

**ANNUAL REPORT**  
April 1, 2005 – March 31, 2006

**QUARTERLY REPORT**  
January 1 – March 31, 2006



*Central Asian Republics TB Control Partnership*

**Cooperative Agreement No.: 176-A-00-04-00006-00**

***Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan  
and Uzbekistan***

**ANNUAL and QUARTERLY PROGRESS REPORT**

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**PROGRAM TITLE**                    **USAID Tuberculosis Control Program for the Central Asian Region**

**COOPERATIVE AGREEMENT NO:** 176-A-00-04-00006-00

**PROGRAM SITES:**                    **Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan**

**REPORT PERIOD:**                    **April 1, 2005 – March 31, 2006**

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**DATE:**                                    **May 1, 2006**

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## LIST OF ACRONYMS

ADB	Asian Development Bank
BCC	Behavioral Change Communication
BPPS	Best Practice Performance Site
CAR	Central Asian Republics
CCES	Committee of Criminal Executive System
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CMCC	Central Medical Consultant Committee
DMOH	Deputy Minister of Health
DOTS	Directly Observed Therapy Short Course
DST	Drug Sensitivity Testing
FDC	Fixed Dose Combination
FMC	Family Medical Center
GDF	Global Drug Facility
GFATM or Global Fund	Global Fund for AIDS, Tuberculosis and Malaria
GLC	Green Light Committee
GoT	Government of Tajikistan
GUIN	Penitentiary System
HLWG	High Level Working Group
HMIS	Health Management Information Systems
HQ	Headquarters
IC	Information and Communication
ICRC	International Committee of the Red Cross
IEC	Information, Education and Communication
JHU	Johns Hopkins University
JSI	John Snow Incorporated
KNCV	Royal Dutch Tuberculosis Association
LSAT	Logistics System Assessment Tool
M & E	Monitoring and Evaluation
MDR-TB	Multi-drug Resistant Tuberculosis
MIA	Ministry of Internal Affairs (Kazakhstan)
MIS	Management Information System
MOHMI	Ministry of Health and Medical Industry (Turkmenistan)
MOJ	Ministry of Justice
NCPH	National Center of Phthiology (Kyrgyzstan)
NJ	New Jersey Medical School – Tuberculosis Center
NRL	National Reference Laboratory
NTBC	National Tuberculosis Center of the Republic of Kazakhstan
NTP	National Tuberculosis Program
OTBD	Oblast TB Dispensary
PHC	Primary Health Care
PRI	Penal Reform International
PSF	Pharmacies San Frontieres
PTI	Pretrial Isolators
RCCTBC	Republican Coordination Council for TB Control

RDU	Rational Drug Use
RK	Republic of Kazakhstan
R&R	Recording and Reporting
RRCS	Republican Red Crescent Society (Kazakhstan)
SES	Sanitary Epidemiological Service
SM	Social Mobilization
SOW	Scope of Work
SS- or S-	Sputum Smear Negative
SS+ or S+	Sputum Smear Positive
TB	Tuberculosis
TBD	TB Dispensary
TOR	Terms of Reference
TOT	Training of Trainers
TWG	Thematic Working Group
UNDP	United National Development Program
USAID	United States Agency for International Development
WFP	World Food Program
WHO	World Health Organization
X pulmonary	Extrapulmonary

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In Response To:  
Cooperative Agreement No: 176-A-00-04-00006-00

### **Regional Summary**

#### **Introduction**

1. In April 1, 2006, the Project HOPE Consortium finished Year 2 of the project under its Cooperative Agreement with USAID. Overall the project is on course. The notification of the award of the project grants in May 2004 was followed by implementation planning and partner briefing, by presentations to USAID and regional staff on the strategy of the approach, which resulted in the launch of the project-specific activities in July 2005.

#### **Epidemiology**

2. During the period of April 1 – Dec. 31, 2004, 9,030 TB cases of all types were notified in project areas. In 2005, another 15,286 cases were added, bringing the total of notified cases in the Project HOPE supported sites to 24,316 cases. Of these, a total of 7,730 cases (32%) were the new smear positive cases that are the primary focus of the DOTS strategy. Smear conversion rates among the cases identified and reported on so far in the period have increased from the reported 80% in 2004 to an average of 86% in 2005.
3. It is now also possible to report on the cure rates of the cases notified in 2004. Of a total of 3,874 cases that were evaluated over this period a favourable outcome was achieved on average in 81%. Uzbekistan has a lower success rate (67.6%), primarily because of a high reported default rate. This poses a challenge for program improvement in the coming years.

#### **Building Political Support for Sustainable TB control**

##### **Structural Support**

4. To achieve ownership and thereby sustainability for the national TB control program, Project HOPE has been inducing the creation of multisectoral High Level Working Groups in all 5 countries in Central Asia. In Year 2, in four countries such a mechanism has been established; Uzbekistan has reached consensus on the establishment of a HLWG, the structure has been decided upon and the terms of reference have been prepared, but its official status has not yet been confirmed.

5. In all five countries, technical working groups have been established that look at the various aspects of TB control and advise the government through the HLWGs how to improve TB control interventions.
6. In Tajikistan, through Project HOPE's advocacy, in many rayons financial support for the TB control program increased, including higher salaries for TB staff.
7. In Turkmenistan, a five-year (2005-2009) National TB Control Program has been adopted by the government, outlining a stepwise further expansion of the DOTS strategy. Project HOPE was deeply involved in drafting that plan.

### **Funding for TB Control**

8. Project HOPE also helped with drafting proposals for the Global Fund against AIDS, Tuberculosis and Malaria (GFATM) Round Five Applications in Turkmenistan and Kazakhstan. Unfortunately, Turkmenistan decided not to submit, while Kazakhstan's proposal was rejected. In Tajikistan, Project HOPE supports the MoH in TB control as the Principal Recipient of the Global Fund, while in Uzbekistan Project HOPE has been subcontracted by the Global Fund to help with increasing the training output and improved monitoring of performance. In Kyrgyzstan, Project HOPE collaborates closely with the PIU of the GFATM grant and conducts joint seminars for medical staff. When Round Six will be announced, Project HOPE once more will assist the governments in drafting the proposals for the Global Fund

### **Interagency Coordination**

9. Many organisations are active in the support of TB control and its related aspects in the five countries. Interagency Coordination Councils have been set up in Tajikistan, Uzbekistan and Kyrgyzstan. In all countries, Project HOPE coordinates with other agencies to avoid duplication and add synergy. It has a regular consultation with the WHO Sub Regional Office and collaborates closely with Zdrav Plus on issues regarding integration into PHC, with CDC on laboratory and surveillance issues and with the Capacity project on TB/HIV interventions. In Tajikistan, the collaboration with the World Food Program is especially important to provide support to poor TB patients and their families.

### **Website**

10. The intranet section of the project website for which CAMRIS is the leading Partner was reviewed by Project HOPE and opened up to all Intranet users at the beginning of the first quarter of 2006. The Content Manager contacted all field offices and consortium partners with instructions on how to submit documents for posting and began to receive submissions. The website continued to be improved with the addition of instructional materials for users; a web-based System Change Request/System Incident Report (SCR/SIR) process; the development of an Intranet site map in English and Russian; the addition of a Related Links page in English and Russian; refinements to the calendar, discussion board, keyword search capability, and organization of the site; and continued development of the Russian Intranet interface. Work also began on the development of the digital libraries (public and Intranet).
11. Anticipated for next quarter: The Intranet will continue to serve as a useful project resource for document management and information sharing as CAMRIS will continue to work with the Chief of Party to encourage additional feedback and submissions of new and updated documents by project staff. The site will also be improved based on any feedback received from USAID. The structures of the digital libraries (public and Intranet) will be developed, and CAMRIS will work with the Project HOPE Consortium to identify and obtain relevant documents, in addition to those already on the site, with which the digital libraries will be populated. Collaboration will also take place with project staff to continue developing appropriate public site materials, such as country briefs and success stories, as

well as to improve the site visually with any available photos or graphics. Development of a Russian interface will also continue.

### **Building Human and Systems Capacity for Sustainable TB control**

#### **Integration into the Primary Health Care structure**

12. In all five countries, the primary health care services have become involved in case detection and treatment delivery. Project HOPE contributes to a large scale training of PHC staff in all five countries. In each country, there is a lack of a clear overall strategy in which roles and responsibilities (and appropriate funding) has been described. How to address this situation is on the common agenda of Project HOPE and Zdrav Plus.
13. Input for these discussions will be given through the Health Policy Assessments that Project HOPE started with its Partner CAMRIS. The first assessment has been done in Kyrgyzstan, and the report will be ready in April 2006. The next country to be visited will be Kazakhstan in June 2006. CAMRIS is the leading Partner in these assessments and to that end has hired a Regional Policy Research Specialist, who is based in Project HOPE's Regional Office in Almaty, next to Project HOPE's Regional Policy Advisor.

#### **Strengthening the Laboratory Network**

14. A base line assessment of the laboratory network in all countries was done by Project HOPE's Regional Laboratory Specialist. Based on her findings, a Rationalisation Plan has been developed. She also lent support for an assessment of needs, both in equipment and consumables. Although Project HOPE under the present grant does not provide equipment, it has been involved in the providing microscopes, reagents and consumables to facilities in Tajikistan (Global Fund) and Turkmenistan (British Embassy)
15. In collaboration with CDC, a Training Package for basic sputum smear microscopy has been developed and is used by Project HOPE's laboratory coordinators in the respective countries.
16. Project HOPE has also assisted with the introduction and strengthening of quality assurance of the laboratory network with the region. The Regional Laboratory Specialist, together with HOPE staff and local counterparts, has introduced both panel testing and blinded rechecking as methods of assuring quality assurance in the laboratory network. These activities are complimentary to the work that the CDC has conducted.
17. Culture and susceptibility testing (DST) activities have started in several countries. Project HOPE's Regional Laboratory Specialist started to develop a Manual and Training Package for Culture Laboratories. A protocol for DST surveys is almost finished, and it is expected that in the beginning of Year 3 a DST survey will start in Almaty Oblast in Kazakhstan.

#### **Strengthening Human Resource Capacity**

18. In all five countries, Project HOPE takes part in training activities for a variety of professionals and at different levels. Since Project HOPE started its activities in 1998, over 10,000 staff have been trained. (Without taking into account the laboratory technicians). On top of that, many staff received On-the-Job training during supervision visits. Training activities have shifted from providing training directly towards the Training of Trainers. For the coming years, the emphasis will be on increasing the pool of trained (and certified) Trainers and creating in each country a pool of Master Trainers for that purpose.
19. In Kazakhstan a National Training Centre in the National TB Institute has been established. Support is given to the development of Oblast Training Centers.



**Creating Rational Drug Management Systems**

20. The lead in the creation of rational drug management is with Project HOPE's Partner John Snow International (JSI). JSI is assisted by Project HOPE's Regional Drug Specialist, who is based in Tajikistan.
21. A desktop assessment of all regulatory documents related to drug management in each of the countries was undertaken, but in Year 2 the report was not yet available.
22. In all five countries, a drug management assessment was performed, resulting in the creation of a Logistic Management Information System (LMIS). This LMIS has been field tested in the countries using general forms that are adapted to the specific countries needs. A Manual how to use the LMIS will be ready in all five countries in Year 3. Drug managers will be trained and a Training Package is under development. This important initiative will assist local partners in all aspects of drug management, ensuring that an uninterrupted supply of drugs will be available for TB patients.

**Improved Program Management**

23. In all five countries, Project HOPE is involved in improving monitoring during supervision visits. In Uzbekistan, an alternative approach towards supervision is being field tested, freeing Project HOPE staff to be able to put more emphasis on the training aspects and at the same time increasing the country's own capacity to be able to continue monitoring visits, in spite of logistical and human capacity restrictions. Project HOPE has formed an internal working group to discuss the decentralization of monitoring and supervision activities. Similar work as is being piloted in Uzbekistan is also taking place in Kazakhstan and Tajikistan.
24. Surveillance will be electronic in future years in all countries. Implementation of Electronic Case Base Management (ECBM) will be the task of CDC, but Project HOPE has been involved in discussing definitions and adaptations of existing forms.

**MDRTB Management**

25. To develop a strategy for dealing with the serious MDRTB epidemic, Project HOPE's partner the New Jersey Medical School (NJMS), together with Project HOPE Regional Specialist for MDRTB/HIV, visited Uzbekistan and Kyrgyzstan. A report with recommendations was not yet available at the end of Year 2. In Year 3, the other countries will be assessed, and where needed, the national strategy proposal will be adapted. Ultimately, these strategies will be submitted for the consideration of the Technical Working Groups.
26. In Kazakhstan, the strategy will be developed in close coordination with the National TB Centre and the GORGAS project. MDRTB management (DOTS Plus has been introduced in Kyrgyzstan and Kazakhstan), and a pilot will start in 2006 in Uzbekistan.

**TB/HIV Management**

27. New Jersey Medical School will also assist Project HOPE in the development of a national TB/HIV strategy, and, during the country visits to Uzbekistan and Kyrgyzstan, progress in this field was also assessed. Awaiting their findings Project HOPE has started coordination with the Capacity project both at the Regional and local level. Capacity has started pilots in Uzbekistan, Tajikistan and Kyrgyzstan, and will start also in Turkmenistan and Kazakhstan. Project HOPE's Regional Specialist for MDRTB/HIV will coordinate Project HOPE involvement.

**TB in Prisons**

28. The National TB Training Centre for Penitentiary Staff that was established in Karaganda, has been handed over to the Ministry of Justice in Kazakhstan. Project HOPE staff may still be involved in some of the trainings that are organized.

29. To facilitate TB control in prisons, senior administrative and medical staff of penitentiary systems of Uzbekistan and Kyrgyzstan have visited the Karaganda Training Centre. Project HOPE's Regional Specialist for Prisons was the initiator of these visits and also took part in the training. In Year 3, Tajikistan plans to send prison staff to Karaganda. With Turkmenistan, the issue is still under discussion.
30. With its Partner Chemonics, Project HOPE plans to develop a communication strategy on TB for prison administrators and prisoners. This will become part of the National Communication Strategy.

### **Community, Advocacy and Mobilization**

31. A National Communication Strategy is being developed by Project HOPE's Partner Johns Hopkins Bloomberg University/ Center for Communication Programs. Field visits were made together with Project HOPE's Regional Specialist on Social Mobilisation. By the end of Year 2, Communication Strategies were about to be addressed by the Technical Working groups in Kyrgyzstan, Tajikistan and Uzbekistan. The common approach will be that the technical working groups will have to approve the newly developed materials.
32. In Tajikistan and Uzbekistan, KAP surveys were undertaken to assess the needs for health promotion materials for several target groups. The Tajik report has been finalized and will be presented at the next TWG meeting in Year 3. The Uzbek report is being finalized. Extracts from this survey will be published in an international journal.
33. In Kazakhstan, a Memorandum of Understanding was signed with the Healthy Life Style Institute to develop a common National Communication Strategy, based on already existing initiatives in Kazakhstan.
34. In all countries Project HOPE was deeply involved in the preparation for and activities on World TB Day 2006.
35. Training in Interpersonal Communication/Counselling (IPC/C) skills has started in Tajikistan, where patronage nurses are the prime target group. These nurses are already working and supporting patients and their families while the patients are under treatment.
36. Preparations for the initiation of Small Grants are well underway in Kazakhstan and Tajikistan. In Kazakhstan, the Call for Proposals is expected in May 2006. Uzbekistan laws forbid initiation of such programs.

### **Incentives and Enablers**

37. In Tajikistan, the collaboration with the World Food program continues. A new Cost Sharing Project Agreement was signed in February 2006 that will allow food distribution to patients and their dependants, as well as institutional feeding schemes. The cost sharing has enabled the program to expand to an additional 5 rayons in the country; the incentive program is now functioning in seven rayons with Project HOPE assistance.

### **Administrative Issues**

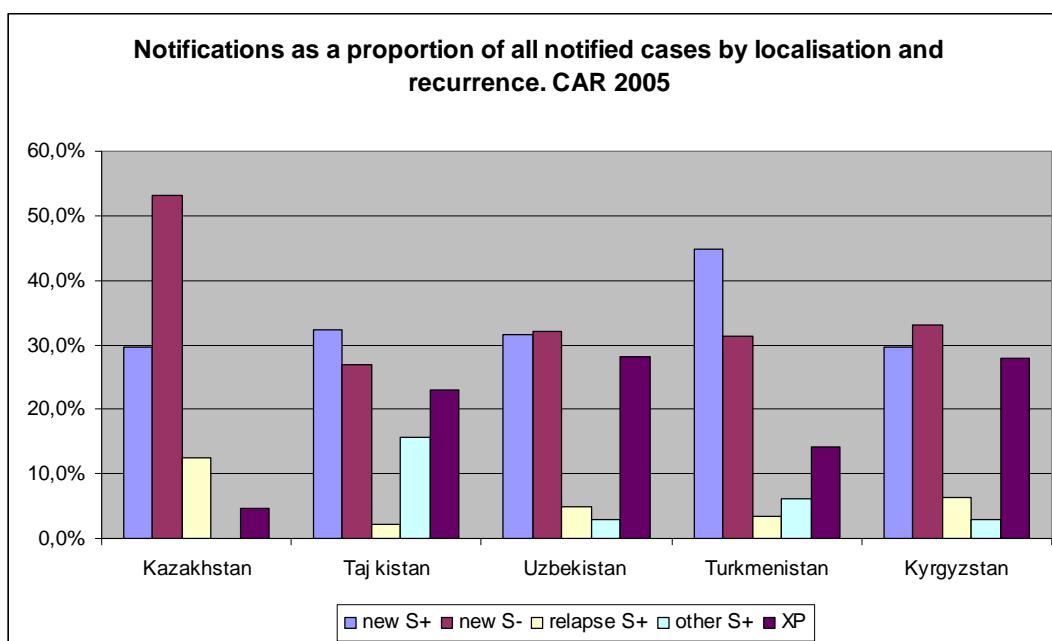
38. In Year 2, several new staff members were hired in support of the Project HOPE program. All positions are fully staffed and the new employees bring a lot of experience and knowledge to the project. The Technical Director is now stationed in the region and working directly with Regional Specialists and Program Managers. The Regional Director/Chief of Party relocated to the US to take on regional responsibilities only and the Chief of Party position was promoted from the Program Manager from Tajikistan. In addition, a new Regional Policy Specialist was hired and has been working with all of the country programs and with CAMRIS partners on Policy issues in each country.

39. Project HOPE has been serving as the Principle Recipient of the Global Fund in Tajikistan since October 2004. This allows for synergy between the programs in support of TB Control in Tajikistan.
40. Project HOPE has a subcontract for the Global Fund in Uzbekistan in support of TB training and monitoring in 8 regions. This 12 month subcontract started in January 2006, and again allows for synergy between the programs.

## Epidemiological Analysis

### Notification

41. In 2005, in the Central Asian Republics the notification for all TB cases was 15,286, ranging from 683 in Turkmenistan (4 sites) to 6,390 in Kyrgyzstan (whole country). (Table 1) Compared to 2004, this is an increase of 27%. The number of new smear positive cases notified was 4,795 in 2005, an increase of 22% compared to 2004.<sup>1</sup> But this has to be seen against the background of an expanded number of sites where Project HOPE is active. The population covered increased by 11%, from 11 million to 12.2 million. (Table 2)

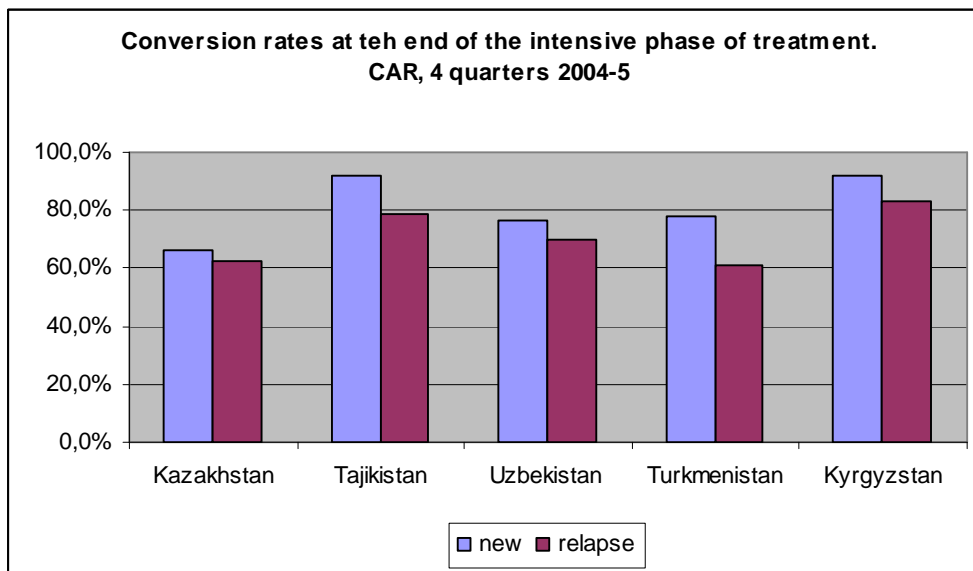


42. The notification for new smear positive cases in 2005 in the CAR ranged from 298 in Turkmenistan to 1,901 in Kyrgyzstan. As a proportion of all notified cases the average was 31%, ranging from 30% in Kyrgyzstan to 45% in Turkmenistan. The latter figure is at least 10% higher than in any of the other countries and is compatible with a newly implemented program, where the initial success will be relatively high. As a proportion of new pulmonary TB cases, smear positivity on average was 48%, ranging from 36% in Kazakhstan to 56% in Turkmenistan, with proportions of 47% in Kyrgyzstan, 50% in Uzbekistan and 54% in Tajikistan. The target is 65%, so the performance rate in DOTS sites still needs improvement.
43. In Kyrgyzstan (28%), Tajikistan (23%) and Uzbekistan (28%), a high proportion of extrapulmonary TB is reported. This could be the result of over-diagnosis by fluorography if a large proportion of pleurisies were found and the definition of pulmonary TB was strictly adhered to. Reporting on

<sup>1</sup> Data for 2004 were available for 3 quarters only and have been extrapolated for a full year. Although this induces some inaccuracy, it still allows for a reasonable estimate of the increase in 2005.

