Report of the Asian National Stop TB Partnership Forum 2016

The Stop TB Partnership Japan

The Asia Stop TB Partnership Forum 2016 was held in Tokyo, Japan, on 14 and 15 March, 2016. Following is the summary report of the presentations and discussions in the Forum meeting.

Main theme

Community people's roles in End TB Strategy in Asia

Purposes of the Forum

To bring together the delegates of Stop TB Partnerships (or similar non-governmental organizations, e.g., Anti-Tuberculosis Association)) of Asian countries / territories, and to discuss over the current non-governmental efforts against tuberculosis, their perspectives into the near future, with special emphasis on the roles of women, and possibility of its strengthening, and collaboration between partnerships across borders, aiming at the earlier achievement of End TB Target in Asia.

Expected Outcomes

1. To enhance people's awareness of the importance of their ownership for and commitment with the tuberculosis control activities
2. To promote the effective collaboration between governmental and non-governmental sectors in the fight against tuberculosis
3. To clarify the problems and challenges of tuberculosis control of each country / area and to develop action plan addressing them with non-governmental efforts
4. To deepen the understanding of the potentiality of women's efforts in the community activities
5. To advance cooperation between partners of different countries / territories

Date

14 and 15, March, 2016

Venue

United Nations University, Shibuya, Tokyo (14, March)

Research Institute of Tuberculosis, JATA, Kiyose, Tokyo (15, March)

Participants

A total of 18 participants representing non-governmental organizations of 8 countries / territories were invited (see Appendix 1). In addition, there were 26 observers from various governmental and non-governmental institutions / groups, including Ministry of Foreign Affairs and JICA.

Agenda and Results

1. Opening and Introduction of Participants and Staff
   Chair: Dr. Toru Mori (Executive Board Representative, Stop TB Partnership Japan)

2. Lecture 1: 14 March (United Nations University)
   Thema: Women's Anti-TB Activities in Japan
   Lecturer: Ms. Takeko Yamashita
   Secretary General, Japanese Council of women's Anti-TB Associations
   Abstract (see Appendix 2)

3. Lecture 2: 14 March (United Nations University)
   Thema: Challenges of Current TB Problem to Today's Asia
   Lecturer: Dr. Nobuyuki Nishikiori
   Coordinator, Stop TB and Leprosy Elimination, WPRO, WHO
   Abstract (see Appendix 3)

4. Courtesy visit and exchange with Japanese Council of Women's Anti-TB Associations members, 14 March (Hotel New Otani, the venue of Annual National Assembly of the Council)

5. Presentation and discussion of activities of Country / Territory partnerships: 14 and 15 March (Research Institute of TB)
   Chair: Dr. Kosuke Okada (Director, International Cooperation, Japan Anti-TB Association)
   (See Appendix 4)

6. Group Discussion 1: 15 March (Research Institute of TB)
   Thema : Challenges to NGO's activities and women's roles
   Moderator: Dr. Nobukatsu Ishikawa (Director, Research Institute of TB, JATA)

(See Appendix 5)

7. Group discussion 2 : 15 March (Research Institute of TB)
   Thema: Fund raising plan in the community activities
   Moderator: Ms. Jintana Ngamvitayapong-Yanai (TB-HIV Research Foundation, Thailand)
   (See Appendix 6)

8. Adoption of the Forum Statement: 15 March (Research Institute of TB)
   Chair: Dr. Toru Mori (Executive Board Representative, Stop TB Partnership Japan)
   (See Appendix 7; Tokyo Statement of Asian National Stop TB Partnership Forum 2017)

9. Reception: 15 March (Research Institute of TB)
   Special Guest: Mr. Kintaro Shibuya, Mayor of Kiyose City

Appendix 1

List of Participants

Country /Territory	Name	Affiliation
Cambodia	Khloeung Phally	Deputy Director of National Center for Tuberculosis and Leprosy Control (CENAT)
	Monyrath Chry	Program manager of Cambodia Anti-Tuberculosis Association(CATA)
	Chharvy Ringsey KEO	Cambodia Anti-Tuberculosis Association(CATA)
Indonesia	Mariani Reksoprodjo	Head Quarter/ Executive Secretary of Forum Stop TB Partnership Indonesia
	Fitriani Manan	Board member of Stop TB Partnership Cimahi City
Korea	Seungjoon Chang	Executive Director of Stop TB Partnership Korea , Korean National Tuberculosis Association(KNTA)
	Kanghee Kim	Chief of Stop TB Partnership Korea, Korean National Tuberculosis Association(KNTA)
	Hong Jo Choi	Korean institute of tuberculosis(KIT)
Myanmar	Tha Zin Nwe	Chairperson of Myanmar Maternal Welfare Association(MMWA)
	Ei Ei Chaw	State TB Officer of National Tuberculosis Program, Kachin State, Myitkyinar
Nepal	Ram Sharan Gopali	Country Representative of Japan-Nepal Health & TB Research Association RIT(JANTRA)／JATA Nepal Office
	Jamuna Panthi	Board member of JANTRA
Philippines	Aurora G. Querri	Deputy Executive Director of RIT/JATA, Philippines, Inc.(RJPI)
	Leonardo G. Parungo Jr	Administrative Officer of RIT/JATA, Philippines, Inc.(RJPI)
Taiwan	Chih-Yun Lin	Research Assistant of Tuberculosis MDR Department, Chang-Hua Hospital/Anti-TB Association(TATA)
	Wei-Wen Chen	Chang-Hua Hospital MDR TB Department/Anti-TB Association(TATA)
Thailand	Luangjina Sarmwai	Secretary of THRF, Member of the Chiang Rai Volunteer Ladies against TB/

