**Global Fund Country Team Pre-assessment KAZ-809-G04-T**

**New Funding Model Grant – May 2013**

**Summary of the main Country Team recommendations to the CCM when preparing the concept note:**

**1. Main programmatic strategic recommendations:**

1. The concept note should be based on the recommendations included in the report “Extensive review to tuberculosis prevention, control and care in Kazakhstan” issued by WHO in 2012, this include in particular:

a. Expansion of ambulatory treatment of patients, home based care and day care treatment.

b. Rationalization of hospitalization practices in order to prevent further spread of drug resistance and to use the available resources from the governmental budget more efficiently.

c. Address the urgent needs of cross border TB control and treatment for migrant populations.

2. Additionally, the concept note should address TB and MDR-TB among high risk groups including prisoners an outline clear strategies and actions to improve coverage at national level including: improving treatment success rate (currently at 61%), enrolling TB/HIV co-infected patients on ART (currently only at 9%), and enrolling MDR-TB diagnosed patients on treatment (currently at 63%).

3. Finally, the concept note should be based on a robust, ambitious and budgeted national strategy, based on above mentioned WHO report to identify the financial gaps and trigger the needed TB health reforms.

**2. Dual Track financing** is recommended.

**3. Risks and shortcoming in financial and pharmaceutical and health product management.**

Following OIG Audit report and last management letter recommendations respectively issued on 21.12.2012 and 29.04.2013 and FPM’s visit in February/March 2013 Financial and Pharmaceutical and Health Product Management, especially in the field of procurement, are considered as high risk areas and, as such, should be urgently addressed.

**1. Epidemiological situation: summary**

**Kazakhstan is among 27 high multidrug-resistant (MDR) TB burden countries in the world with an estimated MDR TB prevalence of 30% in new cases and 51% in previously treated cases.** It is also listed among 18 high priority countries for stopping TB in the European region (ranked as 2nd in the European region in terms of case notification rate).

WHO estimates the incidence, prevalence and mortality rate of TB in 2011 to be 129, 168 and 14 per 100.000 population respectively. **The program achieved 92% case detection rate for all forms of TB; however treatment success rate, especially smear-positive cases (new and retreatment) has been low and declining over recent years, which could be partly attributed to a high rate of MDR TB.** Considering this fact the country started addressing the problem (with the support of the Global Fund) through scaling-up MDR TB response; the results of these interventions were quite successful, resulting 73% of treatment success for 2009 MDR TB cohort (2851 MDR TB cases out of 3897 were successfully treated).

By October 2012 Kazakhstan received a cumulative of 54 million USD from the Global Fund to combat TB and it is ranked 14th among GF-supported countries in terms of TB disbursement.

**DOTS:** Kazakhstan witnessed a major upsurge in TB incidence and mortality in 90’s. **The current trend of TB incidence, prevalence and mortality demonstrated substantive reductions in burden (68%, 79% and 67%) compared to the peak in 1998.** Case notification rate also peaked in early 2000 (173 per 100.000 population) and started steady decline since then, reaching 113 per 100.000 in 2011. The case detection rate reached 92% in 2011. Out of the 12249 new pulmonary TB cases only 50% have a bacteriological confirmation indicating that almost half of the TB cases are diagnosed and started treatment based on the clinical picture or chest X-ray. Male to female ratio for new smear-positive TB cases was 1.6 and the most affected age group was 25-34.

**Treatment success rate for New Smear Positive TB cases is low and constitutes 61% for 2010 cohort.** Treatment success declined from 71% to 61% in the 2006-2010 (with the failure rate of 7%, death rate of 3% and defaulter rate of 5%); 27% cases were not evaluated as majority of these patients were diagnosed having MDR TB and second-line TB treatment has been initiated.

**MDR TB**: In 2011 DST was performed for 5293 (83%) new and 4790 (80%) retreatment bacteriologically-confirmed cases. **MDR TB was confirmed in 7408 cases. 4684 (63%) of confirmed MDR TB patients were enrolled on second-line TB treatment.** **Treatment outcome for 2009 MDR TB cohort was quite good reaching 73%.** However, MDR-TB is one of the major public health threats to the success of implementation of TB program.

