



AUDIT REPORT

Global Fund supported TB/MDR-TB programs in Eastern Europe and Central Asia – focus on Uzbekistan, Kyrgyzstan and Tajikistan

GF-OIG-22-13
26 August 2022
Geneva, Switzerland

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1. Executive Summary

1.1 Opinion

Nine countries in the Eastern Europe and Central Asia (EECA) region are among the 30 countries with the highest burden of multi-drug resistant tuberculosis (MDR-TB) in the world. About 70,000 people in the region develop MDR-TB each year. There are high TB treatment success rates (81%-91%)¹ in the three countries reviewed (Kyrgyzstan, Tajikistan and Uzbekistan); 38%^{2,3} of drug-resistant cases are among previously treated patients.

The Global Fund Secretariat has prepared an EECA regional strategy to accelerate and sustain progress made in the fight against TB. However, challenges in implementing essential parts of the strategy, insufficient differentiation within Focused Portfolios, a slow reaction to addressing COVID-19's impact on TB programs, as well as the impact of Russia's invasion of Ukraine could all hinder grants from achieving their intended impact. The Global Fund's approach to implementing its EECA strategy is rated as **partially effective**.

In the reviewed countries, estimated TB incidence and mortality declined during 2015-2020 by 7% and 9% respectively. This decrease has been accompanied by substantial and important innovations in the fight against TB. MDR-TB case notification remains low. Limited active case finding in vulnerable groups, insufficient diagnostic and lab services, and sub-optimal data management are impacting countries' ability to find more MDR-TB cases. The implementation of grant activities to ensure effective MDR-TB case finding is rated as **partially effective**.

MDR-TB treatment success rates have increased. Delays in treatment enrolment and the lack of electronic registers in several countries are contributing to losing patients before they start treatment. A lack of medication for MDR-TB treatment side effects, and the slow movement to ambulatory treatment, contribute to loss of patients after treatment enrolment. The implementation of grant activities to ensure effective enrolment and treatment of MDR-TB patients is rated as **partially effective**.

1.2 Key Achievements and Good Practices

The Global Fund has designed a strategic plan and priorities for the EECA region

With the aim of accelerating and sustaining progress made in reducing the burden of the three diseases, the EECA regional team at the Secretariat prepared a regional strategy during the 2020-2022 funding cycle, which includes dedicated strategic priorities for TB and MDR-TB. To better align efforts and avoid duplications, the strategy was developed through consultations with key stakeholders and partners. The strategy's TB priorities are well designed and aligned with regional challenges, and national grants in Kyrgyzstan, Tajikistan and Uzbekistan are largely aligned with the EECA strategic priorities.

¹ Progress Updates/ Disbursement Request as of December 2020

² [WHO Global Tuberculosis report 2021](#)

³ The MDR-TB among previously treated in Uzbekistan, Tajikistan and Kyrgyzstan is 38.4%, 43.2% and 60% respectively

Declining TB incidence and increased treatment success have contributed to a reduction in TB mortality

Estimated TB incidence in the countries reviewed declined by on average 7.2% during 2012-2020, while estimated number of deaths from TB decreased by 29%⁴ during the same period.⁵ The National Strategic Plans of the countries reviewed are based on World Health Organization recommendations; for example, to use rapid molecular diagnostics (GeneXpert being the most common) as the initial test to diagnose TB. GeneXpert machines and testing coverage have also increased. Eleven of the 15 countries in the EECA⁶ region have begun piloting the modified all-oral Short Treatment Regimen (mSTR) for MDR-TB and the BPAL⁷ short regimen for extensively drug-resistant TB (XDR-TB). These treatment regimens are expected to reduce the number of defaulted and lost-to-follow up cases and increase treatment success rates.

Increased government commitment for TB response

Domestic funding increased between 30% and 120%, depending on the country, between the 2017-2019 and the 2020-2022 allocation periods, with notable new government investments in First Line Drugs (FLD) and reagents for microscopy. Tajikistan plans to co-finance procurement of 10% and 15% of Second Line Drugs (SLDs) in 2022 and 2023 respectively. Similarly, Uzbekistan co-financed procurement of approximately 20% of SLDs in 2020, and plans to increase this figure to cover 60% of SLDs in 2024. Kyrgyzstan initially financed 15% of the required procurement in 2021, and plans to increase to 17% in 2022 and to 20% in 2023.

1.3 Key Issues and Risks

Better monitoring of Global Fund strategic priorities in EECA is needed to achieve grant impact

In view of the limited funds available for the region, priority is given to procuring MDR-TB medication and diagnostic equipment. Approximately 60%-90% of grant budgets of countries reviewed are used for procurement. As a result, some critical strategic interventions such as assessing and enhancing lab capacity, expanding sample transportation systems, active case finding, and civil society engagement in the EECA regional strategy, are not included in country grants and have limited funding from government and other development partners, hindering programs from achieving the intended impact. There is no defined implementation/operationalization plan for the strategic priorities and strategic interventions not funded by the Global Fund, and these interventions are not systematically monitored by the Secretariat.

The EECA region consists mainly of Focused⁸ portfolios/countries (14 out of 15)⁹. Through the Global Fund's portfolio categorization design, Focused countries receive smaller funding allocations and streamlined support. However, despite the region's high MDR-TB burden,¹⁰ the Global Fund has not sufficiently differentiated its approach when defining the support the region receives. The region has also received limited support through Global Fund Special Initiatives. There is no formal risk assessment of MDR-TB in the region, despite the high disease burden. The organizational risk register focuses mainly on finding TB missing cases in 20 high impact and core portfolios.¹¹ Although the COVID-19 pandemic had a significant impact on programs, COVID-19 catch up plans were developed late by the countries reviewed.

The Russian invasion of Ukraine will also undoubtedly impact the region, posing a high risk of further TB and MDR-TB infections, as well as other broader consequences such as economic instability and supply chain issues. Action plans have yet to be developed in response.

⁴ In Kyrgyzstan TB mortality per 100K decreased from 12/100K in 2012 to 5.8/100K in 2020, in Tajikistan it remained the same 10/100K and Uzbekistan decreased from 5.2/100K to 4/100K.

⁵ [WHO TB Burden Estimates data extract](#) – Accessed on 25 April 2022

⁶ The eleven countries are Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Tajikistan, Turkmenistan, Ukraine and Uzbekistan (Source: 2021-2023 Strategic Initiative for Accelerated Introduction of Innovations)

⁷ BPAL regimen (comprised of bedaquiline, pretomanid and linezolid) pilot for the treatment of extensively drug-resistant TB (XDR-TB) and intolerant or nonresponsive Multi Drug Resistance TB with the intent to cure.

⁸ Under the Global Fund differentiated approach, countries are classified into High-impact, Core and Focused countries. Focused countries are smaller portfolios with a lower disease burden and a lower mission risk.