	Jintana Ngamvitayapong-Yanai	President of TB/HIV Research Foundation (THRF)

Appendix 2

Abstract of Lecture 2

Beautiful Health: Introduction of Japanese Women's Anti-TB Association

- The 30-year history of the Japanese Women's Fight against TB –

Origin The Association (Officially: Council of Japanese Women's Anti-TB Associations) dates back to the foundation of the Women's Committee of Nagano City in July 1950, when there was an opportunity for the leaders of the women's association of Nagano City to have an audience with Princess Chichibu, who was then the President of the Japan Anti-TB Association (JATA). The Princess inspired them to dedicate themselves to TB control.

The anti-TB movement of Nagano was further stimulated by a tuberculosis (TB) outbreak that occurred in September of the same year. The TB epidemic broke out in a primary school of a town of Nagano Prefecture. This incident ignited the women's activity to eliminate TB from their community and homes.

This movement developed into an organization covering the entire prefecture of Nagano by 1957, the Nagano council of Women's Anti-TB Association, as the very first organization of this kind in Japan.

Development The movement to eliminate TB through the wisdom and efforts of housewives has been further expanded. It became increasingly active and has been materialized as the All Japan Housewives' Convention for Healthy Family, and the Leaders' Seminar of Women's Anti-TB Association. A poster for Anti-TB Week adopted the slogan, "The Housewife is a key person in TB prevention."

In 1975, the National Women's Anti-TB Association was established. It was approved as a corporate juridical person in 1977 and has become the largest women's health organization in Japan. In 1996, the Association celebrated its 20th anniversary. The Association has come a long way, extending activities all over Japan, responding to the changing time and situation, as the largest women's health movement in Japan.

During these several decades, deaths due to TB that used to be feared as a non-curable illness, have decreased drastically. This may be ascribed to the efforts of related organizations and authorities, as well as the activities of the women's Association. To disseminate ideas of TB prevention and its motivation, the Association

continues its activities at the grass-roots level, as an organization for protecting people's health.

Liaison with JATA The National Assembly of TB Prevention of JATA has been held every year since 1949. This assembly discusses what to do in the non-governmental anti-TB activities and how to address their current challenges. The Women's Association supports this assembly and is actively involved in planning and implementing this event. The National Assembly is also the venue for the Women's Association to convene for the Annual Convention Meeting and the Annual Board Meeting to discuss the future agenda of the Association.

National Seminar The National Seminar of the Women's Ant-TB Association was launched in 1997. The seminar provides the opportunity for learning about TB and other related public health issues and also for exchanging information among members. Having acquired new knowledge and information in the course, the participants became more aware of the importance of community activities for communication with the people.

Local Leader's Seminar Such achievements as these could be reflected in the local leaders' seminar in a total of seven areas of Japan, as bases for local associations' guidelines, which in turn will be a source of their community activities.

Advocacy in Community The Association actively targets the communication and advocacy activities on TB prevention not only for the family but for the society in general. Public information media such as leaflets and brochures have been developed in order to disseminate the ideas and knowledge of TB prevention to children and adults. Regarding actions toward local governments, the Association members pay courtesy visits to governors/mayors to appeal for strengthening the public TB control services. Such grass-roots activities of women are significant for disseminating knowledge of TB and for increasing the awareness of the people, and can also help to fill any gaps in governmental services.

Fund Raising The Association has been involved in fund raising as a means of talking about TB prevention directly to the people. In cooperation with the JATA branch of prefectures, the Association runs the double-barred cross-seal campaign for fund-raising all over Japan during the TB Prevention Week, i.e., during the 4th week of September. Indeed, the women's activities provide important support for the double-barred-cross seal campaign. The double-barred-cross seal campaign was

initiated in the beginning of the 20th century in Denmark as the Christmas Seal Campaign and now has now become a symbol of TB prevention worldwide. In Japan, JATA has devoted itself to this program since 1952 with the support of the government to promote TB control with the support and cooperation of the general public and in partnership with foreign countries.

The funds raised by this campaign are an important source for supporting JATA's activities. The Women's Association plays the most vital role in this campaign, contributing about 30% of the total funds raised. The funds thus raised by this campaign are spent for the various activities of JATA for the sake of people's health.

