTS Guidelines Training and Educational tools

Since this is the first time that a CB DOTS approach will be implemented in Mozambique, the TB CAP program has as a priority the development of CB DOTS &TB-HIV Guidelines, training and educational materials as well as monitoring tools. All these materials have been produced by FHI under the TB CAP program. The head of NTLP agreed to have the IEC materials tested and the guidelines for CB DOTS used for the first CB DOTS pilot in Chôkwe.

8. Establishment of the TB/HIV Task Force

In support of the TB CAP, the TB/HIV Task Force was established. The first meeting took place on September 4th and was led by the Head of NTLP. The participants included representatives from the MoH, the head of the Counseling and Testing technical unit for HIV program, the National TB Supervisor, the Clinical TB supervisor as well as representatives from USAID, CDC, WHO, Columbia University, IFO, ILEP, MSF, JHPIEGO and FHI. Since then 3 additional meetings took place where participants discussed relevant and pending issues on regards TB and TB/HIV activities.

9. TB CAP Country base-line information 2005-2010

Based on recommendations made by PMU, the TB CAP program in Mozambique reviewed the information system that is being used by NTP, the National AIDS Control in order to gather the information requested in the Baseline List. While reviewing the information, we realized that the available information at the MoH will not be sufficient for a good baseline, therefore visits to selected Provinces (Maputo, Gaza, Sofala, Zambézia and Nampula) will be planned for FY2007 to get more detailed information.

10.The Hague Workshop

In August 2006, the TB CAP Project Director participated in an interactive Workshop for TB CAP Project Officers and Field Officers, in the Hague, Holland. This Workshop provided a valuable opportunity to know each TB CTA partner s and to improve the knowledge of the overall structure and management procedures of the TB CAP. The Workshop was also an excellent opportunity to exchange experiences among the participants from different countries, and strengthen the commitment of the TB coalition to achieve its goals for 2010 ***"Less TB and HIV/AIDS in higher TB burden countries".***

Internal and external factors that have had a positive impact on project implementation are as follows:

- Early participation of TB CAP Project Director in the process to develop the TB CAP work plan,
- Excellent disposition to collaborate with the TB CAP Project by the Head of the NTLP,
- Consistent support and understanding of USAID/Mozambique, particularly through the close involvement of the Mission Director, Jay Knott, and the TB CAP CTO, Dr. Abuchahame Saifodine, in addressing the challenges faced by TB CAP due to the delay in the MOH's authorization of the workplan,
- Excellent country coordination between FHI as a coordinating partner, the CTO-USAID, CDC, WHO and the Head of NTLP,
- Support of the National Director of Health to advise and facilitate the ways forward to re-submit the TB CAP Workplan for approval, and
- The Head of NTLP has placed TB CAP as leading counterpart at the national level, despite the full TB CAP workplan not having been officially authorized at the moment.

The timely implementation of activities has been delayed due to a combination of factors including delays stemming from guidance and bureaucratic processes within the MOH and most importantly, delay in approval of TB CAP Work Plan by the MOH.

Internal and external factors that have had a negative impact on program implementation are as follows:

- Delays within the Ministry of Health for approval and in communication,
- Extended absence of the Head of NTPL has contributed to delays in decision-making and additional advocacy for TB CAP,
- The delay in the approval of the overall workplan has led to the development of several workplans and budget, which has led to confusion and burden, and
- Long delay to get authorization of the "Mini-Workplan" which subsequently delayed the signature of the sub-agreement with World Relief/ Carmelite Order of Nuns to Implement pilot CB DOTS in Chôkwe.

Next steps and outstanding issues for Year 2:

- Expedite the approval of the Year Two Workplan,

• Work with National Laboratory Staff at MoH and MSH to start the revision and update of guidelines, training manuals and operational & quality control procedures, • Procure the project vehicle, • Finalize and execute an MoU and sub-agreement with the MoH, • Execute a sub-agreement with the selected implementing agency and initiate the implementation of CB DOTS in Gaza, • Follow up on the process for testing the TB/HIV as well as CB DOTS training manuals and educational materials, • Request bids for the renovation of Beira Laboratory, and • Implement a separate and complimentary workplan to be executed with the KNCV/WHO funds on TB/HIV activities.		
Intended Project Output 1/3	CB DOTS successfully piloted in Gaza province and case detection rate increased from 46% to 70% and the treatment success rate increased from 63% to 85% in three districts of Gaza province.	
Main Activities	**Progress To Date**	**Outstanding Issues & Achievements**
1.1 CB DOTS experience in Mozambique reviewed	**Completed** During APA1 the following activities were conducted: • Site visit to Manhiça, • Participate in NTLP program review, • Study Tour Zambia, and • Conduct baseline data gathering in Gaza for CB DOTS activities.	Lessons learned from CB DOTS and TB/HIV activities will be applied in Pilot in Gaza Province.
1.2 Stakeholders in Gaza Province engaged	**Completed** During APA1 the following activities were conducted: • Pilot districts selected, • District meetings conducted, and • Sub-agreement(s), work plan and budget with NGO(s) developed.	DPS Gaza is keen to collaborate with TB CAP on implementing pilot CB DOTS.
1.3 CB DOTS tools and materials prepared for pilot site	**In progress** During APA1 the following activities were conducted: • Adapt training materials/modules prepared for facility level staff, CVs and “Padrinhos” based on roles and responsibilities, • Forms prepared for health posts, CVs and Padrinhos, • CB DOTS monitoring tools prepared.	Production/copies of materials will be completed in Year 2.
1.4 Capacity built	**In progress** During APA1 sensitization meetings conducted for District Directors of Health in Gaza with local NGOs and community leaders.	Training workshops in pilot site including TOT on DOTS/HIV will be completed in Chôkwe District by KNCV/WHO remaining funds.

