Mid Term Evaluation Report of IFRC and Russian Red Cross Tuberculosis, HIV/AIDS and Visiting Nurses Service Programme

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Acknowledgements

The Evaluation Team would like to thank all those who gave so generously of their time and expertise to give a comprehensive overview of the Red Cross TB/HIV/AIDS programme. It is hoped that the findings of this evaluation will contribute to a strengthening of the programme.

Dr Brenda Corcoran
Team Leader
October 2001
Executive Summary


The Red Cross programme was set up in September 1999 as a result of the increasing tuberculosis rates in Russia. The programme had five immediate objectives:

- to increase the awareness of the population regarding the prevention and control of TB, HIV/AIDS and other sexually transmitted diseases (STDs),
- to promote human rights and dignity and through this minimise discrimination and stigmatisation against people with HIV/AIDS and TB and their families and the provision of social support for the most vulnerable,
- to enhance the capacity of the Visiting Nurses Service.
- to assist line ministries in the improvement of TB diagnosis and treatment compliance
- to render psychosocial support and care for persons living with TB/HIV/AIDS and their families.

The programme was established in eight pilot regions through the provision of adequate funding from ECHO. However this funding stopped in early 2001 and since then funding has been provided by a number of donor Participating National Societies on a short tem basis.

The relationship between the TB services and the Red Cross was developed and strengthened at central, regional and district levels. A basic health information strategy has been developed and regional committees were given guidelines to follow and asked to publicise the TB programme and wider issues around TB and HIV/AIDS. A wide range of health education materials about TB have been produced and widely distributed to patients, families and the general community. Different methods have been used to give messages about the prevention and control of TB and there is widespread use of the media.

In each of the pilot regions Visiting Nurses were recruited who initially received training in TB Control and homecare. The programme include primarily WHO Category 1 and 2 patients according to their social situation. The Visiting Nurses provide eligible TB patients with medication and social support and also are involved in health education and fund raising activities. The social support consists of hot meals or food parcels and acts as an incentive to encourage the TB patients to continue treatment at home and also improves their nutritional status. Family food parcels and hygiene kits have also been supplied to the patients. The majority of the programme funding (80-90%) is used for the provision of this social support.

The RRC programme has promoted the international TB methodology (as recommended by WHO) and consultation took place with local TB authorities to ensure the RRC role was understood. The RRC has no role in the diagnosis of TB, which is made by TB doctors in the state hospitals. However to improve the laboratory diagnosis of TB microscopes and other equipment have been procured for use in state hospitals in the pilot regions and training provided.
Selection of TB patients to be included in the programme is made by the TB specialist and the RRC medical co-ordinator based on standardised medical criteria and the social situation. Chronic and multi drug resistant patients are ineligible as only those who became smear negative can be considered for inclusion.

The rates of TB are much higher in the prison population and many prisoners are released whilst still on treatment. The programme has worked closely with the prison medical services and other NGOs to ensure these patients continue medication.

The evaluation found that the programme has been successfully implemented in the eight pilot regions. There is now good collaboration between the RRC TB team at Central Committee and the Federation Delegation in Russia and other national and international agencies involved in the control of TB. However to ensure long term sustainability donor funding needs to be secured together with the implementation of increased funding from regional governments.

The programme is filling a gap in national TB care by monitoring TB care using social support as an incentive for the most vulnerable TB patients. At the same time it is advocating international TB control guidelines. Treatment compliance has improved significantly in those receiving social support. The drop out rate for patients receiving social support is 2-7% compared to 20% before the programme started. The social support needs to be targeted to those TB patients who are sputum positive at diagnosis and consideration given to extending the criteria to include chronic and/or MDR patients. The links with the penitentiary service need to be strengthened to reduce the level of dropouts when patients are released on treatment.

Materials and information about HIV/AIDS need to be more widely disseminated to TB patients, their families and the general public and the programme should strengthen links with other HIV/AIDS agencies.

Ongoing training for the VNS and RRC staff is essential and operational research should be carried out to demonstrate the effectiveness of the programme.
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1. Introduction

The Russian Federation has a population of 147 million people with a landmass of 17.1 million square kilometres. The country is divided into 89 administrative regions or oblasts. The population has been falling since 1992 with the death rate exceeding the birth rate. The average life expectancy is 59 years for males and 71 years for females with the primary causes of death being cardiovascular disease, accidents and alcoholism. The birth rate has fallen sharply largely due to economic factors.

After the former Soviet Union collapsed in 1991 Russia became the largest of the newly independent republics. Transition to the market economy and political reforms were followed by a severe economic crisis. This resulted in high inflation rates and spiralling unemployment leading to an increasing proportion of the population living below the official poverty line.

In the former Soviet Union the delivery of health care was carried out by large numbers of institutions with the major emphasis on inpatient services. The Ministry of Health was responsible for health departments in the oblasts with each oblast having a central hospital with several specialised departments. Tuberculosis was outside the general health service receiving special funding. Each oblast was divided into several districts that in turn had a small district hospital and more peripherally there were polyclinics or feldsher (paramedical) points in the villages. Delivery of integrated primary health care services was poorly developed.

Following the formation of the Russian Federation the provision and funding of health care was decentralised to the oblast level in 1992 and since then the financial support to the health services reduced substantially leading to run down institutions and out of date equipment. However the ratio of medical personnel to the population remains high compared to Western countries - there are over 9000 tuberculosis specialists in Russia.

2. Background to the Programme

In 1993 the World Health Organisation (WHO) took the extraordinary step of declaring tuberculosis (TB) a global emergency following dramatic increases in the number of cases worldwide. In the Russian Federation the incidence of TB has risen from 34.2/100,000 populations in 1990 to 85.2/100,000 population in 1999 and the mortality rate has also increased. The disease is most prevalent among the poor and their families including the homeless, alcoholics, ex prisoners and the malnourished. In addition the incidence of TB in the penitentiary system is 30 –40 times higher and the mortality rate is estimated to be 100 times higher than that for the civilian population. According to some estimates the rate of multi drug resistant TB has reached 10% in primary (newly diagnosed) cases and 30-40% in relapse cases.

The accuracy of the TB statistics is difficult to assess as there are many different organisations involved (e.g. health services, prisons, occupational services). Nevertheless the trends indicate a worsening situation and these figures do not yet reflect the effect of an increasing HIV/AIDS problem.

In the past the TB Control Service was well funded centrally by the Federal budget. A vertical in patient approach was used involving mass screening, long hospitalisations and a range of
medical and surgical interventions. This approach was very different from other countries and was very costly, nevertheless the results of treatment were effective. Traditionally the majority of TB cases were diagnosed by mass X-raying of adults and skin testing for children and the numbers of cases presenting with symptoms and diagnosed by sputum examination was small.

However, following the political, social and economic changes in the 1990s it has been difficult to continue this approach. Under funding of the TB and penitentiary services from the state budget, migration and an increasingly vulnerable population have led to a serious public health problem.

The Russian approach to TB Control is different from that advocated by WHO approach which has five key elements
5. Political and financial commitment
6. Case detection through sputum smear examination
7. Directly observed treatment short course (DOTS)
8. Regular drug supplies
9. Accurate monitoring systems

In June 2001 President Putin signed a TB law, which shows the commitment of the Russian Federation to the care and management of TB. It describes the rights and duties of TB patients, TB staff and the state and introduces involuntary treatment for the most difficult patients. The implementation of the law varies from oblast to oblast reflecting the resistance to change in the Russian TB care system, which for long has applied different principles.

3. The Russian Red Cross Involvement

The Russian Red Cross (RRC) has an extensive nationwide network and a long history of active involvement in health programmes and social support to vulnerable population groups including those with tuberculosis. In the former Soviet Union the Visiting Nurses Service (VNS) was one of the most important national activities providing professional medical and social assistance to the vulnerable and the handicapped either at home or in the medico social rooms (MSR). Following socio economic decline this service lacked human and financial resources and was close to collapse in some areas.

Following the increasing TB problem the National Red Cross Societies of Russia, Belarus, Ukraine and Moldova requested that the International Federation of Red Cross and Red Crescent Societies (IFRC) launch an Emergency Appeal for funding. In March 1999 an Emergency TB/HIV/AIDS/VNS/STD Appeal was launched by the IFRC in Moscow.