International Cooperation: Study Tour An important area of activity supported by the fund from the campaign is international cooperation. JATA's international cooperation includes its unique grass-roots project that is a long-lasting program with promoting DOTS as its core. The study-tour is a group tour for the members of the Association who are involved in fund raising to become more aware of the TB situation of developing countries. The tour is a good opportunity to understand the significance of the seal campaign vividly and is a source of energy for future activity. The program of the study tour was launched in 1994, and since then, we have visited TB project sites, such as Nepal and Myanmar, and we visited Cambodia in 2006.

The Association's cooperation has been extended to the national anti-TB associations of developing countries that are faced with various difficulties in TB control.

TB control takes a long time to bear fruit and needs a solid organizational basis with financial assistance. In this context, the seal campaign can be a great help for people of developing countries, and it proved surely useful.

Publication "Health Circle" is the official journal of the Association intended to transmit the newest knowledge of tuberculosis and public health in general to the Association members, and to strengthen the partnership among members. The journal was first published in 1977 and is now issued three times every year (40,000 copies each). This communication paper is distributed not only to the Association members, but also widely to related organizations throughout Japan, such as JATA branches; the Ministry of Health, Labour and Welfare; and Prefectural and Local governments and Public Health Centers to broadly report the activities of the Women's Association.

The Way Forward Thirty years have passed since the foundation of the

Association as a corporate juridical person. Its contribution to TB control in Japan has been indispensable. However, TB still has not been eliminated. The emergence of multidrug-resistant TB, the upsurge of TB among elderly persons and urban youngsters -- -- -- all these issues are complicating the TB problem, and we should address them properly. Also, we need to address the increasing life-style related illnesses and newly emerging respiratory diseases.

Globally, over 1.5 million people lose their lives due to TB every year. In order to contribute to the worldwide fight against TB, the Association joined the Stop TB Partnership Japan. The Women's Anti-TB Association is steadily endeavoring to achieve its purpose. Its current slogan is: health management throughout the life of the people through promoting control of TB and life-style related illnesses so that people can enjoy a happy and healthy life. This slogan was adopted in the 58th National Anti-TB Assembly. Thus, the women are determined to lead the national movement for the people to maintain their own health.

Appendix 3
Presentation of Dr Nishikiori

"Challenges of Current TB Problem to Today's Asia"

Regional Framework for Action
on Implementation of the End TB Strategy
in the Western Pacific Region

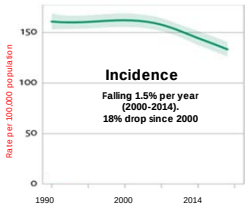
The Asian National Stop TB Partnership Forum,
14–15 March 2016, Tokyo, Japan

Dr Nobu Nishikiori, Coordinator
Stop TB and Leprosy Elimination
World Health Organization
Regional Office for the Western Pacific

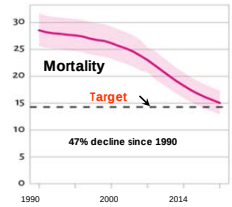
MDG6 TB target achieved

43 million lives saved between 2000 and 2014

TB EPIDEMIC REVERSED



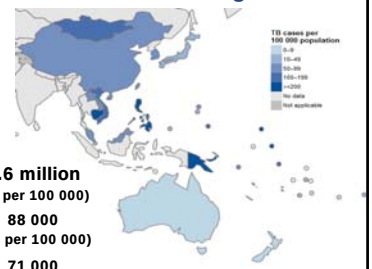
47% DROP IN TB MORTALITY



But huge burden of deaths and suffering remains.
9.6 million people fell ill with TB in 2014, and there were 1.5 million deaths

Surpassing MDGs and other targets in the Western Pacific Region

TB burden in the Western Pacific Region

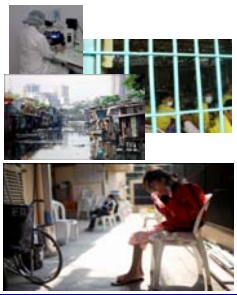


Estimate number of TB (all forms)	1.6 million (85 per 100 000)
Estimated number of deaths due to TB*	88 000 (4.8 per 100 000)
Multidrug-resistant TB	71 000
HIV-associated TB	31 000

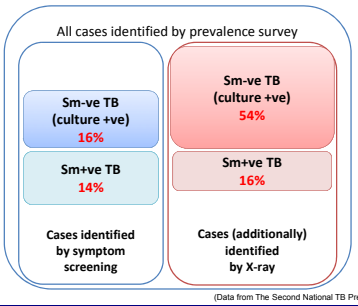
All estimates are for 2014.
Source: Global TB Report 2015 (WHO)
* Excluding death due to TB-HIV co-infection

Challenges

1. Many patients unreached
2. Insensitive diagnostics
3. Vulnerable and high-risk groups
4. Only a small fraction of MDR-TB patients diagnosed, yet treatment capacity insufficient
5. Limitations in health systems

