VERSION April 2014

Tajikistan DEV 200173
(Support for Tuberculosis Patients and their Families)
B/R No.6:

BUDGET REVISION FOR THE APPROVAL OF REGIONAL DIRECTOR

	Initials	In Date	Out Date	Reason For Delay
Country Office or Regional Bureau on behalf of Country Office	.....	.....	……..	…….

CLEARANCE

Ms. Michelle Barrett Project Budget & Programming Officer, RMBP	.....	.....	…….	……
Mr. Laurent Bukera Chief, RMBP	.....	.....	……..	……..
Mr. Adrian van der Knaap Chief, OSLT	.....	.....	…….	……..

APPROVAL

☒ Mr. Mohamed Diab Regional Director	.....	.....	……..	……

PROJECT
Start date: 01 January 2011 **End date:** 30 June 2014 **Extension:** 18 months **New end date:** 31 December 2015

Cost (United States dollars)

	Current Budget	Increase	Revised Budget
Food and Related Costs	US$ 8,308,746	US$ 1,579,962	US$ 9,888,708
Cash and Vouchers and Related Costs	US$ -	US$ -	US$ -
Capacity Development & Augmentation	US$ -	US$ -	US$ -
DSC	US$ 873,018	US$ 605,729	US$ 1,478,747
ISC	US$ 642,723	US$ 152,998	US$ 795,721
Total cost to WFP	US$ 9,824,487	US$ 2,338,689	US$ 12,163,176

CHANGES TO:

Food Tool
☒ **MT**
☒ **Commodity Value**
☒ **External Transport**
☒ **LTSH**
☒ **ODOC**

C&V Tool
☐ **C&V Transfers**
☐ **C&V Related Costs**

☐ **CD&A**
☒ **DSC**
☒ **Project duration**
☐ **Other**

Project Rates
☐ **LTSH ($/MT)**
☒ **ODOC ($/MT)**
☐ **C&V Related (%)**
☒ **DSC (%)**

DISTRIBUTION:

DED & COO	Director, OSZ	Regional Director
Director, OME	Chief, OSZP	RB Programme Advisor
Director, PGG	Chief, OSZR	RB Programme Assistant
Chief, OSLT	Chief, OSZI	RB Chrono
Chief, RMBP	Programme Officer, RMBP	OM Registry
Country Director	Programming Assistant, RMBP	Liaison Officer, OM Cairo

NATURE OF THE REVISION

1. Tuberculosis (TB) is endemic in Tajikistan, negatively affecting food security and livelihoods of patients and their families. TB is widely recognized as a disease of poverty, and in Tajikistan, it is also linked to social and economic processes of labour migration. Remittance income to poor households in Tajikistan from labour migration constitutes more than half of the gross domestic product.

2. This budget revision proposes to extend in time the Development Project (DEV) 200173, Support for Tuberculosis Patients and their Families, in Tajikistan by an additional 18 months until 31 December 2015. This will enable WFP to continue assisting 9,000 TB patients and 18,000 of their family members. Objectives of the food assistance, food basket commodities and activities envisaged in the original DEV 200173 will continue during the extension period. The budget revision reflects WFP and partner commitments to align operational activities with the Government of Tajikistan's priorities, policies and strategies. A new National Development Strategy (2015-2020) and National Tuberculosis Strategic Plan (2016-2020) are currently being drafted. UNDAF for 2016-2020 is being developed by UN agencies. WFP intends to use the project extension period to prepare its assistance programme for the post-2015 period, in line with these documents.

3. During the 18-month extension period, WFP will maintain its overall assistance strategy, with limited modifications reflecting reassessment findings, operational adjustments and corporate realignment. The project has been realigned to the WFP Strategic Plan and Framework (2014-17). In addition, two activities envisaged under the original Development Project will be discontinued and will not, therefore, be proposed for extension: a) WFP will remove the Care and Treatment component for Multi Drug Resistance (MDR) patients, due to lack of national guidelines/protocol for nutritional assessment, counseling and support (NACS). Instead, these patients will receive the same household ration provided to all TB patients, under the Mitigation and Safety Nets component; and b) WFP in agreement with National TB Center (NTBC) will gradually reduce the support to in-patients over time from July 2014 to December 2014.