The development objectives were:
5. To improve the health of the population with particular focus being given to those sections of the population that are most vulnerable to TB and HIV/AIDS.
6. To facilitate progress towards civic society and a strengthened Visiting Nursing Service.

The immediate objectives were
5. To increase the awareness of the population regarding the prevention and control of TB, HIV/AIDS and other sexually transmitted diseases (STDs).
6. To promote human rights and dignity and through this minimise discrimination and stigmatisation against people with HIV/AIDS and TB and their families and the provision of social support for the most vulnerable.

7. To enhance the capacity of the Visiting Nurses Service.

8. To assist line ministries in the improvement of TB diagnosis.

9. To render psychosocial support and care for persons living with HIV/AIDS and their families.

The time frame for the initiative was fifteen years in total. This was made up of an immediate action phase as part of a three-year initial phase, to be followed by a two-year phase and two subsequent five-year periods.

Based on the Appeal the Danish Red Cross and British Red Cross Societies (RCS) submitted an application to European Community Humanitarian Organisation (ECHO). Funding was secured and the joint RRC/IFRC programme started in September 1999 in seven Russian regions - Murmansk, Arkhangelsk, Pskov, Astrakhan, Tomsk, Kemerovo and Buryatiya.

The programme was funded mainly by ECHO for 20 months, and since March-April 2001 it has been funded by the number of donor Participating National Societies - PNSs (British RCS, Norwegian RCS, American RCS, Icelandic RCS). In 2000 a similar TB programme model was extended to Oryol with WHO / USAID funding.

These regions were chosen because they each had a strong active Red Cross committee with an existing VNS. In addition there was good involvement with the local government and a preparedness of the health services to move towards international TB Control guidelines.

During the planning and implementation of the programme regular working meetings were held at field level with involvement of the Federation TB Consultants, PNSs health advisers, Secretariat Health Department staff and all parties concerned. These decided on the programme plan of action, time schedule, target groups, progress indicators, reporting, etc. and approaches to be modified and thus adapted to different requirements or circumstances in a changed environment.

The programme activities were co-ordinated with the national and regional health authorities – the Ministry of Health, both leading national TB Research Institutes (CTRI, RIPP) and regional TB services and international agencies involved in TB Control in Russia (WHO, MERLIN, MSF, PHRI, FILHA, NHLA, ECHO, USAID/CDC, DFID).

It was planned within the Federation Appeal and Background Information document to have an interim evaluation of TB/HIV/AIDS Programme after the completion of the second year of implementation.

The Belarus TB/HIV/AIDS programme was evaluated in July 2001. The overall conclusion was, that the achievements and progress of the programme have been remarkable. The recommendations included a requirement for improved institutional development of the Belarusian Red Cross as well as better support from the Federation to the programme.

4. Methodology of the Evaluation
The evaluation took place from 14 – 27 October 2001 and the team consisted of:
Dr Brenda Corcoran, Independent TB Consultant and Team Leader
Ms Anja Alila, Public Health Specialist, Finnish Red Cross
Ms Jacqueline Greene, Evaluation Specialist, Desk for Russia, American Red Cross
Dr Terhi Heinasmaki, Senior Health Officer, Federation Secretariat Health Department
Ms Tatyana Strongina, President of the Moscow West district committee of the Russian Red Cross and Russian Red Cross Representative
Mr Alexander Rezanov, Interpreter

The methodology of the evaluation involved:
5. A comprehensive review of IFRC/RRC documented materials.
6. Interviews with RRCS and the Federation Delegation programme team and other key stakeholders - WHO, Ministry of Health, UNAIDS, MERLIN and MSF.
7. Visits to two oblasts to interview regional and district RRC staff, visit federal TB services, meet with staff from the TB penitentiary services, and visit TB patients and their families. Tomsk and Kemerovo were chosen as the two oblasts due to their proximity and their varied implementation of the programme.

5. Findings

5.1 General

A comparison of the TB incidence and mortality rates for the eight regions and the Russian Federation in 1999 and 2000 is shown in Table 1 below.

<table>
<thead>
<tr>
<th>Region</th>
<th>Incidence rate / 100,000</th>
<th>Mortality rate / 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1999</td>
<td>2000</td>
</tr>
<tr>
<td>Archangelsk</td>
<td>82.1</td>
<td>104</td>
</tr>
<tr>
<td>Murmansk</td>
<td>68.5</td>
<td>72.4</td>
</tr>
<tr>
<td>Astrakhan</td>
<td>80.3</td>
<td>85.2</td>
</tr>
<tr>
<td>Pskov</td>
<td>87.1</td>
<td>88</td>
</tr>
<tr>
<td>Buryatiya</td>
<td>181.4</td>
<td>140.9</td>
</tr>
<tr>
<td>Kemerovo</td>
<td>139.1</td>
<td>141.8</td>
</tr>
<tr>
<td>Tomsk</td>
<td>113</td>
<td>115.5</td>
</tr>
<tr>
<td>Oryol</td>
<td>71.2</td>
<td>N/A</td>
</tr>
<tr>
<td>Russian Federation</td>
<td>85.2</td>
<td>90.1</td>
</tr>
</tbody>
</table>

During the first stage of the programme the main goal was to develop the model for Russian Red Cross participation in the overall framework of TB activities carried out by the state health service. The relationship between the TB services and the Red Cross was developed and strengthened at central, regional and district levels.

This political commitment is demonstrated by the agreement between the Ministry of Health and RRC on general issues and on TB Control, which has been approved by the legal teams on both sides and was signed in June 2001. Other agreements have been reached between:
5. RRC and CTRI on training
6. Regional RRC branches and regional administrations
7. Regional RRC branches and TB dispensaries

These agreements define the RRC role in TB Control activities. During the field visits to Kemerovo and Tomsk evidence was seen of the close working relationship between RRC personnel and staff in the regional administrations and health authorities.

Involvement in this programme has significantly raised the profile of the RRC at national and regional levels. Nationally there is regular co-ordination between RRC and the state authorities and WHO and NGOs involved in TB Control such as MERLIN, MSF and PHRI. At regional level a member of the RRC branch is on the regional TB Co-ordinating Committee. Other members of this committee include representatives from the local administration, the TB service, penitentiary system, social services and epidemiological control.

This increased profile for the RRC has had a knock on effect on other RRC programmes. The visibility of all RRC programmes has grown. As a result of the ECHO funding additional RRC staff were employed at branch level - for example prior to the programme in Tomsk oblast there were two staff - now there are eleven involved in the running of the programme.

Standardised management systems are now in place in all eight regions for data collection and financial monitoring and staff have been trained in the implementation. In two regions a computerised medical database, compatible with that used in the TB service has been installed on a pilot basis. The other regions use diverse computer programmes. Monthly returns on all aspects of the programme are made to the Central Committee of RRC in Moscow.

5.2 Funding

The ECHO funding to the programme is shown below in Table 2.

| TABLE 2: Budget structure from ECHO funding 1999-2001 (US dollars) |
|-----------------------------|-------------------|-------------------|
|                            | 1999 (4 months)   | 2000              | 2001              |
| Drugs                      | 0                 | 0                 | 0                 |
| Laboratory                 | 0                 | 190,000           | 30,000            |
| Training                   | 30,000            | 60,000            | 20,000            |
| Social Support             | 210,000           | 880,000           | 540,000           |
| Information                | 20,000            | 80,000            | 30,000            |
| Other                      | 220,000           | 800,000           | 380,000           |
| **TOTAL**                  | **480,000**       | **2,010,000**     | **1,000,000**     |

The ECHO funding started in September 1999 and was channelled through the Danish RCS for Archangelsk, Astrakhan, Murmansk and Pskov (until the end of April 2001) and the British RCS for the Siberian regions of Buratiya, Kemerovo and Tomsk (until the end of February 2001). The funding was allocated on a monthly basis to the RRC central committee via the Federation office in Moscow who in turn received it from The Federation in Geneva. The central committee then sent the funds to the eight regions. The regions submitted monthly returns to the RRC and these were forwarded to the Federation office that sent them to IFRC in Geneva.