⁹ In Global Fund terminology, 'Focused' portfolios are smaller portfolios with low disease burdens, in contrast to 'Core' and 'High Impact' portfolios

¹⁰ [WHO Global List of high-burden countries for TB, HIV-associated TB and drug-resistant TB \(Accessed on 28 March 2022\)](#)

¹¹ GF/AF18/07_Risk Report and Chief Risk Officer Annual Opinion, March 2022

MDR-TB case finding needs improvement

Despite the progress made and the high TB treatment success rate (81%-91%), there is a high burden of MDR-TB in the countries reviewed and across the region. Although positive TB cases among key and vulnerable TB populations¹² are increasing, the three countries in scope have limited active case finding activities. National GeneXpert utilization rates have actually decreased since 2018. This is mainly due to clinicians not following the algorithm for TB diagnosis, insufficient maintenance and calibration of GeneXpert machines, and challenges with sputum collection and transportation.

Need to improve patient treatment enrolment and address treatment gaps

The mean MDR-TB treatment success rate in the three countries increased from 57% in 2017 to 66% in 2020.¹³ Clinical management on MDR-TB treatment was updated in 2020 and is in line with current WHO recommendations. There was no evidence of stock-outs of first- or second-line drugs from 2019 to 2021. Despite these achievements, treatment delays, high loss to follow up (LTFU) and a slow shift to ambulatory care are impacting treatment success rates. A lack of medication for MDR-TB treatment side effects in Tajikistan and Kyrgyzstan contributes to LTFU. The "Breaking Down Barriers"¹⁴ 2021 mid-term report highlights stigma as another contributing factor to the challenges in treatment enrolment and success.

1.4 Objectives, Ratings and Scope

The audit's overall objective is to provide reasonable assurance to the Global Fund Board on Global Fund supported TB/MDR-TB programs in EECA, with a focus on Kyrgyzstan, Tajikistan, and Uzbekistan. Specifically, the audit assessed the adequacy, efficiency, and effectiveness of the objectives in the table below.

Objective	Rating	Scope
The Global Fund's approach to implement its EECA strategy, including the design of grants for the selected countries to achieve the strategy.	Partially Effective	The audit covered Principal Recipients and national implementers of TB programs supported by the Global Fund in Kyrgyzstan, Tajikistan and Uzbekistan.
The implementation of grant activities to ensure effective MDR-TB case finding.	Partially Effective	The audit covered the TB grants in the three countries from 1 January 2019 to 31 December 2021, as well as the design of future arrangements for the implementation of TB grants. The effectiveness of C19RM awards in mitigating the impact on TB/MDR-TB in terms of case finding, enrolment and treatment was also reviewed.
The implementation of grant activities to ensure effective enrolment and treatment of MDR-TB patients.	Partially Effective	

OIG auditors visited 24 health facilities in Kyrgyzstan, Tajikistan and Uzbekistan. A remote audit methodology and techniques were deployed where necessary.

¹² Former-prisoners, migrants, PLHIV, persons with addiction

¹³ WHO database on MDR-TB TSR for Kyrgyzstan, Tajikistan and Uzbekistan

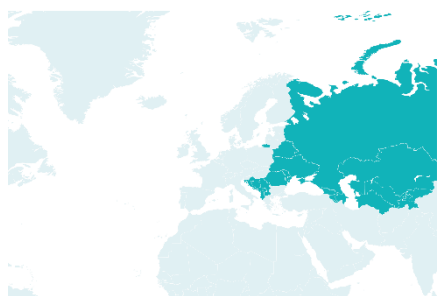
¹⁴ The Global Fund's Breaking Down Barriers initiative provides intensive support to countries to scale up evidence-based programming to reduce human rights-related barriers to HIV, TB and malaria services

Exclusion from scope

The United Nations General Assembly has adopted a series of resolutions and rules which create a framework known as the “Single Audit Principle.” Under this framework, the United Nations and its subsidiaries do not consent to third parties accessing their books and records. Instead, all audits and investigations are conducted by the UN’s own oversight bodies. The Global Fund Board and its committees have considered this assurance over funds managed by the United Nations Development Program (UNDP) and other United Nations (UN) subsidiary bodies and rely on the assurance provided by these UN oversight bodies. Accordingly, the OIG did not audit UNDP expenditures. Details about the general audit rating classification can be found in Annex A.

2. Background and Context

2.1 Overall context



The Global Fund’s Eastern Europe and Central Asia (EECA) Region comprises seventeen countries,¹⁵ of which four are Lower Middle-Income Countries and thirteen are Upper Middle-Income Countries.¹⁶ For the purposes of this audit, three countries (Kyrgyzstan, Tajikistan and Uzbekistan) were selected for review.

The national governments are the main investor in the national TB response in these three countries, providing between 40% to 80% of funding, followed by the Global Fund (11-24%).¹⁷ They also set policies, while regional and district-level governments are responsible for implementing interventions, having separate budgets.

The three countries have among the highest rates of multidrug-resistant TB (MDR-TB) globally. Of the 30 countries with high burden MDR-TB, they collectively represent 2% of the global MDR-TB burden. The nine countries in the EECA region on the WHO list of 30 countries represent 16% of the global MDR-TB burden.

Country Data ¹⁸	Kyrgyzstan	Tajikistan	Uzbekistan
Population	6.6 million	9.5 million	34.2 million
GDP per capita	US\$1,173 (2020)	US\$859 (2020)	US\$1,750 (2020)
Transparency International Corruption Perception Index	144/180 (2021)	150/180 (2021)	140/180 (2021)
UNDP Human Development Index	120/189 (2020)	125/189 (2020)	106/189 (2020)
Health expenditure (% of GDP)	4.5% (2019)	7.1% (2019)	5.6% (2019)

¹⁵ Armenia, Azerbaijan, Albania, Belarus, Georgia, Kazakhstan, Kosovo, Kyrgyzstan, Moldova, Montenegro, Romania, Serbia, Tajikistan, Turkmenistan, Ukraine, Russia and Uzbekistan

¹⁶ [The World by Income and Region – The World Bank 2020](#)

¹⁷ Funding landscape Tables – Funding Request for NFM 3

¹⁸ Sources: [World Bank Population Data](#); [World Bank GDP per capita](#); [TI Corruption Perception Index](#); [UNDP Human Development Index 2020](#); [World Bank Health Expenditure \(% of GDP\)](#) – All accessed March 28th 2022

2.2 COVID-19 situation

EECA countries reacted quickly to the pandemic, imposing countrywide lockdowns as well as a comprehensive public health response to ensure continuous provision of basic health services.¹⁹ Lockdowns and movement restrictions prevented TB patients from seeking care, affecting screening activities. A shortage of available hospital staff due to COVID-19 patients needing medical care, and illness among hospital staff, impacted negatively on TB care. Healthcare workers had limited bandwidth to screen for TB. Hospital beds were repurposed from TB to COVID-19 care.