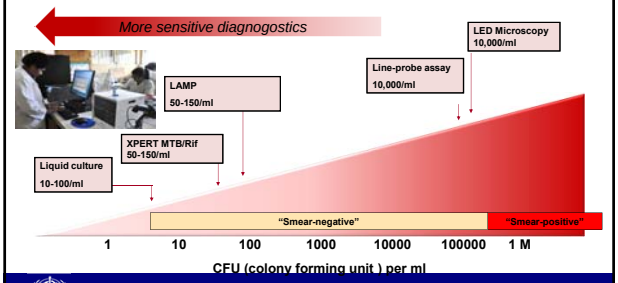


Increasing difficulty in TB diagnosis



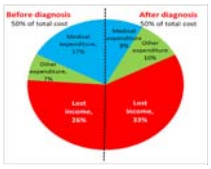
(Data from The Second National TB Prevalence Survey, Cambodia, 2011)

Need for more sensitive diagnostics



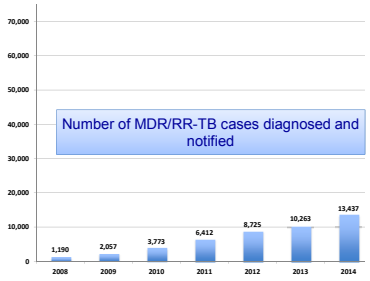
Financial hardship of TB patients and families ~ losing a half of annual income ~

- TB patients in low-and middle-income countries face expense equivalent to more than 50% of their annual income.
- A half of the costs are incurred before TB treatment
- Patients often have to resort to coping mechanisms that may be irreversible:
  - up to 75% of TB patients must take out a loan;
  - up to 50% sell household items; and
  - up to 66% rely on financial support from relatives.
- Addressing catastrophic patient cost is prerequisite for further advancing TB control



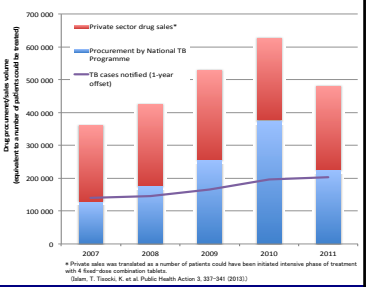
Distribution of medical expenditures, other expenditures and income loss, before and during TB treatment

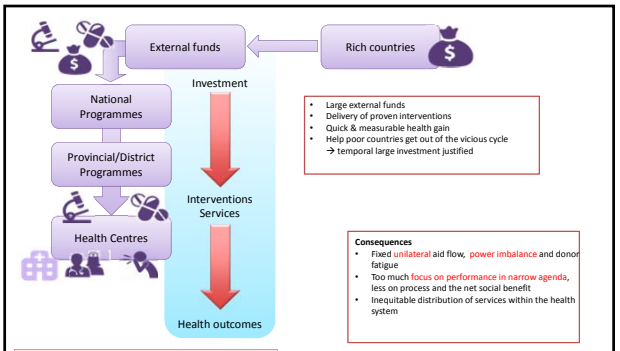
MDR-TB diagnosis, enrolment vs estimated in the Western Pacific Region



TB drugs in the private sector market

- **Growing evidence on a huge private sector drug market**
  - Public procurement sufficient for all notified TB case (Blue bar and line)
  - Private sector drug sales are almost equivalent to the notified TB cases (Red bar)
  - **Five times more drugs for initial treatment** relative to drugs for continuous phase
- **Reflecting:**
  - A weak notification system
  - Incomplete treatment in the private sector
  - Unnecessary patient costs





Health development model in the MDG era

The End TB Strategy

Draft Regional Framework for Action

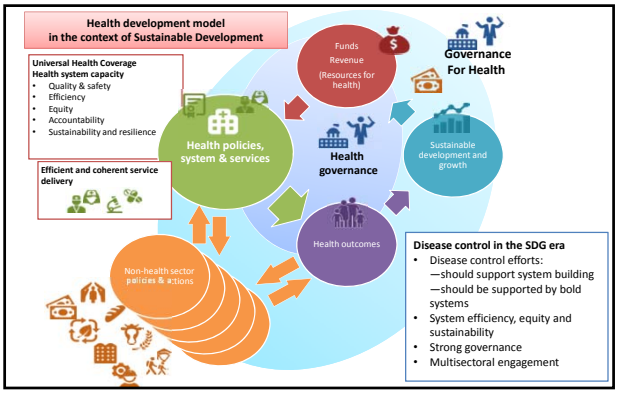
World Health Organization Regional Office for the Western Pacific

Global commitment to End TB

Moving from halting TB to ending TB by 2030

SDG 3.3 "End the epidemics of AIDS, tuberculosis, malaria and neglected tropical Diseases"

World Health Organization | GLOBAL TB PROGRAMME | END TB



END TB Vision, goal, targets, milestones

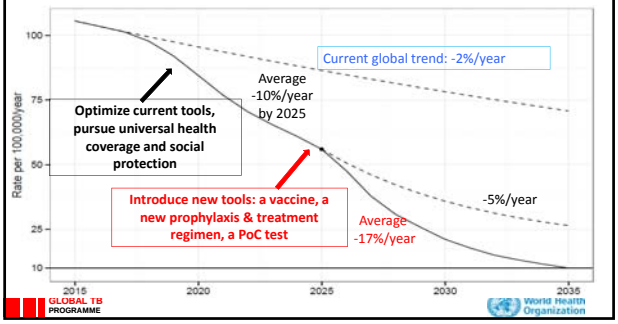
Vision:
A world free of TB
Zero TB deaths,
Zero TB disease, and Zero TB suffering

