

Cambodia developed guidelines for the management of childhood TB in 2008 which are aimed at strengthening case finding, diagnosis and the treatment of childhood TB. Although the guidelines contain provisions for contact screening and management, they have seldom been implemented thus far. TB CARE I Cambodia has been supporting the NTP in the implementation of the guidelines in nine operational districts (OD) with a total population of 2.3 million. The main activities of the childhood TB initiative are: an orientation workshop, guideline/Tuberculin skin testing (TST) training, contact tracing by health centers and Community DOTS partners, referral of TB contacts (children), diagnosis, treatment and supervision.

Preah Net Preah, a poor and remote district with a population of 141,000 in Banteay Meanchey province, is one of the ODs where TB CARE I is implementing the childhood TB project. People usually travel from their villages to nearby health centers for their primary health needs or go to Preah Net Preah district hospital if they need hospitalization. With the support of TB CARE I in June 2011, 19 district hospital staff were given training in TST, they were also supplied with the necessary supplies such as tuberculin and x-ray films to perform a full diagnostic work up for the diagnosis of childhood TB according to the NTP guidelines.

Health centers and community-based DOTS (CB-DOTS) workers in Preah Net Preah OD conduct home visits of registered TB patients to identify and refer children with TB symptoms to the district hospital on the pre-appointed day.

At the district hospital, the referred children are evaluated by TB physicians according to the NTP guidelines which include history of contact with index TB cases, symptoms, clinical

examination, x-ray examination and tuberculin skin testing if deemed necessary.

In the months of July and August 2011 when full implementation began, 740 children suspected of having TB were referred to the district hospital for TB diagnosis. Of these, 212 children were diagnosed (28.6%) with having TB. In comparison, during the previous quarter, 80 children were evaluated for TB out of which 24 (30%) were diagnosed with TB. Although a similar ratio of children were diagnosed with TB, TB CARE’s efforts have led to a nine-fold increase in the detection of children with TB.

The children’s parents/care-givers expressed their happiness with the availability of TB services in the district hospital, which is near to their village. In the past, they had to go to the provincial referral hospital, which is much further away and meant they had to spend more money on both transport and accommodation.

There are some lessons learnt from the pilot implementation of childhood TB. Firstly, contact tracing plays an important role in case finding of TB among TB contact children. Collaboration with CB-DOTS partners and health centers in the referral of children is needed so that the children can reach the hospital. Scheduling a pre-appointed time at the district referral hospital allows TB physicians to book their time at the TB facilities on appointment days meaning patients are seen by the doctor they have been referred to and waiting times are kept to a minimum. It also frees up time for TB physicians to undertake other duties, and by grouping patients on a particular day, it reduces tuberculin wastage which is supplied in 10-15 dose vials which must be used within 24 hours of opening.



A health worker administering a tuberculin skin test to a child suspected of having TB

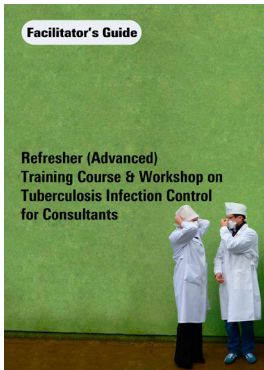
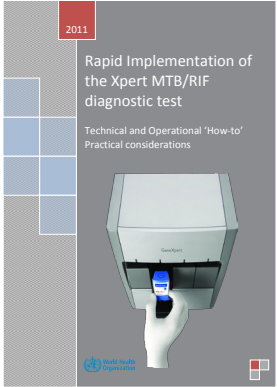


Website for Step-wise approach to TB Lab Accreditation

The Global Laboratory Initiative (GLI) has developed a Stepwise Process towards TB Laboratory Accreditation to assist national level tuberculosis diagnostic laboratories implement a quality management system which meets international standards. This guide translates the requirements of the ISO 15189 international standard into step-by-step activities, structures them in an interactive roadmap and provides many user-modifiable support materials such as document templates, software and information. For more information visit: <http://www.gliquality.org>

Rapid Implementation of the Xpert MTB/RIF diagnostic test - Technical and Operational ‘How-to’ Practical considerations

The development of the Xpert MTB/RIF assay for the GeneXpert platform was completed in 2009 and is considered an important breakthrough in the fight against TB. For the first time, a molecular test is simple and robust enough to be introduced outside conventional laboratory settings. Xpert MTB/RIF detects M. tuberculosis as well as rifampicin resistance-conferring mutations using three specific primers and five unique molecular probes to ensure a high degree of specificity. The assay provides results directly from sputum in less than 2 hours. This new publication is designed to assist in the implementation and scale-up of Xpert MTB/RIF systems.