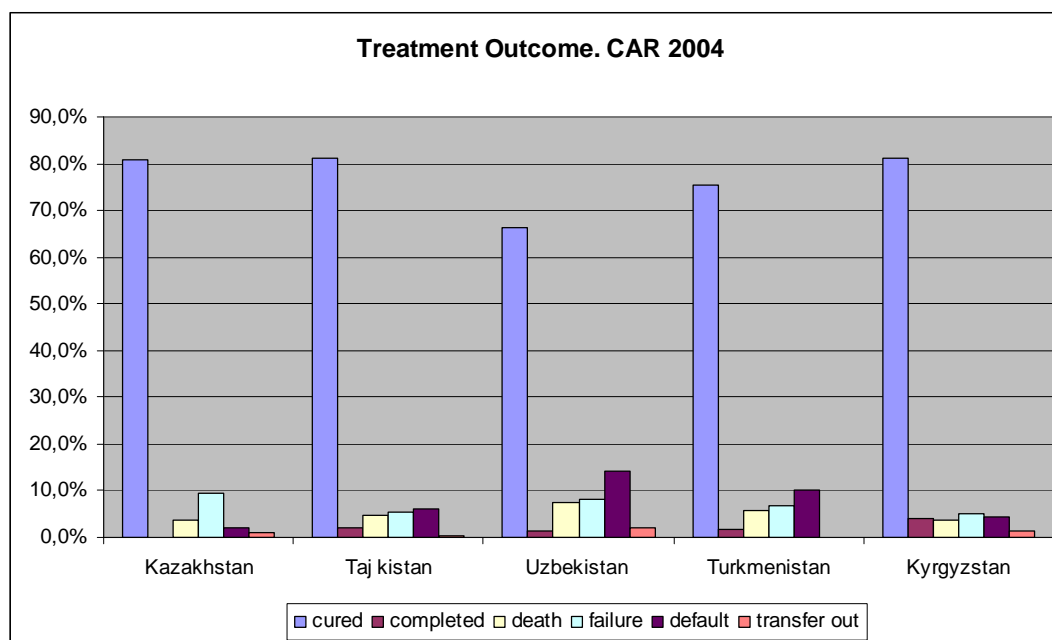
respiratory instead of pulmonary TB is still very common. The difference with Kazakhstan is striking, although in Kazakhstan the rates are probably too low.

44. Theoretically, the number of recurrent and extrapulmonary cases should be lower than 20% each, leaving around 60% for new pulmonary cases of which 65% should be bacteriologically confirmed. All countries comply with this rule of thumb, but that is either because the notification of recurrent cases is low (8% in Uzbekistan, 9% in Kyrgyzstan and 10% in Turkmenistan) or the rate of extrapulmonary TB is low (5% in Kazakhstan).
45. The situation in Kazakhstan is puzzling: Pulmonary TB is 83% of all cases. This also could be the result of over-diagnosis. Notification needs to be assessed together with CDC.



### Conversion

46. Smear conversion rates in new cases ranged from 66% in Kazakhstan to 92% in Tajikistan, with an overall conversion rate of 86%. For relapses, these rates were 61% in Turkmenistan and 83% in Kyrgyzstan, with an overall rate of 75%.
47. It is unclear why conversion rates in new cases in Kazakhstan are so much lower than in the rest of CAR. One explanation brought forward is the frequent prolongation of the intensive period to 5 months. But that in should not be a reason for low conversion rates. Another explanation would be a high rate of drug resistance; but cure rates are relatively high (81%) and failures relatively low (9%). Yet we know that Kazakhstan has a large MDRTB problem with estimates of 10-15% primary MDRTB. This is most likely similar in the other countries. The results of the DST survey that will be undertaken in Almaty Oblast will shed some light on this problem.
48. Similarly, as is commented upon in the Kazakh quarterly report, the low conversion rates eventually result in good cure rates. One aspect of this comparison is that different cohorts are reported upon, so a further analysis is needed: conversion is reported for cohorts in 2004 and 2005, while outcome is for the 4 quarters of 2004.



### Treatment outcome

49. Treatment outcomes are calculated over the cases that could be evaluated. Although that is commonly done for outcome reporting, it is basically wrong. Reporting should be on the total cohort of new smear positive cases that was notified. The differences between cases notified and cases evaluated in the Project HOPE sites are small, ranging from 97% in Kazakhstan to 100% in the other countries.
50. Outcomes are good. Actually better than would be expected in countries where one estimates relatively high levels of drug resistance. The success rate on average is 81.3%, while failure and default rates with each 6% are acceptable. Failure rates probably cannot be lowered within the foreseeable future, which leaves improvement of defaulter rates to increase the success rate to the objective of 85%. Uzbekistan has a high defaulter rate, causing a much lower success rate than in the other countries. Project HOPE and the National DOTS Center must investigate the underlying cause and find ways to remedy it.
51. With increasing expansion, both in geographic and population coverage, it is very likely that the cure rates will decrease.

### Table. Project HOPE in 5 Central Asian Republics:

Case Notifications in 2005; Smear conversion in 2004-05; treatment outcome 2004

	Kazakhstan		Tajikistan		Uzbekistan		Turkmenistan		Kyrgyzstan		Total	
<b>Notifications</b>												
new S+	618	29.8%	1284	32.3%	685	31.7%	298	43.6%	1901	29.7%	4795	31.4%
new S-	1103	53.1%	1073	27.0%	696	32.2%	235	34.4%	2115	33.1%	5202	34.0%
relapse S+	258	12.4%	85	2.1%	107	4.9%	18	2.6%	411	6.4%	884	5.8%
other S+	0	0.0%	618	15.6%	65	3.0%	37	5.4%	181	2.8%	906	5.9%
XP	98	4.7%	911	22.9%	611	28.2%	95	13.9%	1782	27.9%	3499	22.9%
total	2077		3971		2164		683		6390		15286	
<b>conversion</b>												
cohort	639		998		653		298		1815		3750	
new	423	66.2%	919	92.1%	499	76.4%	233	78.2%	1667	91.8%	3242	86.5%
cohort	226		57		99		18		384		685	

relapse	141	62.4%	45	78.9%	69	69.7%	11	61.1%	319	83.1%	516	75.3%
<b>outcome</b>												
notified	676		600		599		306		1716		3897	
evaluated	657	97.2%	600	100.0%	599	100.0%	306	100.0%	1712	99.8%	3874	99.4%
cured	547	80.9%	487	81.2%	397	66.3%	231	75.5%	1393	81.2%	3055	78.4%
completed	0	0.0%	13	2.2%	8	1.3%	5	1.6%	68	4.0%	94	2.4%
death	26	3.8%	29	4.8%	44	7.3%	18	5.9%	66	3.8%	183	4.7%
failure	63	9.3%	32	5.3%	48	8.0%	21	6.9%	88	5.1%	252	6.5%
default	13	1.9%	36	6.0%	86	14.4%	31	10.1%	75	4.4%	241	6.2%
T/O	8	1.2%	3	0.5%	12	2.0%	0	0.0%	22	1.3%	45	1.2%

**Table.** Coverage of the population under Project HOPE supervision\*

country	Kazakhstan	Tajikistan	Uzbekistan	Turkmenistan	Kyrgyzstan	Central Asia
Population total 2004	15,012,700	6,710,200	26,209,000	4,980,700	5,010,800	57,923,400
Population total 2005	15,147,000	6,710,200	26,209,000	5,280,200	5,065,100	58,411,500
Population PH sites 2004	1,580,300	1,246,300	2,456,123	740,200	5,010,800	11,033,723
Population PH sites 2005	1,596,700	1,762,500	2,971,364	852,126	5,065,100	12,247,790
% 2004	10.5	18.6%	9.4%	15%	100%	19.0%
% 2005	10.5	26.3%	11.3%	16%	100%	21.0%

\* For Tajikistan and Uzbekistan 2005 population data are not yet available and 2004 data were used for calculations

**Kazakhstan – Q1, 2006 – Movsar Makhmatov****QUARTERLY PROGRESS SUMMARY****Introduction**

1. The end of this quarter also marks the end of the second year of the project. The Project HOPE Consortium has continued with activities addressed to support the NTP of Kazakhstan in the following areas: (a) strengthening political support for TB control; (b) improving human and systems capacity for TB control; (c) raising community awareness of the TB symptoms and encouraging care seeking behavior. The tasks set for the second year of the program are mainly accomplished.
2. The main activities were directed towards the reformation of the NTP management system in an effort to create an effective mechanism on managing anti-TB activities. As a result, Order # 73 of the Ministry of Health of the Republic of Kazakhstan was issued regarding the establishment of the Technical Working Group (TWG) and eight Thematic Subgroups (TS) on different program aspects. The first TWG meeting was held in Kazakhstan, where the important decision to review the actual TB Order #471 was made in the light of the latest WHO recommendations.
3. All established Thematic Subgroups met to set priority tasks and to develop work plans for the year 2006.
4. Project HOPE took part in developing the GFATM application, which unfortunately was not successful.
5. A National Training Center was established at the NTBC to conduct Advanced DOTS trainings for TB staff and to coordinate activities of the oblast level training centers. The process of creating a Local TB Trainers Team (LTBTT) on DOTS education for the Northern Region of the Almaty oblast was accomplished and a training plan was approved for this region.
6. A comprehensive review of the legal framework and policy related to TB pharmaceutical management was performed by JSI/ Project HOPE.
7. A workshop on the results of Monitoring-Training-Planning (MTP) visits to the Correctional Facilities (CF) of Almaty oblast took place.
8. A Memorandum of Understanding in regard to the IEC component of the NTP was developed and signed between Project HOPE/Kazakhstan and National Center for Healthy Life Styles (NCHLS).

**I. BUILDING POLITICAL SUPPORT FOR TB CONTROL**

9. The first meeting of the TWG on TB was held. A resolution of the TWG includes the following decisions: (a) to confirm plans of the TS for 2006; (b) to review TB Order # 471 in terms of recent WHO recommendations; (c) to apply WHO recommendations to the Treatment Success rate calculation; (d) to strengthen control through the Pharmacy Committee MH RK on implementation of an item “About prohibition to retail TB Drugs with no prescriptions in drug stores” of Order #323; (e) to revise the treatment protocols used in order to exclude TB Drugs from treatment of other diseases; (f) to develop treatment protocols for chronic TB cases; (g) to include Isoniazid needed for chemotherapy of HIV infected patients in the quantifications of TB Drug needs; (h) to hold next the TWG meeting in late 2006.
10. An Oblast Round Table (ORT) was conducted in the Almaty oblast with the NTBC, USAID and Project HOPE representatives. The Oblast Coordinators on clinic, laboratory and statistics have presented an analysis of the activities on their respective program components. Cohort Analysis of treatment outcomes of patients registered in 2004 was done. During the ORT, a detailed work plan on program components was developed to solve existing problems. Oblast Round Tables are conducted in order to: (a) increase TB program management skills among mid-level managers on the basis of

Cohort Analysis of treatment outcomes; (b) develop a detailed plan to correct weaknesses of the existing system.

11. The following activities have been scheduled for next quarter: (a) to hold an ORT in the penitentiary system of the Karaganda oblast; (b) to carry out an initial assessment with reporting following the CAMRIS country visit; (c) to provide organizational and technical support to TS meetings.

## **II. BUILDING HUMAN AND SYSTEMS CAPACITY FOR TB CONTROL**

### **Integration of TB control within a Reformed Health System**

12. The Primary Health Care system of Almaty oblast was included in the system of regular monitoring visits of Project HOPE and Oblast TB Dispensary (OTBD) specialists. Training on the DOTS strategy is conducted among PHC staff on the basis of the training center that was built in the Almaty OTBD. The quantity of trained PHC staff is 78. The detailed integration plan will be developed in the 1<sup>st</sup> quarter of the 3<sup>rd</sup> year of the program.
13. To improve the integration of the TB system and PHC services, the following activities will be undertaken in the next quarter: (a) an integration plan for the Northern region of Almaty oblast will be developed; (b) roles and responsibilities of specialists engaged in an integration process will be reviewed; (c) a referral and coordination mechanism will be improved; (d) indicators to monitor integration quality will be developed; (e) basic DOTS trainings for specialists of the penitentiary and civil sectors of Almaty oblast will be conducted.

### **Strengthening the TB Laboratory Network**

14. As a result of the joint assessment with the NTBC of the existing smear preparation points in Almaty oblast, a decision has been made to close 130 points because of low workload and poor quality of performance.
15. Project HOPE purchased and installed 2 binocular “Leica” microscopes in the culture lab based in the OTBD and the smear microscopy lab based in the City Polyclinics of Taldykorgan city. Standard laboratory registers (TB-04) were prepared and provided to all 13 laboratories in the Northern region of Almaty oblast.
16. A work plan for 2006 was approved at the TS meeting on laboratory TB diagnostics.
17. Project HOPE, jointly with CDC and the OTBD, evaluated the basic smear microscopy training’s impact on the level of knowledge and practical skills of laboratory technicians of Almaty oblast. The results were: the laboratory technicians showed advanced skills in Panel Smears and demonstrated excellent techniques in smear preparation and staining. However, problems were identified in “blinded” rechecking. So, it was decided to implement the “blinded” rechecking method in Taldykorgan during the 3<sup>rd</sup> year of the program.
18. A monitoring visit to the Correctional Facilities of Almaty oblast showed progress: a prison laboratory service was included in the civil oblast quality control system; quality of sputum smear collection was improved; the recording and reporting system was standardized and has been defined.
19. A standardized monitoring system on the laboratory service was not in place. Consequently, the Project HOPE specialists have started working on a Monitoring Manual for TB activity that is to be used as a basis for the Oblast coordinators training that is to take place in May - June 2006.
20. To strengthen the laboratory network of the Almaty oblast the following activities will be undertaken in the next quarter: (a) a situational analysis for implementation of External Quality Assurance system (EQA) “blind” rechecking method will be done; (b) EQA protocols will be developed; (c) an introductory training on the EQA system for laboratory technicians will be conducted.



**Strengthening Human Resources Capacity**

21. The established training centers continue trainings on DOTS strategy for PHC and penitentiary system specialists: (a) Karaganda LTBTT Center for Integrated Education (CIE) has trained 15 clinicians of the Southern region prison system; (b) LTBTT of the Northern region of Almaty oblast under supervision of Project HOPE has trained 16 PHC specialists.
22. Along with the CIE activity, the Committee of Criminal Executive System (CCES) MJ RK is using the capacity of a team of coordinators at the Karaganda penitentiary system to conduct monitoring visits to other regions of the country.
23. The creation of the Local TB Trainers Team for the Northern region of Almaty oblast has been completed. An audit of the teaching quality was done. This team will independently train the PHC specialists on DOTS under a schedule approved by the Oblast Health Care Department. Project HOPE will provide training supplies during the 3<sup>rd</sup> year of the project.
24. An advanced DOTS training was conducted in Almaty oblast for 19 specialists, including the oblast coordinators of TB Control Program, head doctors of PHC facilities and CCES representatives. This training includes a session on the Cohort Analysis of treatment outcomes to develop skills for evaluation and management of the program.
25. The National Training Center (NTC) was established at NTBC. Project HOPE/Kazakhstan, with the financial support of USAID, provided the Center with the equipment to conduct trainings, including a device for simultaneous translation. The NTC will train specialists and coordinate the activities of the nine oblast training centers.
26. Formation of LTBTTs for the Southern region of Almaty oblast and NTBC will be initiated in the next quarter. In this connection, TOT training and training audits of corresponding LTBTTs will be conducted. In addition, training on “Monitoring and Supervision of TB activities” for the Oblast coordinators and specialists of Almaty oblast will take place.
27. During the MTP visit to prisons, the following problems have been identified: (a) limited access to diagnostic microscopy for the prison population; (b) an interrelation between the quality of TB activities and the regime of the facility; (c) low integration both within the penitentiary system and civil sector. In order to solve the problems identified, a workshop (mentioned below) was conducted.
28. At the workshop on the results of the visits to the penitentiary facilities, the coordinators for each program component were appointed and the following decisions were made: (a) to sign a contract with the regional TB facilities of the civil sector in order to rationalize TB microscopy examinations; (b) to delegate responsibility to the facility and oblast levels in order to improve the internal monitoring system in prisons; (c) to make quarterly requests to the TB colony of Shymkent in order to refine departmental interactions within the TB Control prison program; (d) to request re-registration data and treatment outcomes of prison TB patients from the regional civil TB facility in order to strengthen the succession of the two systems; (e) to initiate an appointing process of the oblast coordinators on prison matters from the TB facilities of the civil sector.
29. A work plan for 2006 was developed. Recommendations on how to improve Order # 145 were offered at the TS meeting on TB in prisons.
30. The Training on “Monitoring and Supervision of TB activities” for specialists of the Karaganda penitentiary system and the training on Interpersonal Communication Skills for the LTBTT of CIE in cooperation with ZdravPlus will be conducted in the next quarter. In turn, the LTBTT of CIE will train specialists of Mangystau penitentiary system on “Peculiarities of TB program implementation in prisons.”
31. The TS meeting on MDR TB was held, where it was decided to develop National Guidelines on managing MDR TB and issue a corresponding order.

**Creating Rational Drug Management Systems**

32. The JSI country visit took place in January 2006. In the framework of the visit, the following activities were done: (a) the TB Drug management system in the Almaty oblast was assessed by means of LSAT; the results were reported to HLWG; (b) the results of the initial assessment were presented and a work plan for 2006 was developed during the TS meeting on TB Drug management; (c) recommendations on necessary amendments in TB treatment protocols were reviewed at the TWG meeting.
33. In order to increase health staff capacity in TB drug management, two sessions on “Quantifying TB drug requirements” and “Rational TB drug use” were included into all DOTS trainings.
34. The specialists of NTBC, MH RK and Project HOPE took part in the workshop for GDF drug management consultants.
35. A process on improvement of LMIS in Almaty oblast was initiated. The recording and reporting forms used at different levels of the system were collected and analyzed. The report was submitted to the Regional drug management specialist of Project HOPE for further analysis and development of recommendations.
36. The following activities will be done in the next quarter: (a) develop recommendations for reviewing Order # 471 and LMIS improvement at the TS meeting; (b) conduct JSI country visit and the training on “Drug Management Cycle within NTP.”

**Improve Program Management**

37. Quarterly planned monitoring visits to Almaty oblast were conducted, including visits to the penitentiary sector of the oblast. In the course of the visits, existing practices on TB case detection, quality of treatment, treatment outcomes and other aspects of the program were assessed. For the elimination of the problems identified and for building capacity for performance improvement, on-the-job trainings were conducted and work plans for the next quarters were developed.
38. The first variant of “Monitoring and Supervision of the TB program implementation at oblast level” module was developed. The conducting of the first training for the oblast coordinators of Almaty oblast is planned in the 1<sup>st</sup> quarter of the 3<sup>rd</sup> year of the program to transfer skills to NTP counterparts.
39. Standardization of TB case definitions has been initiated in the framework of revising TB order # 471. The thematic subgroup on TB epidemiology surveillance was established and a work plan for 2006 was developed. A cohort analysis of treatment outcomes session was developed and included into the Advanced DOTS training for TB staff.

**MDR-TB and TB/HIV Management**

40. Thematic Subgroups on MDR-TB and TB/HIV were established, and work plans were developed for 2006.
41. Technical support for the NTP on the development of an MDR-TB treatment manual is being given.
42. The NJMS country visit is planned in the 2<sup>nd</sup> quarter of the 3<sup>rd</sup> year of the program.

**TB in Prisons**

43. The thematic Subgroup on TB in prisons was established and a work plan for 2006 was developed. Project HOPE has started providing technical assistance for the MOJ to revise the existing Order # 145 on TB in prisons within TS activities.
44. The Center for Integrated Education (CIE) was established in Karaganda for penitentiary staff. Project HOPE/Kazakhstan, with financial support of USAID, provided the Center with the necessary equipment to conduct trainings. Creation of the Local TB trainers Team for CIE has been completed.

45. In the framework of the current program, Project HOPE is working in the penitentiary system of Karaganda and Almaty oblasts. The penitentiary component of the program in Almaty oblast is an integral part of all the activities conducted in this field on training, monitoring, and the laboratory part of the program. Therefore, the main achievements in the Karaganda penitentiary system during the 2<sup>nd</sup> year of the program will be presented below.
46. Trainings on the “Peculiarities of TB Program Implementation in Prisons” were conducted for TB prison staff of Karaganda oblast, South and North regions of the country by Project HOPE specialists.
47. Senior administrative and medical staff of the penitentiary systems of Uzbekistan and Kyrgyzstan have visited the Karaganda Training Centre. Project HOPE’s Regional Specialist for Prisons took part in the training.