4. The overall budget increase is US$ 2,338,683 bringing the overall project value to US$ 12,160,431. The increase of each component is detailed below:

    a. Food requirements increased by 2,278 mt, valued at US$ 1,321,965;
    b. External transport costs increase by US$ 5,775;
    c. Landside transport, storage and handling costs increase by US$ 236,326;
    d. Other direct operational costs (ODOC) linked to food increase by US$ 15,896;
    e. Direct support cost increase by US$ 605,729; and
    f. Indirect support costs (ISC) by US$ 152,998.

JUSTIFICATION FOR THE REVISION

Summary of existing project activities

5. WFP started the Development Project in 2011 to assist 45,200 TB patients and 90,600 of their family members. WFP's support represents an effective safety net to both TB patients and their households during the six month period when they undergo the directly observed treatment - short course (DOTS). WFP's assistance to patients and their families fulfils two major objectives in-line with the national campaign to stop TB[1]: 1) It serves as a powerful incentive for TB patients to complete their treatment and avoid the risk of developing drug-resistant strains of the disease; and 2) The food gives a measure of financial security to families that have been deprived of income generated by the main breadwinner.

6. TB patients are usually male members of poor and food-insecure families[2] who migrate to work abroad and become the sole bread-winner of the household. Those who contract TB while living in sub-standard conditions leave their jobs and return home – or are deported by the host country if they receive a positive diagnosis – which results in a triple impact on their households: (i) a loss of main income source; (ii) increased health expenses; and (iii) the risk of spreading the disease to other family members.

7. Tajikistan has the highest estimated number of incident TB cases (all forms) in the Region[3] with 193 (range 159-230) per 100,000 population[4]. Multi-drug resistant tuberculosis (MDR-TB) and extensively drug-resistant tuberculosis (XDR-TB) constitute one of the greatest challenges for TB control in Tajikistan. The primary cause of MDR-TB is inappropriate treatment. Inappropriate or incorrect use of anti-TB drugs, or use of poor quality medicines, can all cause drug resistance.

8. In Tajikistan, it is believed that MDR-TB is partly caused by patients interrupting their drug regimen because they lose motivation or return to a host country to work. The mortality rate for MDR-TB is as high as 80 percent (compared to less than 5 percent for regular TB when treated); the treatment course is at least 18 months in duration (rather than six months) and the medical-care cost is dramatically higher: a full course of treatment for a regular TB patient costs approximately US$10–15, whereas an MDR-TB treatment costs around US$4,000.[5]

9. WFP post monitoring distribution attests that TB patients are among the lowest income-earners in the country and live mainly in disaster-prone and food-insecure areas. About 40 percent of the beneficiaries are expected to reside in Khatlon region, which has the highest population density and some of the worst food security indicators and TB rates.

10. WFP provides food to all patients registered for DOTS treatment for a period of six months. MDR and XDR patients also receive food support to accompany their longer treatment course (18 months and 24 months respectively). For the first two months, a very small proportion of TB patients are hospitalized, during which they receive hot meals. In line with TB hospital bed rationalization, the in-patients constitute a very small proportion of the overall caseload of the project corresponding to two percent of the overall caseload and will be further reduced over the next two years. Once they are released to complete treatment at home, patients receive a take-

[1] The National TB Control Programme 2010-2015 provides an overall framework for the implementation of TB activities in Tajikistan, based on the principles of the WHO Stop TB Strategy. The National TB Control Programme was jointly developed by the United Nations Development Programme (UNDP), WHO and the Ministry of Health (MoH) with financial support from the Global Fund.
[2] When the project started in 2011, 36% of TB patients were women.
[3] WHO, Tajikistan TB profile. WHO Regional Office for Europe covers Western and Eastern Europe, the CIS, Balkans, Caucasus, Israel and Turkey (http://www.euro.who.int/en/where-we-work).
[4] Extensive review of TB prevention, control and care in Tajikistan, WHO, 15-27 July 2013.
[5] WHO/ UNDP Review of Tuberculosis Control in Tajikistan, 2009.

home ration for the remainder of the treatment (four months). Patients' families (the ration is designed for two family members) also receive WFP support as a safety net during 6 months to compensate for the loss of the income-earning power. If, however, the patient drops out of the treatment, the assistance to both the family and patient is stopped - a conditionality that strengthens patients' motivation to complete the treatment as well as encouragement for the family members to support the treatment.