1.5 Monitoring and evaluation improved	**In progress** During APA1 baseline data collection completed on DOTS services and performance in Gaza Province.	Monthly supervision of pilot districts will be initiated in Year 2.
1.6 CB DOTS TB/HIV Guidelines developed	**Completed** First revision completed in collaboration with NTP.	
Intended Project Output 2/3	Improved access to quality assured laboratory diagnosis.	
Main Activities	**Progress To Date**	**Outstanding Issues & Achievements**
2.1 National Reference Laboratory upgraded	**In progress** During APA1 all quotations for local procurement were collected.	Postponed to March 2007 since MDR-TB will start in 2007
2.2 Management of NRL strengthened	**Rescheduled for Year 2**	The following activities will be completed in Year 2: • Review and update Standard Operating Procedures (SOPs) for the NRL, • Develop guidelines on care and maintenance of equipment, • Develop guidelines on documentation, record keeping, store keeping and ordering of supplies and reagents (Data and Logistic management), • Develop guidelines on laboratory safety, and • Conduct management training.
2.3 Quality Assurance (QA) guidelines established	**Rescheduled for Year 2**	Update and printing of National Laboratory QA guidelines will be completed in Year 2.
2.4 Performance on direct sputum-smear examination improved	**Rescheduled for Year 2**	Training of provincial laboratory supervisors on new QA guidelines, sputum smear examination refresher course for district laboratory microscope technicians and supervisory visits will be conducted in Year 2.

2.5 Access to M. TB culture improved through decentralization of culture to Beira regional laboratory	**In progress** Needs assessment of Beira regional laboratory was completed. Quotations are also ready to start procurement for renovation.	Renovation of the laboratory will start in Year 2.
2.6 Laboratory network expanded	**In progress** Quotations are ready for start-up procurement. A list of laboratories requiring microscopes was compiled.	46 persons will be trained in microscopy for 4 months in Year 2.
2.7 Quality assured C/DST by Supra-National Laboratory	**Rescheduled for Year 2**	
2.8 Appropriate technical assistance provided	**Rescheduled for Year 2**	Providing technical assistance on laboratory network development through country visits and distant support depends on TB CAP approval.
Intended Project Output 3/3	TB/HIV collaborative activities expanded and monitored in HIV/AIDS and DOTS services.	
Main Activities	**Progress To Date**	**Outstanding Issues & Achievements**
3.1 Access for TB patients increased to PICT	**In progress** National Meeting on HIV Counseling and Testing for TB patients was conducted in July 2006. Curriculum finalized for training of health workers and counselors on PICT. Clear roles and responsibilities developed for the implementation of PICT for personnel working in DOTS at various levels of care.	Reproduction of revised NTLP training materials that include PICT and ensure dissemination of these materials needs NTP approval. TOT for NTLP national and provincial staff on the new training materials will be conducted in APA2. One training course for district personnel (Gaza proposed) will be conducted in Year 2.
3.2 Competence of TB/HIV/AIDS health workers in TB/HIV activities improved	**In progress** Baseline rapid assessment was completed. A training package prepared that includes all aspects of TB/HIV, including PICT, medical management of patients with both diseases, recording	This assessment will be complemented by field visits to Sofala, Zambézia and Nampula in Year 2. A course on TB/HIV for TB/L supervisors at national and provincial

	and reporting.	level will be conducted in Year 2 under the KNCV/WHO complementary plan.
3.3 Infection control guidelines developed and disseminated	**In progress** International infection control guidelines reproduced for Mozambique.	TB component of the Guidelines was revised and it is ready to be reproduced and disseminated. National one-day workshop for MOH on infection control of TB in HIV/AIDS era will be conducted through KNCV/WHO complementary plan.
3.4 TB patients properly educated on TB/HIV	**In progress** Educational materials for TB patients on TB/HIV (leaflet, flip-over) prepared.	In Year 2 these materials will be submitted for approval by NTLP. Printing and distribution will be completed in Year 2.

F5 Scaling-up TB control in Namibia	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Field	**$580,000**	**$294,242**	**KNCV**

Project will continue in Year 2

The project has been successfully implemented. During the APA1 majority of the main activities were completed. Treatment success rate increased from 70% (2004 cohort) to 74% (mid-year report 2005 cohort). Percent of all registered TB patients who are tested for HIV rose from 16% to 24% (mid-year report 2006)

The following are among the highlights of TB CAP Namibia project:

- TB-Review meetings were successfully held throughout the country,
- Renovation of the MDR-TB ward in Walvis Bay Hospital, Erongo region started,
- DOTS decentralization started in Walvis Bay, and
- Revised TB guidelines printed and disseminated.

Memorandum of understating between the Ministry of Health and Social Services and KNCV and availability of the 5 year national strategic plan has positively affected the implementation.

On the other hand there were several negative factors impeding the project implementation including:

- The demand by the director of Directorate Special Programs, MoHSS to change the guidelines on authorization of expenditure of USAID funds leading to a state of paralysis on implementation of activities, and
- The lack of leadership for the NTCP due to absence of NTCP program manager who

was at the international course. During Year 2 the project will advertise for the post of Senior Program Coordinator for TB CAP.		
Intended Project Output 1/2	Strengthened and expanded DOTS	
Main Activities	**Progress To Date**	**Outstanding Issues & Achievements**
1.1 Strengthened management capacity of NTCP through; • National steering committee meetings • District performance review meetings • District support and data audit visits • National TB course	**Completed** Five national steering committee meetings were organized. Working group meetings (ACSM, Community DOTS, MDR-TB) were conducted. **Completed** 70 meetings in 30 districts from 11 regions were conducted. **Completed** Visits were carried to 7 regions for introduction of FDCs. **Completed** 51 officers (18 men and 33 women) completed the national TB course.	
1.2 CB-DOTS in Erongo implemented through: • Baseline survey on TB control in Erongo region • Regional and district sensitization meetings • Local leadership sensitization meetings • Training of 100	**Completed** **Completed** **Completed** **In progress**	