Goal:
End the Global TB epidemic

	MILESTONES 2020	MILESTONES 2025	TARGETS SDG* 2030	TARGETS END TB 2035
Reduction in number of TB deaths compared with 2015 (%)	35%	75%	90%	95%
Reduction in TB incidence rate compared with 2015 (%)	20%	50%	80%	90%
TB-affected families facing catastrophic costs due to TB (%)	0%	0%	0%	0%

World Health Organization | GLOBAL TB PROGRAMME | END TB

Projected acceleration of TB incidence decline to target levels



END TB The End TB Strategy: 3 pillars and 4 principles

World Health Organization | GLOBAL TB PROGRAMME | END TB

Regional Framework for Action on Implementation of the End TB Strategy

Purpose

- Facilitate the adaptation and implementation of the End TB Strategy

Structure and contents

- Follow the same three-pillar structure with 7 components
- Each component composed of:
  - Strategy
  - Regional situation
  - Proposed actions
- Region specific issues:
  - High risk groups, opportunities for social protection, urban TB control, co-morbidity management

Endorsed by Member States in 66th RCM in Oct 2015

Regional Framework for Action

Pillar 1: Integrated, people-centred care and prevention

1. Treatment and care for all TB patients
   - MDR-TB
   - TB among children
   - High-risk populations (enhancing contact investigation)
   - TB/HIV
   - Co-morbidities
2. TB laboratory networks
3. Latent TB infection and BCG vaccination

Pillar 2: Bold policies and supportive systems

1. Governance and stewardship
   - NSP and TB control financing
   - UHC policy and TB control
   - Drug regulatory systems
   - Disease notification and surveillance systems
2. Engagement of public and private providers
3. Addressing social determinants and social protection

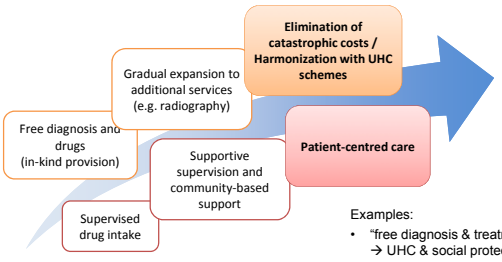
Pillar 3: Research

- Enhancing TB research capacity

Attributes highlighted and elaborated

- Paradigm shift in TB control
- Apply health system strategies and concepts
- Covering the whole epidemiological spectrum
- People-centred care

Paradigm shift in TB control



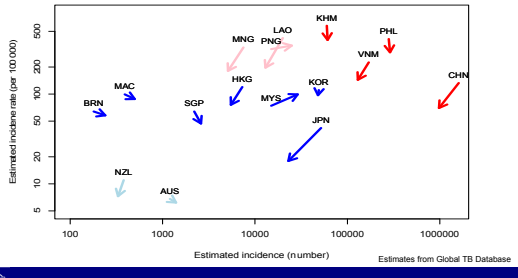
Examples:

- "free diagnosis & treatment" → UHC & social protection
- DOT → Patient-centred care

Key areas elaborated

- People centered care → Principle
  - WPRO/SEARO 2007 Policy Document
- Co-morbidity management
  - Link with ageing societies
- TB care financing in the context of UHC
  - WPRO's policy framework on sustainable financing for priority health programmes
- Social protection floor
  - ILO Recommendation R202
- Social determinants
  - HiAP & Urban TB control

Changes in TB incidence between 1994-2013



Estimates from Global TB Database

Evolution of the TB control components along with an epidemiological spectrum

High burden → Low incidence → Pre-elimination → Elimination

Pillar 1. Quality TB services	
e.g. Basic / resource constraint →	Comprehensive / fully satisfy the standards of care
e.g. Contact investigation: Facility-based → home-based → active epi. investigation	
e.g. LTBI: PLHIV/Childhood contacts →	Expansion to other high risk groups
Pillar 2. Bold support systems (vertical/top-down → sustainable & integrated)	
e.g. Surveillance: Basic system →	Electronic / case-based system
	Link with lab. info system → gene/molecular surveillance
e.g. Social protection: enablers → income compensation → comprehensive health-welfare link	

* Only selected components are shown for the illustrative purpose.