11. WFP's programme is implemented by the NTBC and Project HOPE (an international non-governmental organization) through a network of district TB centers across Tajikistan. NTBC and Project HOPE are responsible for storing, handling and distributing food in their respective areas. Distributions take place every two months. NTBC covers the costs of medical staff and provision of complementary food for in-patients in hospitals throughout the country. The district TB centers register TB patients and administer their DOTS along with, in most cases, the first two months of in-patient care. All registered patients receive treatment free of charge. NTBC manages the lists of patients registered for DOTS and monitors food distributions to in-patients, out-patients and family members.

12. To further improve the efficiency of the programme and strengthen the capacity of the national partner, WFP is providing regular on the job training in food storage and reporting procedures to the TB coordinators in all districts throughout the project implementation. WFP's programme is implemented by the National Tuberculosis Center (NTBC) and Project HOPE[6] through 65 district TB centers across Tajikistan, to provide food assistance to TB patients and their family members. WFP collaborates with UNDP (the principal recipient of the Global Fund to fight AIDS, Tuberculosis and Malaria - GFATM) and WHO on fighting TB in the country; is a member of the TB technical working group on TB; and collaborates with the Country Coordination Mechanism (CCM) to channel the funds of the GFATM.

Conclusion and recommendation of the re-assessment

13. This project contributes to the goals of the National Tuberculosis Programme 2010–2015 and is in line with the National Health Strategy 2010–2020 and the Stop TB Strategy of WHO.

14. The National TB Strategic Plan (NSP) 2016-2020 is currently being drafted. It mainly focuses on ensuring universal access to quality diagnosis and quality patient-centered treatment of all forms of TB including MDR/XDR –TB with appropriate patient support including provision of food incentives to patients to improve adherence; providing appropriate TB care for high-risk and vulnerable population groups (prisoners and people living with HIV, drug users and migrants); enhancing the response to TB epidemic by strengthening involvement of communities, civil society, public and private care providers, enforcing advocacy, communication and social mobilization; and strengthening the National TB programme management at all levels and improve the health system's performance for effective TB control. WFP, as a member of the TB technical working group, has been providing inputs especially on advocating for food support as part of the treatment and incentive to treatment adherence. WFP has identified some additional opportunities in the NSP for support on the implementation of the plan (such as capacity building in treatment of malnutrition in TB children) which will be further explored during the course of this extension.

15. According to the latest drug resistance survey conducted by NTBC in 2011, the prevalence of MDR is 13 percent among new and 54 percent among previously treated TB cases. The latest

[6] The NTBC run 60 districts centers and Project Hope run 5 districts centers.

treatment success rates reported by the NTBC for new sputum smear positive[7] and retreatment pulmonary TB patients are 80 percent and 71 percent respectively (2011 cohort), the same as it was in 2010.

16. Upon request by the Ministry of Health of Tajikistan (MOH), WHO together with NTBC conducted an extensive review of TB prevention, control and care activities in July 2013. This assessment shows that since 2009, Tajikistan has made significant progress in implementation of the National Strategic Plan (2010-2015). However, the main challenges of the TB control programme remain the high dependency on international donors[8], limited diagnostic capacity, inadequate infrastructure and limited human resources. The main recommendations suggested by the WHO review are: to update the national strategic plan; and to develop a budgeted implementation plan for patient-centered approaches, including provision of social support to improve the adherence to TB treatment.

17. The WFP Headquarters and Regional Bureau's review mission of TB support activities conducted in April 2014 recommended extending the project until December 2015. In addition, the mission recommended that the Country Office focus on a Mitigation and Safety Nets component and gradually reduce the number of in-patient beneficiaries. The Ministry of Health steadily increases funds to TB hospitals every year. In view of this and as part of hand over process, the in-patient support will be gradually handled over to the government. In the meantime, WFP will pursue the discussion with donors on possibility of securing funds to implement a cash and voucher project. The option will reduce burden on patients and health sector institutions related to managing food distributions. The Country Office will conduct an effectiveness study in order to strengthen in-country evidence on the impact of food assistance on treatment adherence. The mission also recommended increasing staff capacity by recruiting a standby partner whose main tasks would be to insure a steady WFP presence in existing coordination mechanisms of the TB sector (technical working group & Country Coordination Mechanism).

Purpose of change in project duration and budget increase

18. The current extension in time increases the overall number of beneficiaries, plans to increase the volume of food commodities accordingly, as well as associated costs for the implementation of the project until end-2015. The revision takes into consideration the results of the mission review of TB activities conducted in April 2014.