volunteers on CB-DOTS	40 volunteers (out of 100 targeted) trained and are now engaged in providing DOT at various clinics. The project provides transport and lunch allowance to the volunteers. The project is purchasing Containers which will be converted into DOTS points located closer to the communities. This will allow for decentralization of the only treatment centre-right now.
• Social mobilization meetings	**In progress** Started in August 2006
• Procurement of one vehicle	**Completed** A vehicle purchased and delivered in September 2006.
• Field visits for tracing defaulted patients and TB contacts	**In progress** Field visits have started in Walvis Bay District
1.3 Better managed MDR-TB through; • Renovation of MDR-TB facility at Walvis Bay district hospital	**In progress** Contract to renovate the wards has been awarded and renovations have started at the MDR-TB wards.
• Providing specialized MDR-TB Training to Medical Officers working in TB Reference Hospital	**Completed** Two doctors (1 man and 1 woman) received training in management of MDR-TB in Latvia in February 2006.
• Conducting clinical supervisory visits from national to regional MDR-TB centers and hospitals conducted	**In progress** Dr Gordon Cupido, a physician recently trained in Latvia on MDR-TB, state employed, is currently supervising other state physicians (Erongo region completed) on management of MDR-TB.
1.4 An IEC campaign implemented	**Completed** Mission was completed to finalize the TB COMBI plans and funds relocated for printing NTCP guidelines. So far, 5000 copies of NTCP guidelines printed and distributed to all regions/districts.
1.5 A situational analysis conducted	**Completed** Dr Agnes Gebhard, Senior Consultant from KNCV conducted

to determine TB burden and TB control practices in specific sectors to develop sector-wide DOTS expansion strategy	mission in the first week of September 2006. The final report will be available soon.
Intended Project Output 2/2	Strengthened and Expanded TB and HIV/AIDS Coordinated activities.
Main Activities	**Progress To Date**
1.1 A strategy on collaborative TB & TB/HIV activities developed	**Completed** Dr Pedro Suarez from MSH conducted a mission during the last week of August & first week of September 2006. Final report will be available soon.
1.2 Infection control measures instituted in health facilities	**Rescheduled for Year 2**

F6 Philippines technical assistance	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Field	**$97,752**	**$44,610**	**PMU**
Project will be completed in Year 2 A detailed evaluation report was submitted to the USAID. A coordinating partner for the follow-up of the project will be identified, and a workplan will be developed in Year 2.				
Intended Project Output 1/1	Phil-TIPS program evaluation supported.			
Main Activities	**Progress To Date**		**Outstanding Issues & Achievements**	
1.1 Phil-TIPS program evaluation completed with support from TB CAP	**In progress** Program evaluation was carried out and a report prepared.		Follow-up will be in Year 2.	

F7 Field Support to South Africa	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Field	**$0**	**$0**	**KNCV**
A workplan will be prepared and implemented during Year 2.				

F8 South Sudan National TB control	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Field	**$150,000**	**$15,750**	**WHO**
Project will continue in Year 2 During APA1 work on the construction of TB reference laboratory started. WHO engineers finalized the construction plan, bidding was done and the contract was signed. Contractors will initiate the work soon. The engagement of two WHO resident engineers in January				

2006 and the formation of the Government of Southern Sudan and subsequent transfer of the Ministry of Health to Juba have all had positive impact on the progress in the construction of the reference laboratory.

The receipt of funds, though late, by EMRO has enabled other activities to be started. A training workshop on TB management for staff of Juba teaching hospital took place from 10/10/2006 to the 16/10/2006. A similar workshop is scheduled in Wau from the 20/11/2006 to 24/11/2006.

Despite delay in disbursement of funds from TB CAP, the former government garrison towns are already assessed and plans are advanced to integrate these areas into the Southern Sudan TB program. A stakeholders meeting to unify the TB treatment regimens in Southern Sudan is planned and a meeting to initiate private-public mix TB program involving the private clinics, army, prison and private pharmacies in Juba has been held.

Scheduling of consultants' visits particularly consultants needed to strengthen the quality of the laboratory in Juba is needed. This is important because it is basically dependent on the completion of the construction. This construction is projected to be completed in 3 months time.

South Sudan project has provided valuable lessons learnt:

- There is always substantial time delay between processing of the proposal, approval and release of funds. In addition, the funds have to be transferred from donors to WHO Headquarters and finally to EMRO before the program implementation can start and this usually take a long time making the process of meeting dates impossible.

- Project implementation delayed by the formation of the Government together with transfer of institutions from abroad to Southern Sudan impacted negatively on the project implementation because these institutions are pivotal in policy decisions and actual implementation of the program.

- In the case of WHO, the lack of basic structures such as construction units can be a constraint. It took WHO long time to recruit resident engineers and this delayed the construction of the reference laboratory in Southern Sudan.

- Getting approval for contracts for building from EMRO sometimes involves a lot of hurdles that tend to delay project implementation.

Intended Project Output 1	DOTS program is in place in South Sudan.	
Main Activities	**Progress To Date**	**Outstanding Issues & Achievements**
1.1 Strengthen national capacity	**In progress** Equipment for TB unit was purchased. A local TB expert was identified and recruited. The person will start work at the MOH by November 1st, 2006.	Equipment is now being stored in Nairobi until the completion of laboratory building. His training is scheduled for Year 2.