From September 1999 to April 2001 the funding for the programme was received in a regular and timely manner and during this time the regional RRCs were actively seeking alternative
funding. In most regions the local administration committed to fund the RC office accommodation and the ongoing running costs – in some areas the regional government agreed to fund the salaries of the RC staff for the TB programme – both VNS and management staff. However the majority of the budget expense (85%) at regional level was for provision of social support.

Since April 2001 the funding arrangements are shown in Table 3

<table>
<thead>
<tr>
<th>Table 3: Funding by oblast and donor</th>
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<tbody>
<tr>
<td>Oblast</td>
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<tr>
<td>Archangelsk</td>
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<td>Tomsk</td>
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<td>Oryol</td>
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* funding received after the evaluation was completed

As is seen in Table 3 different donors have pledged funds to support each region since the end of the ECHO funding. However in the two oblasts visited there had been a substantial reduction in the funding allocation from the Central Committee since April 2001. This was due to a delay in funding from DfID channelled through British RC. The situation changed just after the evaluation was completed as indicated by the asterisks in Table 3.

By the time of the evaluation, the decrease of funds had led to a reduction in the numbers of TB patients receiving social support from the programme and to a crisis of confidence by local Red Cross staff. They were unaware of the commitment by donors and feared that funding might dry up and the programme would have to close down.

In the other pilot oblasts donor funding has been secured but in most areas it is only short term (12 months) and the sustainability of the programme is in question.

The RRC recognised these funding difficulties and has been planning for the long-term future for the programme. Each regional RC committee was asked to submit development plans up to the end of 2003 outlining their sources of funding. In addition they were requested to increase the local contribution from the state authorities and local fund raising activities for the programme.

Following discussions with the regional health authorities agreement has been reached to significantly increase their contribution to the programme. In Kemerovo it is planned to increase funding from the regional health authorities from 35% of the total budget in 2001 to 60% by 2003. Likewise in Tomsk this figure will increase from 0.5% to 30%. These figures are similar to those from the other regions. Although donor funding will still be required for some time it is planned that the regional RC administrations will source an increasing percentage of funds from the local administration and through fundraising. This will lead to increased sustainability for the programme.

All the oblasts are actively involved in fundraising for the programme. This involves street collections as well as lobbying local businesses either for a regular financial commitment or
the donation of goods such as food or clothes. The funds that are raised are used in a variety of ways.

In Tomsk a local bank has given a commitment to provide RuR 240,000 every year for three years. They have stipulated that these funds must be used for children and the RRC is using the money to provide food to a children’s TB sanatorium.

The White Camomile day is a traditional fundraising event for TB activities run by the Red Cross and the TB service. In Kemerovo part of the previous funds raised during this day have been used for the purchase of medical equipment for the local TB hospital as well as vitamins for TB patients. This year over RuR 1,000,000 was raised from the local community in Kemerovo but the regional committee has not yet decided how the money will be used.

As of January 2002, a new law, tightening the governmental grip on Non Governmental Organisations (NGOs) will take effect. According to this law, all financial donations from any source to the account of a Russian NGO for charitable purposes (and currently non-taxable) will have to be approved by the State Commission on Humanitarian Aid in order to qualify for tax-free status. This will make fundraising more difficult for the Red Cross. The RRC is aware of this proposed legislation and efforts are underway to minimise its effect.

5.3 Increasing the awareness of the population regarding the prevention and control of TB, HIV/AIDS and other sexually transmitted diseases (STDs).

At national level two aims were identified for health education activities
5. To produce health education materials for use in the seven regions
6. To use national and international media and other resources to convey key messages

The RRC and the Federation devised twelve different information leaflets and posters. These included general information for the wider community as well as specific booklets and leaflets for TB patients and their families. In addition a booklet and a poster were produced on HIV/AIDS and TB. The evaluation team found that there was widespread evidence of the posters and leaflets both at central and regional level.

Two films on the programme have been produced – one made by the Federation is aimed at a donor audience, the other made by RRC is intended for the domestic audience and has a larger health education component.

At the start of the programme a basic health information strategy was developed and regional committees were given guidelines to follow and asked to publicise the TB programme and wider issues around TB and HIV/AIDS. In the regions the VNS, local Red Cross staff and volunteers have been active in going into the community and giving talks to students in schools and colleges, youth groups, families of TB patients and other relevant groups. Youth peer education is ongoing in the regions although the evaluation team found outdated manuals in use for the training of this group. Some regions have produced their own leaflets and posters on various aspects of TB control.

Both nationally and at local level there has been widespread coverage of the Red Cross TB programme on television and radio especially around the time of world TB Day – 24 March
and World AIDS day – 1 December. Visits to the regions by the Federation / RRC monitoring teams have been very productive in securing high levels of media coverage as camera crews accompany the team and interviews allow Red Cross personnel to clarify the RC role and give standard messages about TB. The evaluation team experienced high levels of media coverage during field visits especially in the Kemerovo region.

In March – April 2001 the “White Camomile” action took place – this involved lectures, meetings, drawing competitions and media events giving relevant information on TB as well as street collections to raise money for the programme. The Federation / RRC arranged a joint press conference devoted to World TB day in co-operation with other agencies. In addition a TB poster competition was organised and the winner was awarded a prize during the TB day.

5.7. Assisting the ministries and local health authorities in the improvement of TB diagnosis and treatment compliance

5.4.1 General

From the beginning of the programme the international TB methodology (as recommended by WHO) was promoted by the Red Cross in the eight pilot regions. The RRC medical coordinators, VNS and other local RRC staff were trained on all aspects of DOTS. This differed from the existing approach to treatment of TB patients in many of the regions and consultation took place with the local TB authorities to ensure the RRC role was fully understood.

To promote the laboratory diagnosis of TB in accordance with international guidelines the programme procured binocular microscopes as well as stain kits for a 12-month period and distributed these to the regions. In some regions some laboratory needs were already covered by other agencies such as FILHA and NLHA in both Murmansk and Archangelsk and MERLIN and PHRI in Tomsk. Additional laboratory equipment - centrifuges and autoclaves was also procured and distributed to all the regions. To maximise the use of this equipment training courses funded by RRC have been run by CTRI for laboratory assistants. Regional and national laboratories provide quality control. The evaluation team saw evidence of the use of these microscopes and data relating to the number of samples examined is collected regularly and monitored by the regional RRC.

Partly as a result of this intervention there has been a significant increase in the percentage of TB patients diagnosed by laboratory examination in all the regions. In the Tomsk oblast 65% of TB patients are now diagnosed by sputum examination and 35% detected by chest X-ray screening. This compares to a previous figure of 70% patients detected by chest X-ray screening and only 30% diagnosed by laboratory testing of sputum.

According to WHO treatment guidelines TB patients are divided into the following groups

5. Category 1
5.7. new sputum smear positive pulmonary TB
5.8. severely ill smear negative and extrapulmonary TB
6. Category 2
6.7. relapses
6.8. treatment failures
6.9. return after treatment interruption (default)
7. Category 3
7.7. sputum smear negative pulmonary TB
7.8. extrapulmonary TB
- Category 4
  - chronic cases

Initially recipients of the programme were drawn from all TB patient groups including chronic and smear negative patients. Children who were contacts of contagious TB patients were included for nutritional support. The medical criteria for inclusion in the programme were later focussed to Category 1 and 2 patients. Category 3 patients were included on an individual basis if resources permit.

However the evaluation team met with TB patients included in the programme who were smear negative or diagnosed by chest X-ray alone. Some of these had very few symptoms of TB but the state TB doctors are responsible for the diagnosis and categorisation of the disease. The RRC programme has no control over the diagnosis of TB.

After some initial confusion the regional committees agreed to standardise the criteria for inclusion into the programme. The selection of patients is made by the TB specialist and the RRC medical co-ordinator towards the end of the in patient period. The TB specialist identifies the patient according to their medical category and social situation. The RRC medical co-ordinator meets the patient and the VN visits the patient at home. The assessment is usually carried out in conjunction with the TB dispensary and the local social services. The main selection criteria are the patient’s income - lower than the regional minimum per person and one of the following:
5. Chronic illness / invalidity
6. Lonely pensioner
7. Multi child / incomplete family
8. Unemployed
9. Homeless
10. Migrant
11. Alcohol or drug abuser
12. Former prisoner

Table 4 shows the numbers of TB patients included in the programme and their social vulnerability grouping.