Three tiers of actions

Spectrum of TB epidemiology

High burden → Low incidence → Pre-elimination

Progressive actions towards elimination

Universally applicable actions for all settings

Setting specific considerations (e.g. Pacific islands, urban areas)

TB control as a global public good for health

- Public goods—e.g. safe drinking water, clean air, etc.
- TB control has been regarded as a classic example of "a public good for health"
  - TB control in one setting will benefit everybody
  - Collective (global/regional) TB control is impacted by the level of control achieved in the worst national TB program (the weak link characteristics)
- This principle is a key for continued advocacy for sustainable public financing as well as cross-country collaboration

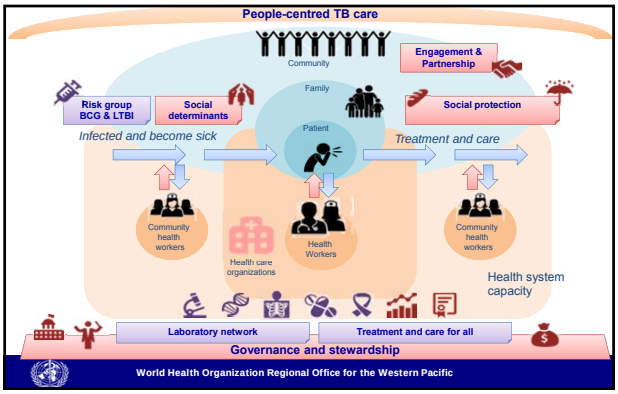
Smith R., Beaglehole R., Woodward D., Drager N. (ed.) Global Public Goods for Health: health economics and public health perspectives.

A vision beyond DOT: People-centred health care

- Health care that is organized around patients, families and communities
- Responding holistic needs of patients, rather than the needs of programmes or systems
  - Medical, psychological, social, and financial
  - Strong service coordination

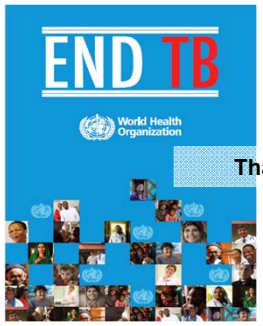
Action domains

1. Informed and empowered patients, families and communities
2. Competent and responsive health workers
3. Efficient and humane health care organizations
4. Supportive health systems



Summary

- Substantial achievement in TB control globally
- Remaining and emerging challenges
  - TB among high-risk and vulnerable populations
  - Scaling up response to drug-resistant TB
  - Building sustainable TB control system while contributing to the overall health system strengthening efforts
- The End TB Strategy and its Regional Framework opened up new era of TB control
  - From a vertical programme to "an essential health system competency"
  - People-centeredness as a core principle
  - All countries to be aligned and cooperate for regional/global TB control



Regional Framework for Action on Implementation of the End TB Strategy in the Western Pacific, 2016–2020

Thank you!

Appendix 4

Country Presentations

1. Epidemiological Data (Cited from WHO: Global TB Report 2015, and others)

Cambodia ■ Population 2014 **15 million**

Estimates of TB burden[a] 2014

	NUMBER (thousands)	RATE (per 100 000 population)
Mortality (excludes HIV+TB)	8.9 (6.3–12)	58 (41–78)
Mortality (HIV+TB only)	0.82 (0.63–1)	5.3 (4.1–6.7)
Prevalence (includes HIV+TB)	100 (87–120)	668 (565–780)
Incidence (includes HIV+TB)	60 (54–66)	390 (353–428)
Incidence (HIV+TB only)	1.8 (1.6–2)	12 (10–13)
Case detection, all forms (%)	72 (66–80)	

Estimates of MDR-TB burden[a] 2014

	NEW	RETREATMENT
% of TB cases with MDR-TB	1.4 (0.7–2.5)	11 (4–22)
MDR-TB cases among notified pulmonary TB cases	330 (160–590)	200 (73–400)

TB case notifications 2014

	NEW[b]	RELAPSE
Pulmonary, bacteriologically confirmed	12 168	445
Pulmonary, clinically diagnosed	11 286	709
Extrapulmonary	18 310	141

Total new and relapse	**43 059**
Previously treated, excluding relapses	679
Total cases notified	**43 738**

Among 43 059 new and relapse cases:
12 050 (28%) cases aged under 15 years; male:female ratio: 1.2

Reported cases of RR-/MDR-TB 2014

	NEW	RETREATMENT	TOTAL[b]
Cases tested for RR-/MDR-TB	646 (5%)	1 329 (67%)	1 975
Laboratory-confirmed RR-/MDR-TB cases			110
Patients started on MDR-TB treatment[c]			110

TB/HIV 2014

	NUMBER	(%)
TB patients with known HIV status	35 635	(81)
HIV-positive TB patients	953	(3)
HIV-positive TB patients on co-trimoxazole preventive therapy (CPT)	938	(98)
HIV-positive TB patients on antiretroviral therapy (ART)	938	(98)
HIV-positive people screened for TB	3 504	
HIV-positive people provided with IPT	901	

Treatment success rate and cohort size

	(%)	COHORT
New and relapse cases registered in 2013	(93)	35 536
Previously treated cases, excluding relapse, registered in 2013	(90)	1 701
HIV-positive TB cases, all types, registered in 2013		
RR-/MDR-TB cases started on second-line treatment in 2012	(79)	110
XDR-TB cases started on second-line treatment in 2012		