### III. COMMUNITY ADVOCACY AND MOBILIZATION

48. During the second year of the program, JHU and the Project HOPE Regional specialist conducted a country visit to provide local counterparts with technical assistance in developing the National TB communication strategy.
49. Questionnaires for interviewing target groups were developed to assess TB knowledge among medical staff and patients, and a KAP survey was conducted among 200 respondents in Almaty oblast. The survey results are being used for the TB communication strategy development.
50. A Chemonics International consultant carried out a country visit to assess the current system on TB information, education and communication in prisons. The findings and conclusions of the assessment are being used in the process of developing the TB communication strategy.
51. Training on Interpersonal Communication Strategy (IPCS) was delivered to the local TB trainer’s team of Almaty oblast by ZdravPlus and Project HOPE. The session developed on IPCS was included into the DOTS training for PHC staff.
52. A Thematic Subgroup on TB –IEC/BCC was established and a work plan was developed for 2006.
53. At a meeting with the director of NCHLS, coordination of the IEC activities within the NTP was discussed. A Memorandum of Understanding was developed and signed.
54. In cooperation with NTBC, NCHLS, Red Crescent Society and ZrdavPlus II, World TB Day activities were carried out. Since President Nazarbayev declared 2006 as “A Family Year”, the theme for World TB Day in Kazakhstan was chosen as “Protect children from tuberculosis.” Project HOPE participated in a Press-conference for Kazakhstani mass media and held a contest, “The best success story of treatment of a child,” among the children in TB facilities in the Almaty oblast. Project HOPE provided support to the activities that took place in the Oblast Child Boarding-house for TB contacts.
55. The following activities of the next quarter will be: (a) finalization of the TB communication strategy for Almaty oblast; (b) participation of the specialists of Project HOPE and NCHLS in the regional TOT training on developing information materials and a pre-test in Bishkek; (c) conducting a workshop for country specialists on IEC informational materials development.

### DESCRIPTIVE ANALYSIS OF EPIDEMIOLOGICAL DEVELOPMENTS IN THE ALMATY OBLAST

56. During the period of April 1 – December 31, 2004, the number of all types of notified TB cases was 19,902 in Kazakhstan. For the same period – 1,529 all types of TB cases were notified in Almaty oblast amounted to 7.7% of the country data. In 2005, all types of notified TB cases were 25,529 in Kazakhstan, including 2,077 in Almaty oblast (8.1%). Of these 3,606 TB cases – 1,148 cases (31.8%) were new smear positive cases in Almaty oblast. The percentage of new PTB+ cases was lower – 28.4% (12,894).

57. The Smear conversion rates among new PTB+ cases notified per 3 quarters of 2004 in Almaty oblast made up 69.4%, and for same period of 2005 – 77.8%, an increase of 8.4%.
58. The Cure rate among the new PTB+ cases of a total of 530 notified per 3 quarters of 2004 was 81% (428) in Almaty oblast and 71.4% (4,274) in Kazakhstan, which is 9.6% lower than in Almaty oblast.
59. **Chart 2** shows proportions of different types of TB patients detected during 2005. The proportions of all types of patients did not change during the year, and did not correlate with seasonal factors. This reflects stable work of the TB detection system in the oblast.
60. **Chart 2.** Data analysis showed that the proportion of new PTB+ cases was low (average 30%), pointing out a few weaknesses in the TB detection system, such as mistaken TB diagnoses and errors that occurred during smear collection and laboratory diagnostics. This has been proved by routine monitoring visits.
61. **Chart 2.** The current TB legal framework makes it difficult to achieve a standard percentage of new PTB+ cases, as it includes smear-negative TB cases patients with pleurisy and lymph nodes as new pulmonary TB cases. For example, in 2005 - 153 patients with pleurisy were registered in the oblast.
62. **Chart 3-4.** The sputum conversion rate was lower than the treatment success rate among the cohort of new PTB+. Existence of this “negative difference” can be explained by the new PTB+ did not convert their smear to negative after 2 or 3 months of treatment, however they were cured with the same TB drugs regimen. According to the local TB Order, the intensive phase of treatment can be prolonged up to 4 months. In practice, TB physicians extend the initial phase of therapy for 5 months. The following reasons of slow smear conversion have been identified during monitoring visits: (a) extensive cavitation; (b) poor supervision of treatment. The comparative analysis conducted on conversion rates among new pulmonary SS+ TB cases registered in the 1st quarter 2005 after 3 months and 5 months of treatment showed that the conversion rate after 3 months of treatment was 67.3%, while after 5 months of treatment it was 88.8%.
63. **Chart 4.** From Q1 to Q3 of 2004 there was a difference in the number of registered TB cases and the number of evaluated TB cases in terms of treatment outcomes. The reasons for taking off from the standardized DOTS treatment regimens: intolerance of the 1st line TB Drugs, exclusion from TB diagnosis in accordance with the local TB order.
64. **Chart 5.** The failure outcome in Q4 decreased in comparison with Q3. The quarterly analysis of the reasons for failure outcomes conducted on the basis of the monitoring visits data showed that the major reasons were drug resistance and incomplete adherence to DOT. So, in 2004, 45 new PTB+ cases had a failure outcome. One third of these cases (14 – 31.1%) had MDR, 24 (53.3%) had other forms of drug resistance.
65. **Chart 6.** The notification rate of new PTB+ cases is lower in Almaty oblast than in the republic. Over the last 2 years, the tendency of decline was noted.
66. **Chart 7** shows new PTB+ cases represented by age groups for the last 3 years. The most cases of the infectious forms of tuberculosis develop in both males and females of 25-34 years old. Male patients prevail in all age groups.

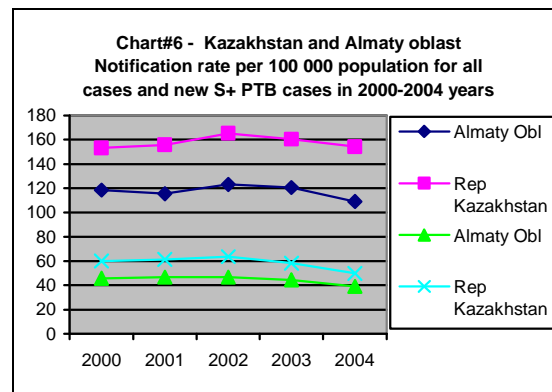
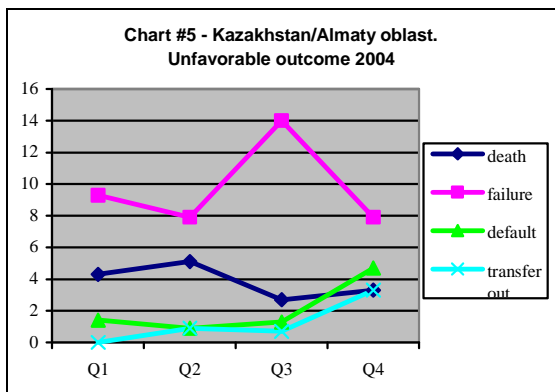
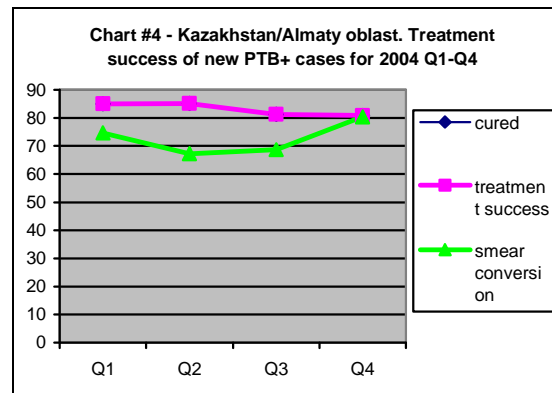
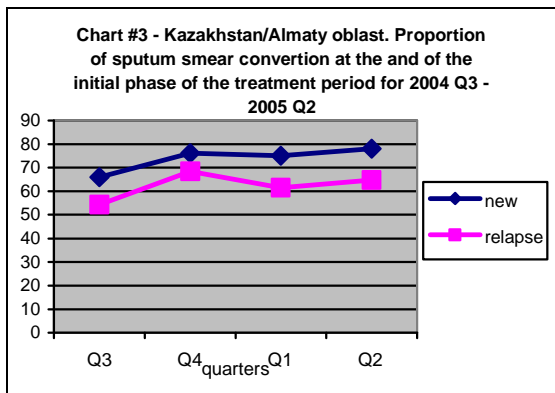
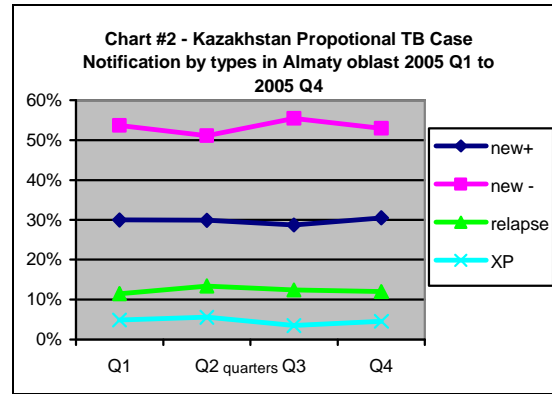
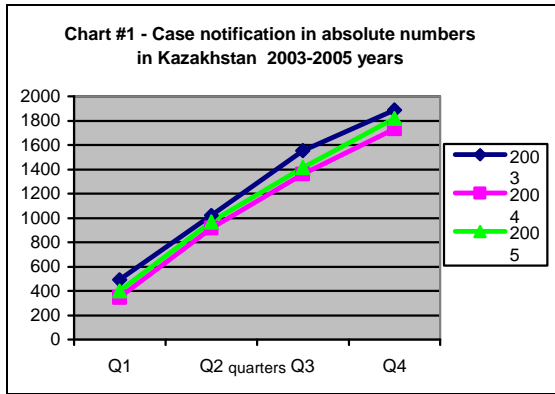
#### **DESCRIPTIVE ANALYSIS OF EPIDEMIOLOGICAL DEVELOPMENTS IN THE KARAGANDA PENITENTIARY SYSTEM**

67. **Chart 2** reflects a constant decrease of the registered TB cases. The ratio of the different TB patient types during the year are being changed due to an increase of the “other” cases.
68. **Chart 3-4-5** reflect the negative tendencies in the smear sputum conversion rate among all patients’ types – the biggest ones among the “others.” The effectiveness of treatment among new TB cases

follows the same tendencies. The quantity of failed outcomes during that period increased by 4 times. Laboratory DST results show a simultaneous increase of MDR among new cases.

69. **Chart 7** shows the new PTB+ cases prevailed in the age group of 25 – 34 years.

**ANALYSIS OF EPIDEMIOLOGICAL DEVELOPMENTS IN CHARTS AND TABLES – ALMATY OBLAST**



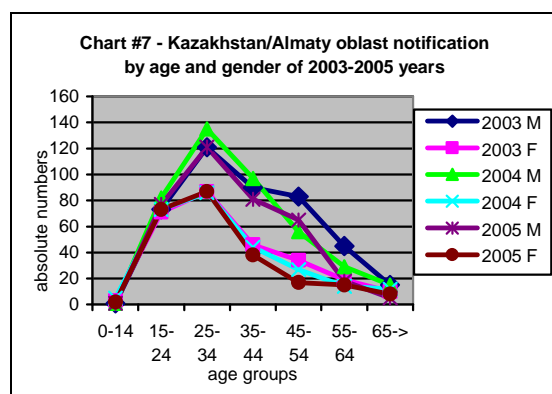


Table to Chart 2. Kazakhstan/Almaty oblast. Absolute and proportional case notifications for TB categories for 4 quarters of 2005

types	Q1		Q2		Q3		Q4	
new S+	136	30%	196	29.9%	146	28.7%	140	30.5%
new S-	243	53.6%	335	51.1%	282	55.4%	243	52.9%
relapse	52	11.5%	88	13.4%	63	12.4%	55	12%
other S+	-	0%	-	0%	-	0%	-	0%
XP	22	4.9%	37	5.6%	18	3.5%	21	4.6%
total	453	100%	656	100%	509	100%	459	100%

Table to Chart 3. Kazakhstan/Almaty oblast Sputum smear conversion at the end of the initial treatment period in absolute and proportional figures for 2004-Q3 to 2005-Q2 among new SS+ and relapses.

	Q3			Q4			Q1			Q2		
	absolute numbers			absolute numbers			absolute numbers			absolute numbers		
	cohort	converted	%	cohort	converted	%	cohort	converted	%	cohort	converted	%
New	156	103	66.0	151	115	76.2	136	102	75.0	196	153	78.1
Relapse	48	26	54.2	38	26	68.4	52	32	61.5	88	57	64.8

Table to Charts 4 and 5. Kazakhstan/Almaty oblast. Treatment outcomes 2004.

	Q1		Q2		Q3		Q4	
	N	%	N	%	N	%	N	%
notified	146		223		156		151	
evaluated	140		216		150		151	
cured	119	85	184	85.2	122	81.3	122	80.8

completed	0	0	0	0	0	0	0	0
death	6	4.3	11	5.1	4	2.7	5	3.3
failure	13	9.3	17	7.9	21	14	12	7.9
default	2	1.4	2	0.9	2	1.3	7	4.7
transfer out	0	0	2	0.9	1	0.7	5	3.3
		100		100		100		100

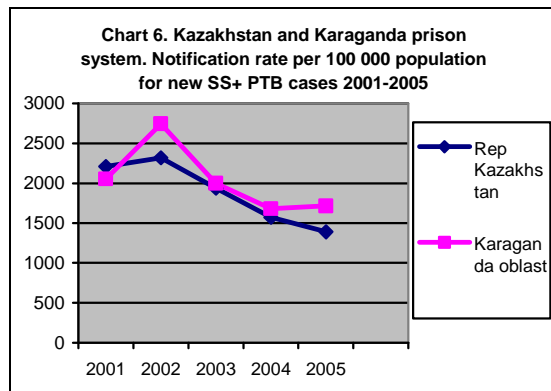
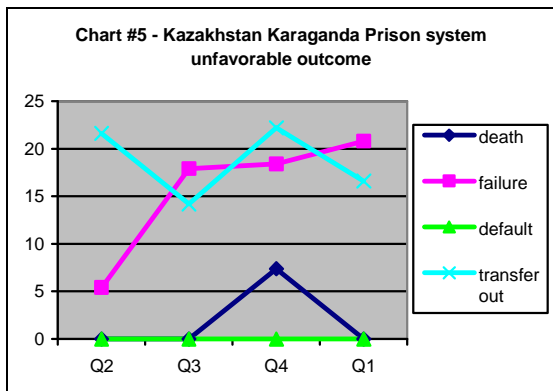
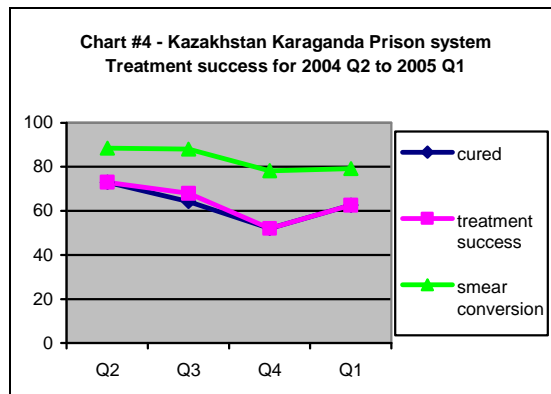
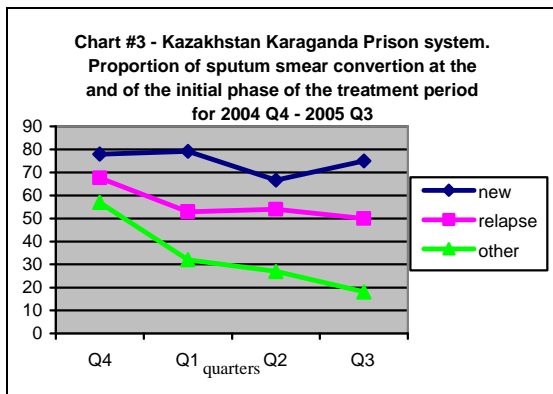
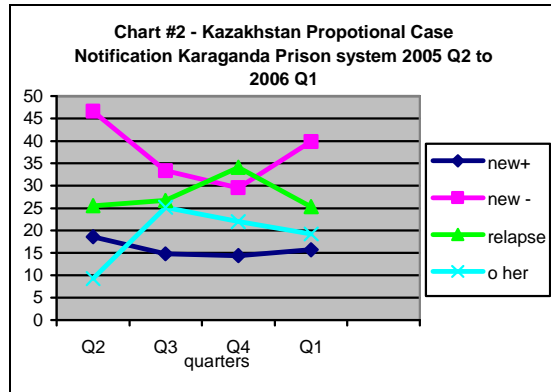
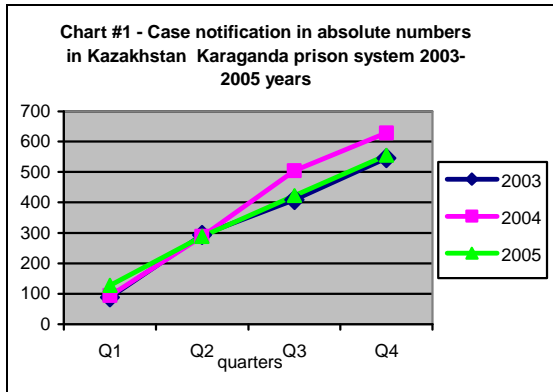
**Table to Chart 6. Kazakhstan and Almaty oblast.****Notification rate per 100,000 population for all cases and new S+ PTB cases 2000-2004.**

	2000	2001	2002	2003	2004
Almaty Oblast	118.4	115.5	123.1	120.6	108.9
Republic Kazakhstan	153.2	155.7	165.1	160.4	154.3
Almaty Oblast	45.8	46.8	46.7	44.5	39.1
Republic Kazakhstan	59.9	61.2	63.7	58.1	49.8

**Table to Chart 7. Kazakhstan/Almaty oblast. Case notification of new PTB+ in absolute numbers by age and gender 2003-2005.**

		0-14		15-24		25-34		35-44		45-54		55-64		65-	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F
<b>2003</b>	<b>Q1</b>	0	0	24	20	34	20	29	9	23	8	17	8	4	3
	<b>Q2</b>	0	1	19	17	28	27	25	17	22	12	8	4	4	3
	<b>Q3</b>	0	0	16	20	34	25	18	14	26	9	11	5	4	4
	<b>Q4</b>	1	2	14	14	25	15	18	6	12	5	9	2	3	0
	<b>total</b>	1	3	73	71	121	87	90	46	83	34	45	19	15	10
<b>2004</b>	<b>Q1</b>	1	1	17	18	26	14	24	11	10	8	8	4	2	2
	<b>Q2</b>	0	3	28	21	47	35	25	18	15	6	10	6	3	6
	<b>Q3</b>	0	1	13	16	35	18	29	5	16	7	5	3	6	2
	<b>Q4</b>	0	0	24	18	27	19	19	10	15	6	6	1	4	2
	<b>total</b>	1	5	82	73	135	86	97	44	56	27	29	14	15	12
<b>2005</b>	<b>Q1</b>	0	0	8	18	31	18	20	9	15	4	2	6	2	3
	<b>Q2</b>	0	1	35	20	42	27	21	11	18	3	3	6	2	7
	<b>Q3</b>	0	1	17	18	25	24	18	8	17	6	7	2	0	3
	<b>Q4</b>	1	0	17	17	23	18	22	10	15	4	6	1	1	5
	<b>total</b>	1	2	77	73	121	87	81	38	65	17	18	15	5	18

**ANALYSIS OF EPIDEMIOLOGICAL DEVELOPMENTS IN CHARTS AND TABLES - KARAGANDA PRISONS**





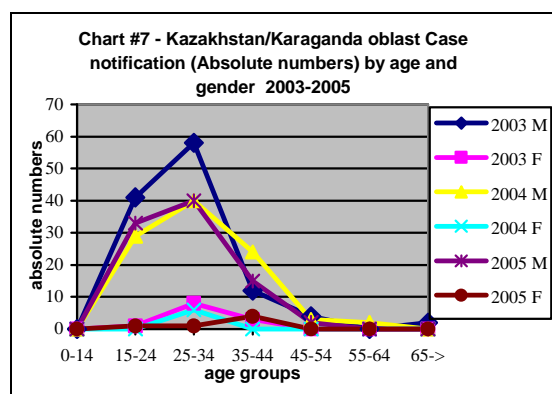


Table to Chart 2. Kazakhstan, Karaganda Prison system. Absolute and proportional case notifications for 5 TB categories for the 4 quarters of 2005 Q1, Q2, Q3 -2006 Q1.

	Q2		Q3		Q4		Q1	
new S+	30	18.6	20	14.8	19	14.4	13	15.7
new S-	75	46.6	45	33.3	39	29.5	33	39.8
relapse	41	25.5	36	26.7	45	34.1	21	25.3
other S+	15	9.3	34	25.2	29	22	16	19.2
XP	0	0	0	0	0	0	0	0
total	161	100	135	100	132	100	83	100

Table to Chart 3. Kazakhstan, Karaganda Prison system. Sputum smear conversion at the end of the initial treatment period in absolute and proportional figures for 2004, Q4 to 2005 Q3 for different categories of smear positive TB cases.