<table>
<thead>
<tr>
<th>TABLE 4: Details of TB patients included in RRC programme</th>
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<tr>
<td>Region</td>
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<td>Buratiya</td>
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<td>Kemerovo</td>
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</table>
It is estimated that between 70-80% of TB patients in the pilot regions from Categories 1 and 2 fulfil the criteria for social vulnerability and availability of funding also influences if a patient is included in the programme. Recent funding difficulties in Tomsk and Kemerovo have led to TB patients not being included in the programme even though they fulfil both the medical and social vulnerability criteria.

The evaluation team met with many TB patients and verified that most fulfilled the social vulnerability criteria. Once a patient is eligible for inclusion to the programme on both medical and social grounds he/she signs a written agreement with local RRC staff. This agreement states that the patient will take medication as prescribed by the TB authorities under the supervision of RRC staff and he/she will receive social support from the Red Cross during the treatment period.

The patient receives the continuation phase of TB treatment from the visiting nurse as prescribed either by visiting the MSR or the soup kitchen or occasionally the VN travels to the patient’s home to give the drugs. The VN documents the administration of the drugs on a record sheet, which is countersigned by the patients. The evaluation team found DOT was implemented properly and there was no evidence of any shortages or delay in the supplies of TB drugs.

In the continuation phase TB patients are prescribed either daily or thrice weekly medication. The social support used to be given seven days a week but due to financial difficulties the patients receive it in the visited regions only five days a week. In Kemerovo oblast the medication is not given to the patients over the weekend whereas in Tomsk oblast the drugs are given to the patient on a Friday for self-administration over the weekend. In remote areas feldshers may implement DOT and provide social support.

In addition family food parcels and hygiene kits were given to the TB patients every two months until May 2001.

There is close liaison with the staff from the TB dispensaries and if there is any evidence of side effects or other complications the TB patients are referred back to the TB dispensary or hospital.

Prior to the start of the RRC programme the estimated drop out rate for TB patients was 20% - this figure has improved significantly to between 2-7% for those patients included in the RRC programme.

All staff from the TB hospitals and dispensaries, doctors, nurses and administrators interviewed during the evaluation spoke of the positive impact of the programme in reducing the drop out rate. However all raised concerns that chronic and multidrug resistant TB patients who are equally if not more vulnerable are unable to benefit from the programme.
In Oryol sputum positive bacillary patients have been included in the programme and VNAs have been given additional insurance.

5.4.2 Co-operation with the penitentiary system

The Russian penal system has a national incarceration rate of almost 700/100,000 population – one of the highest in the world. The health care system in the prisons is the responsibility of the Ministry of Justice and not the Ministry of Health.

Of over 1 million Russian prisoners at least 10% are sick with TB and at least 20% of them have multi drug resistant TB. The incidence of TB is much higher in the prison population with estimated rates of 570 – 2500 / 100,000. The main reasons for these rates are

- severe overcrowding, poor ventilation and inadequate nutrition
- decrease in prison budgets even though the number of those detained has risen
- poor coordination and follow up between prison and civilian health officials

The release of prisoners whilst still on TB treatment takes place on an ongoing basis. The prison health authorities inform the state TB services of details of such patients and advise them to register for follow up.

It is estimated that over half of TB patients released from prison fail to register at the TB dispensary for continuation of treatment. In addition the 2000 prison amnesty released large numbers of TB patients into the general community thus adding to an already overstretched service. The RRC TB programme has a key role to play in this area especially as it is an independent organisation.

The internationally accepted guidelines of TB are widely used in both the civilian and prison population in Tomsk through the activities of first MERLIN since 1994 and then PHRI. Both these organisations have a close working relationship with the staff of the RRC TB programme. Initially a member of the RRC programme visited TB patients in prison regularly for about two months before they were to be released to inform them of the facilities offered by the programme and encouraging them to register for treatment. More recently a social work coordinator employed by MERLIN has carried out this function.

Figures from MERLIN show that almost 80% of released prisoners now register and continue treatment with the RRC programme. Even so in Tomsk there is a difference in the drop out rates for ex prisoners on treatment and civil TB patients of 9%.

In Kemerovo oblast MSF is active in the treatment of prisoners and the promotion of international TB guidelines. TB patients are given an information leaflet about the RRC programme prior to their release from prison and encouraged to register for follow up treatment. Many patients disappear and do not finish their treatment following their release and thus act as a continuing focus of TB infection to their families and the general community. Following the 2000 amnesty it was reported that 1000 prisoners were released on TB treatment and only 70 of these registered for follow up treatment. This was in spite of MSF and RRC working closely together to prevent dropouts. According to MSF the difference in the drop out rates for ex prisoners on treatment and TB patients from the civil sector is estimated to be 20%.
The Tomsk oblast has been selected for a DOTS Plus pilot project treating multi drug resistant TB patients with second line drugs. DOTS Plus builds on an established DOTS programme and adds to the basic approach the diagnosis and treatment of drug resistant TB with second line drugs for a period of 18-24 months. MERLIN and PHRI are coordinating this project for initially 200 patients from the prison and civilian sectors. However many of these TB patients are likely to be released whilst still on treatment and the continuation of their treatment is of vital importance. Both MERLIN and PHRI would like this group of TB patients to be included in the RRC TB programme to improve their compliance.

5.7. Providing material and social support to the most vulnerable

The provision of social support is a key component of the RRC TB Programme and consists of daily hot meals or daily food parcels. The purpose of this is two fold –

5. to encourage patients to continue treatment during the continuation phase of treatment
6. to improve the nutritional status of the patient whilst on treatment

Once the patient has been deemed eligible for inclusion in the programme he/she signs an agreement form to continue to take TB treatment and then to receive social support.

The daily social support is administered in different ways

5. In Kemerovo the TB patient comes to a soup kitchen every time TB treatment is due. They are then given their medication under direct supervision by the VN and then given a hot meal, which they eat on the premises. Provision of food support is strictly linked to the patient’s adherence to the treatment. The soup kitchens are located in a variety of buildings – a TB dispensary, a separate room of a privately owned café or a local authority café for needy people. The TB patient is given a nutritious three-course meal of soup, main course with meat or fish and dessert such as jelly and a drink. The evaluation team visited many soup kitchens and found differing approaches to hygiene precautions. In some the TB patients are given their food by staff from the local authority after they have fed other needy people in the same room with no additional precautions. In others patients are given their meal in a canteen in the local TB dispensary with the staff wearing facemasks and there are bactericidal ultra violet lights in the room. However overall the staff in the soup kitchens was now very positive about the RC TB programme having initially had many reservations.

Due to funding shortages the cost of the meal has reduced – at the beginning of the programme in 1999 the RRC paid RuR 28 for the cost of each meal. In October 2001 this had dropped to RuR 20 but the nutritional value remained the same (2000 calories). The soup kitchens used to be open seven days a week but due to financial difficulties they now only operate five days a week. The patient does not receive any medication at the weekends. If a patient does not come for the treatment and meal the VN visits their home with the medication but no food is received.

5. In Tomsk oblast soup kitchens were not successful as it was felt there was a stigma attached to attending them and many patients were unable to travel long distances to them. Those TB patients who are able to visit the medico social rooms for their medication are given daily food parcels. These consist of tins of condensed milk and fish or meat and the cost has also reduced due to funding difficulties from RuR 31/day to RuR 24/day. The medico social rooms are open from Monday to Friday and on Fridays patients are given their drugs and food parcels for the weekend. The VN visited those patients who did not come for their
drugs bringing both the medication and daily food tins. Most of those TB patients interviewed said they shared the food at home with their families.

6. In some cases the VNs visit some patients at home on a daily basis giving the TB medication and bringing the food parcels. For those patients living in remote areas in some regions the local feldshers are asked to provide the medication and give food parcels, which are supplied by RRC.