The above factors significantly impacted program implementation, especially on access to TB and MDR-TB diagnosis and treatment, as shown in *Figure 1* overleaf. Although COVID-19 decreased hospitalization for MDR-TB patients, it contributed to putting many TB patients on ambulatory treatment.

COVID-19 statistics (28.03.22)

Total Cases:

- KGZ: 200,892
- TJK: 17,388
- UBZ: 237,679

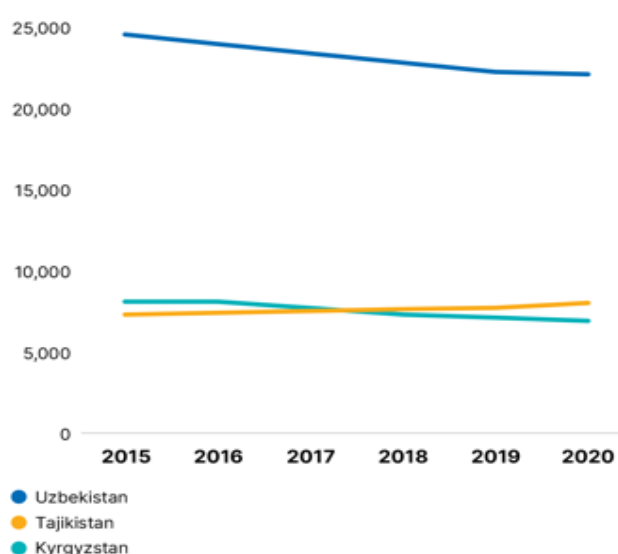
Recovered

- KGZ: 196,181
- TJK: 17,264
- UBZ: 235,501

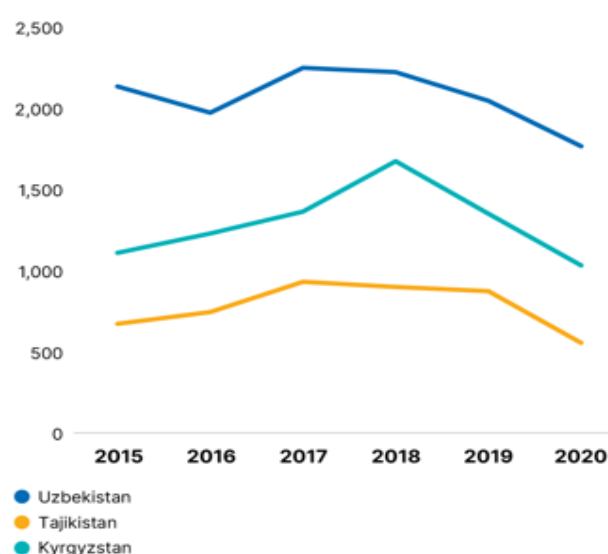
Deaths:

- KGZ: 2,985
- TJK: 124
- UBZ: 1,638

Estimated number of TB cases (all forms)



Number of laboratory-confirmed RR-TB or MDR-TB cases identified



¹⁹ University of Oxford [Our world in data](#) – Accessed on 28 March 2022

2.3 Global Fund Grants in EECA

Since 2002, the Global Fund has disbursed US \$2.5 billion to HIV, TB and malaria programs in Eastern Europe and Central Asia (EECA), of which US \$925 million was for TB. Following a successful replenishment in 2019, allocation to the EECA region in the current NFM3 allocation cycle (2020-2022) increased by 12% (US \$336 million). Full details on the grants in EECA can be found at [the Global Fund's Data Explorer](#). This audit reviewed Global Fund TB grants in Kyrgyzstan, Tajikistan and Uzbekistan.

Country	Disbursed since 2003 for TB and HIV (US\$)	TB disbursements since 2003 (US\$)	TB/HIV disbursements for 2020- 2022 (US\$)
Kyrgyzstan	168,735,777	38,182,465	19,057,796
Tajikistan	101,825,751	85,238,751	16,587,248
Uzbekistan	204,687,641	97,890,421	13,660,331
Total	475,249,169	221,311,637	49,305,375

Source: Global Fund Data Explorer

Global Fund allocations to Uzbekistan, Tajikistan and Kyrgyzstan increased by 37%, 11% and 17% respectively from the previous to the current allocation cycle. In the current cycle, all three countries have combined TB and HIV grants. Kyrgyzstan and Tajikistan implement their grant through UNDP. Uzbekistan is implementing its combined HIV/TB grant via a government entity, The Republican Aids Center. The Global Fund supports only HIV and TB interventions in these three countries.



TUBERCULOSIS

Kyrgyzstan	Tajikistan	Uzbekistan
Estimated number of TB cases decreased from 7,100 in 2012 to 6,900 in 2020	Estimated number of TB cases decreased from 8,500 in 2012 to 8,000 in 2020	Estimated number of TB cases decreased from 26,000 in 2012 to 22,000 in 2020.
TB treatment coverage (notified/estimated incidence), 2020 was 62% (53-73)	TB treatment coverage (notified/estimated incidence), 2020 was 52% (41-68)	TB treatment coverage (notified/estimated incidence), 2020 was 55% (40-79)
Estimated number of deaths from TB decreased from 630 in 2012 to 300 in 2020	Estimated number of deaths from TB increased from 790 in 2012 to 920 in 2020	Estimated number of deaths from TB decreased from 2,200 in 2012 to 1,100 in 2020
MDR-TB/RR notified cases has decreased from 1,638 in 2018 to 1,038 in 2020	MDR-TB/RR notified cases has decreased from 1,638 in 904 to 557 in 2020	MDR-TB/RR notified cases has decreased from 2,238 in 2018 to 1,778 in 2020
MDR-TB cases who started treatment has decreased from 1,282 in 2018 to 946 in 2020	MDR-TB cases who started treatment has decreased from 781 in 2018 to 545 in 2020	MDR-TB cases who started treatment has decreased from 2,239 in 2018 to 1,911 in 2020.
MDR-TB treatment success has increased from 54% in 2015 to 62% in 2018	MDR-TB treatment success has increased from 58% in 2015 to 70% in 2018	MDR-TB treatment success has increased from 59 in 2015 to 67% in 2018.

Source: WHO Country Profiles 2020, WHO TB Burden Estimates Data and WHO Diagnosis, notification and treatment of rifampicin-resistant TB(MDR/RR-TB) up to 2018.

3. Portfolio Risk and Performance Snapshot

3.1 Portfolio Performance

Historically, Global Fund grants in the three selected countries have performed well against targets, as shown below. COVID-19, however, negatively impacted grant performance in 2020.