	Q4 2004			Q1 2005			Q2 2005			Q3 2005		
	absolute numbers			absolute numbers			absolute numbers			absolute numbers		
	cohort	converted	%	cohort	converted	%	cohort	converted	%	cohort	converted	%
New	27	21	78	24	19	79.2	30	20	66.7	20	15	75
Relapse	31	21	67.7	38	20	53	41	22	54	36	18	50
Other	21	12	57	25	8	32	15	4	27	34	6	18

Table to Charts 4, 5. Kazakhstan. Karaganda Prison system. Treatment outcomes 2004 Q2, Q3, Q4 - 2005, Q1.

	Q2		Q3		Q4		Q1	
	N	%	N	%	N	%	N	%
notified	37	100	28	100	27	100	24	100

evaluated	37	100	28	100	27	100	24	100
cured	27	73	18	64.3	14	52	15	62.6
completed	0		1	3,6	0		0	
death	0		0		2	7.4	0	
failure	2	5.4	5	17.9	5	18.4	5	20.8
default	0		0		0	0	0	
transfer out	8	21.6	4	14.2	6	22.2	4	16.6
	37	100	28	100	27	100	24	100

**Table to Chart 6. Kazakhstan and Karaganda prison system. Notification rate per 100,000 population for new SS+ PTB cases <2001-2005>**

	2001	2002	2003	2004	2005
Rep Kazakhstan	2210	2316.2	1936.7	1573	1391
Karaganda oblast	2052.6	2743.9	1997.2	1679	1714

**Table to Chart 7. Kazakhstan\Karaganda oblast Case notification (Absolute numbers) by age and gender <2003-2005>**

		0-14		15-24		25-34		35-44		45-54		55-64		65-	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F
<b>2003</b>	<b>Q1</b>			6		5	3	1						1	
	<b>Q2</b>			18		30	3	7	2	4				1	
	<b>Q3</b>			7		8	2	1							
	<b>Q4</b>			10	1	15		3	1						
	<b>total</b>			41	1	58	8	12	3	4					2
<b>2004</b>	<b>Q1</b>			2		6		4				1			
	<b>Q2</b>			10		15		9		1					
	<b>Q3</b>			10		7	3	8				1			
	<b>Q4</b>			7		12	3	3		2					
	<b>total</b>			29		40	6	24		3		2			
<b>2005</b>	<b>Q1</b>			9	1	8	1	4		1					
	<b>Q2</b>			12		12		3	3						
	<b>Q3</b>			3		12		4	1						
	<b>Q4</b>			9		8		4		1					
	<b>total</b>			33	1	40	1	15	4	2					

**Kyrgyzstan—Q1, 2006—Timur Aptekar****ANNUAL PROGRESS SUMMARY**

1. The main emphasis in the activities of CAR TB Control Partnership in Kyrgyzstan in Y2 of the project has been directed towards strengthening the work of the Coordinating Council on tuberculosis, increasing the role of TWGs and further integration between TB and PHC services in Bishkek city.
2. Creation of the Coordinating Council on TB and TWGs has considerably strengthened political commitment. At present, all-important decisions, drafts of prikazes, and development of recommendations, the National TB Program puts exclusively through TWG. All local and international organizations take an active part in the work of TWGs. The work through TWGs helps to coordinate activities of various organizations, make decisions and eliminate work duplication.
3. Two Round Tables were conducted in Osh and Jalalabat oblasts. The topic of the Round Tables was “TB Program implementation issues.” As a result of the Round Tables, the participants came to general decisions:
  - Provide stable funding for logistics and hospital patients’ nutrition and allot cash from the local budget to pay for round trips of TB patients and accompanying people to the treatment places and back.
  - Develop an action plan for TB control jointly with the oblasts’ state administrations for 2006.
4. In late 2005, the TB service in Issyk-Kul oblast was expelled from PHC and, currently, the Oblast TB Center is being created. It was senseless to holding the Round Table in that situation. Jointly with the National team it was decided to postpone those events for a later date. In Bishkek city, the first TB patients’ treatment outcomes, when integrating with PHC, will be known in the second half of 2006. For a more qualitative integration analysis, it was decided to postpone the round table for a later time. In year 3 of this program, those Round Tables are designed for the 3<sup>rd</sup> Quarter.
5. Last year, the Project HOPE Consortium conducted a drug management assessment in Kyrgyzstan, and assessed the IEC\BCC component, Policy and MDR TB, HIV/TB components as well.

**QUARTERLY PROGRESS SUMMARY**

6. By April 1, 2006, the Project HOPE Consortium has finished year 2 of the project. In the 1<sup>st</sup> quarter of 2006, a final version of the Project HOPE Kyrgyzstan work-plan for year 3 has been developed and coordinated with the partners.
7. In Kyrgyzstan, the frame of the Country Coordination Mechanism (CCM) has changed and now it consists of the presidium and several sectors. One such sector is responsible for coordination and monitoring Global Fund programs on HIV/AIDS, TB, and Malaria. The Project HOPE TB Program Manager, as a member of that sector, took part in the work of its three sessions. There were hearings of reports on execution of the first phase of the grant, and an application for the second phase was approved. Project HOPE rendered technical assistance in development of the application, which is currently approved by the Global Fund. The first segment is expected on June 1.
8. There was a visit of the New Jersey Medical School – National TB Center in January 2006. At the end of the quarter the visit report is still pending.

**I. BUILDING POLITICAL SUPPORT FOR TB CONTROL**

9. Thematic Working Groups performed active work. There were 8 different meetings in Q1. All TWG have prepared their plans for 2006. Several prikazes were prepared for MoH. All local and international organizations took an active part in the work of TWGs. The TWG’s on DOTS, Lab, Drug Management, MDR TB and HIV/TB started to work on development of the National Guideline on TB. Project HOPE is taking an active part in the work of TWG on prisons.

**I. BUILDING HUMAN AND SYSTEMS CAPACITY FOR TB CONTROL****Integration between TB Services and PHC network**

10. Integration of TB services into the PHC network in Bishkek city has been well established. However, regardless of the progress in providing the population with TB services, some weaknesses in the work of Family Medicine Centers (FMC) was revealed during monitoring. To eliminate those shortcomings, some explanations were made during on-the-job trainings. Routine monitoring with on-the-job training enables rendering practical assistance to PHC physicians in both diagnosis issues and treatment control organization.
11. As a result of the monitoring, a meeting attended by NCPH, TB specialists and family doctors of Bishkek was organized to analyze the shortcomings detected.
12. Actions aimed at strengthening integration of TB services into PHC were jointly worked out on the basis of challenges detected during monitoring. Those actions are as follows:
  - Introduce standard recording and reporting forms for TB drugs at FMC level.
  - Support better adherence by PHC to the diagnostic algorithm.
  - Improve the work on the quickest defaulter tracing.
  - Provide practical assistance to the Bishkek Lab Coordinator.
  - Entrust some part of control over FMC laboratory work, like sanitation and epidemiological regimen, introduction of recording and reporting registers, to TB specialists-supervisors.

**Strengthening the Laboratory Network**

13. During monitoring held in Bishkek, it was noted that Bishkek city laboratories were improving their work. That is proven by the detection rate by microscopy in PHC facilities: 7.2% in 2005, in contrast to 6.3% in 2004.
14. At the previous meeting for the TWG on labs, the work plan for 2006 was approved and work summary for 2005 was made. Project HOPE was involved in the organization of that meeting, and together with NCPH elaborated the draft of work plan for 2006 and the meeting agenda.

**Strengthening Human Resources Capacity**

15. Three trainings were conducted for health professionals: 1 training was held in Karaganda on "Peculiarities of TB program implementation in prisons," where 9 individuals were trained; 2 trainings on "DOTS Strategy" in Bishkek for Bishkek city medical workers within the framework of improving integration between TB services and PHC network, where 18 physicians were trained. The elements of cohort analysis, built on reporting data for Bishkek compared to the national data, were included into the training program. Those two trainings in Bishkek will enable improvement in the quality of TB services provided to the population in Bishkek, and increase knowledge and skills of health professionals.

**Creating Rational Drug Management Systems**

16. In cooperation with JSI and the Regional drug management specialist, a drug management assessment in Kyrgyzstan was carried out in May. After having this draft assessment translated into English, it was disseminated for the National team review. Remarks and suggestions were discussed during the next visit of JSI in November on TWG.
17. In Q1 2006, the TWG on Drug management meeting took place and the work plan for 2006 was approved there. At that meeting, Talas oblast was selected as a pilot-site for testing adjusted recording and reporting forms for the Logistics Management Information System (LMIS). The timeframe for pilot testing was defined. The draft for the MoH Prikaz on implementation of that project was developed. Introduction of adjusted recording and reporting forms will allow improvement in practical aspects of organization and management of LMIS.

18. Project HOPE assisted the National TB program in preparation of the application to GDF for the grant on the TB drugs supply for 2007-2009. A document describing the flow of drugs from the time of receipt by the program until the use in PHC facilities has been prepared. Assistance was provided in calculating the drug needs. A report on the independent drug management assessment, prepared with Project HOPE and JSI, was submitted to the National Team, along with a cover letter explaining the necessity of that grant. The GDF Advisory Committee approved the application for the grant. That grant will provide constant TB drug supply maintenance for the NTP, availability of good quality drugs, and lead to the saving of funds.
19. The Drug Management Specialist of Project HOPE-Kyrgyzstan, Jyldyz Ysyskeeva, took part in the meeting of the TWG on drug management in Almaty at the invitation of Project HOPE-Kazakhstan. A presentation about Project HOPE-Kyrgyzstan and NCPH participation in the international research on Incidences of Adverse Reactions to TB drugs was made at the meeting. The results of the research will lead to an increase in the level of knowledge about adverse-reactions, the undertaking of efficient actions within the National TB program and reduce state expenses for the treatment of TB patients.

### COMMUNITY ADVOCACY AND MOBILIZATION

20. In Y2, an assessment on IEC/BCC was made in cooperation with JHU and the Project HOPE Regional specialist. Trends for further work were identified and recommendations were developed.
21. A survey on identification of knowledge, attitude and practices about TB was carried out among the general population, health providers and TB patients. The survey data was used for development of the National Strategy for IEC to control TB. The implementation of that strategy is planned for Y3.
22. There were 4 TWG on IEC/BCC meetings in Q1. The meetings were devoted to consideration of the final version of the National strategy for IEC, approval of the strategy logo, and development of the action plans for World TB Day. That enabled prevention of duplication of actions and at the same time increased the number of actions done.
23. The campaign dedicated to the World TB day (WTBD) was conducted under the motto "One can win TB!" and it was directed to the increase of awareness of TB patients, health professionals, and general population about TB. The following events took place:
  - For health professionals:
    - Project HOPE, together with Global Fund, Swiss Red Crescent and ZdravPlus, issued a medical newspaper "Be healthy", where articles on TB were published
    - On TV, an announcement about TB was run in the Kyrgyz language
  - For TB patients:
    - Poster contest on TB
    - Lecture-debate about TB for TB outpatients in Bishkek TB Center and the contest for the best answers
  - For general population:
    - Press-conference dedicated to WTBD
    - Distribution of information about TB over the internal radio at the largest bazaars in Bishkek.
    - Distribution of booklets among sellers and visitors at the bazaar
    - Leaflets placed in public conveyances
    - Broadcasting (interview and informational messages) in Russian and Kyrgyz
    - Together with the National Red Crescent, a poster contest among schoolchildren, a race for schoolchildren, with a lecture about TB before the race

**PRISONS**

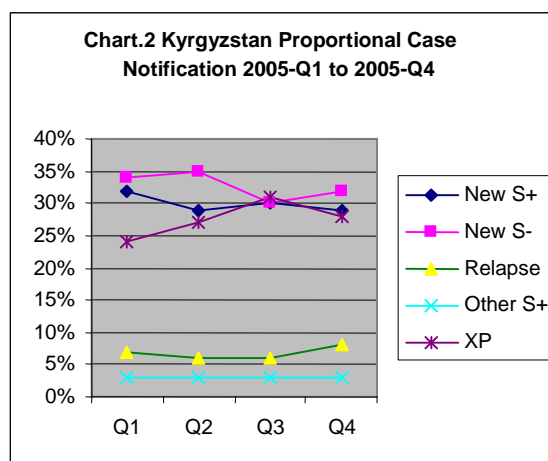
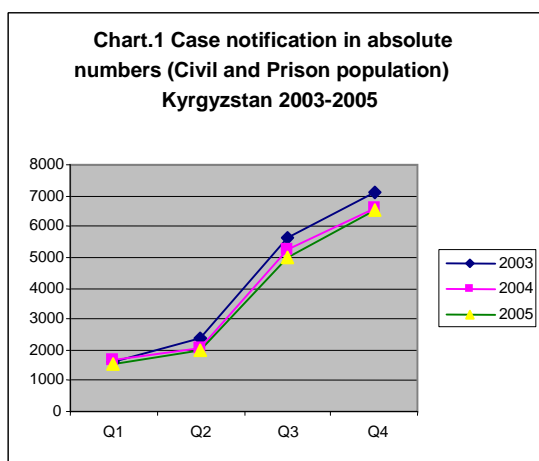
24. In year 2 of the program, coordinators for the different components of the TB program in the penal system were assigned through the GUIN MoJ KR Order #393. The scope of work for coordinators is highlighted in this document, which is a sign of decentralization of responsibilities within the TB program in prisons. It is expected that this will lead to quality improvement in implementation of all TB aspects through delegation of responsibilities among members of the TB control team in prisons.
25. A TWG on prison meeting that was devoted to the discussion of the ICRC program on support of TB actions in KR MoJ GUIN was held. TB colonies for re-treated patients were defined as pilot sites. Recommendations regarding protocols for cultural and DST examination of TB re-treatment patients were developed. The decision about the necessity of coordinating all actions carried out through TWG in the penal system was adopted.
26. Practical assistance was rendered in the development of the NCPH Prikaz in preparatory work to implement the "Before jail release program" for convicted TB patients. This Prikaz identifies persons responsible for interaction between the civil and prison populations at the oblast level. This was a recommendation of the TWG on prison in the past quarter.
27. The persons responsible for inter-sector interaction between the MoH and MoJ were appointed by the Prikaz of MIA and MLSP for the work in the TWG on prisons. Project HOPE familiarized those representatives of MIF and MLSP with the "Before jail release program." Currently, those coordinators are working on adjustment of protocols for inter-sector interaction for presentation at the TWG and further approval. Participation of those ministries will considerably strengthen on-going work.
28. At the initiative of the TWG, the training "Peculiarities of TB program implementation in prisons for physicians of GUIN, MoJ, NCPH, and MSF" was held at the Karaganda GUIN Training Center in Kazakhstan. The training was held with financial assistance from Project HOPE, Global Fund, ICRC, and MSF. Practical use of this knowledge will increase the quality of identification and treatment of TB patients in the penal system and strengthen interaction of the civil and penal systems.

**TB/HIV and MDR TB**

29. In year 2, activities on TB/HIV were conducted in close cooperation with the CAPACITY project. The CAPACITY project began its activities in the republic within the framework of the strategy "Quality improvement of TB/HIV services," with one focus of activities on implementation of actions to improve integration of TB and HIV/AIDS services. The MoH prikaz "On measures for strengthening the fight against HIV/TB co-infection in the Kyrgyz Republic" was an outcome of that work. Project HOPE took an active part in the development of that prikaz.
30. The WHO Guidelines for Surveillance of MDR in TB was translated into Russian for the TWG on Lab members. The draft developed for conducting the survey had been discussed and sent to WHO. Project HOPE is planning to assist in that project per the plan for 2006-2007. This survey will enable an assessment of the MDR rate in Bishkek.
31. In February 2006, an assessment visit of specialists from the New-Jersey Medical School and the Project HOPE Regional Specialist on HIV/TB and MDR was done. The report will be submitted for consideration of the TWG on HIV\TB and MDR TB in Q2 of 2006.
32. Project HOPE was involved in the development of the model for interaction of HIV/AIDS and TB services that is being elaborated by CAPACITY. The final version of the module will be presented at the TWG on HIV/TB.
33. Project HOPE rendered technical assistance in conducting training on TB/HIV for NCPH physicians. The training was held by the members of TWG on HIV in the form of lecture-debate and awoke keen interest, since TB service physicians are poorly informed about HIV/AIDS and HIV/TB co-infection.

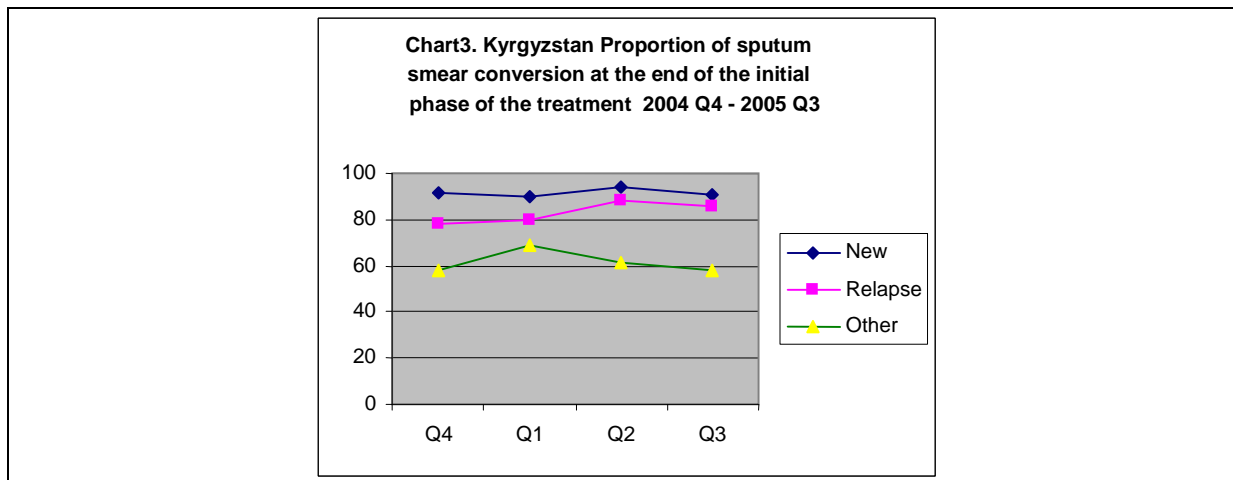
34. A meeting with MDR TB patients was held in the form of a lecture, followed by a question and answer session, to increase adherence of patients to treatment. The meeting was conducted at the NCPH MDR ward for the in-patient MDR TB patients.
35. The epidemiological situation in Kyrgyzstan remains tense – TB incidence exceeds 100 per 100,000 population, but the tendency towards decreasing numbers is continuing. There is no sharp leap in rates. High rates of treatment efficiency remain: sputum conversion for all quarters is more than 90%; and the cure rate exceeds 80%. Treatment success in patients notified in Q4 2004 is 86.2%. Nationwide treatment outcomes are the lowest in Bishkek at 72.2%. However, in Q4 2004, when integration into PHC had started, a higher result of 77.8% was observed. One ought to expect continuation of that positive tendency hereafter. Per the explanation of the National program, some increase in the new TB case notification rate - 116 per 100,000 population in 2005 in contrast to 114 in 2004 – is caused by internal migration to the Chui oblast and Bishkek city within 2005. The highest incidence rates of TB are noted in these country areas, 178.8 and 136.6 correspondingly per 100,000 population.