Staff from RRC, local health services, local administration, NGOs as well as the TB patients themselves all agreed that the provision of the food by whatever method was a large motivating factor in encouraging patients to continue their treatment. As a result the default rate in the RC programme is only 3-7%.

As a direct result of the funding difficulties the number of TB patients in the RRC programme has reduced, in some areas by over 50%. All those interviewed said they had the capacity to cater for many more vulnerable TB patients if the funding issues were resolved.

When the RRC TB programme started TB patients were provided with additional social support in the form of family food packages and hygiene kits, which were distributed every three months. These have not been supplied since the funding difficulties in Kemerovo and Tomsk.

In Tomsk there have been difficulties in sourcing second hand clothes. In Kemerovo and some of the other regions patients are given second hand clothes supplied by the Swedish Red Cross. However, it is unclear if this practice can continue, as the State Commission on Humanitarian Aid has now banned duty-free importation of second hand clothes to the Russian Federation by all NGOs as humanitarian aid.

When the programme first started social support was given to many children on preventive TB treatment either by providing food to the TB sanitoria, by giving daily hot meals to the children in the soup kitchens or giving the parents daily food parcels. In May 2000 it was agreed to prioritise those TB patients from Categories 1 and 2 and only if funds allow extending the social support to other groupings. However many areas still provide some social assistance to such children. This is due to the fact that funds raised through local activities are often specifically given to help children with TB. It is felt that people are more willing to donate funds if they know they are for children.

5.6 Promoting human rights and dignity and through this minimise discrimination and stigmatisation against people with HIV/AIDS and TB and their families.

This objective was a key consideration in the development of the health information materials and the Red Cross has actively promoted the interests and rights of TB patients. A nationwide radio campaign around the time of World TB day sought to dispel myths about TB and encourage those with symptoms to seek an early diagnosis. Health promotion activities have also been held around the time of World AIDS day.

In Tomsk and Kemerovo all TB patients undergo mandatory HIV testing from the health authorities. To date the numbers of co infected TB/HIV patients has been small. However with a rapidly increasing level of HIV infection throughout the country this will change dramatically in the near future.
5.7 Strengthening the RRC Visiting Nurses Service

All nurses were trained by the Red Cross at the beginning of nursing history in Russia. The Visiting Nurses Service was established in 1960. The VNS was set up in all republics of the Soviet Union to provide professional medical and social assistance to the lonely and the handicapped. By 1990 there were almost 7000 visiting nurses in the service in Russia.

However following the collapse of the Soviet Union and the socio economic crisis the number of VNs dropped to just over 2000 by 1999. Although the VNS had been regarded as one of the key activities of the RRC by 1999 it was close to collapse due to lack of human and financial resources in some regions. One of the main objectives of the RRC TB programme was to strengthen the VNS.

When the programme started in 1999 one of the first activities was the training of VN instructors. A three-day seminar was held for key personnel from the seven pilot regions on the WHO approach to TB Control and the new role of RRC. A manual “Care of TB Patients” was produced in co-operation with CTRI/WHO for the training of VNs in TB Control activities.

About ten visiting nurses were recruited to the TB Programme in each of the seven oblasts in 1999. Many were unemployed nurses who had previously worked in institutions and most had little experience of caring for TB patients. They each attended a two-week training course, which covered the standard programme of “Basics of homecare” (10 days) and a 3-day course on “Care of TB patients”. Since then there has been ongoing training for the VNs and the regional RC staff on issues such as organisational development and fund raising. These training courses were reviewed by IFRC consultants and WHO and found to be appropriate.

However in the two oblasts visited the evaluation team found the information given to the TB patients differed between the VNs and the TB service. This particularly related to the infectiousness of the TB patient and the appropriate hygiene precautions.

Initially the VNs salaries were paid from ECHO funds. Since this funding stopped earlier this year agreements have been reached with local authorities to fund most VNs salaries with the remainder paid by funds from RRCC or locally raised funds. There was no evidence of any delay in the payment in the salaries of the VNs.

The visiting nurses were provided with kits and the MSRs were equipped for TB Control activities. Table 5 shows the numbers of VNs working in the TB programme and their funding arrangements.

<table>
<thead>
<tr>
<th>Oblast</th>
<th>Number of rayons + cities</th>
<th>Number of rayons with RRC TB programme</th>
<th>Number of VNs</th>
<th>Funded by RRC</th>
<th>Funded by local administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Archangels</td>
<td>20+2</td>
<td>7</td>
<td>12</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Astrakhan</td>
<td>11+6</td>
<td>5</td>
<td>8</td>
<td>8</td>
<td>0</td>
</tr>
</tbody>
</table>
In most regions the VNs see the TB patients in the MSR for the administration of DOT and social support is then provided. Less frequently the VNs visit the TB patients at home and bring the treatment and food parcels. If a TB patient does not come to the MSR the VN visits their home with the medication and usually they return to continue the treatment. If the TB patient is not at home the VN continues to visit the home to try to find the patient every day for fourteen days. If the patient is not found or refuses to take treatment they are then declared a drop out.

In addition the VNS is also involved in health education and fund raising activities visiting schools, colleges, workplaces and the general community giving information about TB and HIV/AIDS. This is an important role but did not take place in all areas visited.

The development of a Red Cross volunteer base has been an important component of the TB/HIV/AIDS programme. Volunteers are recruited from all sections of the community – e.g. through schools and colleges, retired health care workers and occasionally ex TB patients. Training for the volunteers has taken place raising their awareness in TB and other Red Cross programmes. Their activities are co-ordinated by the VNS. Large amount of volunteers participate in TB fundraising and education activities. The role of volunteers in the actual patient care is minimal because it requires technical skills. The volunteers provide non-medical assistance to patients, peer support, distribute food and hygiene kits and participate in fund raising activities.

There is considerable variation in the numbers of volunteers by oblast as shown in Table 6.

<table>
<thead>
<tr>
<th>Oblast</th>
<th>Number of regular volunteers</th>
<th>Number of irregular volunteers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Archangelsk</td>
<td>43</td>
<td>52</td>
</tr>
<tr>
<td>Astrakhan</td>
<td>280</td>
<td>3000</td>
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<td>Murmansk</td>
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<td>200</td>
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<tr>
<td>Pskov</td>
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<td>63</td>
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<td>Buratiya</td>
<td>10</td>
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<tr>
<td>Kemerovo</td>
<td>265</td>
<td>1243</td>
</tr>
<tr>
<td>Tomsk</td>
<td>69</td>
<td>208</td>
</tr>
<tr>
<td>Oryol</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

6. Expansion of programme

The RRC TB/HIV/AIDS programme has been successfully implemented in eight pilot regions in Russia. This is due to the following essential components – the commitment of the regional government to implement internationally approved TB guidelines and to provide an increasing level of funding and the presence of an active RRC committee with an existing VNS.
However in order to reduce TB rates priority must be given to sputum smear positive TB cases including MDR and chronic cases. Any future expansion of the programme in Russia should first include these additional groups of patients before extension to other regions.

One of the main problems in TB Control worldwide is to encourage TB patients to continue their treatment and improve compliance. The feasibility of implementing the successful RRC programme in other high prevalence countries should be explored. However it must be noted

- any intervention in TB Control is long term (10-15 years)
- starting a TB programme needs strong involvement from the Secretariat in technical, advisory and monitoring issues. With current capacities in the Secretariat and with the ongoing programmes needing a lot of attention it would be difficult to implement a TB programme outside Europe.
- almost all countries with high TB rates have adopted WHO guidelines
- many countries with high rates of TB have increasing rates of HIV/TB co-infection
- primary health care (PHC) is comparatively well developed in many 3rd world countries and the use of incentives for TB Control may adversely affect other integrated programmes
- only those TB patients who are sputum positive at diagnosis should be considered for inclusion
- the issue of who would deliver the incentives and monitor treatment needs to be looked at – does National Society have capacity, and if so, would this then take TB from integrated decentralised PHC.

7. Conclusions

Relevance

1. The Federation initiated and provided technical assistance to the Red Cross TB/HIV/AIDS programme, which is now well established in eight pilot regions. The success of the programme has shown that the International Federation has an important role in TB control and the care of TB patients.