KYRGYZSTAN

	Grant number	Principal Recipient	Grant Period	Grant Signed Amount (USD)	Total Budget Amount (USD)	Amount disbursed (USD)	% Abs. from signed	Expenditure	% Abs.	Grant ratings				
										Dec 18	Jun 19	Dec 19	Jun 20	Dec 20
NFM2	KGZ-C-UNDP	Republican Center of Tuberculosis Control	1 Jul 18 – 31 Dec 20	23,604,255	26,019,855	23,361,929	99%	25,016,543	96%	A1	A2	A2	B1	B1
										Dec 21	Dec 22	Dec 23		
NFM3	KGZ-C-UNDP	UNDP	1 Jan 21 – 31 Dec 23	34,061,297	34,061,297	19,107,796	56%	5,717,772	17%	TBD	TBD	TBD		

TAJIKISTAN

	Grant number	Principal Recipient	Grant Period	Grant Signed Amount (USD)	Total Budget Amount (USD)	Amount disbursed (USD)	% Abs. from signed	Expenditure	% Abs.	Grant ratings				
										Dec 18	Jun 19	Dec 19	Jun 20	Dec 20
NFM2	TJK-T-RCTC	Republican Center of Tuberculosis Control	1 Apr 18 – 31 Dec 20	10,389,400	11,172,359	9,453,867	85%	9,559,864	86%	A2	A2	B1	B1	B2
										Dec 21	Dec 22	Dec 23		
NFM3	TJK-C-UNDP	UNDP	1 Jan 21 – 31 Dec 23	29,358,198	29,358,198	16,587,248	56%	3,261,154	11%	TBD	TBD	TBD		

UZBEKISTAN

	Grant number	Principal Recipient	Grant Period	Grant Signed Amount (USD)	Total Budget Amount (USD)	Amount disbursed (USD)	% Abs. from signed	Expenditure	% Abs.	Grant ratings				
										Dec 18	Jun 19	Dec 19	Jun 20	Dec 20
NFM2	UZB-T-RDC	RDC	1 Jul 18 – 31 Dec 20	20,211,246	21,118,257	18,968,848	94%	14,684,263	70%	A1	A1	A1	B1	B1
										Jun 21				
NFM2	UZB-T-RSSPMC PhP	RSSPMCPPhP	1 Jan 21 – 30 Jun 21	841,212	841,212	723,372	86%	233,833	28%	B1				
										Jun 22	Jun 23	Jun 24		
NFM3	UZB-C-RAC	RAC	1 Jul 21 – 30 Jun 24	55,047,832	55,047,832	13,660,331	25%	2,666,187	5%	TBD	TBD	TBD		

3.2 Risk Appetite

As per the portfolio differentiation, the Secretariat systematically assesses risk across High Impact and Core portfolios only. As a result, the risk levels for the three countries in scope are not assessed because they are Focused portfolios. The OIG was therefore not able to compare the Secretariat's aggregated assessed risk levels of the key risk categories covered in the audit objectives. See Annex B for further explanation.

4. Findings



4.1 Better monitoring of the Global Fund's strategic priorities is needed to achieve intended impact

The Global Fund's EECA strategy is well designed and aligned with regional priorities and challenges. However, there is limited monitoring of the strategy to ensure key supportive interventions are funded and that mission critical risks are identified. Slow reaction to addressing COVID-19's effect on programs, and the Russian invasion in Ukraine, also threaten the achievement of impact.

The EECA region, which has a high MDR TB burden (66,300 cases in 2019,²⁰ representing 14% of the total global burden), received US \$336 million for the 2020-2022 allocation cycle, representing 3% of Global Fund allocations globally. Seeking to maximize the limited funding available, the Global Fund developed a dedicated regional EECA Strategy for the current funding cycle, which includes dedicated priorities for TB and MDR-TB (detailed in Annex C).

Strategic priorities were developed through consultations with key stakeholders, including regional partners, to align efforts and avoid duplications. The strategy also defined which interventions would be covered by Global Fund grants and which were to be funded either by governments and/or other development partners. Considering the limited funding, this regional approach/strategy represents good practice by allowing countries to prioritize interventions for maximum impact. The TB priorities are well designed and are aligned with regional challenges.

Despite the progress made, challenges remain which could prevent grants from maximizing the intended impact. These include limited monitoring of wider strategic interventions, and slow reaction in addressing COVID-19's effect on programs and the impact of the Russian invasion in Ukraine.

Limited monitoring of priority interventions in the EECA strategy is affecting the achievement of intended impact in the EECA region

Global Fund TB grants mainly focus on improving diagnosis of MDR-TB through the procurement of diagnostic equipment, and on medicines to put people on treatment. Available Global Fund funding was directed to critical activities, with approximately 60%-90% of grant budgets going towards procuring MDR-TB medication, laboratory equipment including GeneXpert machines, reagents and other health consumables. These procurements are critical to diagnosing and treating MDR-TB.

The strategic priorities were designed, funded and are to be implemented through collaborative efforts between the Global Fund, governments, and development partners; however, there is no monitoring plan to ensure the strategy is properly implemented. While priority interventions funded by the Global Fund are monitored via progress update reports, no mechanism is in place to track strategic interventions funded by government and/or other development partners on which Global Fund investments depend. This limits the Secretariat's ability to monitor the key strategic priorities not funded by the Global Fund. Ensuring accountability of partners and sovereign states to fulfil their commitments has also been a challenge.

As a consequence, a number of key elements of the EECA regional strategy not included in grants have limited funding from government and development partners. These include: assessing and enhancing lab capacity, boosting efforts to find and link high-risk groups to treatment, expanding sample transportation systems at all levels to ensure timely and correct laboratory diagnosis and active case finding to increase case notifications.

²⁰ WHO RR/MDR TB burden data - 2019. This information for 2020 was not captured by WHO.

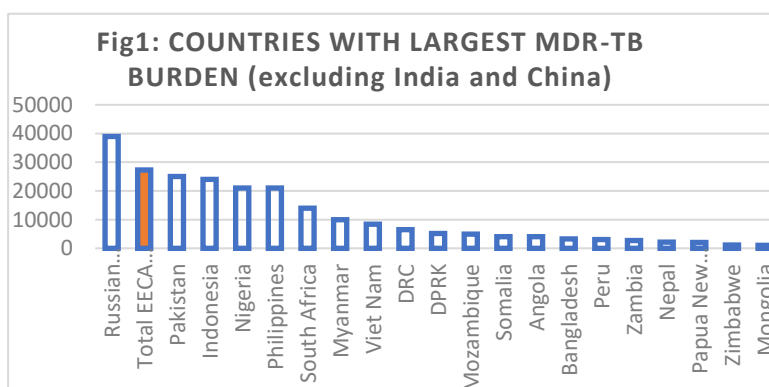
Although concerns over data quality have been flagged in recent Green Light Committee²¹ reports, there is limited support for electronic information systems. District Health Information System (DHIS2) and other electronic systems are not systematically implemented. Data quality is low, and monitoring and evaluation processes are not mature or automated. In Tajikistan, GeneXpert machines are not connected to the central server and therefore data is consolidated manually, increasing delays in communicating results to patients and the risk of manual errors. In Tajikistan and Uzbekistan, there is no structured and systematic electronic reporting system at health facilities, laboratories and TB treatment centers. This contributes to the inability of doctors to track patient results and increases the chance of losing them.