1.2 DOTS expansion to former GoS areas	**In progress** Assessments have been carried out in Malakal, Juba and Wau. One advocacy workshop was conducted in Juba in September 2006. One training workshop in Juba completed in October 2006.	Training in Wau scheduled for November 2006.
1.3 Expand and strengthen DOTS at 10 states	**Scheduled for Year 2**	State Government structures are still being formed.
1.4 QA and strengthening laboratory network	**Scheduled for Year 2** Recording and reporting system will be introduced in December 2006.	Delay in adoption of the WHO recording and reporting format. Delay in construction of the laboratory.
1.5 Pilot study TB in prisons	**In progress** Initial workshop for prison authorities and stake holders was conducted and taskforce formed to develop further guidelines for PPM implementation	

F9 Zambia TB CAP	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Field	**$1,000,000**	**$384,742**	**FHI**

Project will continue in Year 2

Major accomplishments of APA1 are as follows;

1.1 Introduction of TB CAP to Zambia

In 2005, the Ministry of Health, National TB Control Program (NTP) in Zambia welcomed support from the USAID for TB and TB/HIV through a five year program completely funded by USAID through TB CAP. Four areas of support were identified for TB control in Zambia in the year one work plan for program implementation. These areas are listed below:

- DOTS strengthening,
- Collaborative TB/HIV activities,
- Community mobilization and involvement in TB and TB/HIV care, and
- Involvement of all providers in TB control (TB/HIV in the workplace, public/private and public/public mix DOTS).

1.2 Memorandum of Understanding

The Memorandum of Understanding (MoU) between the Ministry of Health and TB CAP was signed on the 13th September 2006 after consultations and discussions between both parties. The MoU has established terms and conditions for TB CAP to work through the Ministry of Health in support of TB and TB/HIV activities.

1.3 Provincial visits
An introductory trip to the three provinces planned for support for year one was made toe. Luapula, Copperbelt and North Western. The trip was held from 13-23rd September 2006. The provincial trip enabled TB CAP to visualize the extent of the support required by the provinces which was more than what was projected prior to project implementation.

1.4 DOTS strengthening and enhancement
TB CAP through the WHO partnership supported the revision of the National TB Manual and the write up of the Global fund proposal for round six for TB, HIV and malaria. The Tropical Diseases Research Centre (TDRC) and the Chest Diseases Laboratory (CDL) held initial meetings to map their collaborative activities with TB CAP in support of scaling up of External Quality Assessment (EQA). JATA and TDRC agreed to cost-share for additional district laboratory training, increasing the number of planned district lab trainings from two to three.

1.5 Collaboration between TB and HIV Programs
Routine HIV counseling and opt-out HIV testing has become an important component of care for symptomatic patients that present to health facilities. In Zambia 70% TB patients are co-infected with HIV. TB CAP, through FHI is supporting TB staff training in HIV counseling and testing. Provincial and District focal point persons were trained as trainers in the Diagnostic Counseling and Testing (DCT) and Clinical Training Skills (CTS) courses. The participants were from the five Northern Provinces; Luapula, North- Western, Copperbelt, Central and Northern Provinces. This training was a support to the NTP plans to have all TB provincial and district focal point persons skilled in providing TB and HIV services to TB patients.

Internal and external factors that have a positive impact on accomplishments in APA1 are as follows;
2.1 Open communication with the NTP, PHOs, the Chest Diseases Laboratory (CDL), the Tropical Diseases Research Centre (TDRC) and other partners has enabled TB CAP to have a good start up in supporting the MOH. Good communication and agreement on program plans and activities between JATA, WHO and FHI has also had positive impact on program implementation.

2.2 Technical support from JATA for the local staff was provided by Dr. Satoshi Mitarai and Mr. Andy Beggs the JATA focal point person's on a visit to Zambia in May 2006. Dr. Mitarai made an overall assessment of the appropriate activities for RIT/JATA to implement under TB CAP. He had a series of meetings with MOH, WHO, FHI, Chest Diseases laboratory (CDL) and the Centers For Disease Control and Prevention (CDC). Andy Beggs, JATA TB CAP project officer, participated in the provincial visits In addition; he reviewed JATA's financial and administrative management systems, and established office space for JATA at the University Teaching Hospital TB laboratory.

2.3 TB CAP has been involved in the National TB Program's Global Fund to fight AIDS, TB and Malaria Round 6 proposal development for the activities in the National Strategic Plan for the next five years. TB CAP will support the MOH in implementing the activities planned, with full knowledge of MOH activities and timelines.

2.4 At the very end of the quarter, JATA and TDRC agreed to cost-share in order to provide additional district laboratory training, increasing the number of planned district lab trainings

from two to three.

Major challenges experienced this year are as follows:

3.1 Program Implementation

Project start up was delayed until June 2006. The restructuring of the Ministry of Health by the governments' dissolution of the Central Board of Health (CBOH) and restructuring of staff establishment has affected implementation of some planned activities. Program start up was also affected by the delayed flow of funds from PMU to FHI.

3.2 Staff recruitment at provincial level

The Government has revised the staff structure and at provincial level there is a Public Health Unit and Clinical Care unit structure where there were the TB personnel. This will delay the TB CAP recruitment for provincial staff as TB CAP is dependent on getting guidance from the MOH on the provincial staff recruitment both for laboratory and technical support.

The next steps in Year 2 are as follows:

- Submission of TB and TB/HIV action plan activities by the districts/provinces from the action planning process for the period 2007 to 2009 to the MOH including areas for TB CAP support,
- Scheduling of laboratory activities by TDRC, CDL and TB CAP,
- Scheduling of provincial quarterly meetings and semi-annual performance visits for TB CAP participation,
- Submission of detailed equipment and supplies in each province, for TB CAP procurement in Year 2, and
- Procurement of fluorescent microscope for Luapula province, ten binocular microscopes, and additional equipment and supplies, and
- Identification of staff needed by each province for employment under TB CAP.