2. Tuberculosis is a health emergency in Russia. The programme is filling a gap in the national TB care by monitoring TB care using social support as an incentive for the most vulnerable TB patients. In the same time it is advocating the internationally accepted TB guidelines, hence enforcing the work of WHO.

3. The programme follows the Federation’s Strategy 2010 especially in assisting the vulnerable and in addressing HIV/AIDS and facilitating Organisational Development and Capacity Building.

4. The TB/HIV/AIDS programme has increased the profile of the RRC and allowed other RRC programmes to expand.

5. The programme assists TB patients primarily from 1st and 2nd categories, which leaves a possibility of including patients who are smear-negative in the beginning and diagnosed only by X-ray even without clear symptoms. However, the programme has to rely on the expertise of the Russian TB doctors in diagnosing the patients as the scope of the Red Cross role is in monitoring treatment.
6. The programme offers social support only to patients who are smear-negative, because the VNPs are not insured to take care of infectious patients. Patients with multi drug resistant and chronic TB are not eligible for inclusion into the programme although many are in great need of social support.

**Effectiveness**

1. The RRC TB/HIV/AIDS programme has been successful in achieving many of the immediate objectives through the provision of adequate funding to carry out a variety of activities. The stigma against TB/HIV/AIDS patients is still strong in the Russian society.

2. The programme has had a clear impact on both RRC and TB care: As a direct result of the RRC TB programme activities the profile of RRC has been raised and this has had a positive knock on effect on other RRC programmes. The programme has strengthened the existing VNS by increasing the numbers of nurses and their skills. The number of patients diagnosed by laboratory examination has increased - although this is the responsibility of the state TB service the RRC programme provided the laboratory equipment.

3. The indicators used in the programme are detailed in Annex 1. However the evaluation team did not find background data for all the indicators and some do not give appropriate information. A suggestion for more targeted output is presented in annex 2.

4. The only measurable objective data obtained is the drop in defaulter rates. The drop out rates for TB patients receiving social support is 2-7% compared to about 20% before the programme started. The drop out rates for TB patients treated by the state TB services is much higher than in the RRC TB programme.

5. The effect of the programme on the cure rate of tuberculosis can not be measured as the Russian TB service still uses non-WHO approved criteria as indicators of cure. The programme can also not measure the number of patients diagnosed by sputum exam vs. X-ray as an indicator of its own effect, as many other agencies influence this.

6. After initial mistrust between the federal TB-service and RRC VNS there is now good cooperation in those oblasts visited and according to reports in the other pilot oblasts. In addition there is now good collaboration between the RRC TB team at Central Committee and the Federation Delegation in Russia and other national and international agencies involved in the control of TB.

7. The incidence of TB is much higher in the prison population and there are high drop out rates in ex prisoners released from prison on TB treatment. There has been ongoing cooperation between the RRC, the penitentiary system and other NGOs to ensure TB patients continue their medication on release from prison.

8. The role of the PNSs in the oblasts visited has been obscure in this current stage of the programme when the funding has been short term and non-consistent. However the Norwegian and American RCSs closely monitor the oblasts they are funding.
9. Although the programme uses the WHO approved DOTS approach the national TB service has different criteria for treatment. This leads to different interpretations and mixed messages are given to the patients e.g. regarding the level of infectiousness of TB. This is a clear obstacle, but very little can be done before the Russian health system recognises the internationally accepted TB guidelines.

10. The VNs and staff from the regional RRC have received training in all aspects of the programme but the consistency and specific areas need more attention.

**Efficiency**

11. Agreements have been signed between the RRC and the Ministry of Health and regional and local administrations in relation to the TB programme. These define the roles of each organisation and their relationships have been strengthened thus leading to higher efficiency.

12. A medical coordinator from central level manages the local VNs. There was good supervision and monitoring was well controlled but the VNs were not aware of where the funding for the programme comes from.

13. The majority (80-90%) of the funds required for the running of the programme are for the provision of the social support to the TB patients. The administrative costs are therefore relatively small indicating good cost-effectiveness.

14. A wide range of cost-effective health education materials about TB have been produced and widely distributed to patients, families and the general community. Materials and information about HIV/AIDS is less evident. Different methods have been used to give messages about the prevention and control of TB and there is widespread use of the media.

15. The decrease in funds has led to a direct reduction in the number of TB patients and VNs admitted to the programme and there have been cutbacks in many regions.

16. Financial reports seen were timely and accurate. In the financial reports there was adequate knowledge of computer programmes.

**Sustainability**

17. ECHO provided initial funding for the programme. Since this funding stopped there have been difficulties in sourcing funding from donor agencies. In addition most donor funding is short term.

18. Fund raising events by RRC and the state TB service have been held in all regions with varying levels of success. The funds collected have been used for TB control activities such as the purchase of hospital equipment and food for children on preventive TB treatment.

19. In order to achieve sustainability of the programme local funding needs to increase. The regional RRCs have drawn up development plans, which will increase the level of financial support from the regional government and local fundraising to the programme over the next three years. Some local enterprises have shown interest for longer term support of the Programme.
20. The proposed state legislation concerning charitable organisations may adversely affect the fund raising capacity of RRC.

21. The volunteers have an important role in supporting TB patients and fund raising activities. Some regional RRC have been more active in recruiting volunteers than others.

22. As the programme is planned for 10-15 years, it is difficult to determine the appropriateness of an exit-strategy. If the regional government continues to fund the majority of the programme and local RRC branches are able to take increasing responsibility of the programme, the exit-strategy should not be an obstacle.

23. Recommendations

24. Those TB patients who are sputum smear positive on diagnosis and who fulfil the social vulnerability criteria should considered to be targeted as a priority for inclusion in the programme.

25. Consideration should be given to the extension of the programme to include MDR TB and / or chronic patients. Many of these patients are in poor social circumstances and continue to infect others as they are sputum smear positive. This could be done by either giving social support to these patients through the insured national TB-service nurses or by insuring the VNs

26. The stigma against TB/HIV/AIDS is still wide-spread in Russia. Information about HIV/AIDS needs to be more widely disseminated to TB patients and their families and the general public. This will require ongoing training for the VNS and RRC staff. The link between TB and HIV/AIDS Youth Peer Education programme should be strengthened.

27. The links with the TB service in the penitentiary system should be strengthened to reduce the level of drop outs when patients are released on treatment.

28. Operational research should be carried out to document the effectiveness of the incentive that the social support provides. Publicising the success of the programme internationally would lift the profile of the Red Cross as an important player in the TB field.

29. A structured ongoing training programme should be implemented for the VNs and RRC staff using updated materials on e.g. HIV/AIDS and health education. There should be regular meetings between staff from different regions to exchange ideas and learn from differing experiences.

30. The databases used for the monitoring of the programme should be computerised and compatible with those used by the RRCS and the TB service. Sufficient training in the use of different databases should be provided.

31. The knowledge of the VNs should also include administrative aspects of the programme. The VNs should understand the structure of the programme, sources of funding and the criteria for sustainability.
32. Co-operation should be increased with HIV/AIDS centres for public education campaigns and in other relevant activities.

33. Following the end of ECHO funding a patchwork system has developed whereby the oblasts are funded by different donor organisations for short periods of time. For the programme to continue it is essential that future donor funding is secured for years to come.

34. In order to secure the long term sustainability of the programme the development plans for funding from the regional governments must be implemented and increased. Efforts should be made to source food donations from local companies to reduce costs.

35. The funds raised during National TB Day and other activities should be used for the most vulnerable TB patients. Efforts should be made to encourage companies donating funds to allow them to be used for this group to try to reduce the spread of TB.

36. The RRCS should lobby the government for an exemption from the proposed legislation on donations to charitable organisations.

37. The recruitment of volunteers should continue in order to provide patient support and public awareness activities. Special effort should be made to encourage those with a high public profile to become volunteers to promote fund raising.

38. Each of the recommendations from this evaluation should be reviewed by those implementing the programme and addressed.

Annex 1

Terms of Reference

International Federation of the Red Cross and Red Crescent Societies
Monitoring and Evaluation Division

Evaluation of support by the International Red Cross and Red Crescent Movement to the TB epidemic in Russia.