Facilitating engagement with civil society, communities, private sector and other service providers involved in TB control activities is a key component of the EECA strategy. However, this activity receives limited funding in the Global Fund grants and is not sufficiently funded by national governments or by other donors. There is limited involvement of community-based organizations (CSOs) in finding TB cases and linking them to treatment. The CSO sector is underdeveloped in the three countries reviewed with limited funding. Improved patient support and CSO involvement could increase treatment adherence and treatment success rates. While the three countries reviewed had completed transition preparedness assessments and developed capacity building plans, these plans have not been implemented.

Recognizing the limited available funding in the EECA region, many complementary strategic activities were included in the Prioritized Above Allocation Request (PAAR). Many activities were added to the Register for Unfunded Quality Demand, to be implemented should funds become available via savings from country grant or other grants.

Better risk monitoring is needed within Focused portfolios for regions with high disease burden

Global Fund investment and oversight in Focused countries is tailored to reflect the targeted investment and to ensure investments produce maximum impact. The Secretariat does not however further differentiate its approach in these countries/regions for mission critical risk. The combined MDR-TB burden in the nine EECA countries is material and exceeds the MDR-TB burdens in Nigeria, Indonesia and Pakistan, as shown in Figure 1.²²



By further differentiating based on mission risk linked to the high MDR-TB burden, a formal risk assessment could highlight areas of concerns and allow for more effective follow-up of the current strategy, including the monitoring of non-GF funded activities.

National COVID-19 pandemic catch-up for MDR-TB were not timely developed due to lengthy review processes

The three countries reacted quickly to COVID-19, imposing countrywide lockdowns as well as a comprehensive public health response to ensure continuous provision of basic health services. Additionally, countries in the EECA region accessed the Global Fund's Grant Flexibility reprogramming in early March 2020²³ to meet immediate COVID-19 challenges. The pandemic nevertheless had a negative impact on TB: the number of detected TB cases, including

²¹ The Green Light Committee for the WHO European Region (GLC/Europe) was established to address the need for scaling up the programmatic management of drug-resistant tuberculosis in the Region

²² [WHO global lists of high burden countries for tuberculosis \(TB, TB/HIV and multidrug/rifampicin-resistant TB \(MDR/RR-TB\) 2021-2025](#). Published June 2021. The graph above excludes China and India

²³ Global Fund Grant Flexibilities: Grant flexibilities allow countries with current Global Fund grants to meet immediate COVID-19 response demands by: Using up to 5% of their current grant value if there are savings, and/or reprogramming up to 5% of the value of a grant. Activities include, but are not limited to, epidemic preparedness assessment, laboratory testing, sample transportation, use of surveillance infrastructure, infection control in health facilities, and information campaigns. Repurposing equipment already purchased through a Global Fund grant is also an option to respond to COVID-19

MDR-TB cases, decreased on average by 30% in 2020 compared to 2019 in the countries reviewed. The number of GeneXpert tests conducted in 2020 also decreased, on average by 47% compared to 2019.

Despite COVID-19's significant impact on programs, the response was slow. Tajikistan approved a COVID-19 catch up plan in late 2021 due to lengthy review, and the budget associated with the reprogramming is yet to be approved, while Kyrgyzstan does not have specific COVID-19 catch up plans as they are yet to account for the 2021 savings. Uzbekistan approved a TB Action Plan for COVID-19 in February 2021.

The impact of the war in Ukraine and associated risk in the region is likely to limit programmatic progress

Approximately four million people from Kyrgyzstan, Tajikistan and Uzbekistan are migrant workers in the Russian Federation, which has the largest proportion (49%) of new and relapsed TB cases (58,723)²⁴ and MDR-TB cases (21,963)²⁵ in the region. Many of these workers are likely to return to their home countries, with increased vulnerability or rates of infection among migrants in the region due to the Russian invasion in Ukraine, causing the numerous unaddressed risks below.

- While returning labour migrants are screened for TB in Uzbekistan, there is no systematic approach for this in Kyrgyzstan and Tajikistan. While acknowledging that the Secretariat prioritized the rapid response to Ukraine, regional action plans need development to manage a potentially large inflow of returning migrants in a short time period. There is a risk that returning migrants may not be diagnosed in time, potentially increasing infections.
- Several countries in the region procure first-line TB drugs from manufacturers in Russia. There is a risk that commodity supply challenges could result in stock-outs of essential TB drugs. With the current sanctions in place, drug supplies in the countries are likely to be adversely affected. The risk of stock-outs of first line drugs procured by governments could contribute to drug resistance and increased mortality.

Agreed Management Action 1

The Secretariat will review and update the current EECA strategic priorities and approach for MDR-TB to drive further impact and efficiency considering the funding limitation. This will include a review of key focused portfolios of EECA relating to MDR-TB to determine how to better support them to achieve organizational objectives.

OWNER: Head of Grant Management Division

DUE DATE: 30 June 2023

²⁴ WHO Tuberculosis profile: Russian Federation 2020 (Accessed on April 12th, 2022)

²⁵ *ibid*

4.2 Progress on MDR-TB is hindered by limited active case finding and insufficient diagnostic services

Progress has been made in the fight against TB in the EECA region. However, limited active case finding, insufficient lab and diagnostic services, and sub-optimal data management are limiting countries' ability to find more MDR-TB cases.

The countries reviewed saw a decline in estimated TB incidence (averaging 7.2%)²⁶ during 2012-2020, and the usage of molecular diagnostic technology (GeneXpert) as the initial TB test is increasing in the EECA region. Despite the progress made and the high TB treatment success rate (81%-91%), there is a high burden of MDR-TB. MDR-TB notification rates have fallen since 2018, while MDR-TB among new patients and previously treated patients continues to be high (see figure 2²⁷). Limited active case finding, insufficient lab and diagnostic services and sub-optimal data management are limiting countries' ability to find more MDR-TB cases.