## Tables and Charts



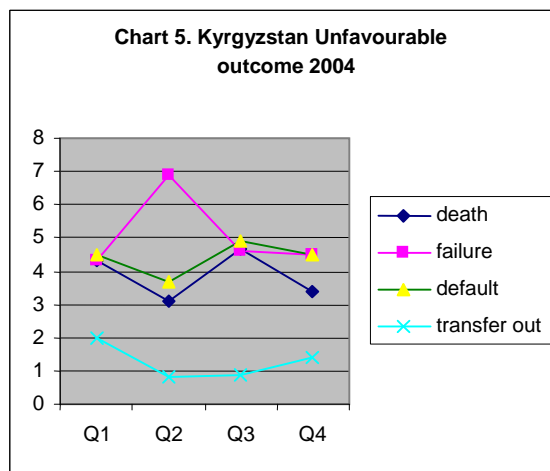
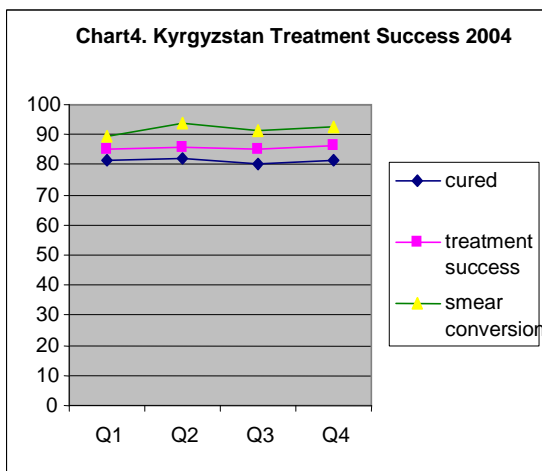
**Table. Kyrgyzstan. Absolute and proportional case notifications for 5 TB categories for the 4 quarters of 2005**

	Q1		Q2		Q3		Q4	
<b>New S+</b>	458	32%	553	29%	448	30%	442	29%
<b>New S-</b>	492	34%	679	35%	451	30%	493	32%
<b>Relapse</b>	100	7%	110	6%	84	6%	117	8%
<b>Other S+</b>	40	3%	51	3%	52	3%	38	3%
<b>XP</b>	357	24%	530	27%	462	31%	433	28%
<b>Total</b>	1447	100%	1923	100%	1497	100%	1523	100%



**Table. Kyrgyzstan. Sputum smear conversion at the end of the initial treatment period in absolute and proportional figures from Q2, 2004 to Q3, 2005 for different categories of smear positive TB cases**

	Q4			Q1			Q2			Q3		
	abs			abs			abs			abs		
	Coh	conv	%	Coh	conv	%	coh	con	%	coh	con	%
<b>New</b>	356	329	92	458	410	90	553	520	94	448	408	91
<b>Relapse</b>	90	70	78	100	80	80	110	97	88	84	72	86
<b>Other</b>	48	28	58	35	24	69	41	25	61	40	23	58

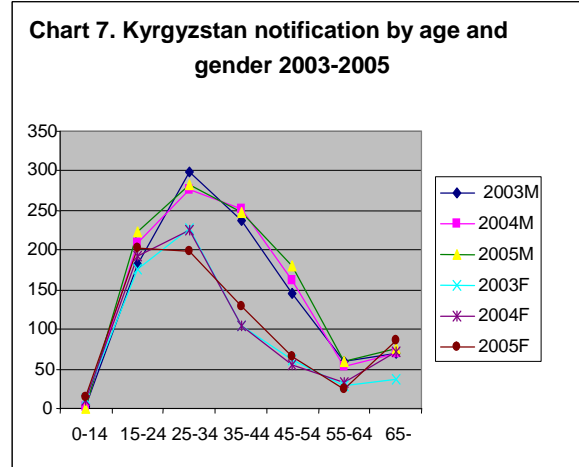
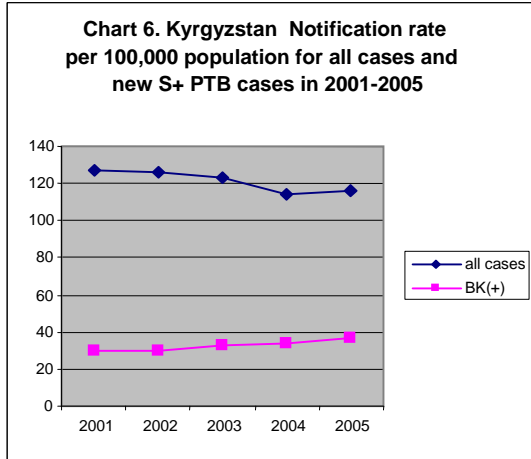


**Table. Kyrgyzstan. Treatment outcomes in 2004**

	Q1		Q2		Q3		Q4	
	N	%	N	%	N	%	N	%
Notified	446		512		402		356	
Evaluated	444		511		402		355	



Cured	362	81.5	418	81.8	323	80.3	290	81.7
Completed	15	3.4	19	3.7	18	4.6	16	4.5
Died	19	4.3	16	3.1	19	4.7	12	3.4
Failed	19	4.3	35	6.9	18	4.6	16	4.5
Default	20	4.5	19	3.7	20	4.9	16	4.5
Transferred out	9	2	4	0.8	4	0.9	5	1.4
		100		100		100		100



**Table. Kyrgyzstan. Notification rate per 100,000 population for new cases and new SS+ cases 2001-2005**

	2001	2002	2003	2004	2005
<b>All cases</b>	127	126	123	114	116
<b>BK(+)</b>	30	30	33	34	37

**Tajikistan—Q1, 2006—Tatyana Vinichenko****ANNUAL AND QUARTERLY SUMMARY**

1. **Preamble.** Please note that the annual and quarterly summary provides a general overview of TB control activities in Tajikistan. It includes information on all areas of the country and all agencies involved in TB control efforts, while the description under the USAID objectives deals only with activities directly supported by the USAID grant, unless mentioned otherwise. Project HOPE, as implementing agency of the USAID grant and the primary recipient of the Global Fund grant, is synergizing its activities with the National TB program and other implementing agencies. This helps to ensure that DOTS implementation throughout the country will build a comprehensive, effective and sustainable TB control program.

**Annual Summary**

2. By the end of 2005, the DOTS program covered 32 rayons of Tajikistan, which corresponded to 62% of the population (the national target for 2005 was 50% coverage). As the DOTS coverage at the end of 2004 was 32.45%, the coverage almost doubled in 2005. Merlin, that assisted NTP with DOTS expansion in Khatlon oblast, stopped its TB activities in August 2005 but with Project HOPE support the NTP continued work in those rayons.
3. In Q1, 2006, the DOTS program expanded to four new rayons - Kolkhozobod, Spitamen, Khuroson and Jomi with support of GFATM (6.6% of total country population). At the end of March 2006, 68.6% of country's population is covered by the DOTS program.
4. The population of thirteen rayons where the DOTS program is implemented by using mainly USAID funds is 1,762,500 – 26.3 % of the country (Dushanbe city, Rudaki rayon, Vosse, and Kulyab region: Kulyab city, Kulyab rayon, Farhor, Hamadoni, Mominobad, Taimur Malik, Shourobod, Nurek, Khowaling, Balijuwan).
5. The close collaboration between Project HOPE and Project SINO (which by the end of 2005 assists with implementing of the DOTS program in four rayons) is very beneficial for the program. Both programs have been working on standardization of approaches to training and monitoring that allows going beyond pilot approaches to the building of the national system. Gradual transfer of responsibilities to the national team works on making this system sustainable.
6. Project HOPE has a unique experience in the TB field in Tajikistan and is able to synergize activities of its programs. For example, the USAID program leads to creation of mechanisms of provision of sound technical expertise for national decision-making in the form of TWG or developing various guidelines. The GFATM program provides all DOTS rayons (even if they are mainly supported by USAID or Project SINO) with the necessary reporting and recording forms, laboratory reagents and first-line TB drugs.

**Quarterly Summary**

7. Two GDF missions visited the country in Q1. The GDF third year monitoring mission on drugs conducted monitoring of the use of drugs provided by the GDF grant, including the use of STOP-TB kits. The other aim of the visit was an estimation of the country's needs in TB drugs for the following years, and considering various scenarios for financing these needs, including a new application for a GDF grant. The other mission, a GDF mission on the use of laboratory kits, conducted the final assessment of new reagents and microscope kits that aimed at better tailoring of laboratory equipment to local conditions (e.g. The microscopes were provided an alternative power supply that allows conducting microscopy in the absence of electricity). Project HOPE specialists assisted with the organization and conducting of both missions. With this experience in the use of the new GDF STOP TB kits and laboratory kits, Tajikistan helps to pioneer this new initiative of the GDF.

8. Preparation and celebration of World TB Day was conducted by the joint efforts and collaboration of MoH, RTBC, Republican Healthy Life Style Centre, public organization “Youth Legal Support Centre”, Tajik Youth Committee, Project HOPE, IFRC, NICRC, AKF, and Project SINO. Work of the Thematic Working Group on IEC/BCC created in the framework of the USAID project allowed better coordination of activities of various organization and donors. Project HOPE activities were supported by GFATM and USAID funds: round tables in all oblasts; TV and radio programs on TB with participation of NTP leadership; gifts for the best TB Coordinators, PHC physicians and nurses, and laboratory workers; as well as hygiene kits with IEC materials for TB patients in Republican TB hospital and oblasts’ hospitals in Khorog, Khudjand, Kulyab, Kurgan Tyube, and Dushanbe children hospital; a student quiz in Dushanbe; and a special issue of health magazine “Shifo.”
9. The Project HOPE Chief of Party and Technical Director visited the Tajikistan office in Q1 to provide managerial and technical advice to the local team and national partners. Several meetings with the governmental and international counterparts were organized (MOH, Republican SES, Project SINO, PSF, CARITAS) that allowed for increasing understanding among implementing agencies. The Chief of Party met with the Rudaki rayon Chief Doctor to evaluate the program progress in the rayon and to visit Machiton hospital. The Technical Director also visited Rudaki rayon and Machiton hospital. The Technical Director recommended focusing on development of a coherent NTP structure, which should include determining the SES mandate, as well as on strengthening of planning and managerial capacity of RTBC. Also, technical assistance on the development of protocols for children chemoprophylaxis was provided.

#### **I. BUILDING POLITICAL SUPPORT FOR TB CONTROL**

10. **Annual progress.** The program made many efforts to strengthen political support to the TB control program on all levels - from rayon to national level. At the rayon level, Project HOPE increased advocacy efforts targeted at rayon administrations – hukumats. In many rayons hukumats increased financial support of the TB program through increasing the salary of TB program workers, assisting with renovation of TB facilities, organizing of drug warehouses, and providing food for inpatient facilities. All this is an important sign of increasing political commitment. The CAMRIS Assessment planned for year 2 was postponed until summer 2006.
11. Project HOPE held numerous meetings with the NTP, regular meetings with the First Deputy Minister of Health, as well as meetings with Heads of oblast health departments. Also, Project HOPE actively participated in the meetings of the Coordination Council on TB chaired by the First Deputy Minister of Health. These meetings served as advocacy tools for Project HOPE, giving the opportunity to influence the decision-making process as well as facilitate transparent evidence-based discussion on TB control issues in the country.
12. Project HOPE promoted creation of the Interagency Coordinating Committee to increase collaboration between implementing national and international non-governmental agencies.
13. As for providing sound technical expertise to the NTP, the TWG on Drug Management and the TWG on IEC/BCC were organized and approved in year 2. The preparation for creation of the TWG on laboratory was done in year 2 (the group held a first meeting in the first week of year 3). Also, Project HOPE actively participated in the work of the TWG on HIV/TB that was created by the CAPACITY Project that is funded by USAID.
14. **Quarterly progress.** In February Project HOPE called a regular meeting of the Interagency Coordination Committee – a group of national and international non-governmental partners working on TB control in Tajikistan. The main aim was to discuss the plans for 2006. The extensive list of participants (ZdravPlus, PSF, CAPACITY, IFRC, NICRC, ARC, AKF, Project Sino, MERLIN, CARITAS, Project HOPE) gave a good opportunity to share plans and discuss harmonization of

organizations' approaches to some important issues, such as incentives for medical workers and building a system of drug distribution.

15. In Q1, Project HOPE held several meetings with the First Deputy Minister and numerous meetings with the Director of RTBC and the Chief TB MOH specialist to discuss program implementation. One of the main aims of the meetings was advocating for the necessity to increase the strategic planning capacity of the RTBC (or another body that could be charged with overall TB control policy planning and decision-making).

## II. BUILDING HUMAN AND SYSTEMS CAPACITY FOR TB CONTROL

### Integration of TB Control within a Reformed Health System

16. **Annual progress.** The program was able to achieve better interaction between the PHC and TB services. PHC facilities started to participate more actively in identifying TB cases, contact tracing, and organization of treatment in the out-patient stage (including direct observation).
17. **Quarterly progress.** As DOT practices are not always followed and have to be strengthened, in Q1 the program focused on achieving progress through targeted work with rayon Chief Doctors who represent the PHC system. As a result, DOTS program implementation was regularly discussed at the rayon level at the medical committees that are chaired by rayon Chief Doctors and include representatives of both TB and PHC networks. It provides a good opportunity to discuss problems and find solutions.

### Strengthening the TB Laboratory Network

18. **Annual progress.** The number of functioning laboratories in the rayons supported by Project HOPE but funded by USAID is 25 (65.8% of all laboratories organized in DOTS rayons). Eight of them were organized in PHC health facilities. The system of internal and external quality control (external analysis is conducted quarterly for all rayons by the Central laboratory in RTBC) was substantially improved in year 2 but still requires constant attention. Other positive developments are improvement in recording and reporting, quality of smears, microscopy and staining of slides in all USAID rayons.
19. The issues that need to get special attention in year 3 are the establishing of proper links between central and field levels for collection and transfer of statistical data, as well as for building an effective mechanism of laboratory supplies management and training of laboratory specialists.
20. **Quarterly progress.** *Monitoring of laboratory component.* All seven monitoring visits supported by USAID included laboratory specialists – representatives of Project HOPE or the NTP. A monitoring team provided on-the-job training and presented monitoring results with recommendations to DOTS Coordinators and Laboratory Coordinators. In Q1, it has become more evident that while there is gradual progress in many laboratory aspects of the program, the mechanism of ordering laboratory commodities is the main area that needs improvement.
21. *Work on training packages.* The team continued to work on creating two packages for laboratory trainings – basic and advanced – that would better address the needs of laboratory workers. The Project HOPE Regional Specialist on laboratory visited Tajikistan in February to assist with this work. The basic package was prepared (the first training was conducted with GFATM financial support in April 2006).
22. *Assistance to GDF mission.* The Regional Specialist and Project HOPE local laboratory specialists helped GDF to conduct the final assessment on the use of laboratory kits delivered to 9 rayons and microscopy kits delivered to 5 rayons. Project HOPE preliminarily decided to order more microscopes from GDF but not to buy liquid reagents, as dilution could be done locally which would save money on transportation costs.

### Strengthen Human Resource Capacity

23. **Annual progress.** The plan for year 2 called for strengthening the capacity of the national team. The program has been working on this through the increase in NTP staff participation as trainers in the trainings it conducts, and formation of a trainers' team at the oblast level (such a team has been created in Sughd oblast with GFATM support but in year 3, similar teams will be created in Khatlon oblast and Dushanbe where the program is mainly supported by USAID).
24. The DOTS strategy guideline for PHC doctors and all lecture slides were updated. The DOTS strategy guideline for nurses was updated by Project HOPE and is under NTP revision at the moment.
25. All planned workshops were conducted. An additional training was organized for family doctors of the post-graduate institute. In year 3, Project HOPE will consider how to better incorporate the DOTS curriculum into post-graduate education. Also, in year 2 Project HOPE worked on developing training for SES specialists (trainings are to be conducted in year 3).
26. **Quarterly progress. Trainings.** The program continued building local human capacity through various trainings and on-the-job trainings during monitoring visits. These activities have been carried out together with the national partners. In Q1, five trainings were conducted in the framework of the USAID grant: two quarterly cohort analysis workshops/refresher trainings for DOTS coordinators and laboratory specialists, and three IPC/C trainings for patronage nurses further described under Objective 3 (95 people were trained: 64 of them were certified and 31 participated in cohort analysis trainings that do not include certification).
27. *Work on preparation for SES trainings.* In Q1, the training team of Project HOPE had several meetings with SES management and technical staff working on developing DOTS trainings for epidemiologists. These trainings will provide an opportunity for re-engaging SES in TB control activities, including relevant epidemiological control measures. The preparation for the trainings is a part of the broad discussion on NTP structure and the SES role in the TB control program that have to be continued in year 3.
28. *Linkages between monitoring and training.* The training team uses results of the monitoring visits for planning its activities. Visits to Kulyab and Vose rayons revealed problems with following the diagnostic algorithm, leading to over-diagnostics of extra-pulmonary TB and weakness of treatment control practices that increases the number of early relapse cases. To reinforce the DOTS practices, the training team is planning to conduct refresher training for PHC doctors in these rayons in Q 3-4. Also, two trainings on sputum collection are planned for PHC nurses in Rudaki rayon which has high rates of case detection of pulmonary smear negative cases.

### Creating Rational Drug Management Systems

29. **Annual progress.** Overall, in Y2 the mechanism of distribution of drugs from central to oblast and then to rayon level started to work efficiently. The country moved to the new system – STOP TB kits. Tajikistan is the first country in Central Asia that has started to use the STOP TB drug kits developed by GDF. This step is a further development of the MOH/Project HOPE initiative to use patient kits in order to ensure a sufficient drug supply for all registered patients. Project HOPE developed training materials and a workshop curriculum on utilization of the STOP TB kits, and organized several workshops for drug managers in all USAID rayons.
30. One of the tasks for year 2 was to implement the recommendation of the TB drug management initial assessment. As a main result, Project HOPE presented the recommendation of including first-line TB drugs in the essential drug list that was approved by the MOH. The Thematic Working Group on Drug Management was established and approved by MOH decree in June 2005. The group held two meetings.

31. The development of the LMIS system has started. The draft of the manual was developed by JSI and Project HOPE. In the end of year 2, pilot testing started and it will be finished in Q2, 2006.
32. **Quarterly progress. Monitoring of drug component.** Drug specialists participated in all monitoring visits (seven visits). All monitoring visits were conducted with active participation of republican, oblast and city coordinators (in the case of Dushanbe) on drug management. It should be noted that all drug warehouses at the oblast and rayon TB and PHC facilities have the entire list of first-line TB drugs. In Q1, the mechanism of delivering drugs from republican to oblast and then to rayon level started to function as planned.
33. Despite many improvements, some problems persist. While drug specialists in the field have started to estimate drug needs, there are many mistakes which would require conducting trainings for these specialists - it will be conducted in year 3. Also, one of the issues that has to be addressed is development of a mechanism of transferring drugs between the in-patient and out-patient stages (especially if the treatment for different stages is managed by different administrative territories). The problem will be discussed at the next meeting of the TWG on drug management, where Project HOPE will provide consultancy support.
34. *Assistance to the GDF mission.* The Project HOPE Regional Specialist on drug management assisted in conducting a GDF monitoring mission. The aim of the mission was to evaluate the usage of STOP TB kits, evaluate the country's handling of the drug supply provided by GDF in 2005, and estimate the country TB drug needs and available resources – to consider if the new application to GDF for TB drugs is necessary. The mission, accompanied by the Project HOPE Regional Specialist, had several meetings with MOH officials and international NGOs, and visited several TB facilities and DOTS centers in Dushanbe, Rudaki rayon and Republican TB hospital. GDF presented the mission report to partners who work on TB control in Tajikistan. The mission found that the all conditions and terms of GDF support were met.
35. *Development of LMIS system and visit of JSI consultant.* In Q1, the work on the pilot field testing of LMIS forms continued – it will be finished in Q2. Information for analysis and the forms further development was collected. The JSI consultant visited Tajikistan to provide assistance in finalization of the LMIS manual and development of training materials.
36. *Input on development of Drug Procurement Center.* The JSI specialist and Project HOPE Program Manager participated in a meeting called by PSF on selecting of board members for the future Drug Procurement Center that could be contracted for purchasing medical items for the country. The elections were postponed as some issues (including the issues of legal liability of board members) should be further clarified. Project HOPE provided comments on the proposed DPC management structure.

### **Improve Program Management, Supervision, and Surveillance**

37. **Annual progress.** There are many positive developments in year 2 that reflect the program's day-to-day work and strategic priorities: substantial strengthening of the management skills of rayon coordinators, improvement in following DOTS guidelines on TB cases registration and standard treatment protocols, improvement in completing reporting and recording forms. Cohort analysis became a tool for program analysis at the rayon level, which allows for successful decision-making.
38. At the same time, many fields have to get special attention in year 3. One of the important tasks is developing of an effective mechanism of transferring statistical data from rayon to oblast and to the national level. The flow of information about the patient when he/she transfers from the in-patient to the out-patient stage has to be improved as well. All this makes the task of strengthening of coordination functions (especially planning) of oblast and national TB centers essential. These centers should serve as leaders of the TB program in the country.

39. **Quarterly progress. Monitoring.** In Q1 2006, seven monitoring visits supported by the USAID grant were conducted. The program continued gradual transfer of responsibilities to the national monitoring team - the number of Project HOPE monitoring specialists has decreased to one or two people. Young prospective specialists came to the national team. The national team started to work more actively with oblast level specialists during their monitoring visits, to better analyze program results and to independently discuss them with oblast health departments. Also, in Q1 the Khatlon oblast monitoring team became more active (discussions of results with rayon administrations and provision of sound recommendations on program improvement). In addition to monitoring visits, quarterly cohort analysis discussions (two in Q1) have strengthened program analysis and management skills of the local specialists.
40. Monitoring results demonstrate improvement in following the standard treatment protocols (including the following guidelines on length of treatment according to DOTS protocols), contact tracing, registration of TB cases following DOTS classification and timely presentation of materials to Central Medical Control Commission for confirming TB diagnosis.
41. *TB and HIV/AIDS.* At the request of the Tajik team, the Project HOPE Technical Director and HIV/AIDS Specialist prepared comments on the draft document on organization of TB/HIV services created in the framework of the CAPACITY Project. Representatives of Project HOPE participated in a Partners Meeting and TWG on TB/HIV organized by CAPACITY where the document was discussed. In written and verbal comments during the meeting, Project HOPE called for prioritization of the activities, adopting the WHO M&E framework, collection of baseline data and selecting measurable targets. As similar documents have been/are being adopted by other countries, the discussion has been continued at the regional level.