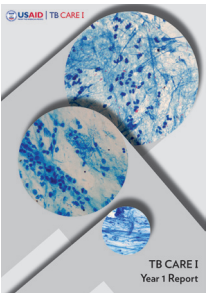


Facilitator Guide - Refresher (Advanced) Training Course & Workshop on TB-IC for Consultants

This guide is meant for trainers and facilitators involved in the “Refresher Advanced Training Course and Workshop on Tuberculosis Infection Control for Consultants”. It is accompanied by reading materials, tools, reference articles and slides. It aims facilitate the training of up to 20 (inter) national TB Infection Control (TB-IC) consultants a number of which will be available to perform TB-IC missions with limited scope or independent missions within one year.

The full Year 1 TB CARE I Annual Report will be available to download from the TB CARE I website:

<http://www.tbcare1.org/reports/>



Contact Details

E-mail [pmu@tbcare1.org](mailto:pmu@tbcare1.org)  
Phone +31-70-7508447  
Website [www.tbcare1.org](http://www.tbcare1.org)

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| Year 1 Report Summary | January 2011 |

TB CARE I - Year 1 Summary

Tuberculosis (TB) continues to be a significant public health issue worldwide. Although the absolute number of TB cases has been declining since 2006, there were still roughly 8.8 million incident cases of TB in 2010. USAID’s response to this global crisis, is the TB CARE program which is implemented by two coalitions, TB CARE I and TB CARE II. The strategy used is based on 1) Building on foundations to achieve new levels of success; 2) Using innovations to respond to USAID Missions and country needs; 3) Strengthening partnerships to achieve universal access and improve outcomes; and 4) Strengthening health systems to ensure sustainability.

TB CARE I began in October 2010 and the following is a summary of the program’s contributions towards USAID’s targets and expected outcomes, as well as results achieved in the first year of the project (October 2010-September 2011) through 26 core projects, three regional projects and 20 country.

TB CARE I contributes to three USAID target areas:

- Sustain or exceed 84% case detection rate and 87% treatment success rate
- Treat successfully 2.55 million new sputum-positive TB cases
- Diagnose and treat 57,200 new cases of MDR-TB

By focusing on eight priority technical areas:

- Universal and Early Access
- Laboratories
- Infection Control (IC)
- Programmatic Management of Drug Resistant TB (PMDT)
- TB/HIV
- Health Systems Strengthening
- Monitoring & Evaluation (M&E), Operations Research (OR) and Surveillance
- Drug Supply and Management

And four over-arching elements:

- Collaboration and Coordination
- Access to TB services for all people
- Responsible and Responsive Management Practices
- Evidence based M&E

**1) Number of Cases Notified (all forms and smear-positive cases)** - In 2010, one million TB cases (all forms) were registered across all TB CARE I countries. Indonesia has the highest number of TB cases (300,659) and Dominican Republic reported the lowest number of TB cases (3,964). From the 2010 baseline, 466,009 new smear-positive TB cases were registered across all TB CARE I countries in the first year.

**2) Case Detection Rate (all forms)** - The baseline average case detection rate (CDR) in 18 TB CARE I countries was 64% (2010). Whilst none of the countries have yet reached the targeted 84%, Kazakhstan, Kenya and Namibia have reached 82%.

**3) Treatment Success Rate (TSR) of confirmed cases** - The average treatment success rate across all TB CARE I countries is 88%. Rates ranged from 62% in Kazakhstan to 95% in Cambodia. There are still 12 countries which have not reached the 87% target. The median TSR is 85%, which better reflects the situation across TB CARE I countries than the mean (88%).

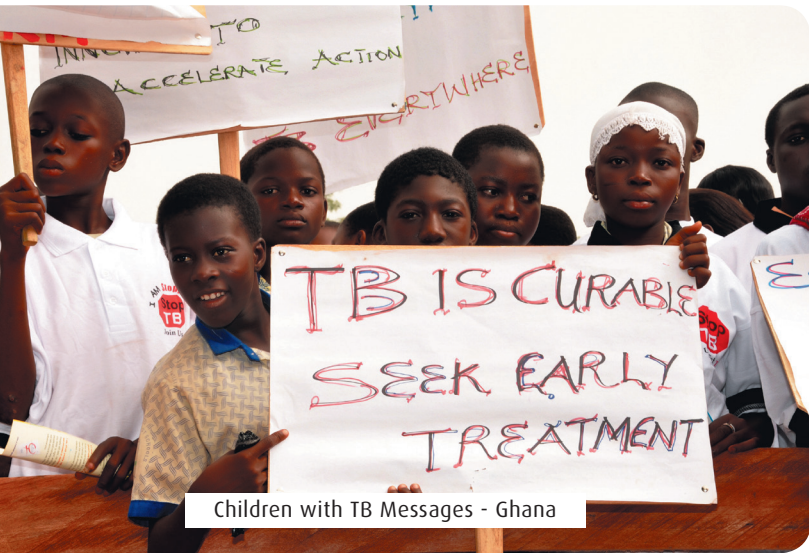
**4) Number of new MDR-TB cases diagnosed and put on treatment** - In 2010, before TB CARE I began, 11,241 MDR-TB cases were diagnosed. During the same year 7,912 MDR-TB cases were put on treatment. The majority of cases diagnosed (87.9%) and put on treatment (87.3%) are from Kazakhstan, Kyrgyzstan and Uzbekistan.