Intended Project Output 1/5	Strengthened and expanded quality DOTS in all districts of 5 provinces over 5 years.	
Main Activities	**Progress To Date**	**Outstanding Issues & Achievements**
1.1 Strengthened laboratory services at the provincial, district and facility level	**In progress** Discussions held with each provincial health office, on whether and how to hire a provincial level lab staff in each of the provinces targeted during APA1 and 2. A visit was made to Tropical Diseases Research Center and meetings were held at TDRC and FHI offices to plan for EQA trainings. A request for approval to purchase fluorescent microscope for Luapula province submitted.	Pending provincial recommendations Consolidation of joint laboratory activities, including support supervision to provinces Pending for approval
1.2 Improved case management at the facility level	**In progress** Baseline assessments conducted in Luapula, Copperbelt and North-Western	Trainings, supervisory visits and technical review meetings will be

	Provinces through the Provincial Health Office. During the TB CAP visits to the provinces inclusion and involvement of WHO, FHI and JATA on provincial and district level training schedules, support visits and technical meetings were discussed.	scheduled in APA2.
1.3 Better drug management at provincial, district and facility level	**In progress** Staff training was conducted in fixed dose combinations (FDCs) for TB drugs as a national roll-out of new FDCs countrywide.	Supervisory visits of NTP will be conducted in APA2.
1.4 Improved recording and reporting system	**Completed** National revised TB laboratory registers and laboratory request forms for sputum examination were printed, revision and printing of National TB manual was supported.	Some of the new forms and registers already in use.
1.5 Better supervision and management at the district level	**In progress** The project has transport available for provincial program support by central staff. A TB CAP vehicle was procured and used during the first provincial visit.	
Intended Project Output 2/5	Improved access to TB/HIV care.	
Main Activities	**Progress To Date**	**Outstanding Issues & Achievements**
2.1 A functioning TB/HIV coordinating body at provincial & district level	**Rescheduled for Year 2** Provincial meetings are pending guidelines from NTP.	The NTP needs to give guidelines to provinces to establish TB/HIV coordinating bodies at Provincial level, which will then oversee the setting up of similar coordinating bodies at district level.
2.2 HIV counseling and testing provided for TB suspects/patients	**Completed** 26 Provincial and District TB focal point persons were trained as trainers in the newly introduced HIV counseling and testing in a clinical setting (DCT). This has been advised by the MOH for all patients including TB patients.	TB CAP shared costs with Churches Health Association of Zambia (CHAZ) for this training. One participant was sponsored by the Centre for Infectious Diseases Research in Zambia (CIDRZ).
2.3 Established formal managed referral networks	**In progress** Referral networks are not fully established. Some TB patients are	A standard referral form has not been developed by the NTP. The diversity of

between TB and HIV corners/centers	receiving counseling and testing in TB corners (especially ZPCT sites) and staff are using the newly developed reporting and recording forms which capture HIV data. Some health facilities have developed referral forms to refer patients from TB corners to HIV care and treatment centers.	health facilities makes developing a standard referral form a challenge.
2.4 Cotrimoxazole preventive therapy offered	**In progress** The NTP and collaborating partners proposed to keep the standard NTP recommendations for children according to the National TB manual.	Strengthening TB diagnostic and treatment services is priority for NTP before implementation of scaled-up Cotrimoxazole preventive therapy.
2.5 Active TB screening for HIV infected individuals	**Rescheduled for Year 2**	Implementation of activity is restricted by the separation of TB screening and HIV care and treatment facilities. TB CAP will wait for implementation of new HIV forms by MOH that have incorporated TB screening.
Intended Project Output 3/5	Increased awareness of TB and TB/HIV in communities	
Main Activities	**Progress To Date**	**Outstanding Issues & Achievements**
3.1 Strengthened local organizations to mobilize communities	**Rescheduled for Year 2**	
3.2 Available treatment supporters and caregivers for the program	**In progress** During introductory visits, TB CAP established TB treatment supporters in health facilities.	Candidate facilities that do not have treatment supporters will be identified in Year 2. Plans for treatment supporter trainings in Year 2 have been made (TB/HIV management and DOTS).
Intended Project Output 4/5	Improved treatment success rate in targeted workplace settings.	
Main Activities	**Progress To Date**	**Outstanding Issues & Achievements**
4.1 Successful	**In progress**	A national PPM meeting

workplace treatment program in place	In order to engage public and private practitioners PPM was discussed during the provincial visits.	in Year 2 is planned for by the NTP to be followed by start up activities in the Copperbelt province.
Intended Project Output 5/5	DOTS training mainstreamed into pre and in-service training.	
Main Activities	**Progress To Date**	**Outstanding Issues & Achievements**
5.1 Facility Assessment completed for mainstreaming DOTS training into pre-service training	**Rescheduled for Year 2**	

F10 Kenya TB CAP assistance	**Funding Source**	**Approved Budget**	**Total Expenses**	**Coordinating Partner**
	Field	**$55,000**	**$55,000**	**KNCV**

Project completed

TB CAP project aims to support TA of KNCV to Kenya as defined under the Intensified Support and Action Country (ISAC) initiative. ISAC started in April 2005 and two of the three TA visits were realized before TBCAP funding was available. The initial funds were supposed to come from the USAID country mission directly to KNCV but no appropriate structure could be found to do this. Three took place 10-15 July and 21-26 November 2005 and 20-31 August 2006.

During the first visit, the technical assistance focused on the establishment of ISAC (development of agreements with KAPTLD, TOR for all newly employed staff etc) and also addressed issues such as the roll out of joint TB/HIV activities, drug management, routine TB reference laboratory support and monitoring and evaluation. The second visit was completely committed to the joint development of the new 5 year strategic plan 2006-2010 and the third visit addressed issues related to case detection, treatment results, laboratory, drug management, TB/HIV, technical partner coordination, donor coordination, and DOTS expansion activities.

Looking at country program results in the past year one could claim that TBCAP contributed somehow to the impressive TB/HIV results Kenya has achieved and that TB CAP contributed to the development of a solid foundation for the coming years. The same results are rightfully claimed by PEPFAR, USAID country mission, CIDA-KNCV, CDC, WHO and ISAC/Stop TB partnership and to a lesser extend by GFATM. What is known is that the NLTP, in close collaboration with the technical partners KNCV, WHO and CDC played an impressive in the roll out of TB/HIV activities and Kenya is currently one of the few countries world wide reporting national TB/HIV indicators that are collected through an adapted recording and reporting system. By June 2006, 59% of all TB patients have been counseled and tested of which 53% tested HIV positive. Over 80% of the HIV positive TB patients were commenced on CPT. However, less than 5% of HIV positive TB patients was able to start ART. Detailed information is available from the mission report and the program has submitted a paper for publication.