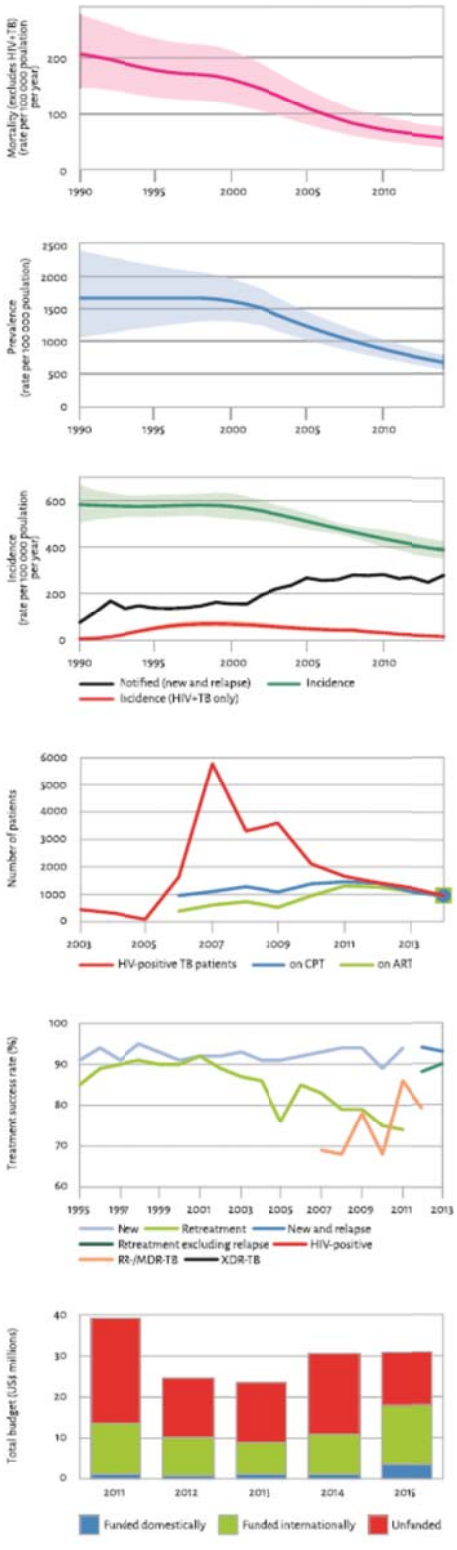
Laboratories 2014

Smear (per 100 000 population)	1.4
Culture (per 5 million population)	1.3
Drug susceptibility testing (per 5 million population)	1.0
Sites performing Xpert MTB/RIF	17
Is second-line drug susceptibility testing available?	No

Financing TB control 2015

National TB programme budget (US$ millions)	31
% Funded domestically	12%
% Funded internationally	47%
% Unfunded	42%

Data are as reported to WHO. Estimates of TB and MDR-TB burden are produced by WHO in consultation with countries.
[a] Ranges represent uncertainty intervals.
[b] Includes cases with unknown previous TB treatment history.
[c] Includes patients diagnosed before 2014 and patients who were not laboratory-confirmed as having RR-/MDR-TB.



Data for all years can be downloaded from www.who.int/tb/data

Indonesia ■ Population 2014 **254 million**

Estimates of TB burden[a] 2014

	NUMBER (thousands)	RATE (per 100 000 population)
Mortality (excludes HIV+TB)	100 (66–150)	41 (26–59)
Mortality (HIV+TB only)	22 (13–32)	8.5 (5.2–13)
Prevalence (includes HIV+TB)[b]	1 600 (1 300–2 000)	647 (513–797)
Incidence (includes HIV+TB)	1 000 (700–1 400)	399 (274–546)
Incidence (HIV+TB only)	63 (41–90)	25 (16–36)
Case detection, all forms (%)	32 (23–46)	

Estimates of MDR-TB burden[a] 2014

	NEW	RETREATMENT
% of TB cases with MDR-TB	1.9 (1.4–2.5)	12 (8.1–17)
MDR-TB cases among notified pulmonary TB cases	5 600 (4 200–7 400)	1 100 (770–1 600)

TB case notifications 2014

	NEW[c]	RELAPSE
Pulmonary, bacteriologically confirmed	193 321	6 449
Pulmonary, clinically diagnosed	101 991	1 391
Extrapulmonary	19 653	1

Total new and relapse	**322 806**
Previously treated, excluding relapses	1 733
Total cases notified	**324 539**

Among 322 806 new and relapse cases:
23 170 (7%) cases aged under 15 years; male:female ratio: 1.4

Reported cases of RR-/MDR-TB 2014

	NEW	RETREATMENT	TOTAL[b]
Cases tested for RR-/MDR-TB	1 058 (<1%)	8 445 (88%)	9 503
Laboratory-confirmed RR-/MDR-TB cases			1 812
Patients started on MDR-TB treatment[d]			1 284

TB/HIV 2014

	NUMBER	(%)
TB patients with known HIV status	15 074	(5)
HIV-positive TB patients	2 355	(16)
HIV-positive TB patients on co-trimoxazole preventive therapy (CPT)	963	(41)
HIV-positive TB patients on antiretroviral therapy (ART)	624	(26)
HIV-positive people screened for TB		
HIV-positive people provided with IPT		