1. Background
In 1993, in response to the alarming resurgence of TB in many parts of the world, the World Health Organisation (WHO) declared tuberculosis to be a global emergency. The high prevalence rates of TB in Russia have been recognised as a serious public health problem. The IFRC and National Society response to the challenges of the TB epidemic in Russia has grown in the past number of years. Validation, collation and analysis of available data on rates of prevalence and incidence is difficult. Accordingly, available data underestimate the actual rates. However, trends in Russia indicate a three-fold increase since 1991. The situation is complicated due to wide variations in prevalence that reflect the higher rates of TB among the institutionalised, non compliers and those with drug resistance. Parallel to the spread of TB there is the dramatic rise in recent years in HIV/AIDS and STDs, and this combination tends to become a major public health threat in Russia.

In March 1999, responding to the requests of National RC Societies of Russia, Belarus, Ukraine and Moldavia an Emergency TB/HIV/AIDS/VNS Appeal was launched by the International Federation in Moscow. Based on the Appeal the Danish and British RC National Societies submitted application to
ECHO and the joint RRC/IFRC programme started in September 1999 in seven Russian regions (Murmansk, Arkhangelsk, Pskov, Astrakhan, Tomsk, Kemerovo, Buryatiya).

The programme was funded mainly by ECHO for 20 months, and since March-April 2001 it has been funded by the number of donors - PNSs (British RCS, Norwegian RCS, American RCS, Icelandic RCS). Positive results of the programme activities raised interest in the international donors and the programme since September 2000 has been expanded to the new region within the joint WHO/Red Cross TB Control programme. During the programme implementation the programme objectives and activities were permanently clarified in order to raise the programme’s effectiveness and achieve its sustainability.

During these two years regular working meetings at field level with involvement of the Federation TB Consultants, PNSs health advisers, Secretariat Health Department staff and all parties concerned took place to decide on the programme plan of action, time schedule, target groups, progress indicators, reporting, etc. and approaches to be modified and thus adopted to different requirements or circumstances in a changed environment. The programme activities were co-ordinated with the national and regional health authorities (Ministry of Health, both leading national TB Research Institutes ( CTRI, RIPP), regional TB services) and international agencies involved in TB Control in Russia (WHO, Merlin, MSF, PHRI, FILHA, NHLA,ECHO, USAID/CDC, DFID).

2. Reasons for the Evaluation
It has been planned within the Federation Appeal and Background Information document to have an interim evaluation of TB/HIV/AIDS/VNS Programme after the completion of the second year of implementation. The results from the evaluation will be used by managers and planners to assess the appropriateness, progress and implementation of the current intervention and provide information for use in the design and implementation of any future interventions.

3. Scope and Focus of the evaluation
The exercise will take note of previous information and available data form the intervention. The following issues will be addressed in the course of the evaluation exercise.

3:1 Relevance:
- Assess the relevance of the initiative for the International Federation;
- Assess the role of the Federation in the process;
- Assess the degree to which the intervention reflects problems identified by all the stakeholders;
- Assess whether the intervention is compatible with and reflective of IFRC policies, guidelines and standards (Gender, HIV/AIDS, Organisational Development and Capacity Building);
- Identify any unexpected outputs from the intervention;
- Suggest alternatives, adjustment or appropriate action to improve its relevance.

3:2 Effectiveness:
- Assess the degree to which the objectives of the intervention have been achieved;
- Determine the level of impact of the intervention;
- Identify any constraints to the achievement of intermediate and long term objectives specifically in relation to the availability of accurate baseline information and indicators;
- Assess the level of coherence, complimentarity and co-operation among all stakeholders involved in the intervention;
- Examine the working arrangements and linkages with the National Society and PNS ;
- Where appropriate, make recommendations on increasing the effectiveness of the intervention.

3:3 Efficiency:
- Examine the execution and management of the intervention and assess levels of efficiency;
Examine the cost-effectiveness of the approach;
Assess whether the inputs, budgets and costs for the intervention were adequate and reasonable in relation to the achievements of the intervention;
Assess whether systems of financial reporting and reconciliation are appropriate.

3:4 Sustainability:

Determine whether the intervention demonstrates financial and institutional sustainability particularly in terms of ongoing costs and any required capacity;
Identify the factors that may influence sustainability;
Determine the appropriateness, at this stage, of an exit strategy, reorientation or planning for future interventions.

4. Methodology, Evaluation Team and Time Schedule

4:1 Methodology
Review of IFRC/RRC documented materials;
Interviews and/or other approaches to a sample group of past and present programme beneficiaries selected on the basis of agreed criteria;
Interviews and or workshops with RRCS HQ and regional RRCS staff, as well as with the Federation Delegation programme team;
Field visits (possibly with the review team dividing up) to two programme oblasts;
Interviews with other key stakeholders - WHO, Ministry of Health, CTRI, RRPI, Merlin, MSF, Oblast TB services etc;

4:2 Evaluation Team
The team will consist of a maximum of four participants. This will include;
One participant nominated by the National Society as their representative;
One representative from the Federation Secretariat Health Department;
The team leader who will manage the process and write the report;
A specialist in Infectious Diseases to provide technical guidance;
The requirement of a translator will be assessed at a later stage.

Potential consultants will be sought for the role(s) of the team leader and specialist in infectious diseases. The team leader will write the report and have significant expertise in development initiatives preferably within the health sector(s) and specifically within an Eastern European context. Detailed knowledge of the aetiology, pathogenesis and current treatment regimes for TB will be required. Identification and selection of the consultant(s) will be undertaken jointly by the Evaluation Department and the Health Department in consultation with the National Society. Selection will be based on the quality of response to the TORs, availability and cost.

4:3 Time Schedule
The exercise will be implemented in early October 2001. Consultant identification and selection will take place in late August and early September. The schedule will be agreed as far as possible in advance to facilitate the logistics and administrative needs of the National Society and IFRC Secretariat.

5: Reporting and Feedback
The Consultant(s) will be required to produce a draft report within two weeks return from the country visit. The team will produce an aide-memoire for discussion at a debriefing in Russia prior to departure. The final report will be presented in electronic format and will include a stand-alone executive summary. The report will be brief and concise and meet the needs of all stakeholders. Final
reporting to the IFRC secretariat may also include a presentation of findings and conclusions in Geneva.

Annex 2
Annex 3
## Annex 4

### List of Key Informants

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
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<tbody>
<tr>
<td><strong>Federation Delegation</strong></td>
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</tr>
<tr>
<td>Mr Alasdair Gordon Gibson</td>
<td>Head of Delegation</td>
</tr>
<tr>
<td>Ms Gunilla Fargus</td>
<td>Programme Coordinator</td>
</tr>
<tr>
<td>Dr Yelena Yurasova,</td>
<td>Health Coordinator</td>
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<td>Ms Yelena Tanskova</td>
<td>Health Assistant</td>
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<td><strong>Russian Red Cross Central Committee</strong></td>
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<td>Ms Ludmilla Potravnova</td>
<td>President</td>
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<td>Mr Boris Ionov</td>
<td>First Vice President</td>
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<td>Mr Oleg Chesnov</td>
<td>RRCS Director General</td>
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<td>Dr Valentina Shishkina</td>
<td>Head of Programmes</td>
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<td>Dr Veronika Agapova</td>
<td>Medical Co-ordinator</td>
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<td>Ms Marina Lubeznova</td>
<td>Finance Manager</td>
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<td>Mr Igor Shirokov</td>
<td>Social Manager</td>
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<td><strong>World Health Organisation</strong></td>
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<td>Dr Wieslaw Jakubowiak</td>
<td>WHO TB Representative in Russia</td>
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<tr>
<td>Dr Hans Kluge</td>
<td>TB Manager for USAID-funded project</td>
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<td><strong>UNAIDS</strong></td>
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<td>Mr Arkadiusz Majsyk</td>
<td>UNAIDS Representative</td>
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<td><strong>Department for International Development</strong></td>
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<tr>
<td>Ms Yelena Tkachenko</td>
<td>Health Adviser</td>
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</table>
Finnish Embassy
Ms Helena Kuivila  Co-ordinator of Technical Assistance