The NLTP developed a solid 5 strategic plan (2006-2010) with all relevant partners. This plan is for 80% funded in the first two years. Delays in CIDA funding and the delay in releasing phase two of the 2nd round GFATM threaten to create a larger funding gap for 2006. Under ISAC, 26 additional staff members were recruited. The staff was contracted by KAPTLD (private TB association of Kenia) with specific TOR mainly addressing the roll out of TB/HIV. This initiative strengthened the already existing PPP between KAPTLD and the NLTP. One of the persons contracted under ISAC was added as technical officer to KAPTLD to assist the organization to expand existing PPP activities in Nairobi and other major cities in Kenya. The Government (Office of the President personnel department) of Kenya has also been extremely supportive in allowing externally funded staff under contract of a private organization to work under Government responsibility. Collaboration with PATH was established, which contracted an additional 10 District staff under the same conditions and same TOR. The main challenge was the realization of TB CAP funding as part of the ISAC initiative as local USAID office was not able to fulfill the ISAC contribution to KNCV directly.	
Intended Project Output 1/1	High quality TA provided to NTP Kenya.
Main Activities	**Progress To Date**
1.1 Conduct TA visit	**Completed** Three TA visits conducted in June and November 2005 and August 2006.

Annex 2: TB CAP Year 1 Monitoring and Evaluation Report

Table 1: 2005 - Baseline Results of TB CAP M&E Plan Indicators

2005 - Baseline Results of TB CAP M&E Plan Indicators	Average 2005	Cambodia	DR Congo	Indonesia	Malawi	Mozambique	Namibia	South Africa	Zambia
Impact Indicators									
Total Population (millions)	**382**	13	56	224	13	19	2	44	11
TB incidence (WHO estimates) per 100.000 population	**494**	508	366	245	413	450	717	718	532
HIV sero-prevalence among TB patients	**37%**	10%	21%	1%	69%	32%	61%	35%	70%
Case fatality of HIV positive TB patients (estimated)	**30%**	30%	30%	40%	30%	No data	20%	30%	No data
Outcome Indicators	**Average 2005**	**Cambodia**	**DR Congo**	**Indonesia**	**Malawi**	**Mozambique**	**Namibia**	**South Africa**	**Zambia**
Percent of public clinics implementing DOTS strategy									
Country total	**88%**	98%	No data	96%	100%	45%	100%	80%	100%
TB CAP geographic areas	**100%**			100%					
Case detection rate (all cases)									
Country total	**61%**	44%	46%	48%	52%	33%	104%	78%	83%
TB CAP geographic areas	**51%**			51%					
Case detection rate (SS+ cases)									
Country total	**63%**	61%	70%	67%	40%	No data	88%	85%	28%
TB CAP geographic areas	**56%**			56%					
Treatment success rate (new ss+)									
Country total	**79%**	93%	83%	87%	76%	76%	70%	67%	82%
TB CAP geographic areas	**87%**			87%					
Country meets MDR TB quality standards defined by TB CAP (max. score 3 = Yes)	**1.9**	3	0	0	2	3	2	2	3
Nationwide TB and HIV programs effectively coordinated (max. score 4=Yes)	**1.6**	2	0	0	2	4	1	0	4
IR 1: Increased Political Commitment for DOTS	**Average 2005**	**Cambodia**	**DR Congo**	**Indonesia**	**Malawi**	**Mozambique**	**Namibia**	**South Africa**	**Zambia**

Country uses the components of Toolkit	**0.0**	0	0	0	0	0	0	0	0
Amount of government budget dedicated to NTP (millions)	**No data**	No data	No data	25	No data	No data	No data	No data	No data
Number of countries that has formally adopted a national TB policy	**7**	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
IR 2: Strengthened and Expanded DOTS Programs	**Average 2005**	**Cambodia**	**DR Congo**	**Indonesia**	**Malawi**	**Mozambique**	**Namibia**	**South Africa**	**Zambia**
Number of countries where NTP has identified priority challenges to be addressed within a defined time period according to a measurable action plan using MOST	**1**	No	No	No	No	Yes	No	No	No
Technology of assessing and improving leadership and management skills in the selected TB CAP institutions has been transferred	**0**								
Number of countries where NTP has expanded case detection in other health programs and sectors	**2**	Yes	No	No	No	No	No	No	Yes
Country provides TB culture and sensitivity services meeting international quality standards (max. score 4 = Yes)	**2.0**	3	0	0	0	2	3	4	4
County has implemented "TB Laboratory Standard Operating Procedures (SOPs)" (max. score 3=Yes)	**0.3**	0	0	0	0	0	0	0	2
Average population per laboratory performing TB microscopy	**70,467**	70,400	No data	75,000	No data	No data	66,000	No data	No data
Percent of laboratories performing TB microscopy with over 95% correct microscopy results	**77%**	77%	No data	No data	No data	No data	No data	No data	No data
Country has implemented the "X-ray Diagnosis Guidelines" (max. score 3=Yes)	**0.0**	0	0	0	0	0	0	0	0
Country has a policy on MDR TB (max. score 3=Yes)	**1.5**	2	0	1	2	3	1	3	0
Number of countries conducting MDR TB surveys or having MDR TB surveillance systems	**4**	Yes	No	No	No	Yes	No	Yes	Yes