Limited active case finding in vulnerable groups, and insufficient contact investigation

Although 38% to 48% of TB cases are missing for the three countries reviewed, there are insufficient contact investigation activities (2 to 5 contacts vs. 10 contacts recommended by WHO).²⁸ Despite the increase²⁹ in the number of positive TB cases in Kyrgyzstan, there is relatively low availability of TB diagnostic services at primary health center (PHC) levels; diagnostic coverage ranges between 36% in the capital and 8% in other regions³⁰. In Tajikistan, active case finding (ACF) is supposedly applied as contact tracing, as well as regular screening of key and vulnerable TB populations.³¹ However, the number of contacts investigated per patient per household is sub-optimal, considering the size of households in Tajikistan (average 10 persons, with 3.8 children per household).³² TB contacts who do not have sputum are referred for X-Ray testing (to be paid by patients) at PHC levels in Kyrgyzstan and Tajikistan, posing a challenge to patients who cannot afford to pay.

ACF is mainly the responsibility of primary health centers. PHCs in the three countries are understaffed,³³ and health workers are responsible for treating patients with many diseases, including TB. As a result, they have limited resources to prioritize contact investigation. The additional workload burden from COVID-19 on PHCs meant that resources to screen for TB were reduced even further. Limited CSO involvement in contact investigation and increased stigma have



MDR-TB among new patients 2020

10.7 – 39.5%

Georgia	10.7%
Azerbaijan	12%
Armenia	14.1%
Uzbekistan	18.3%
Tajikistan	24.2%
Moldova	26%
Kyrgyzstan	28.3%
Ukraine	28.6%
Kazakhstan	36.2%
Russian Federation	36.3%
Belarus	39.5%



MDR-TB among previously treated 2020

24.4 – 74.5%

Azerbaijan	24.4%
Georgia	26.5%
Uzbekistan	38.4%
Ukraine	41.3%
Tajikistan	43.2%
Kazakhstan	49.7%
Armenia	50%
Moldova	53%
Kyrgyzstan	54%
Russian Federation	68.4%
Belarus	74.5%

²⁶ Tajikistan 6%, Uzbekistan 15% and Kyrgyzstan 3%

²⁷ Global Fund EECA Strategy 2020-2022 and WHO Global TB Report 2020

²⁸ [WHO Operational Handbook on Tuberculosis Module 2](#), 2021 (page 21).

²⁹ increased by 14% in 2018, 15% in 2019, and 16% in 2020 in the key and vulnerable TB populations

³⁰ Patient Pathway Analysis in Kyrgyzstan in 2021

³¹ TB patients (children, adults), PLHIV, migrants, detainees and former prisoners

³² TB/HIV Funding Request Allocation Period 2020-2022

³³ Kyrgyzstan Green Light Committee Report, 2021; Tajikistan Green Light Committee Report, 2021; and Uzbekistan Green Light Committee Report, 2021

also contributed to the low case finding. Patients hesitated to seek care for TB symptoms because of movement restrictions, hesitations to visit healthcare facilities during COVID-19 as well as similarity of symptoms between TB and COVID-19 and the stigma related to the latter.³⁴ Case finding interventions and targets are not tailored to local gaps, needs and available resources (mapping). Global Fund grants also have limited ACF activities in these countries, except for supporting screening interventions in prisons in Kyrgyzstan and Uzbekistan. Limited active case finding contributes to missing TB cases, particularly in key and vulnerable populations.

Insufficient diagnostic services and lab management due to non-compliance with national algorithm and low-quality sputum transportation is limiting countries' ability to find more MDR-TB cases

National GeneXpert utilization rates in the countries reviewed have decreased since 2018 by 52%, 18% and 49% in Tajikistan, Kyrgyzstan and Uzbekistan respectively. The visited PHCs in Kyrgyzstan are not adhering to the diagnostic protocol and not sending people with presumptive TB for either microscopy or GeneXpert testing.³⁵

According to WHO guidance and the national algorithm, GeneXpert is supposed to be the primary test. GeneXpert platforms are however not effectively used in Uzbekistan, where there is a high reliance on microscopy, with a slow increase in GeneXpert tests; 41% of TB diagnostic tests used GeneXpert in 2021. In Kyrgyzstan, 66% of the total modules were operational in 2021. The country included procurement of GeneXpert machines in the grant without including the critical complementary activity of replacing modules, and did not allocate this to other stakeholders, making it difficult to replace them. In Tajikistan, 27% of modules needed urgent calibration, and 9% of GeneXpert modules in Uzbekistan were out of order.³⁶

Weaknesses in sputum collection and transportation are another contributor to low testing. According to national laboratory guidelines, sputum is supposed to be transported 48-72 hours after collection, but the PHC lab register does not include information on which laboratory sputum samples are sent, or whether they arrived on time. As a result, 12% of sputum samples collected in Kyrgyzstan were rejected for GeneXpert testing in 2021,³⁷ while Uzbekistan does not maintain records of this. Sputum collection depends on each region's budget. In Tajikistan, the current grant only covered sputum transportation from district to national levels. The Secretariat is now piloting collection of samples in two regions from PHC to the district, from where most samples originate. In Uzbekistan, PHCs lack sputum collection containers with sputum often collected in old medicine containers. There is no structured sputum transportation system in Uzbekistan from facility to district-level laboratories – PHC facilities are responsible for transporting the sputum themselves. Some pilot initiatives are under way to improve sputum transportation systems at district-regional levels, but these do not extend to peripheral levels.

The lack of quality assurance for regional-level laboratories in Tajikistan is a contributing factor to low GeneXpert utilization. An average of 3% – 4% GeneXpert errors were noted between 2019 and 2021, with 23% of the errors at Rudaki TB clinic in Q1 2022. No External Quality Assessment has been done for regional-level laboratories. Consequently, the number of false negative tests at regional level increased from 1% to 6%, from 2017 to 2021. OIG field visits noted challenges with lab equipment, including Mycobacteria Growth Indicator Tube (MGIT)³⁸ machines not functioning and machines to ensure uninterrupted power supply for GeneXpert platforms not working. These challenges weaken the capacity of peripheral laboratories to conduct testing. Negative microscopy results and positive GeneXpert test results were also noted for the same samples in Uzbekistan, increasing the risk of missing TB cases by using microscopy as a first test.

³⁴ Uzbekistan Green Light Committee Report, 2021

³⁵ In Kyrgyzstan, SWOT analysis performed by USPC in 2021 (Situation Analysis of Tuberculosis Diagnostic Laboratory Network in the Kyrgyz Republic) showed that "The weak point (of the laboratory network) is the ineffective use of GeneXpert machines in district-level laboratories, due to inaccurate adherence to the algorithm for TB diagnosis. This was confirmed during the site visits where the referral from general practitioners were at some sites as low as 12%.