Norwegian RCS/ RRC
Mr Andrei Novikov  Co-ordinator of Bilateral Projects

Tomsk
Ms Vera Bayerlen  Chairperson RCC
Ms Lidia Pleshakova  Executive Director RCC
Ms Klavdia Polishchuc  Financial Manager
Ms Svetlana Baskakova  Social Manager
Ms Elena Khaidarova  Senior Visiting Nurse
Ms Oksana Gulyayeva  Secretary
Ms Ludmila Bolotinkova  Visiting Nurse
Ms Aleftina Kapenko  Visiting Nurse
Dr Sergei Ilyin  State TB Doctor
Dr Vasili Borin  Head Doctor, Central Regional Hospital
Dr Gennady Peremitin  Head Physician, TB Dispensary
Dr Evgeny Andreev  Head of Health Care Department, Tomsk Penitentiary
Dr Sergey Mishustin  Head Doctor, TB Dispensary, Tomsk Penitentiary
Mr Alexander Pasechnikov  Public Health Research Institute Programme, Tomsk
Dr Vera Golubchikova  Deputy Head Doctor, Tomsk Oblast TB Dispensary
Ms Vera Pavlova  Head of Laboratory Services, Oblast TB Dispensary
Dr Olga Sharaburova,  First Deputy Head Doctor Tomsk Oblast TB Dispensary
Mr Andy Gale  Programme Manager, MERLIN

Kemerovo
Ms Elena Malakhova  Executive Director, Regional Committee, RRC
Dr Vera Porfirma  Chairperson RCC
Ms Valentina Matvianko  Deputy Chairperson RRC
Dr Yelena Ivanova  Assistant Medical Co-ordinator
Ms Natalya Ryabikova  Finance Manager
Ms Galina Veritinikova  Senior Visiting Nurse
Dr Mikhail Chernov  Acting Head Doctor Oblast TB dispensary
Dr Natalia Stachinkova  Chief TB Doctor Penitentiary Service
Dr Andrei Slavuckij  Medical Co-ordinator MSF
Dr Dominic Lafontaine  Project Co-ordinator MSF
Dr Lara Lobera  Civil Project Co-ordinator MSF

Novokutznetsk
Mr Vladimir Rokkel  Deputy Mayor for Social Issues
Mr Alexander Shadrin  Head of Health Authority
Ms Tatyana Maoirova  Chairperson RRC
Dr Boris Karpinski  Head Doctor
Dr Sergei Slogin  Deputy Head Doctor
Dr Irina Zakharova  Deputy Head Doctor
Ms Vera Tavrovskaya  Head Red Cross Coordinator
Dr Lidia Vdovina  Head Physician, Local Health Authority

Prokofyevsk
Dr Galina Nkitina  Head Doctor TB hospital
Dr Octyabrina Sivalnyana  Head Doctor TB dispensary
Ms Nadazhda Kamzyczagova  Deputy Head Health Authority
Mr Ivan Garifulin  Chairman RRC
Ms Elena Borodenko  Visiting Nurse
Ms Ludmilla Dodchenko  TB dispensary
Mid Term Evaluation Report of International Federation of the Red Cross and Russian Red Cross Tuberculosis, HIV/AIDS, Visiting Nurses Service Programme October 2001

Kisilevsk
Ms Aleftina Geranina  Deputy Head Local Authority
Ms Lydia Labanova  Chairman of Town Committee
Dr Vitaly Lopatun  Paediatrician and Member of Health Authority
Dr Svetlana Koldyshkina  Head Doctor TB dispensary
Dr Galina Ivanova  Doctor TB dispensary
Ms Anna Kauter  Visiting nurse

Yurga
Mr Nikolai Lyapin  First Deputy Mayor
Mr Alexei Irtikeyev  Deputy Mayor Social Issues
Dr Victor Saposhkov  Deputy Mayor Health Care
Ms Nadia Smirnova  Chairperson RRC
Dr Yuri Costenko  Head Doctor TB Services
Dr Vera Sapaskova  Head Doctor TB Dispensary
Ms Lybov Uslamina  Visiting Nurse
Ms Nadia Silkina  RC volunteer

Other Oblasts
Ms Anzhelika Ishmakova  Social Manager, Pskov
Dr Elena Bonarenko  Medical Co-ordinator, Pskov
Ms Anna Agapitova  Social Manager, Murmansk
Dr Tatyana Ankudinova  Medical Co-ordinator, Murmansk
Ms Elen Kinarova  Social Manager, Astrakhan
Dr Elena Bobrova  Medical Co-ordinator, Astrakhan

Annex 5

Programme

Sunday 14 October  Arrive Moscow

Monday 15 October
900  Meeting with Federation Delegation Staff
1  Meeting with RRCC Staff
1  Meeting with Federation and RRCC Staff

Tuesday 16 October
900  Planning of field visits
1400  Meeting with WHO TB Programme Staff
2200  Flight to Tomsk

Wednesday 17 October
0600  Arrive Tomsk
0830  Accommodation at hotel
1400  Meeting with Tomsk RRC staff
  Visit medicosocial room

Thursday 18 October
0930  Visit to Shigarskii rayon
1400  Visit to Kozhevnicheskii rayon

Friday 19 October
0930   Visit to homes of TB patients with VNS
1430   Meeting with staff from Oblast TB dispensary staff and
       penitentiary TB service
1600   Meeting with staff from MERLIN

Saturday 20 October
1000   Debriefing with RRC staff
1500   Travel to Kemerovo

Sunday 21 October
               Reading and report preparation

Monday 22 October
0730   Travel to Novokutznetsk
1130   Visit to TB Dispensary
       Meeting with Novokutznetsk City Administration
4      Meeting with RRC staff
       Travel to Prokofyevsk

Tuesday 23 October
0930   Meeting with RRC staff
1000   Meeting with TB Doctors and Visit to soup kitchen
1001   Travel to Kisilevsk
       Meeting with local administration
1430   Programme monitoring, visit to soup kitchen
1431   Travel to Kemerovo

Wednesday 24 October
0900   Meeting with staff from Oblast TB dispensary penitentiary TB
       service and MSF
1100   Travel to Yurga
1101   Meeting with city administration
1102   Programme monitoring
1103   Travel to Kemerovo
       Debriefing with RCC staff

Thursday 25 October
0900   Flight to Moscow
1200   Meeting with UNAIDS representative
1201   Preparation for workshop

Friday 26 October
1000   Presentation and discussion of findings at workshop for staff from
       IFRC, RCC and donor agencies
1001   Debriefing for Head of Delegation, IFRC
1400   Report preparation
Annex 6

Glossary

AIDS  Acquired Immunodeficiency Syndrome
CDC  Center for Disease Control
CTRI  Central Tuberculosis Research Institute
DfID  Department for International Development
DOTS  Directly Observed Treatment Short course
ECHO  European Community Humanitarian Organisation
Feltsher  Medical Officer (between a nurse and a doctor)
FILHA  Finnish Lung Health Association
HIV  Human Immunodeficiency Virus
IFRC  International Federation of Red Cross and Red Crescent Societies
MDR TB  Multi Drug-Resistant TB
MERLIN  Medical Emergency Relief International
MoH  Ministry of Health
MoJ  Ministry of Justice
MSF  Medecins Sans Frontieres
MSR  Medical-Social Room, RRCS premises for DOTS distribution
NGO  Non Governmental Organisation
NLHA  Norwegian Lung Health Association
Oblast  Region
PHC  Primary Health Care
PHRI  Public Health Research Institute
PNS  Participating National Society
Rayon  District
RRC  Russian Red Cross Society
RRCC  Russian Red Cross Central Committee
RIPP  Research Institute of Phthysiopulmonology
RCS  Red Cross Society
RuR  Russian Ruble
STD  Sexually Transmitted Disease
TB  Tuberculosis
TB-dispensary Like MSR, but a part of federal TB-service
TB-service System for ambulatory TB treatment, in civil sector led by MoH and in prison sector by MoJ
UNAIDS United Nations Programme on AIDS/HIV
USAID United States Aid
VN Visiting Nurse
VNS Visiting Nursing Service
WHO World Health Association

Annex 7