Number of countries measuring socioeconomic status to document equitable access	**2**	No	No	No	No	Yes	No	No	Yes
Number of countries that have an official pro-poor policy	**4**	Yes	No	Yes	No	Yes	No	No	Yes
IR 3: Increased Public and Private DOTS Participation and Collaboration	**Average 2005**	**Cambodia**	**DR Congo**	**Indonesia**	**Malawi**	**Mozambique**	**Namibia**	**South Africa**	**Zambia**
Number of countries that have used the "Situation Analysis Tool''	**0**	No	No	No	No	No	No	No	No
"ISTC" have been fully implemented and used at the national level (max. score 3=Yes)	**0.0**	0	0	0	0	0	0	0	0
Country has developed and implemented a PPP strategy (max. score 4=Yes)	**0.6**	1	0	1	2	1	0	0	0
IR 4: Increased and strengthened TB and HIV/AIDS coordinated activities	**Average 2005**	**Cambodia**	**DR Congo**	**Indonesia**	**Malawi**	**Mozambique**	**Namibia**	**South Africa**	**Zambia**
Country has implemented the revised recording and reporting system for TB/HIV (max. score 3=Yes)	**0.8**	1	0	0	1	0	1	2	1
Number of countries where there is joint planning at national (and TB CAP areas) level for collaborative TB/HIV activities between NTP and NACP	**4**	Yes	No	No	Yes	Yes	No	No	Yes
Percent of co-infected TB patients referred for HIV/AIDS care	**#DIV/0!**	No data	No data	No data	No data	No data	No data	No data	No data
Percent of all registered TB patients who are tested for HIV	**32%**	No data	No data	No data	47%	No data	16%	No data	No data
Percent of co-infected TB patients on ART	**40%**	No data	No data	No data	26%	No data	54%	No data	No data
Number of persons living with HIV receiving TB prophylactic therapy	**#DIV/0!**	No data	No data	No data	No data	No data	No data	No data	No data
Percent of all registered persons living with HIV who are screened for TB	**#DIV/0!**	No data	No data	No data	No data	No data	No data	No data	No data
IR 5: Improved human and institutional capacity	**Average 2005**	**Cambodia**	**DR Congo**	**Indonesia**	**Malawi**	**Mozambique**	**Namibia**	**South Africa**	**Zambia**

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	**1**	No	No	Ongoing	No	Yes	No	No	Ongoing
Number of countries where NTP has an HRD MIS in place that collects and produces up-to-date information	**2**	Yes	No	Yes	No	No	No	No	No
Number of regional training courses conducted by regional institutions meeting international technical and educational quality standards	**0**								
Percent of all TB CAP consultant trainees who have completed at least two consultancies in the last 12 months	**No data**								
TFH provided leadership and quality technical assistance on HRD to both internal and external clients	**NA**								
Number of countries where NTP has an HRD focal point	**5**	Yes	No	Yes	Yes	No	No	Yes	Yes
HRD plans prepared based on global HRD guidelines for comprehensive TB control (max. score 3=Yes)	**0.8**	0	0	2	2	0	0	2	0
Percent of TB treatment facilities with at least one health care professional trained in TB case detection and treatment based on the DOTS strategy	**98%**	100%	No data	90%	100%	100%	No data	No data	No data
Percent of key managerial NTP staff positions filled at national, intermediate and district levels per country according to the HRD plan									
Country Total	**72%**	No data	No data	80%	95%	No data	32%	No data	80%
National Level	**75%**	No data	No data	90%	90%	No data	60%	No data	60%
Intermediate Level	**59%**	No data	No data	0	100%	No data	16%	No data	100%
District Level	**97%**	No data	No data	90%	100%	No data	No data	No data	100%
TB microscopy units with at least one laboratory technician trained in AFB microscopy	**86%**	100%	No data	80%	No data	100%	100%	No data	49%

Table 2: 2006 Results of TB CAP M&E Plan Indicators

2006 Results of TB CAP M&E Plan Indicators	Average 2005	Average 2006	Cambodia	DR Congo	Indonesia	Malawi	Mozambique	Namibia	South Africa	Zambia
Impact Indicators										
Total Population (millions)	**382**	**329**	14	No data	227	13	19	No data	44	12
TB incidence (WHO estimates) per 100.000 population	**494**	**405**	No data	No data	240	No data	460	No data	No data	515
HIV sero-prevalence among TB patients	**37%**	**40%**	No data	No data	1%	No data	49%	No data	No data	70%
Case fatality of HIV positive TB patients (estimated)	**30%**	**40%**	No data	No data	40%	No data	No data	No data	No data	No data
Outcome Indicators	**Average 2005**	**Average 2006**	**Cambodia**	**DR Congo**	**Indonesia**	**Malawi**	**Mozambique**	**Namibia**	**South Africa**	**Zambia**
Percent of public clinics implementing DOTS strategy										
Country total	**88%**	**88%**	100%	No data	96%	No data	55%	No data	No data	100%
TB CAP geographic areas		**96%**			96%					
Case detection rate (all cases)										
Country total	**61%**	**59%**	52%	No data	60%	No data	37%	No data	No data	85%
TB CAP geographic areas		**60%**			60%					
Case detection rate (SS+ cases)										
Country total	**63%**	**50%**	No data	No data	70%	No data	No data	No data	No data	30%
TB CAP geographic areas		**70%**			70%					
Treatment success rate (new ss+)										
Country total	**79%**	**83%**	85%	No data	85%	No data	78%	No data	No data	>82%
TB CAP geographic areas		**85%**			85%					
Country meets MDR TB quality standards defined by TB CAP (max. score 3 = Yes)	**1.9**	**2.0**	3	0	1	2	3	2	2	3
Nationwide TB and HIV programs effectively coordinated (max. score 4=Yes)	**1.6**	**2.0**	3	0	2	2	4	1	0	4
IR 1: Increased Political Commitment for DOTS	**Average 2005**	**Average 2006**	**Cambodia**	**DR Congo**	**Indonesia**	**Malawi**	**Mozambique**	**Namibia**	**South Africa**	**Zambia**
Country uses the components of Toolkit	**0.0**	**0.0**	0	0	0	0	0	0	0	0