### III. COMMUNITY ADVOCACY AND MOBILIZATION

42. **Annual progress.** The overwhelming part of the planned activities for year 2 were completed: establishing of a TWG, developing the National Communication Strategy on TB, conducting a KAP survey and finalization of the report (some last touches will be done in April 2006), establishing of treatment support groups (patronage nurses) in Kulyab, Vose and Rudaki rayons, printing and distribution of 1200 IEC materials (1000 diagnostic algorithms, 100 calendars and 100 posters on smear microscopy). While the program conducted some day-to-day IEC activities, the focus was on developing of sustainable mechanisms for integrating IEC/BCC activities in the TB control program (TWG is an example of this approach). Also, with creation of Treatment Support Groups the program demonstrated how IEC/BCC work could contribute to decreasing unfavorable treatment outcomes.
43. The Small Grant Program was under development in year 2 – the first call for Proposals will be done in Q2, 2006.
44. **Quarterly progress. TWG work.** The TWG on IEC met in February. The agenda of the meeting included selection of a TWG chairman and secretary, discussion on the final draft of the National Communication Strategy, evaluation of existing IEC materials on TB, and preparation for World TB Day. The Director of the Republican TB Center was selected as the TWG Chairman and the National IEC Coordinator as the Secretary. Taking into account comments (including those of the JHU advisor), TWG made some changes in the Strategy. After the TWG chairman presents the document to the MOH, it will be sent for approval to the National Coordination Committee. Also, the meeting allowed creating a joint plan of activities for celebration of World TB day. Concerning evaluation of existing IEC materials developed by various organizations, members of the TWG were provided with an Evaluation Checklist, which was developed by JHU. It was decided that newly developed materials have to be submitted to the TWG for approval. The TWG is becoming an effective tool for providing technical expertise in the IEC field and increasing efficiency of efforts of many organizations involved in this work.

45. *KAP Survey*. In March, the Project HOPE Chief of Party visited the Tajik office to work on finalizing the KAP survey report. After translating the report in Russian, it will be widely distributed to partners working in TB field in Tajikistan.
46. *Trainings for patronage nurses*. Project HOPE started work on strengthening Interpersonal Communication/Counseling (IPC/C) skills among patronage nurses. The first three trainings on IPC/C for the 60 patronage nurses who are members of treatment support groups from Kulyab, Vose and Rudaki districts were conducted in Q1. Trainees received knowledge on interpersonal communication, DOTS principles, and the role of a PHC patronage nurse in TB control, IEC and patient education. During the practical part of the training, nurses applied their IPC/C skills working with patients in TB hospitals. The program will continue training and support of these groups as it considers them an important mechanism for delivering highly focused counseling services to TB patients and their relatives.
47. *World TB Day*. World TB Day activities were organized in collaboration with various governmental structures as well as local and international NGOs (MoH, RTBC, Healthy Life Style Center, NGO Youth Legal Support Center, Youth Committee of Tajik Government, Project SINO, National Red Crescent society, Aga Khan Foundation. Some presents (20 clocks and 100 calendars with “World without TB” slogan) were specially developed for this occasion using USAID funds. These presents were awarded to the country’s best TB coordinators, PHC physicians, nurses and laboratory workers. As incentives, 100 bags with the slogan “World without TB” were distributed to treatment support group members.

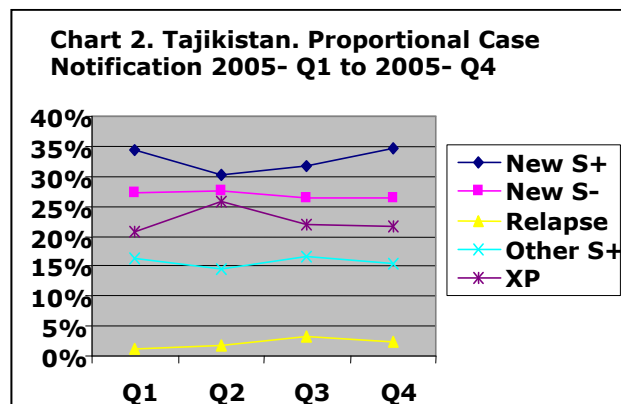
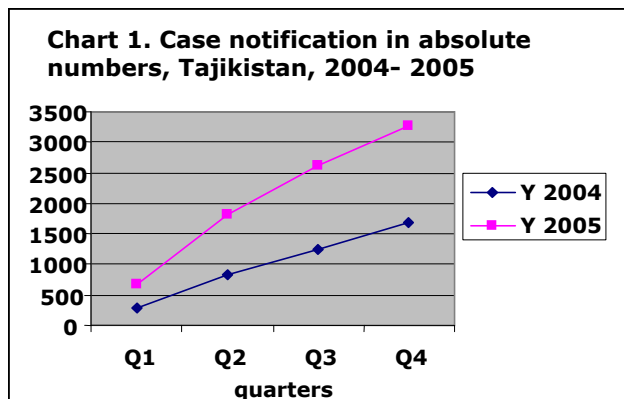
#### IV. INCENTIVES AND ENABLERS PROGRAM

48. **Annual progress**. The program expansion and introduction of a cost-sharing scheme (WFP covering part of operational expenses) is clear evidence of this program’s success. The program results continue to get international attention – the Project HOPE/Tajikistan PM was invited to present on the subject on the annual IUTLD 35<sup>th</sup> in October 2005.
49. **Quarterly progress**. *Program expansion*. In February, Project HOPE and WFP signed a new Cost Sharing Project Agreement VGF/2006/02. The agreement not only expands the food program to five new regions (in addition to Dushanbe and Rudaki): Khujand, Konibodom, Mastchoh, Kulyab and Vose but also supports establishing of two sub-offices and hiring the staff in Khujand and Kulyab with WFP direct contribution. The program run by Project HOPE is evidence of effective cooperation between WFP, USAID and national structures (some office space for the program was provided by Kulyab and Khujand city TB centers).
50. *Take Home Ration Distribution*. In February, one Take Home Ration (THR) distribution was conducted in Rudaki rayon for 179 TB patients and 1,268 beneficiaries and another in Dushanbe for 461 patients and 3,129 beneficiaries. Also, two THR food distributions were conducted in new program rayons: Vose and Kulyab. Food distribution in Vose covered 121 patients and 597 beneficiaries. Due to the long distance from villages to the Vose center, distribution was conducted at two distribution points (one warehouse in Pakhtakor and one in the center of the rayon). In Kulyab, 114 patients and 629 beneficiaries received food rations.
51. *Institutional Feeding*. In Q1, institutional feedings were provided to the Machiton and Children’s TB hospitals: Machiton hospital received food for 257 patients and the Children’s hospital for 28 patients. In March, food was delivered to TB hospitals in new rayons: Kulyab received food for 80 patients and Vose received for 60 patients. Institutional feeding is provided for three months and calculated based on the number of patients present in facility.



## Analysis

Charts 1, 2, 6 and 7 reflect data from 27 DOTS rayons. Chart 3 reflects data from 24 rayons where smear conversion results are available. Charts 4 and 5 reflect treatment outcomes of the patients from 16 rayons (Dushanbe, Rudaki, Vosse, Kulyab, Varzob, Dangara, Khujand, Khorog, Rushan, Farkhor, Shurabad, Hamadoni, Muminabad, Baljuvan, Temur-Malik and Matcha).



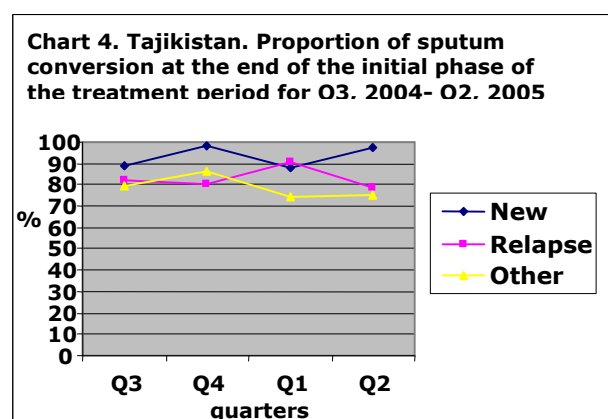
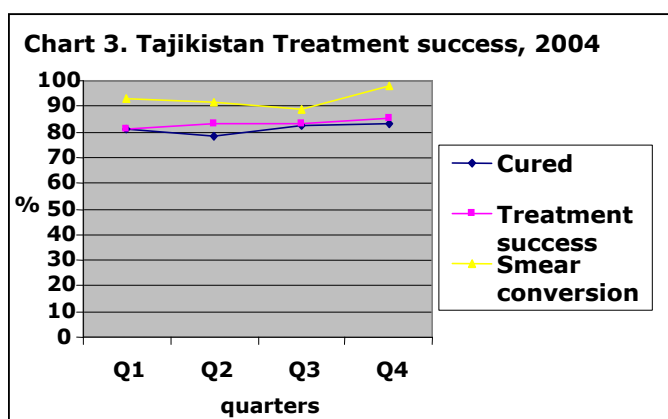
**Chart 1** reflects an increasing number of all new cases. While in 2004 the absolute number was 1,676 patients, the number for 2005 is 3,268. It is considerably higher than in 2004 due to DOTS expansion to new rayons. The DOTS coverage increased from 32.45% at the end of 2004, to 62% at the end of 2005. At the same, improvement in case detection also contributes to an increase of the absolute number. 2005 witnessed better PHC involvement in case finding and improving of official case registration (more patients entering the official TB treatment system – partly as a result of free drug availability).

**Table 1: Tajikistan. Absolute and proportional case notifications for 5 TB categories for the 4 quarters of 2005**

	Q1		Q2		Q3		Q4	
New S+	286	34.3%	409	30.3%	311	31.6%	278	34.6%
New S-	228	27.4%	374	27.7%	260	26.4%	211	26.3%
Relapse	11	1.3%	23	1.7%	33	3.4%	18	2.3%
Other S+	135	16.2%	196	14.5%	164	16.7%	123	15.3%
XP	173	20.8%	349	25.8%	216	21.9%	173	21.5%
Total	833	100%	1351	100%	984	100%	803	100%

**Chart 2** divides all TB cases registered in 2005 on various categories. The proportion of new sputum smear positive cases among all new pulmonary cases remains stable during the year in the 52-57% range. While results demonstrate that the microscopy method is employed for TB diagnosis, there is a scope for DOTS program improvement as WHO suggests that a goal for TB smear-positive cases of total pulmonary TB cases should be at least 65%. Project HOPE will continue to assist the NTP in strengthening links between the PHC and TB services to better involve PHC in TB control, particularly in the areas of case-finding and adherence to the microscopy diagnostic method.

A high percentage of extra-pulmonary cases (23% of all cases) underscores the necessity of following the diagnostic algorithm for extra-pulmonary cases, including the procedure for differential diagnosis with other diseases. As for sputum smear negative cases, the lack of control in the procedure of sputum collection might lead to mistakes in assigning of type of TB case when a smear-positive case could be registered as a smear-negative.



**Table 2: Tajikistan Sputum smear conversion at the end of the initial treatment period in absolute and proportional figures for 2004-Q3 to 2005-Q2 for different categories of smear positive TB cases.**

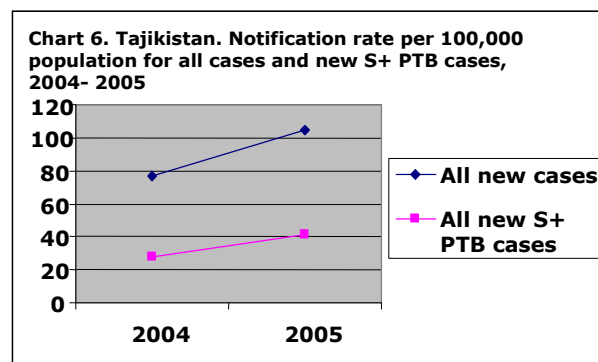
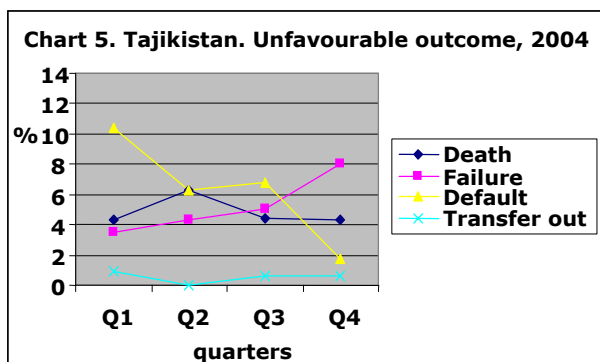
	Q3			Q4			Q1			Q2		
	absolute numbers		%	absolute numbers		%	absolute numbers		%	absolute numbers		%
	cohort	converted		cohort	converted		cohort	converted		cohort	converted	
New	161	143	88.8	167	164	98.2	286	251	87.8	409	398	97.3
Relapse	11	9	81.8	10	8	80.0	11	10	90.9	23	18	78.3
Other	67	53	79.1	91	79	86.0	135	100	74.1	196	148	75.5

**Chart 3** reflects good results of smear conversion among new cases (it should be noted that the program has expanded without sacrificing its quality). It reflects the good adherence to treatment on intensive phase, demonstrates that the primary drug resistance in the country is relatively low, and that microscopy is used as a tool for measuring the treatment progress.

**Table 3: Tajikistan Treatment outcome of new S+ Pulmonary TB cases, 2004**

	Q1		Q2		Q3		Q4	
	N	%	N	%	N	%	N	%
Notified	115		160		161		164	
Evaluated	115		160		161		164	
Cured	93	80.9	125	78.1	133	82.6	136	82.9
Completed	0	0	8	5	1	0.6	4	2,4
Death	5	4.3	10	6.3	7	4.4	7	4.3
Failure	4	3.5	7	4.3	8	5	13	8
Default	12	10.4	10	6.3	11	6.8	3	1.8
Transfer out	1	0.9	0	0	1	0.6	1	0.6

**Chart 4** shows that the cure rate remains in the range of 78% - 83% (treatment success rate is in the range of 80 - 85%). The results could be improved if DOT practices, which often are not followed in the continuation phase usually conducted by PHC, will be strengthened.



**Chart 5** shows unfavorable treatment outcomes (the low number of patients could lead to some quarterly variations that are not obviously signs of major trends). Annual results were following: “transfer out” 0.5%, “default” 6%, “failed” 5.3%, “death” 4.8%.

Although the death rate is not alarmingly high, the indicator is varied by regions and was worse (around 10%) in rural areas that tend to be especially poor. Analysis of death cases reveals late detection due to limited patient access to health services.

The failure rate in the last two quarters increased up to 8%, including Rudaki (8.7% for the cohort of Q3, 2004, 18.8% for the cohort of Q4, 2004), Dushanbe (8.9% for a cohort of Q4, 2004), Vose (10.5% for the cohort of Q3, 2004). These particular rayons required strengthening of DOT practices that was addressed by creating of treatment support groups in Rudaki, Kulyab, and Vose.

The default rate decreased during the year from 10.4% to 1.8% (in Dushanbe - 13% in Q1, 0% in Q4; in Rudaki - 15% in Q1, 6.3% in Q4). The IEC/BCC work with patients and their relatives should be continued in order to explain patients the importance of treatment completion (especially taking into account high rates of labor migration). The food program run with WFP support provides extra help in ensuring that a patient will complete a full course of treatment.

**Table. Tajikistan Notification rate per 100,000 population for all cases and New S+PTB cases, 2004-2005**

	2004	2005
All new cases	76,9	104,9
All new S+ PTB cases	27,5	41,2

**Chart 6** shows the case notification rate for all new TB cases was equal to 104.9 in 2005 and was 82.7% of the estimated number of June 2005 WHO assessment mission – 127/100,000. The case notification rate for all new sputum smear positive cases was 41.2 per 100,000 population that was 74.9% of the assessment’s estimation (55/100,000). As was discussed under Chart 1, the increase could be partly caused by better official registration – the treatment went informally before but now new cases are registered officially as free drugs became available (it takes time for information about the success of the program to trickle down).

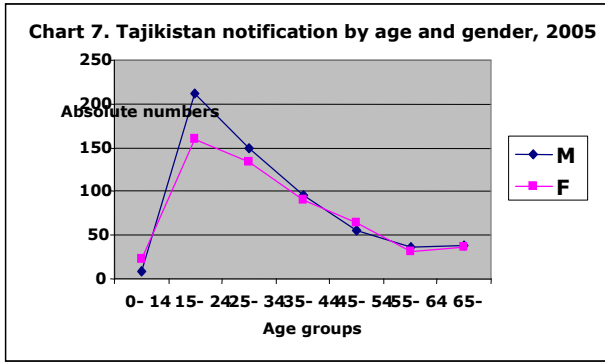


Chart 7 shows that the most affected group is young men.

**Turkmenistan - Q1, 2006 - Batyr Kochumov****QUARTERLY PROGRESS SUMMARY**

1. The majority of the activities planned for the 1<sup>st</sup> quarter of 2006 were conducted. Project HOPE intensified relations with the British Embassy, involving them in solving problems faced by the National TB Program regarding laboratory equipment and supply for DOTS implementation in the etraps of the 2005 DOTS expansion plan. Discussion on further cooperation will continue. There were visits by regional specialists, the Project HOPE Regional Technical Director and Project HOPE Regional Chief of Party, as well as trainings and a number of monitoring were conducted. A number of activities were conducted for World TB Day. The issues with microscopy labs supply for the DOTS sites for the period 2006 – 2007, was finally resolved through collaboration with the British Embassy and the CDC. The booklet “Diagnosis of pulmonary TB and Chemotherapy Control” for family doctors and nurses has been drafted. The CAMRIS and Regional Policy Specialist visits were postponed to a later period in 2006.

**PROJECT OBJECTIVES****I. BUILDING POLITICAL SUPPORT FOR TB CONTROL**

2. The main achievements of the TB Programs’ political strengthening component during the second year of the Program (April 2005-March 2006) were:
  - Approval of the National TB Prevention and Control Program for the period 2005-2009 by the MOHMIT, which lays out the road to DOTS expansion for the coming years
  - Establishment of the Interdepartmental Coordination Board for the TB Control program
  - Creation of two Thematic Working Groups, one on IEC/BCC, the other on TB Drug Management
  - DOTS expansion in Balkanabat city of Balkan velayat; bringing the population covered by DOTS in that velayat to 44%.
  - Incorporation of a new stakeholder, The British Embassy, into the TB Control Program
  - Completing the application to the Global Fund.
3. The Global Fund application was not submitted. At the moment, the Ministry of Health and Medical Industry of Turkmenistan (MOHMIT) lags behind in DOTS expansion as issues regarding laboratory supplies and funding for trainings and monitoring are still unresolved. In 2006, the government planned to implement the DOTS strategy in 15 etraps according to their plan. During the 1<sup>st</sup> quarter of 2006, the issue regarding further DOTS expansion was discussed among the DOTS program partners. MOHMIT initiated such discussions, since it tries to involve different international organizations (Project HOPE, WHO, Medicines San Frontiers) to assist them in further DOTS expansion activities.
4. Project HOPE assists MOHMIT in solving the issue of expansion through involving other donors’ funds to obtain lab equipment and reagents supplies. Despite Project HOPE’s joint grant project with the British Embassy which supplied the laboratories in 5 etraps in 2005, it is still unclear when the DOTS strategy will begin to be implemented in these etraps.
5. Coordination issues regarding different aid organization’s activities on how they may effectively strengthen the TB Control Program were discussed during meetings with representatives from the National Red Crescent Society (NRCS), Medicines San Frontiers (MSF) and the ZdravPlus Project. It was agreed that ZdravPlus and NRCS would render financial support for Project HOPE activities devoted to World TB Day (WTBD). Later, ZdravPlus will support Project HOPE through printing of training materials about DOTS for the TB Faculty of the Turkmen State Medical Institute.
6. Additionally, the concept of Project HOPE’s TB Program in Turkmenistan and possible ways to address the current situation of DOTS expansion in Turkmenistan were discussed during the visits of the Project HOPE Technical Director and Chief of Party from the Regional Office.

**II. BUILDING HUMAN AND SYSTEMS CAPACITY FOR TB CONTROL**

7. The main achievements during the second year of the TB Control Program regarding the “building human and systems capacity for TB Control” component include: supplying the microscopy labs with equipment and reagents in 5 etraps, drafting a Prikaz on the “Lab network structure of the National TB Control Program,” designing guidelines on TB detection and treatment and on the Logistic Management and Information System. Additional accomplishments included establishment of a TWG on Drug Management and holding the first meeting of that TWG, conducting a one-day training on Drug management cycle for TWG members, TB drugs were supplied by the GDF to ensure the drug supply in 2006 has a 100% buffer stock, assessment visits by Project HOPE Technical Director and Regional Specialists on the laboratory component and drug management component and trainings on the “Logistics, Management and Information Systems” for drug management.

#### **Strengthening the Laboratory Network**

8. Project HOPE’s Regional Laboratory Specialist’s regular visit to Turkmenistan occurred in January 2006. The microscopy labs at DOTS sites were assessed and recommendations on how to improve their performance were given. The main recommendation was aimed at human resources development through establishing education centers and the development of a standard program for sputum microscopy trainings. She also advised renewal of the work on arranging contacts with a supranational laboratory.

#### **Strengthening Human Resource Capacity**

9. During the first quarter training was conducted for family doctors in Balkanabat. Due to a lack of qualified trainers in this area, a TB doctor from Turkmenbashi who is trained in TOT was involved as the second trainer. The result of the training of family doctors and health care managers in Balkanabat is the integration of the TB Control Program into Primary Health Care (PHC), through which TB patients are first detected and then later treated during the continuation phase in PHC facilities.