³⁶ Uzbekistan National TB Program and National Reference Laboratory data (2021)

³⁷ GeneXpert utilization reports 2021 from Kyrgyzstan National TB Control

³⁸ MGIT (Mycobacteria Growth Indicator Tube) system is a system that determines whether or not TB bacteria will grow in the presence of TB drugs

Sub-optimal data management

There are no MDR-TB testing or treatment targets at regional levels in the countries reviewed, making it difficult for countries to compare each region's performance against targets and course correct when targets are missed. Mechanisms (and indicators) to monitor diagnosis are not yet developed in the countries reviewed. The lack of interoperability of different electronic database systems³⁹ in Tajikistan and Uzbekistan affects prompt data exchange between labs and the referring/treating doctors and nurses. Although Global Fund Local Fund Agent and Green Light Committee reports for Uzbekistan and Tajikistan raised significant issues with data quality, no data quality verification exercise or audit has been performed in Uzbekistan and Tajikistan in the past three years by the Secretariat. Data quality issues affect estimates, decision making and program design, which could lead to programs not targeting the right interventions.

Agreed Management Action 2

The Global Fund Secretariat will work with relevant development partners and in-country stakeholders to:

- a. strategically position EECA regional priorities for the next allocation cycle;
- b. adapt approaches for active case finding within key and vulnerable groups within the available funding; and
- c. address data quality issues.

OWNER: Head of Grant Management Division

DUE DATE: 30 September 2023

³⁹ lab data recording system (LDRS), individual electronic medical card for TB patients, and a national surveillance system



4.3 Improvement needed to support quick patient enrolment and address treatment success gaps due to late treatment initiation and the slow shift to ambulatory treatment

Prior to the COVID-19 pandemic, treatment success rates were improving with decreasing mortality. The countries reviewed started to pilot a shorter all-oral MDR-TB and XDR-TB treatment regimen to further improve treatment success rates. However, delays in putting people on treatment, the loss of patients to follow up and a slow shift to ambulatory treatment are hindering progress.

In the countries reviewed, MDR-TB treatment success rates increased from 57% in 2015 to 67% in 2018, and treatment failure decreased from 8% in 2015 to 6% in 2018,⁴⁰ while the estimated number of TB deaths decreased on average 29% between 2012 and 2020.⁴¹ The countries started to pilot modified all-oral MDR-TB short treatment regimen and BPAL⁴² for XDR-TB treatment in 2019. Clinical management on MDR-TB treatment was updated in 2020 and is in line with current WHO recommendations. There was no evidence of stock-outs of first- or second-line drugs from 2019 to 2021 in the health facilities visited. Electronic patient cards can be accessed by clinicians in Kyrgyzstan, lowering the number of patients lost to follow up before starting treatment.

Uzbekistan's government has issued a decree that enables the country to procure TB drugs (both first and second line) with domestic funding through the Global Drug Facility procurement mechanism, thus ensuring the country can access quality-assured and affordable TB drugs. This can be considered as leading practice for the region, and fundamental to successful implementation of the Global Fund's EECA strategic priorities. Despite these achievements, treatment delays, high loss to follow up and a slow shift to ambulatory care are impacting treatment and treatment success rates.

Delays between diagnosis and treatment enrolment due to lengthy processes risk losing patients

In Tajikistan and Kyrgyzstan, treatment initiation delays average 7-14 days from the time a suspected TB case is diagnosed as positive. In Uzbekistan, there is no structured mechanism to monitor delays in treatment initiation. WHO recommends immediately starting treatment to reduce the chances of loss to follow up (LTFU⁴³). In 2019, LTFU before treatment enrolment in Tajikistan and Kyrgyzstan was 27% and 9%⁴⁴ respectively among diagnosed patients. A contributing factor is people's inability to access facilities equipped with diagnostic equipment and trained staff. The process to hospitalize patients also contributes to treatment delays. For example, hospitalization in the prison system requires transferring patients to the TB prison hospital, which takes approximately 10 days from the records reviewed by the OIG.

While TB doctors in Kyrgyzstan check the lab electronic system to see patient test results when they arrive, there is no such system in Tajikistan and Uzbekistan. In Tajikistan, where patients take their results to the doctor, the delay in communication between laboratory and clinicians and the inability to obtain results directly contributes to treatment delays and loss of patients. This increases the risk of further spreading infection within the community.

⁴⁰ WHO Diagnosis, notification and treatment of rifampicin-resistant TB(MDR/RR-TB) up to 2018 - Accessed on 25 April 2022

⁴¹ WHO TB Burden Estimates data extract – Accessed on 25 April 2022. In Kyrgyzstan TB mortality per 100K decreased from 12/100K in 2012 to 5.8/100K in 2020, in Tajikistan it remained the same 10/100K and Uzbekistan decreased from 5.2/100K in 2012 to 4/100K in 2020.

⁴² BPAL regimen is a pilot for the treatment of extensively drug-resistant TB (XDR-TB) and intolerant or nonresponsive Multi Drug Resistance TB. This regimen has shorter treatment period and less severe side effects.

⁴³ LTFU is defined as "TB patients who did not start treatment or whose treatment was interrupted for two consecutive months or more" (Link accessed 24.5.22)

⁴⁴ Kyrgyzstan Patient Path Analysis (PPA), 2019

Loss to follow up among MDR-TB patients on treatment remains high due to stigma and limited contact tracing

In Kyrgyzstan, the percentage of cases with MDR-TB on treatment who were lost to follow up during the first six months of treatment decreased by 15% between 2018 and 2019. However, LTFU among MDR-TB patients and XDR-TB patients of the 2019 cohort remains high at 18% and 14% among MDR-TB patients and XDR-TB patients (bacteriologically confirmed) respectively.⁴⁵ A lack of MDR-TB side effect medicines in treatment centers,⁴⁶ as well as stigma, contributes to LTFU. According to the Global Fund's "Breaking Down Barriers" (2021) mid-term report, limited progress has been made in TB and stigma reduction, human rights and gender. TB programs scored between 1 to 1.8 (on a scale of 0-5, with 5 as best).

Limited attention is given to tackling LTFU cases. The Kyrgyzstan draft National TB Action Plan mentions only one activity to improve adherence through social contracting with NGOs that can provide social and psychological support. Patients lost to follow up may contribute to TB transmission in the community. This is especially concerning because of the high LTFU among people with drug-resistant TB.