**5) Number (and percent) of confirmed TB cases among Health Care Workers (HCWs)** - Kazakhstan was the only country to report on TB occurrence among HCWs in 2010 (198 cases).

TB Patient and her mother - Nigeria

Global Tuberculosis control is at a critical juncture. The need for a joint and dynamic approach has never been more urgent. The disease threatens the poorest and most marginalized groups, disrupts the social fabric of society, and undermines gains in economic development. The global resurgence of TB of the past few decades is being fueled by decreasing investments in public health systems, emerging drug resistance, and increasing HIV/AIDS prevalence. New challenges, such as TB/HIV and multi-drug resistant TB, call for innovative and strategic approaches and for more efficient and cost-effective TB programs.





Children with TB Messages - Ghana

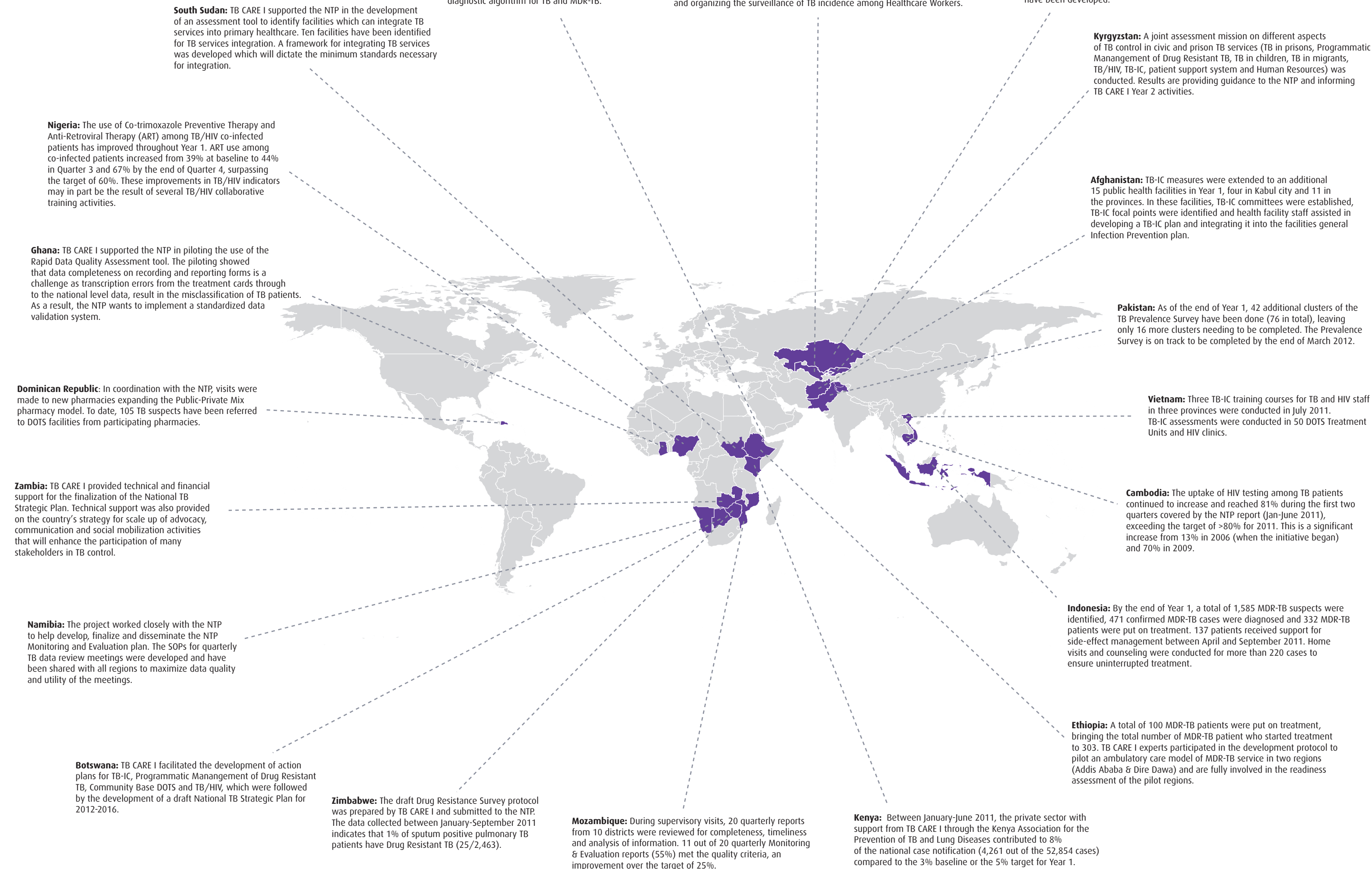


Using GeneXpert - Indonesia



TB Patients - Nigeria

## Selected Achievements in TB CARE I Countries



Monitoring & Evaluation Training - The Netherlands



Man with TB Message Balloon - Dominican Republic



World TB Day - Namibia