**TB/HIV**: **85% of TB cases knew their HIV status, 2% were co-infected, however only 9% of TB/HIV co-infected patients were put on ART.** Low ART coverage in TB patients explains poor treatment outcome for TB/HIV co-infected cases, which only equals 35% in new smear-positive cases for 2010 cohort and deaths (32%), failure (8%), default (3%) account for unfavourable outcome (cohort size– 75 smear-positive TB patients confected with HIV) . In 2011 547 PLHIV were screened for TB and 1329 PLHIV received IPT.

**TB in prisons:** **TB notification rate in penitentiary system is almost 5-times higher than in civil population**. However, increased coverage with treatment of drug-susceptible TB and improved diagnosis allowed the prison sector to decrease the TB burden (case notification rate dropped from 2316/per 100.000 in 2002 to 523 per 100.000 in 2011). Treatment success rate is also relatively lower than in the civil sector – 54% for 2010 cohort.

Based on the above (decreasing trend TB in disease burden, high TB detection rate and good treatment outcome for MDR TB) the country is ***making progress towards impact***, with significant progress on scaling up MDR TB response and screening of TB patients for HIV.

For more information, refer to the annexe at the end of the document.

**2. Programmatic Performance KAZ-809-G04-T**

**Outcome indicators**

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| **Indicator** | **Baseline** | **Year** | **Target 2012** | **Result 2012** |
| Notification rate: new TB cases and relapses | 131 | 2009 | 124 | 114.1 |
| Notification rate: new smear positive TB cases | 33.7 | 2009 | 33 | 26 |
| Treatment success rate: new smear positive TB cases | 61% | 2011 | 76% | 60.8% |
| Treatment success rate of MDR-TB patients; number of patients who were cured +completed Category IV treatment (% of the total number of patients in the same registration cohort) | N\A | N\A | 70% | 75.7% |
| MDR-TB prevalence among new smear positive TB cases | 25.3% | 2010 | 23% | 19.1% |
| MDR-TB prevalence among previously treated smear positive cases | 45% | 2010 | 45% | 53.3% |

**Output indicators**

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| --- | --- | --- | --- |
| Indicator | Cumulative Target | Cumulative Result | Percentage Achievement |
| Number of PHC and TB service staff trained in DR-TB management locally | 400 | 403 | 101% |
| Number of TB cases with results for second line diagnostic drug susceptibility testing for MDR-TB during the reporting period | 4200 | 6203 | 120% |
| Number of laboratory-confirmed MDR-TB cases enrolled on second-line anti-TB treatment | 1400 | 1511 | 108% |
| Interim treatment success rate of MDR TB patients: number of patients who are smear and culture negative at 6 months after start of treatment (% of the total number of patients in the same registration cohort) | N: 1,867 D: 2,277 P: 82 % | N: 521 D: 574 P: 90.8 % | 111% |
| Number of MDR-TB patients reached with education and counselling sessions by adherence counsellors | 4800 | 4829 | 101% |
| Number of MDR-TB patients on treatment receiving all scheduled monthly food and hygienic packages for better adherence to treatment during the reporting period. | 4630 | 5546 | 120% |
| Number of TB service staff trained in infection control locally | 41 | 66 | 120% |
| Number of patients investigated with drug susceptibility testing (DST) to 1st line drugs for DR-TB diagnosis using automated MGIT technique | 10000 | 10880 | 109% |
| Number of investigations of DST to 1st line drugs (manual technique) | 14000 | 20941 | 120% |

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| Training Indicator Rating | 111% |
| Average Performance on Top 10 | 112% |
| Top 10 Indicator Rating | A1 |
| Average Performance All Indicators | 112% |
| All indicators Rating | A1 |
| Number of TOP TEN Indicators with B2 or C Rating | 0 |
| Renewals Indicator Rating | A1 |

**Cumulative performance to date**

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| --- | --- |
| 2011 | 2012 |
| 1 July – 31 December | 1 January – 30 June | 1 July – 31 December |
| A2 | A1 | A1 |

**Main Achievements:**

* Coverage with MDR TB treatment is relatively good, in 2010-2011 nationally about 60-70% of diagnosed MDR TB cases were enrolled on second-line treatment. The Global Fund provided with the second-line treatment big portion of MDR TB cases.
* The program maintains high treatment success rate for MDR TB cases over the past several years (2008 cohort -74%, 2009 cohort 73%.