#### **Creating a Rational Drug Management System**

10. Prior to the visit of the Regional drug specialist, the draft of the LMIS manual and forms sent by JSI were revised and sent to key TWG members for review.
11. The Project HOPE regional drug specialist visited Turkmenistan in February 2006. During the visit, she met with local officials, worked on preparation of the LMIS manual and forms for pilot testing, adaptation of the training materials on LMIS for Turkmenistan and conducting rehearsal training.
  - During the meeting with local officials, drug management related issues were discussed. The agency will distribute the drugs, according to its existing procedures, shortly after their arrival at the warehouse to the velayat levels (i.e. velayat pharmacy department), then the drugs will flow down to the etrap level through the velayat TB hospitals, but not through the etrap pharmacies as it was assumed initially.
  - The stock will be stored at the TB units: at the central level – at the center for TB prevention; at the velayat level- at the velayat TB hospitals, and at the etrap level – at the TB department of the etrap hospital.
  - Since the stock will be stored at the TB units, Turkmenpharmaciya will not do reporting on the drugs status.
12. All these comments were considered during the revision of the manual and adaptation of the training materials. The one–day rehearsal training on LMIS for 12 participants was held on March 6, 2006. Participants of the training made recommendations for improving the training materials presented.
13. Possible pilot sites for testing of the LMIS forms and appointment of the national drug management coordinator was discussed with the director of the TB prevention center. As a result of this

discussion, Turkmenbashi and Balkanabat of Balkan velayat and Ashgabat were defined as pilot testing sites for the LMIS forms. This choice gives a chance to test forms intended for all levels – PHC, etrap, velayat and national.

14. Furthermore, Karayeva Gulnara, the senior research specialist for the scientific department of the TB prevention center, was appointed as the national drug management coordinator. She will be actively involved in all activities run by Project HOPE on drug management.
15. The GDF mission that took place at the end of March 2006 found that the country does comply with the terms and conditions of GDF, therefore, the mission recommend the continuation of the supply of anti-TB drugs to Turkmenistan.

### **Improving program management supervision and surveillance**

16. Regular monitoring in the DOTS sites revealed following problems:
  - The quality of collected sputum in Health Houses (HH) is poor. This was observed in the high percentage of saliva in collected samples and rechecked results.
  - There are human resource shortages in the labs of the TB Prevention Center (TBPC), the TB wards in Turkmenbashi and Mary velayat TB Hospital. Intensive monitoring will be needed by TBPC and Project HOPE. After the monitoring, the joint team will discuss the need to solve the human resources issue with NTP authorities.
  - In Mary, half of the TB patients are detected in the Health Houses of the city. Work on increasing the number of patients detected by PHC facilities will be continued through on-the-job trainings for PHC doctors during regular monitoring by Project HOPE and the local specialist.
17. There is no link between the civil and prison health care systems. If patients are sentenced during treatment it becomes impossible to track their treatment results. This may be solved by implementation of the DOTS strategy in prisons. Currently, the penitentiary system submits lists of ex-prisoners to the PHC system of the country, where ex-prisoners pass medical examinations. The issue of improving these links has been discussed during the meetings with NTP authorities. Treatment adherence among risk groups of patients may be improved to some extent through the strengthening of social mobilization activities or accumulating additional funds from NRCS to motivate patients in the intensive phase of treatment.

### **III. COMMUNITY, ADVOCACY AND MOBILIZATION**

18. During the second year of the program, the main achievements under this component were:
  - JHU and the Regional Social Mobilization Specialist visited the country and conducted an initial assessment of health communication in Turkmenistan
  - A two-day workshop for TWG members on Health Communication Strategy design
  - Establishment of a TWG on Social Mobilization, that has already met five times
  - Start of the National Health Communication Strategy development by a joint team of Project HOPE and local specialists
  - Assessment of existing IEC/BCC materials on TB in Turkmenistan was conducted
  - Carrying out activities related to World TB Day 2006
19. During Quarter 1 of 2006, two Social Mobilization TWG meetings were conducted: first, to discuss the possibility of conducting a KAP survey among target groups and the second, to plan activities for the World TB Day 2006.
20. The issue of holding a KAP survey has been discussed at the different levels of MOH during the last 8 months. But permission for the survey has not been given yet by the MOHMIT. This issue was repeatedly discussed with Project HOPE's Regional Social Mobilization Specialist and JHU partners who suggested using alternative methods of information gathering (focus group discussion, collecting information during monitoring), which were discussed at the TWG meeting. TWG members

welcomed the idea of the survey and methods, but the MOHMIT permission will be needed. It is most likely that not the methodology, but the information gathering itself, is the stumbling block. We think that there is a need to find other ways to proceed with the Health communication strategy design under conditions in Turkmenistan. In particular, this is shown by using generalized information received on the basis of similar assessments in other Central Asian Republics and extrapolating this data for Turkmenistan, since the populations of CAR region have a relatively similar history, educational background, conditions of life and health care structure.

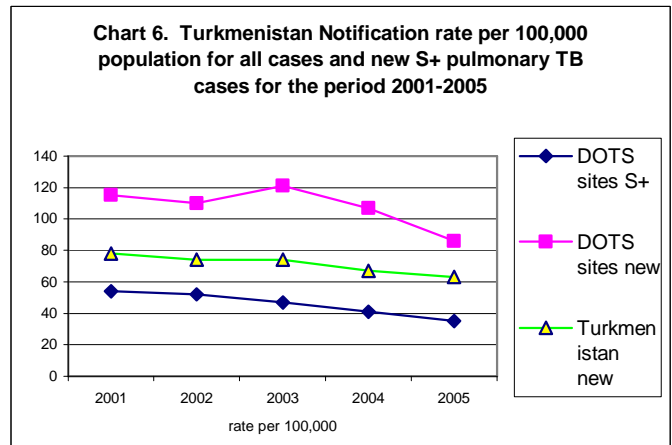
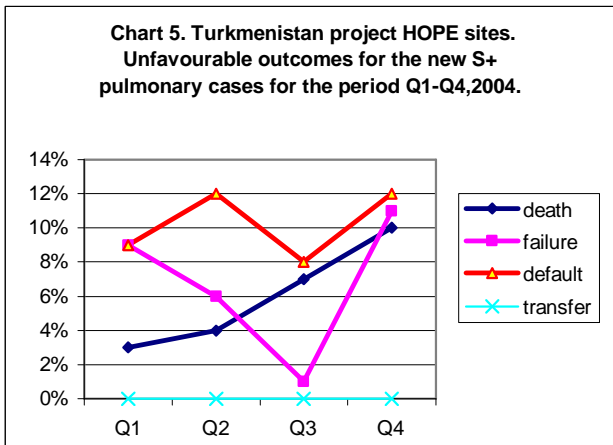
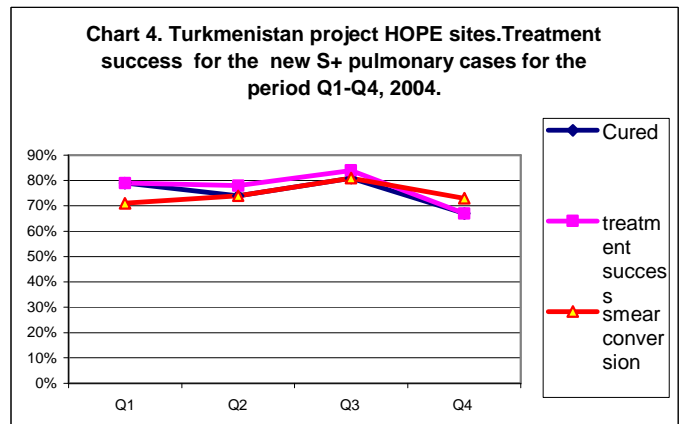
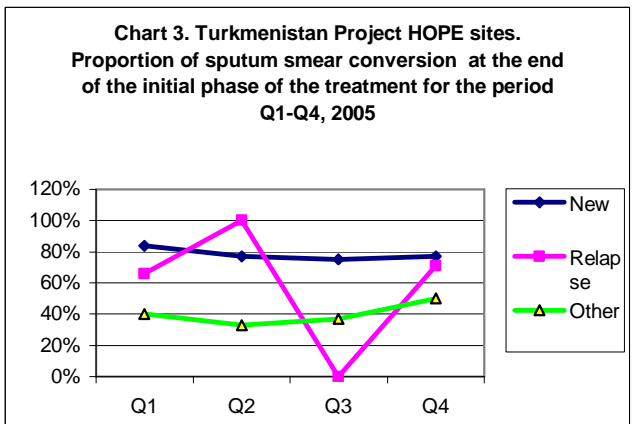
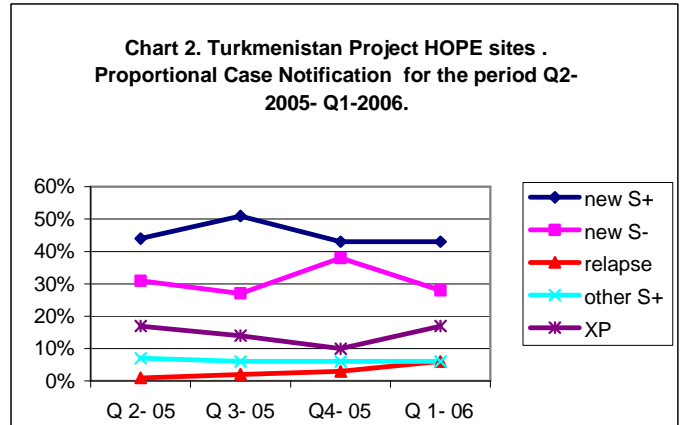
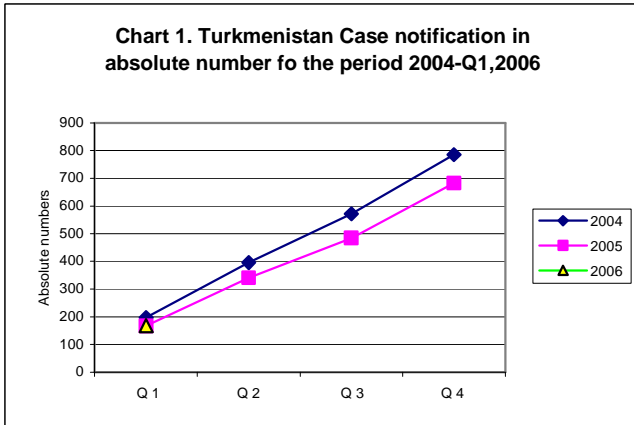
21. This year, for World TB Day the following activities were planned and conducted by MOHMIT, TB Prevention Center, TB Faculty with the support of Project HOPE, ZdravPlus, and the National Red Crescent Society: a students' conference with a quiz, sketch about TB, drawing competition, and gifts awards to winners; a TB conference devoted to World TB Day; poster competition among Health houses of Ashgabat city; radio broadcastings and publications on TB in newspapers aimed at raising awareness about TB and increasing target groups adherence to TB program.
22. To meet the TB program's current needs in health promotion materials on TB and to complement the education component of the program, Project HOPE, jointly with the TB faculty, started developing a booklet for primary health care specialists on "Pulmonary TB diagnosis and treatment control."

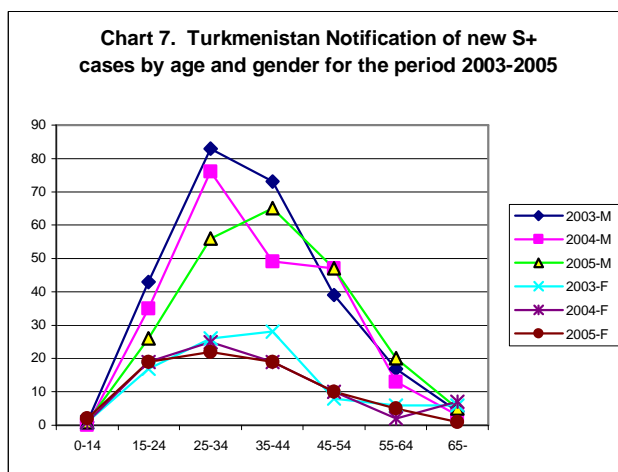
### **Epidemiological Analysis**

23. Epidemiological developments are presented in charts 1-7 and the tables below. Unless indicated otherwise, the graphs and tables reflect the 4 pilot rayons of Project HOPE. The total population of the pilot rayons is 852,126, i.e. 16% of the total population of Turkmenistan.
24. Case notification in 2005 was lower than in 2004. There is no good explanation for this. It is reflected in the case notification rates that are lower in 2005 than in previous years. Among the civil population of all of Turkmenistan, notification rates in 2005 were 63.2 per 100,000 population, while in the DOTS sites it was 86.1 per 100,000, which is 14-20% lower than in previous years. This needs further investigation. More reliance on not yet well functioning PHC services? A real decline in the epidemic?
25. Some decrease in the notification rate may be explained by the decrease of notification in Ashgabat. Two health houses in Ashgabat city detected fewer numbers of TB patients than in the previous year. The Head of TB dispensary of the TB Prevention Center, jointly with the Project HOPE monitoring specialist and TB Faculty, discussed the results of TB detection in these health houses. As a result, Directors of all health houses of Ashgabat city were invited to the TB Prevention center to discuss the results of TB detection and treatment for the year 2005. During this meeting, the TB specialist compared their analysis of TB detection and discussed ways to improve this work.
26. The proportion of new smear positive cases among all cases notified is rather stable, with an average of 45%. This is a relative high proportion. Among new pulmonary cases it is 59%. These are good results, but only in small sample of the population that is well supervised.
27. Sputum conversion rates among new SS+ TB cases over the last 4 quarters in new cases was around 80% and has been rather stable. Conversion rates among relapses vary widely, but this is the result of the very small numbers analyzed. Other smear positive retreatment cases indicate some improvement over the last 2 quarters, but here also small numbers have to be taken into account.
28. A similar problem exists for the analysis of treatment outcome results. Success rates over the last quarter were considerably lower than in previous quarters, but basically because of a higher death rate (10%) and failure rate (11%). But in absolute numbers, the lowest recorded amount of death was 3 cases, and the highest 7 cases. Failures varied from 1 to 8 cases. Consistent though is the default rate at 11% on average. This problem refers mainly to the TB patients who live in Ashgabat, which has a large number of patients from risk groups who show low treatment adherence.



Tables and Charts



**Table for chart 2**

Turkmenistan. Absolute and proportional case notifications for 5 TB cases types for the period Q2, 2005-Q1,2006

	Q2- 05		Q3- 05		Q4- 05		Q1-06	
New S+	77	44%	73	51%	85	43%	72	43%
New S-	54	31%	39	27%	75	38%	47	28%
Relapse	2	1%	3	2%	7	4%	11	7%
Other S+	12	7%	8	6%	12	6%	10	6%
XP	29	17%	20	14%	20	10%	28	17%
Total	174	100%	143	100%	199	100%	168	100%

**Table for chart 3**

Turkmenistan. Sputum smear conversion at the end of the initial treatment period in absolute and proportional figures for the year 2005.

	Q1			Q2			Q3			Q4		
	absolute numbers			absolute numbers			absolute numbers			absolute numbers		
	cohort	converted	%	cohort	converted	%	cohort	converted	%	cohort	converted	%
New	63	53	84%	77	59	77%	73	55	75%	85	66	77%
Relapse	6	4	66%	2	2	100%	3	0	0%	7	5	71%
Other	5	2	40%	12	4	33%	8	3	37%	12	6	50%

**Table for chart 4**

Treatment outcome for the year 2004.

	Q1		Q2		Q3		Q4	
	Number	%	Number	%	Number	%	Number	%
Notified	89		69		75		73	
Evaluated	89		69		75		73	

Cured	70	79%	51	74%	61	81%	49	67%
Completed	0	0%	3	4%	2	3%	0	0%
Death	3	3%	3	4%	5	7%	7	10%
Failure	8	9%	4	6%	1	1%	8	11%
Default	8	9%	8	12%	6	8%	9	12%
Transferred Out	0	0%	0	0%	0	0%	0	0%

**Table for chart 6**

Chart 6. Turkmenistan. Notification rate per 100,000 populations for all cases and new S+ pulmonary TB cases for the period 2001-2005.

	2001	2002	2003	2004	2005
DOTS sites new S+	54	52	47	41	35
DOTS sites all new cases	115	110	121	107	86
Turkmenistan all new cases	78	74	74	67	63

**Uzbekistan – Q1, 2006 – Epco Hasker****I. QUARTERLY PROGRESS SUMMARY**

1. The end of the 1<sup>st</sup> quarter of 2006 also marks the end of the 2<sup>nd</sup> project year for the Project HOPE Consortium. The project has three main objectives: Building political support for TB control, Building human and systems capacity for TB control and raising awareness about TB among health providers and communities. Details on the achievements for each of the main objectives during the quarter of report will be provided in the sections below. Each section will be preceded by a short update on overall developments during the 2<sup>nd</sup> project year.
2. During the first quarter of 2006, many activities have been implemented. Site visits took place by New Jersey Medical School (NJMS), John Snow Inc (JSI) and Johns Hopkins University (JHU), all planned monitoring visits and trainings were carried out according to schedule. In addition to the activities scheduled for implementation of the USAID grant, implementation of a sub recipient contract with the Global Fund to fight AIDS, TB and Malaria (GFATM) started in January. Two additional staff members were hired for implementation of the GFATM activities.
3. The activities implemented in the framework of the GFATM agreement are complementary to other activities of Project HOPE and consist mainly of monitoring/supervision and training. In both fields the main aim is to build local capacity. The scope of supervisory visits was expanded beyond previously defined Project HOPE pilot rayons. As a result, the technical team together with their counterparts from the Republican DOTS Center spent a substantial part of their time in the field.
4. Work on a national communication strategy that had started during the 4<sup>th</sup> quarter of 2005 was almost completed during this quarter.
5. World TB day was celebrated with various activities on 24 and 25 March, 2006.

**ANALYSIS OF RESULTS BY OBJECTIVE****I. BUILDING POLITICAL SUPPORT FOR TB CONTROL**

6. Overall developments during year 2 of the project: Consensus has been reached on establishing a high level working group and thematic working groups. Structure and terms of reference were drafted and several informal thematic working groups have been established. To date however the high level working group itself has not been established and thematic working groups have no formal status.
7. Activities planned for the quarter of report were:
  - To continue advocating the establishment of the high level working group
  - To support establishment of thematic working groups on MDR, TB in prisons and Training
  - To support the process of drafting a unified Prikaz for TB in Uzbekistan
  - To conduct a baseline policy assessment and identify policy reform options
8. The high level working group has still not been established and therefore various ad hoc working groups still have no formal status. As was indicated in previous reports, Project HOPE has little real leverage here since it is not part of the TB Management Group. Other mechanisms are functional though, and a lot of coordination is taking place. Ad hoc thematic working group meetings are usually well attended. During the quarter of report, such meetings took place in the field of training, IEC/BCC and MDR-TB.
9. Once every two weeks, meetings took place with the purpose of defining the contents for a new Prikaz on tuberculosis. This Prikaz will overrule all existing Prikazes and will be fully in accordance with the Stop TB Strategy. The Project HOPE team actively contributed to the process. However, by the end of the quarter, the new Prikaz had not yet been finalized.
10. To inform the process of drafting the new Prikaz, Project HOPE conducted an operational research

study on case finding in Tashkent and Djizzak Oblast. The research clearly showed that the number of patients identified through active case finding is much lower than the numbers found in the official statistics. This finding may help convincing policy makers that active case finding, as it is practiced at present in Uzbekistan, is not effective. The study will be communicated to other stakeholders and submitted for publication in an international journal.

11. The planned thematic working group meeting on TB in prisons did not take place yet. During the quarter the Project Implementation Unit (PIU) of the Global Fund to Fight AIDS, TB and Malaria (GFATM) hired an international consultant for TB in prisons. Project HOPE established close links with the PIU and its consultant and will support them in the process of setting up the Thematic Working Group on TB in Prison.
12. The baseline policy assessment scheduled for February had to be postponed until later this year. Data collection and preliminary analysis are in progress at the time of writing this report.

## **II. BUILDING HUMAN AND SYSTEMS CAPACITY FOR TB CONTROL**

13. Overall developments during year 2 of the project:

- A team of 12 DOTS trainers has been established in Samarkand Oblast, trainers were certified in December after having conducted at least 8 trainings under supervision of Project HOPE staff.
- Important progress has been made in getting DOTS incorporated in pre-service curricula, for details I refer to paragraph 22.
- A Logistics Management Information System (LMIS) for anti-TB drugs has been developed and field tested. The system will be implemented nationwide.
- A decentralized system of supervision has been proposed and agreed upon; training courses to introduce the system have been scheduled for the 2<sup>nd</sup> quarter of 2006.
- A first assessment of the MDR-TB situation was conducted in January 2006; the report will become available in April.
- In the field of TB/HIV, Project HOPE staff has become members of a thematic working group established in the frame work of the CAPACITY project. Policies on coordination and cooperation between TB and HIV/AIDS services have been developed.
- Implementation of activities related to TB in prisons has suffered delays. A study tour for staff of the Ministry of Interior and Ministry of Health to the Karaganda pilot site in Kazakhstan was conducted in November 2005.

### **Integration of TB Control within a Reformed Health System**

14. Activities planned for the quarter of report were:

- To establish a group of DOTS trainers at Oblast level

15. Two TOT trainings were carried out as planned in Andijan and Fergana Oblasts. One TOT was conducted for nurses, the other for doctors. For each group, 14 participants successfully completed the training and passed the post-test. During the remainder of 2006, the newly trained trainers will carry out trainings of PHC doctors and nurses under the supervision of Project HOPE staff.