19. Food assistance provided during the extension period will be a continuation of activities planned under the current phase of the project, including minor adjustments to reflect the findings of the review. WFP will continue to support all DOTS registered TB patients and their family members. During the extension period, WFP will engage with NTBC to assess the effectiveness of food assistance in relation to treatment adherence, to include social economic indicators in WHO software which will be used to inform future programming decisions, to analyze the FSMS and post distribution monitoring data, to review and adjust (if necessary) the households rations and to explore new modalities and livelihood activities to include in the new project.

20. WFP's assistance under the PRRO extension will contribute to the Strategic Objective 4 under WFP's Strategic Plan (2014-2017): Reduce under-nutrition and break the intergenerational cycle of hunger.

[7] Method to diagnose TB by look at sputum samples under a microscope to see if TB bacteria are present.
[8] The share of national budget contribution to TB prevention and control was less than 30% in 2012

21. The Country Office will focus on enhancing the skills and reporting capacity of WFP field monitors, as well as on strengthening the capacity of partners, including local authorities, to transfer knowledge and to improve accountability and results. The M&E focal points in the field and partners will be trained on Strategic Result Framework Indicators. WFP will undertake regular pre/post-distribution monitoring, reporting and continuous training on food management to the NTBC and Project Hope food monitors. The partners will manage the lists of the patients who register for the DOTS treatment, and will monitor the food distributions to in-patients and out-patients and the family members. Both Project HOPE and the NTBC will monitor treatment adherence outcome in their respective districts.

TABLE 1: BENEFICIARIES BY ACTIVITY

Activity	Category of beneficiaries	Current (Jan 2011- June 2014)			Increase (July 2014- December 2015)			Revised (Jan 2011- December 2015)		
		Boys / Men	Girls / Women	Total	Boys / Men	Girls / Women	Total	Boys / Men	Girls / Women	Total
Support TB patients and their family members	TB patients	30,848	17,352	48,200	5,760	3,240	9,000	36,608	20,592	57,200
	TB family members(2)	48,322	48,278	96,600	9,100	8,900	18,000	57,422	57,178	114,600
TOTAL		**79,170**	**65,630**	**144,800**	**14,860**	**12,140**	**27,000**	**94,030**	**77,770**	**171,800**

22. No change is foreseen in modalities of food distribution to beneficiaries. The CO in agreement with NTBC will gradually reduce the in-patient caseload during the next 6 months.

23. Food distribution and partnership arrangements remain the same as under the current project.

24. The number of patients is adjusted in order to reflect the actual number of patients expected to be admitted and released based on monthly actual programme reports. The planned number of patients for 2011-2013 was based on the TB prevalence rate in the country. WFP is planning to assist a total 9,000 TB patients (including MDR/XDR) through the duration of this extension.

25. Experience from WFP's TB food assistance to date has shown that the current food basket composed of fortified wheat flour, fortified vegetable oil, pulses and iodized salt is well accepted by the beneficiaries. WFP is providing 80 percent of required caloric needs to the TB patients and their family members while the other 20 percent is covered by the families. However, WFP will analyse the food security situation through regular household surveys and post distribution monitoring of activities and, if necessary, the food ration will be adjusted accordingly.

TABLE 2: REVISED DAILY FOOD RATION/TRANSFER BY ACTIVITY *(g/person/day)*	
	TB support
	Revised
Wheat Flour	400
Pulses	40
Vegetable Oil	15
Iodised Salt	5
Cash/voucher (*US$/person/day*)	0
TOTAL	**460**
Total kcal/day	***1,725***
% kcal from protein	**19.4**
% kcal from fat	**51.2**
Number of feeding days per year or per month (as applicable)	**30 days**

FOOD REQUIREMENTS

26. Food requirements are revised in order to reflect changes in the number of beneficiaries and the duration.

TABLE 3: FOODAND VOUCHER REQUIREMENTS BY ACTIVITY				
Activity	**Commodity[9] / Cash & voucher**	**Food requirements (*mt*)**		
		Current	**Increase**	**Revised total**
TB patients		**5,076**	**760**	**5,836**
Family members (2)		**10,176**	**1,518**	**11,694**
TOTAL		**15,252**	**2,278**	**17,530**

[9] Please only present overall food requirement. Do not split by commodity.