**3. Financial Performance KAZ-809-G04-T**

The indicative amount proposed within the New Funding Model is USD 34 million.

**Disbursement for the current grant**

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| Budget for the current implementation | USD 50’068’827 |
| Less: disbursed | USD 45’241’253 |
| Undisbursed amount | USD 4’827’564 |

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| Cumulative Budget | Cumulative Expenditures | % Expenditures vs. Budget | % programmatic achievements |
| $ 40,755,079 | $ 42,444,331 | 104.1% | A1 |



**4. Main risks KAZ-809-G04-T**

Refer to the two following files attached:

1. Last management letter issued on 29.04.2013 2. OIG Audit report issued on 21.12.2012

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| Program Management | Satisfactory |
| Monitoring and Evaluation | No systematic appraisal of the quality of TB surveillance data. Uncertainties about the representativeness of cases included in MDR-TB treatment cohort. |
| Financial Management | Poor quality of audit reportsProcurementNo inventory of assetsAccounting software not used to its full capacity |
| Pharmaceutical and Health Product Management | Lack of transparency and compettiveness in procurementValue for Money at riskLack of compliance with Kazak procurement law, Grant agreement and Global Fund requirements and procurement guidelinesLack of supplier performance management Lack of management information systems, esp. for health products |
| Governance and Oversight | Lack of reactivity, anticipation and flexibility from finance and procurement departementPoor quality of financial and programmatic reporting |

Worth noticing that the grant is currently under investigation and that OIG investigation report with recommendations is expected soon.

**5. Final Grant rating KAZ-809-G04-T**

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| --- | --- |
| 2011 | 2012 |
| 1 July – 31 December | 1 January – 30 June | 1 July – 31 December |
| B1 | B1 | B1 |

**Annexe**

**Kazakhstan – TB Program**

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| Upper middle income country |  High MDR-TB burden country |
| **1. Context** |
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|  | Figure | Year |
| Total population | 16 million | 2011 |
| TB mortality (excludes HIV+TB) | 2,200 (14 per 100, 000) | 2011 |
| TB prevalence (includes HIV+TB)  | 27,000 (168 per 100,000) | 2011 |
| Incidence (includes HIV+TB) | 21,000 (129 per 100,000) | 2011 |
| HIV/TB co-infection, incidence  | 330 (2 per 100,000) | 2011 |
| Case detection, all forms (%) | 92% | 2011 |
| TB cases with MDR-TB: New (%) | 30% | 2011 |
| TB cases with MDR-TB: Retreatment | 51% | 2011 |
| Treatment success rate (new smear + or culture positive) | 61% | 2010 |
| Rank in TB mortality (in absolute number) | 44 | 2011 |
| Rank in TB mortality (per 100,000) | 64 | 2011 |

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| Global Fund (GF) TB disbursement (cumulative, up to October 2012) | $54 million |
| Rank in GF TB disbursement across all years | 14 |
| Rank in GF TB disbursement across all years, per estimated average number of new TB cases across same years | 38 |
| Percent share of this country out of total GF TB disbursement across all years | 1.8% |
| Percent share of this country out of total estimated number of TB deaths across all countries | 0.2% |
| Sources: Global TB report and GMS |

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| **2. Impact profile** |
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| **2.1 Impact rating:**  | **Progress towards impact** |