### **Strengthening the Laboratory Network**

16. Activities planned for the quarter of report were:

- To provide supportive supervision
- To standardize the monitoring checklist

17. Supervisory visits to laboratories were intensified, just as general supervisory visits. The emphasis was changed though. Routine supervisory visits to laboratories were carried out by general supervisors as part of their overall supervision of facilities involved in TB control. Visits of the

laboratory supervisor were focused on rayons where problems related to laboratory had been identified during general monitoring visits. During the quarter, 28 laboratories located in Andijan, Fergana, Namangan, Samarkand, Syrdarya and Tashkent were visited.

18. An adapted supervision checklist with instructions was developed in close consultation with the regional laboratory specialist of Project HOPE. These materials form part of the teaching materials to be used in the training scheduled for rayon TB coordinators. Routine supervision of laboratory staff will become part of the tasks of the rayon TB coordinator.
19. Various problems were identified during supervisory visits. The professional level of laboratory staff in the rayons of Fergana Valley that were not among the Project HOPE pilot sites is often too low. None of the laboratories visited during the quarter were properly implementing internal quality assurance procedures.

### **Strengthen Human Resource Capacity**

20. Activities planned for the quarter of report were:
  - To establish a group of DOTS trainers
  - To update the pre service curriculum with inclusion of DOTS
  - To conduct intermediate level DOTS trainings
21. For the first activity, establishing a group of DOTS trainers, I refer to objective IIa. 'Integration of TB Control within a Reformed Health System.'
22. From January 4-6, Project HOPE, together with the Republican DOTS Center and the Tashkent Medical Academy, organized a seminar in which incorporation of DOTS into the curricula of medical universities, para-medical institutes and post graduate institutes was discussed. Participants were the head of the Phthysiology department of the Tashkent Postgraduate Medical Institute, nine heads of Phthysiology departments from different medical universities, nine representatives of para-medical institutes, two representatives of the Republican DOTS Center, a representative of WHO and two representatives of Project HOPE. Prior to the meeting, curricula for training in TB, based on the DOTS strategy, had been developed by the Project HOPE training specialist for doctors and para-medical workers. These curricula were presented, discussed and adapted.
23. The outcome of the meeting was that the proposed amendments to the curricula of medical universities, para-medical institutes and post graduate institutes were approved by all participants. Contents of lectures and teaching materials now need to be adjusted in accordance to the proposed amendments. A responsible person has been appointed for each component, and a second meeting is foreseen during the second quarter of this year in which the process will be finalized. Once the final products are available, they will be presented for official approval to the Council of Rectors of Medical Universities and to the Postgraduate Center for Nursing Education by the head of the Phthysiology department of the Tashkent Medical Academy and the head of the Republican Medical College.
24. During the same meeting, the Uzbek translation of the WHO Glossary made by the Project HOPE training specialist was presented and discussed. Participants approved the translation, after which the Republican DOTS Center was requested to assist by printing 500 copies.
25. Intermediate level DOTS trainings were conducted in Samarkand for two groups made up of general practitioners, TB specialists and laboratory technicians. All participants had previously attended a basic level DOTS training course and are working with TB patients. One of the issues addressed during the training was cooperation and coordination between TB services and general health services.
26. An additional activity that was embarked upon during the quarter of report was to facilitate

participation in a ten-day training on the use of the internet for a group of 10 heads of departments from the National Institute for Pulmonology and Phthisiatry.

### **Creating Rational Drug Management Systems**

27. Activities planned for the quarter of report were:

- To monitor the pilot 'Logistics Management Information System' (LMIS)
- To revise LMIS manual
- To finalize LMIS training curriculum

28. The LMIS was piloted in three rayons of Samarkand Oblast in November 2005. During the quarter of report, two monitoring visits were undertaken by Project HOPE and DOTS Center staff with the purpose of monitoring the pilot LMIS. Overall the LMIS appeared to be functioning well in most facilities, especially those in Samarkand City. In Jambay and Taylak rayon, the LMIS forms were not being used in all facilities, mainly because the staff had difficulty understanding Russian. At this moment the system is still an additional system; the old system is also still in place, leading to extra work for the staff involved. Also, there was a lack of supervision from rayon level TB coordinators. As a result, reports are often not submitted on time. The problems identified were discussed with the head of the Oblast DOTS Center and the Oblast drug management coordinator and solutions were identified. The LMIS manual and forms were translated into Uzbek, and the format of one form was changed to ensure that it is in accordance with Uzbek legislation.

29. The LMIS manual has been revised in accordance with findings from the pilot sites, this process is still ongoing. Training materials for facility level and rayon level were finalized during the quarter of report, for materials at oblast level the work is ongoing. The whole process is implemented in close cooperation between the DOTS Center, Project HOPE and John Snow Inc. (JSI). The training materials were field tested during a training conducted for chief nurses of rayon TB dispensaries in the three pilot rayons, after which the final adaptations were made. An LMIS training roll-out plan was developed and presented to the representative of the Republican DOTS Center.

30. Drug management issues were also looked into during general supervisory visits conducted during the quarter of report. First line anti-TB drugs were available in all PHC facilities visited in 6 Oblasts. All TB patients in these facilities were receiving correct treatment regimens. In four oblasts, drugs were stored in containers without proper markings. None of PHC facilities visited in 6 Oblasts is using the standard TB drug register. The main reason seems to be that staff have difficulty understanding the Russian language. In most facilities, staff have therefore developed their own variant of the register. This problem will most probably be solved once the newly developed LMIS has been fully implemented. LMIS training materials have been translated into Uzbek.

### **Improve Program Management, Supervision and Evaluation of Treatment Outcomes**

31. Activities planned for the quarter of report were:

- To conduct monitoring/supervisory visits together with national counterparts
- To identify effective and sustainable models for TB program management and supervision
- To develop a training course in supportive supervision

32. Monitoring was intensified during the quarter of report, as a result of implementation of the GFATM sub recipient contract mentioned in paragraph 5. Together with their counterparts from the DOTS Center, Project HOPE staff conducted monitoring visits to 39 Rayons in Andijan, Fergana, Namangan, Syrdarya and Samarkand Oblasts and in Tashkent City. During these monitoring trips, visits were conducted not only to existing Project HOPE pilot sites, but also to other rayons.

33. A new approach to monitoring has been worked out and discussed with counterparts. To make frequent monitoring more sustainable, primary responsibility for monitoring/ supervision at rayon

level will be shifted to rayon level TB staff. Already in all rayons there is a rayon TB coordinator. These coordinators will be trained in supervision and carry out the routine supervisory work. Supervisors from Project HOPE and the DOTS Center will supervise the rayon supervisors and strengthen their capacity. For this purpose a training course has been developed that will be conducted in April.

34. Problems identified during supervisory visits were no different from those identified in previous quarters. Case finding is low, probably as a result of low attendance of PHC facilities. Most TB patients are still identified directly by the TB services. The default rate is high, one possible cause being lack of information among patients on the process and duration of treatment.

#### **MDR TB Management**

35. Activities planned for the quarter of report were:

- To assess the MDR-TB situation in Uzbekistan
- To assess training needs related to MDR-TB

36. In January a site visit was conducted by experts of New Jersey Medical School (NMJS) with the purpose of assessing the MDR TB situation in Uzbekistan and assessing training needs related to MDR TB. Uzbekistan is in the process of preparing a DOTS Plus pilot project in Tashkent. At the end of the site visit, a round table meeting was conducted with all stakeholders in order to identify in which specific areas a contribution from Project HOPE and NMJS is required. Agreement was reached by all present to support the efforts of the GFATM PIU in designing the DOTS Plus pilot and in preparing the application for the Green Light Committee (GLC). Project HOPE/ NMJS will contribute specifically in drafting a strategic framework for MDR TB and MDR TB case management protocols. A follow-up meeting in which a more detailed planning will be made has been scheduled for April 12<sup>th</sup>.

#### **TB/HIV Management**

37. Activities planned for the quarter of report were:

- To provide feedback on national (CAPACITY) TB-HIV strategy and identify gaps
- To formulate TB/HIV activities to fill gaps identified
- To assess needs for TB/HIV training, in addition to trainings conducted by the CAPACITY project

38. Though the main emphasis of the NMJS site visit was on MDR-TB, TB/HIV was also part of their terms of reference. Meetings were held with representatives of the Republican AIDS Center and of the CAPACITY project. Recommendations will be part of a trip report that is expected early April.

#### **TB in Prisons**

39. Activities planned for the quarter of report were:

- To contribute to the establishment of a thematic working group (TWG) on TB in prisons
- To develop a detailed work plan

40. Establishing a TWG on TB in prisons had been discussed earlier, but had so far been deferred pending the arrival of an international consultant on TB in prisons appointed by the GFATM PIU. The consultant arrived in January and several meetings between him and Project HOPE staff took place. Establishing a TWG was discussed and agreed upon and terms of reference were drafted. The TWG has not yet been established, though it is expected to be established during the 2<sup>nd</sup> quarter of 2006.

### **III: RAISING AWARENESS ABOUT TB AMONG HEALTH PROVIDERS AND COMMUNITIES**



41. Overall developments during year 2 of the project:

- A thematic working group (TWG) on IEC-BCC has been established and has reviewed all existing IEC-BCC materials related to TB. It has been agreed that all newly developed materials will first be screened by this group. So far this mechanism has been working very well.
- With support of Johns Hopkins University (JHU), the members of the thematic working group have developed a national communication strategy for TB. The strategy is in its final stages of development.

42. Activities planned for the quarter of report were:

- Finalize communication strategy
- Conduct workshop on IEC/BCC material development and pre-testing
- Organize World Stop TB Day celebration

43. Work on the communication strategy had started in November, 2005, and was all but completed during the quarter of report. A few details still remain to be finalized, mainly as a result of translation issues. The strategy is expected to be ready for presentation to all stakeholders before the end of April.

44. In February, a 3-day workshop on development of IEC materials was conducted with support of Johns Hopkins University (JHU). Participants were members of the thematic working group on IEC-BCC, as well as journalists and graphic designers. Some materials were developed and pre-tested during the workshop. A radio spot designed by some of the participants was later recorded and broadcasted.

45. World TB Day activities consisted of recording and broadcasting the radio spot mentioned above, supporting and participating in three press conferences around World TB Day, organizing a children's drawing contest in a park in Tashkent and organizing a contest for developing a logo for the IEC-BCC campaign.

46. All events were organized in close collaboration with other partners of the TWG on IEC-BCC. The events were well attended and there was coverage on national television channels. In the logo design contest, a winner was chosen in agreement with all members of the TWG. The logo will be used in the IEC-BCC campaign which is to be developed based on the IEC-BCC strategy.

#### **ANALYSIS OF EPIDEMIOLOGICAL DEVELOPMENTS**

47. Epidemiological developments during the second project year are presented in charts 1-7 and tables 1-3 below. Unless indicated otherwise, the graphs and tables reflect the 13 pilot rayons of Project HOPE. The total population of the pilot rayons is 2,971,364, i.e. 11% of the total population of Uzbekistan.

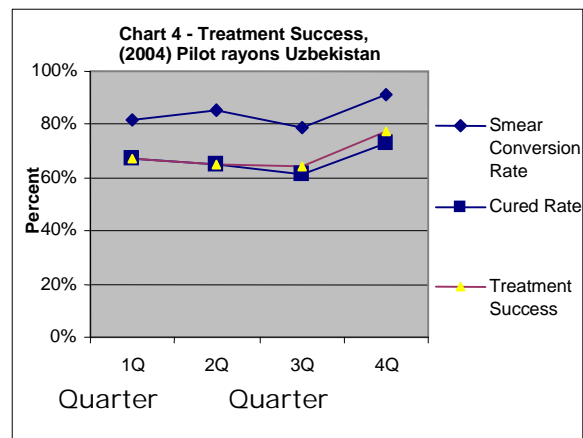
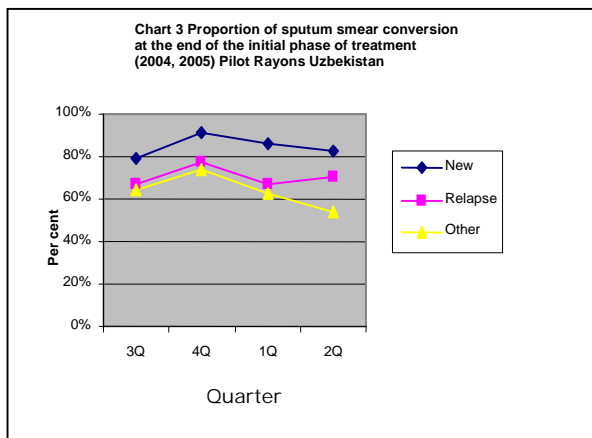
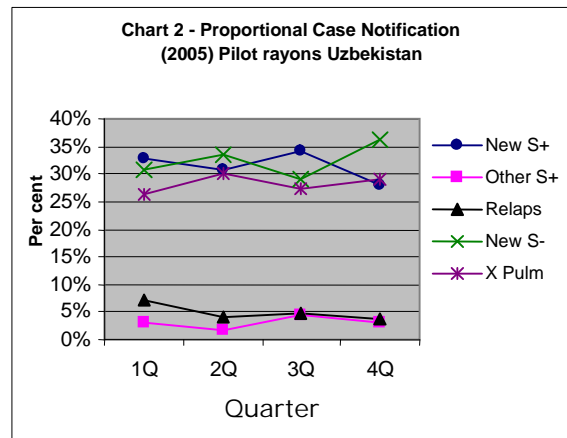
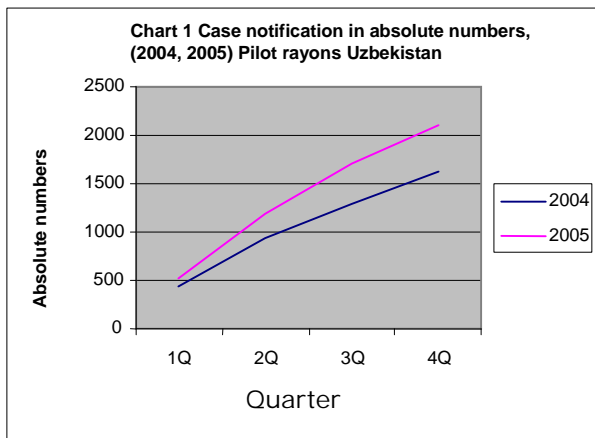
48. As shown in chart 1, case notification in absolute numbers in Project HOPE pilot rayons increased from 2004 to 2005. However this is not a true increase, but the result of inclusion of 3 additional pilot rayons in the 2005 data. Proportional case notification in the pilot rayons slightly decreased, from 76 per 100,000 population in 2004 to 73 per 100,000 population in 2005. Nationwide, similar case notification rates were reported, 75 per 100,000 for 2004 and 76 per 100,000 for 2005.

49. The percentage of smear positives among cases detected remains consistently low, altogether smear positives make up 35% of cases registered in 2005. As shown in chart 2 and in table 1, new smear negative PTB cases outnumber new smear positive cases. The number of extra pulmonary cases diagnosed is close to the number of new smear positives diagnosed. An analysis performed during the 3<sup>rd</sup> quarter of 2005 showed considerable over-diagnosis of both smear negative pulmonary and extra pulmonary TB as a probable cause (see quarterly progress report in the 3<sup>rd</sup> quarter of 2005).

50. At the same time, the case notification for smear positives (chart 6) remains well below the WHO

target. In 2005, 685 new smear positive PTB cases were reported in the Project HOPE pilot sites, equivalent to a case notification rate of 23 per 100,000 population. WHO estimates the actual incidence in Uzbekistan at 53 per 100,000, the case detection rate for new smear positive cases is therefore 38%.

51. The treatment success rate for new smear positives fluctuates but remained consistently below 80% (chart 4). There is a fairly constant gap between sputum smear conversion rate and success rate. For 2004, a smear conversion rate of 83% was achieved for new smear positive cases, however the treatment success rate was only 68%. This is explained largely by the defaulter rate, which was 14% for the cohort of 2004. Though the defaulter rate seems to be declining, this issue urgently needs to be addressed. Alternative treatment delivery schemes might be a possible solution. To identify the best possible treatment delivery options, operational research has been planned for the 3<sup>rd</sup> project year.
52. The age distribution pattern of new smear positive cases has not changed much over the past three years. Though among men the mode appears to have shifted to a slightly older age group, the effect in women is exactly the opposite. Most probably these are chance variations. In absolute numbers, there were more patients in the young age groups in 2005 than in 2002. However this is merely a reflection of an increase in the number of pilot rayons. Young adults still make up the bulk of the patients, an indication that the TB epidemic in Uzbekistan shows no signs of abating yet.



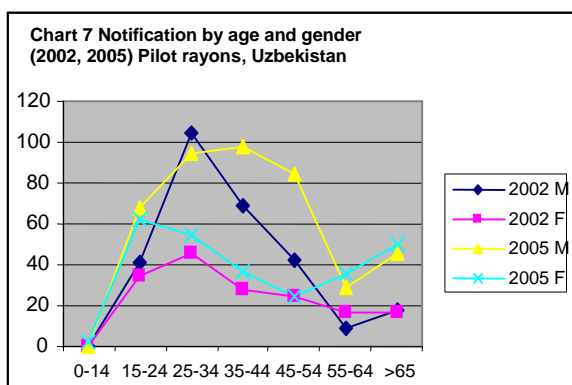
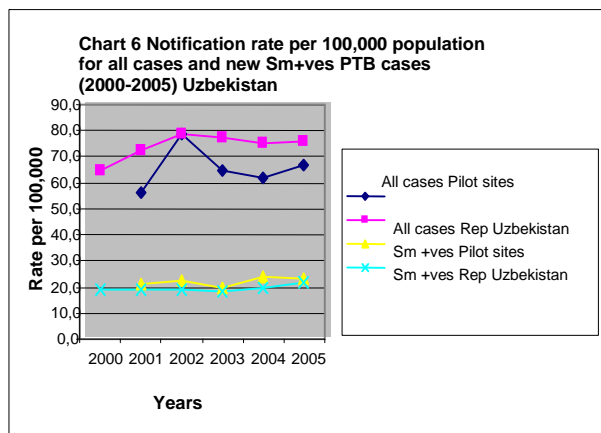
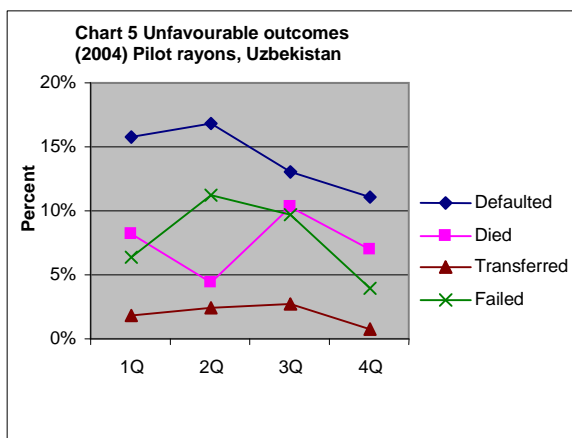


Table Pilot rayons, Uzbekistan. Absolute and proportional case notifications for 5 TB categories for the 4 quarters of 2005

	1Q		2Q		3Q		4Q	
New S+	178	33%	209	31%	186	34%	112	28%
Other S+	17	3%	11	2%	25	5%	12	3%
Relapse	39	7%	27	4%	26	5%	15	4%
New S-	167	31%	226	33%	159	29%	144	36%
X Pulm	144	26%	203	30%	148	27%	116	29%
Total	545	100%	676	100%	544	100%	399	100%

Table Pilot rayons, Uzbekistan. Absolute and proportional sputum smear conversion at the end of the intensive phase for 2004-Q3 to 2005-Q2 for different categories of smear positive TB cases

	3Q			4Q			1Q			2Q		
	absolute numbers		%	absolute numbers		%	absolute numbers		%	absolute numbers		%
	cohort	converted		cohort	converted		cohort	converted		cohort	converted	
New	145	114	79	121	110	91	178	153	86	209	172	83
Relapse	15	10	67	18	14	78	39	26	67	27	19	70

Other	47	30	64	65	48	74	96	60	63	85	46	54
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Table Pilot rayons, Uzbekistan. Treatment outcomes for new smear positives for the 4 quarters of 2004

Outcome \ Quarter	Q1		Q2		Q3		Q4	
	N	%	N	%	N	%	N	%
notified	172		161		145		121	
evaluated	172		161		145		121	
cured	115	67	105	65	89	61	88	73
completed	1	1	0	0	4	3	3	3
death	14	8	7	4	15	11	8	7
failure	11	6	18	11	14	9	5	4
default	27	16	27	17	19	13	13	11
transfer out	3	2	4	3	4	3	1	1
		100		100		100		100

Table Pilot rayons and country, Uzbekistan. Notification rate per 100,000 populations for all cases and new S+PTB cases

Site	Year					
	2000	2001	2002	2003	2004	2005
All cases Pilot sites		56.4	78.7	64.8	62.0	67.0
All cases Uzbekistan	64.5	72.4	79.1	77.2	75.4	75.9
New Sm+ves Pilot sites		21	22	20	24	23
New Sm+ves Uzbekistan	19	19	19	18	20	22