Amount of government budget dedicated to NTP (millions)	**No data**	**Few data**	No data	No data	27.4	No data	2	No data	No data	No data
Number of countries that has formally adopted a national TB policy	**7**	**7**	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
IR 2: Strengthened and Expanded DOTS Programs	**Average 2005**	**Average 2006**	**Cambodia**	**DR Congo**	**Indonesia**	**Malawi**	**Mozambique**	**Namibia**	**South Africa**	**Zambia**
Number of countries where NTP has identified priority challenges to be addressed within a defined time period according to a measurable action plan using MOST	**1**	**1**	No	No	No	No	Yes	No	No	No
Technology of assessing and improving leadership and management skills in the selected TB CAP institutions has been transferred	**0**	**0**								
Number of countries where NTP has expanded case detection in other health programs and sectors	**2**	**4**	Yes	No	Yes	No	Yes	No	No	Yes
Country provides TB culture and sensitivity services meeting international quality standards (max. score 4 = Yes)	**2.0**	**2.5**	3	0	1	3	2	3	4	4
County has implemented "TB Laboratory Standard Operating Procedures (SOPs)" (max. score 3=Yes)	**0.3**	**0.3**	0	0	0	0	0	0	0	2
Average population per laboratory performing TB microscopy	**70,467**	**72,946**	70,400	No data	75,000	No data	94,581	66,000	No data	58,750
Percent of laboratories performing TB microscopy with over 95% correct microscopy results	**77%**	**32%**	No data	No data	No data	No data	60%	No data	No data	3.5%
Country has implemented the "X-ray Diagnosis Guidelines" (max. score 3=Yes)	**0.0**	**0.1**	0	0	0	0	1	0	0	0
Country has a policy on MDR TB (max. score 3=Yes)	**1.5**	**1.6**	2	0	2	2	3	1	3	0
Number of countries conducting MDR TB surveys or having MDR TB surveillance systems	**4**	**4**	Yes	No	No	No	Yes	No	Yes	Yes
Number of countries measuring socioeconomic status to document equitable access	**2**	**2**	0	No	No	No	Yes	No	No	Yes

Number of countries that have an official pro-poor policy	**4**	**4**	Yes	No	Yes	No	Yes	No	No	Yes
IR 3: Increased Public and Private DOTS Participation and Collaboration	**Average 2005**	**Average 2006**	**Cambodia**	**DR Congo**	**Indonesia**	**Malawi**	**Mozambique**	**Namibia**	**South Africa**	**Zambia**
Number of countries that have used the "Situation Analysis Tool''	**0**	**0**	No	No	No	No	No	No	No	No
"ISTC" have been fully implemented and used at the national level (max. score 3=Yes)	**0.0**	**0.1**	0	0	1	0	0	0	0	0
Country has developed and implemented a PPP strategy (max. score 4=Yes)	**0.6**	**1.1**	1	0	3	2	2	0	0	1
IR 4: Increased and strengthened TB and HIV/AIDS coordinated activities	**Average 2005**	**Average 2006**	**Cambodia**	**DR Congo**	**Indonesia**	**Malawi**	**Mozambique**	**Namibia**	**South Africa**	**Zambia**
Country has implemented the revised recording and reporting system for TB/HIV (max. score 3=Yes)	**0.8**	**1.4**	2	0	1	2	0	2	2	2
Number of countries where there is joint planning at national (and TB CAP areas) level for collaborative TB/HIV activities between NTP and NACP	**4**	**4**	Yes	No	No	Yes	Yes	No	No	Yes
Percent of co-infected TB patients referred for HIV/AIDS care	**#DIV/0!**	**40%**	50%	No data	No data	No data	30%	No data	No data	No data
Percent of all registered TB patients who are tested for HIV	**0.3**	**22%**	20%	No data	No data	No data	No data	24%	No data	No data
Percent of co-infected TB patients on ART	**0.4**	**38%**	50%	No data	No data	33%	30%	No data	No data	No data
Number of persons living with HIV receiving TB prophylactic therapy	**#DIV/0!**	**10%**	10%	No data	No data	No data	No data	No data	No data	No data
Percent of all registered persons living with HIV who are screened for TB	**#DIV/0!**	**50%**	50%	No data	No data	No data	No data	No data	No data	No data
IR 5: Improved human and institutional capacity	**Average 2005**	**Average 2006**	**Cambodia**	**DR Congo**	**Indonesia**	**Malawi**	**Mozambique**	**Namibia**	**South Africa**	**Zambia**

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	**1**	**1**	No	No	Ongoing	No	Yes	No	Ongoing	Ongoing
Number of countries where NTP has an HRD MIS in place that collects and produces up-to-date information	**2**	**2**	Yes	No	Yes	No	No	No	No	No
Number of regional training courses conducted by regional institutions meeting international technical and educational quality standards	**0**	**0**								
Percent of all TB CAP consultant trainees who have completed at least two consultancies in the last 12 months	**No data**	**No data**								
TFH provided leadership and quality technical assistance on HRD to both internal and external clients	**NA**	**NA**								
Number of countries where NTP has an HRD focal point	**5**	**5**	Yes	No	Yes	Yes	No	No	Yes	Yes
HRD plans prepared based on global HRD guidelines for comprehensive TB control (max. score 3=Yes)	**0.8**	**1.0**	0	0	2	2	1	0	2	1
Percent of TB treatment facilities with at least one health care professional trained in TB case detection and treatment based on the DOTS strategy	**98%**	**98%**	100%	No data	0.9	100%	1	No data	No data	No data
Percent of key managerial NTP staff positions filled at national, intermediate and district levels per country according to the HRD plan										
Country Total	**72%**	**78%**	No data	No data	90%	95%	No data	36%	No data	90%
National Level	**75%**	**80%**	No data	No data	90%	90%	No data	80%	No data	60%
Intermediate Level	**59%**	**63%**	No data	No data	20%	100%	No data	33%	No data	100%
District Level	**97%**	**81%**	No data	No data	90%	100%	No data	33%	No data	100%
TB microscopy units with at least one laboratory technician trained in AFB microscopy	**86%**	**89%**	100%	No data	90%	No data	100%	100%	No data	54%