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| **Trends in disease morbidity and mortality (**Has there been a favorable change in disease mortality and/or morbidity in line with the increase in coverage of key intervention services and/or improvement of services quality and outcome)? |
| Kazakhstan is a high MDR-TB burden country with an estimated MDR-TB prevalence of 30% in new cases and 51% in previously treated cases. The country had witnessed a major upsurge in TB incidence and mortality in 90s following the breakdown of soviet union. Early 2000 saw a rapid scale-up of TB control efforts, with improvements in case notification and treatment outcomes. The case detection rate in 2011 is estimated at 92%. High MDR TB rates, have kept the treatment success rate at around 65%, being even lower among co-infected.The current trends in TB incidence, prevalence and mortality demonstrate substantive reductions in burden (68%, 79% and 67% respectively) compared to the peak in 1998. The program has rapidly scaled up MDR-TB interventions, and has relatively one of the better treatment outcomes for MDR (73% treatment success rate), where defaults are maintained at around 5%, deaths (7%) and failures (7%) being the main adverse outcomes. Over 85% of TB cases are being screened for HIV, but less than 10% of co-infected are initiated on ART.Based on the above, the country is making Progress towards impact, with good progress on scaling up PMDT and sub-optimal progress in initiating co-infected on ART. The country has a potential for impact, if it successfully bridges the gap for MDR screening and treatment initiation, and ensuring all co-infected are initiated on ART and TB treatment. |
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| Incidence: The estimated TB incidence (per 100,000 population) rose rapidly in the 90s from 79 in 1990 to 403 in 1998, following the breakdown of the soviet republic. Since then there has been over 68% decline in TB incidence, and currently stands at 129 or 21,000 new infections annually. The TB case notification did not increase at the same rate as incidence in the 90s, but saw sizeable improvements in early and mid-2000, followed by decline aligned to trends in incidence. The CDR of all forms of TB was 92% in 2011.Prevalence: As with incidence, prevalence saw a peak in 1998-99 (819) followed by 79% decline to 167 in 2011.Mortality: TB accounts for 2200 deaths annually (14 per 100,000 population) and is rapidly declining. |

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| **2.2 Outcome & services quality** (Has there been an improvement in outcome of the key intervention services?) |
| **TB case notification by type** | **New smear-positive treatment outcomes** | **Treatment success rate by case type (%)** |
| Case notification: TB case notification peaked in early 2000, following the increase in incidence in the 1990s. This phase has been followed by steady decline in notification rates and in 2011 was 112.6 per 100,000 population (92% of estimated incidence). 86% of the notified cases were pulmonary and 14% extra-pulmonary. Among new pulmonary cases, only 35% were smear-positive, and rest classified as smear negative. Male to female ratio was 1.2 (1.6 for NSP, 1.1 for NSN and 0.6 for EP TB), and pediatric TB accounted for just 0.5% of notified NSP cases.New smear-positive treatment outcomes: Smear positive treatment success rate is low at 61%, and is primarily due to high MDR-TB prevalence. Failure rate was around 7%, default and death rates are less than 5%; 27% of cases were categorized as not evaluated for 2010 cohort (2% in 2009 and 2008). Treatment success rate among TB/HIV co-infected was even lower - 35% for HIV+ new smear positive TB and 54% among HIV positive smear negative or extra-pulmonary cases. Treatment success rate among MDR cases was 73% with deaths and failures accounting for 7% each and defaults 5%.Other case types treatment outcomes: Treatment outcome among smear negative/EPTB was high at 85%, but was 47% for retreatment cases which could be partly due to high rates of MDR (505 among previously treated) |
| **2.3 Service coverage** (Has there been an increase in coverage of key intervention services including reaching high risk groups?) |
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| Case detection rate: In 2011, the case detection rate is estimated at 92% and been steadily increasing - indicating that majority of incident TB cases are being notified through the national TB surveillance system, irrespective of point of care.TB/HIV: Although the country has a concentrated HIV epidemic, over 85% of TB cases were tested for HIV, when only 2% were found to be HIV positive. However, among the co-infected only 20% were initiated on CPT and less than 10% on ART. MDR-TB: 83% of new and 80% of retreatment bacteriologically confirmed cases have been tested for MDR-TB. Of the confirmed MDR-TB cases 63% have been initiated second-line treatment. Treatment success rate among MDR cases for 2009 cohort was 73% with deaths and failures accounting for 7% each and defaults 5%. |
| **2.4 Resources** : Government and partners contributions and resource gaps |

**Available Trends in Program Financing**



Source: OECD, WHO TB review, CCM



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| **3. Comparison with other countries and Global targets** [How does the country compare with other countries AELAC-EECA Region and Global targets on key areas of the TB program? |

As compared to Global targets and countries in AELAC-EECA regions, Kazakhstan is performing well on case detection (92%, all forms) and HIV testing among notified TB cases (85%). Area that require specific attention for include: improving treatment success rate (currently at 61%), enrolling TB/HIV co-infected patients on ART (currently only at 9%), and enrolling MDR-TB diagnosed patients on treatment (currently at 63%).