Slow shift to ambulatory treatment due to challenges with Video Observed Treatment (VOT) implementation prevents programs from achieving better treatment results

The World Health Organization (WHO) recommends that MDR/RR-TB patients should be treated using mainly ambulatory care, rather than hospitalization.⁴⁷ Hospitalization should occur only if required for particular clinical reasons.⁴⁸ In Kyrgyzstan, there is a decreasing trend in hospital admissions: the total number of beds for treatment of TB decreased by 6% between 2018 and 2021, and the number of hospitalizations decreased by 34%. Despite this, 70% of MDR-TB patients are still hospitalized for treatment in Kyrgyzstan.⁴⁹

According to WHO guidelines, TB patients can begin out-patient care from the first day of treatment. However, in Kyrgyzstan, Drug-sensitive and Drug-resistant TB patients have to stay in hospital up to sputum conversion, with an average stay of 56 and 62 days in 2020 and 2021 respectively.⁵⁰ In Uzbekistan, the average length of hospital stay for TB patients was 48 days in 2020, a decrease of 19% since 2018.⁵¹ In Tajikistan, the average length of stay has decreased from 56 days in 2017 to 42 days in 2021.⁵²

A decreasing trend in full ambulatory treatment was also noted. In Kyrgyzstan, the National TB Program reported 142 patients with MDR-TB on full ambulatory treatment in 2019, 86 patients in 2020, and 76 in 2021.⁵³ Reasons for the decrease include the support received during hospitalization: when patients are hospitalized, they receive food, psychological support and social care. While Video Observed Treatment (VOT) helps to provide support to patients and allows for dealing with a high volume of people with active disease,⁵⁴ it is still a pilot and yet to be fully rolled out. In Tajikistan, PHC staff are not able to monitor VOT due to the heavy workload, and the task is carried out by regional coordinators, affecting the number of patients who can be monitored and kept on treatment. In Uzbekistan, VOT is still in a pilot phase and non-compliance with VOT guidelines was noted during OIG site visits.

⁴⁵ Kyrgyzstan National TB center operational data 2021

⁴⁶ The Republican TB Center reports, 2019

⁴⁷ WHO consolidated guidelines on drug-resistance TB treatment page 11 (2019), [WHO consolidated guidelines on tuberculosis – Module 4: Treatment Drug-resistant tuberculosis treatment](#) (Accessed on April 12th, 2022)

⁴⁸ [A people-centered model of TB case](#) – Annex 1 Hospitalization criteria. (Accessed on April 12th, 2022)

⁴⁹ Kyrgyzstan PR report (2021) on the progress of ambulatory treatment in the country

⁵⁰ National TB Program report

⁵¹ Uzbekistan Green Light Committee Mission Report 2021

⁵² Tajikistan Green Light Committee Virtual Mission Report 2021

⁵³ Kyrgyzstan National TB program report 2019

⁵⁴ Video-Observed Therapy for tuberculosis: [strengthening case](#) - 2019 ([https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(19\)30293-4/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)30293-4/fulltext) – accessed 11 May 2022)

The slow shift to ambulatory treatment increases treatment costs, limiting the number of people who can be treated in a proper infection control environment. This may contribute to LTFU, creates inconveniences for hospitalization of some patient categories, and risks transmission of infection within in-patient institutions where there are no mechanisms to separate patients awaiting full Drug Susceptibility Testing results.⁵⁵

Agreed Management Action 3

The Global Fund Secretariat will work with relevant development partners and in-country stakeholders to improve timely treatment enrolment and monitor treatment delays.

OWNER: Head of Grant Management Division

DUE DATE: 30 September 2023

⁵⁵ According to the *WHO technical manual for drug susceptibility testing of medicines used in the treatment of tuberculosis* (2018), culture-based phenotypic drug susceptibility testing (DST) methods are currently the recommended standard for drug resistance detection as per WHO.

Annex A: Audit rating classification and methodology

Effective	No issues or few minor issues noted. Internal controls, governance and risk management processes are adequately designed, consistently well implemented, and effective to provide reasonable assurance that the objectives will be met.
Partially Effective	Moderate issues noted. Internal controls, governance and risk management practices are adequately designed, generally well implemented, but one or a limited number of issues were identified that may present a moderate risk to the achievement of the objectives.
Needs significant improvement	One or few significant issues noted. Internal controls, governance and risk management practices have some weaknesses in design or operating effectiveness such that, until they are addressed, there is not yet reasonable assurance that the objectives are likely to be met.
Ineffective	Multiple significant and/or (a) material issue(s) noted. Internal controls, governance and risk management processes are not adequately designed and/or are not generally effective. The nature of these issues is such that the achievement of objectives is seriously compromised.

The OIG audits in accordance with the Global Institute of Internal Auditors' definition of internal auditing, international standards for the professional practice of internal auditing and code of ethics. These standards help ensure the quality and professionalism of the OIG's work. The principles and details of the OIG's audit approach are described in its Charter, Audit Manual, Code of Conduct and specific terms of reference for each engagement. These documents help safeguard the independence of the OIG's auditors and the integrity of its work.

The scope of OIG audits may be specific or broad, depending on the context, and covers risk management, governance and internal controls. Audits test and evaluate supervisory and control systems to determine whether risk is managed appropriately. Detailed testing is used to provide specific assessments of these different areas. Other sources of evidence, such as the work of other auditors/assurance providers, are also used to support the conclusions.

OIG audits typically involve an examination of programs, operations, management systems and procedures of bodies and institutions that manage Global Fund funds, to assess whether they are achieving economy, efficiency and effectiveness in the use of those resources. They may include a review of inputs (financial, human, material, organizational or regulatory means needed for the implementation of the program), outputs (deliverables of the program), results (immediate effects of the program on beneficiaries) and impacts (long-term changes in society that are attributable to Global Fund support).

Audits cover a wide range of topics with a particular focus on issues related to the impact of Global Fund investments, procurement and supply chain management, change management, and key financial and fiduciary controls.

Annex B: Risk appetite and risk ratings

In 2018, the Global Fund operationalized a Risk Appetite Framework, setting recommended risk appetite levels for eight key risks affecting Global Fund grants, formed by aggregating 20 sub-risks. Each sub-risk is rated for each grant in a country, using a standardized set of root causes and combining likelihood and severity scores to rate the risk as Very High, High, Moderate or Low. Individual grant risk ratings are weighted by the grant signed amounts to yield an aggregate Current Risk Level for a country portfolio. A cut-off methodology on high risks is applied (the riskiest 50% of grants are selected) to arrive at a country risk rating.

OIG incorporates risk appetite considerations into its assurance model. Key audit objectives are generally calibrated at broad grant or program levels but OIG ratings also consider the extent to which individual risks are being effectively assessed and mitigated.

For country audits of High Impact and Core countries, OIG assesses residual risks are compared against the Secretariat's assessed risk levels at an aggregated level for those of the eight key risks which fall within the audit's scope. In addition, a narrative explanation is provided every time the OIG and the Secretariat's sub-risk ratings differ. For risk categories where the organization has not set formal risk appetite or levels, OIG opines on the design and effectiveness of the Secretariat's overall processes for assessing and managing those risks.

Global Fund TB grants in Kyrgyzstan, Tajikistan, and Uzbekistan

The risk levels for the three countries audited are not assessed by the Secretariat because they are Focused portfolios. The OIG was therefore not able to compare the Secretariat's aggregated assessed risk levels of the key risk categories covered in the audit objectives.

Annex C: TB strategic priorities of the 2020-2022 EECA strategy

Source: EECA Regional Strategy 2019