Treatment success rate and cohort size

	(%)	COHORT
New and relapse cases registered in 2013	(88)	325 582
Previously treated cases, excluding relapse, registered in 2013	(64)	1 521
HIV-positive TB cases, all types, registered in 2013	(49)	2 438
RR-/MDR-TB cases started on second-line treatment in 2012	(54)	432
XDR-TB cases started on second-line treatment in 2012	(64)	11

Laboratories 2014

Smear (per 100 000 population)	2.2
Culture (per 5 million population)	0.4
Drug susceptibility testing (per 5 million population)	0.3
Sites performing Xpert MTB/RIF	41
Is second-line drug susceptibility testing available?	Yes, in country

Financing TB control 2015

National TB programme budget (US$ millions)	133
% Funded domestically	13%
% Funded internationally	21%
% Unfunded	66%

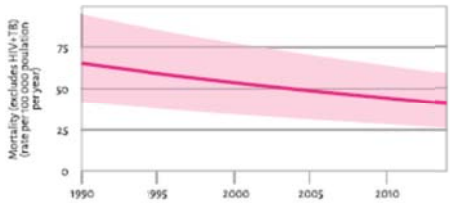
Data are as reported to WHO. Estimates of TB and MDR-TB burden are produced by WHO in consultation with countries.

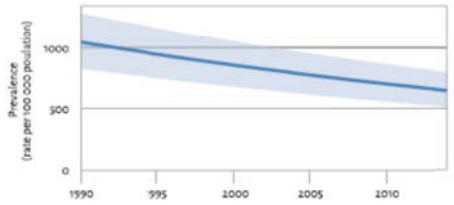
[a] Ranges represent uncertainty intervals.

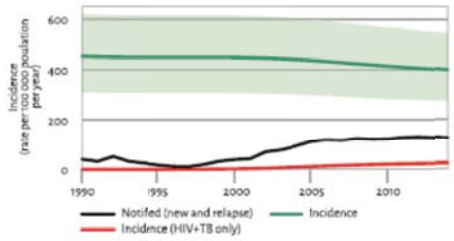
[b] The prevalence rate of bacteriologically confirmed TB was 531 (421–655) per 100 000 population; the prevalence rate of clinically diagnosed TB (i.e. smear-negative and culture-negative TB, including all extra-pulmonary cases) was 116 (91–143) per 100 000 population; the prevalence rate of extra-pulmonary TB (a subset of those in the clinically diagnosed category) was 58 (43–75) per 100 000 population.

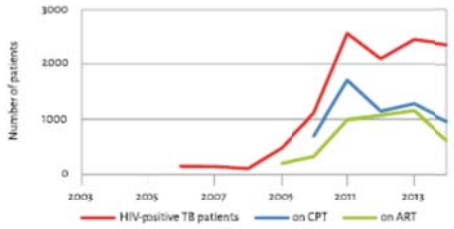
[c] Includes cases with unknown previous TB treatment history.

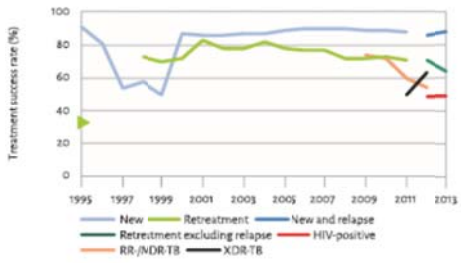
[d] Includes patients diagnosed before 2014 and patients who were not laboratory-confirmed as having RR-/MDR-TB.

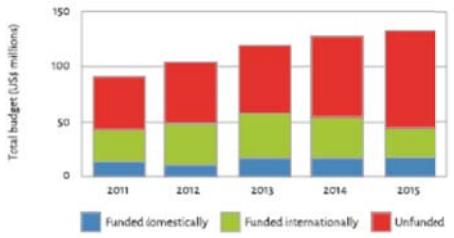












Data for all years can be downloaded from www.who.int/tb/data

Myanmar ■ Population 2014 **53 million**

Estimates of TB burden[a] 2014

	NUMBER (thousands)	RATE (per 100 000 population)
Mortality (excludes HIV+TB)	28 (20–37)	53 (38–70)
Mortality (HIV+TB only)	4.1 (3.3–5.1)	7.7 (6.1–9.5)
Prevalence (includes HIV+TB)	240 (190–310)	457 (352–575)
Incidence (includes HIV+TB)	200 (180–220)	369 (334–406)
Incidence (HIV+TB only)	19 (15–24)	36 (28–44)
Case detection, all forms (%)	70 (64–78)	

Estimates of MDR-TB burden[a] 2014

	NEW	RETREATMENT
% of TB cases with MDR-TB	5 (3.1–6.8)	27 (15–39)
MDR-TB cases among notified pulmonary TB cases	5 600 (3 500–7 700)	3 400 (1 900–4 900)

TB case notifications 2014

	NEW[b]	RELAPSE
Pulmonary, bacteriologically confirmed	42 608	5 276
Pulmonary, clinically diagnosed	70 305	3 650
Extrapulmonary	16 108	405

Total new and relapse	**138 352**
Previously treated, excluding relapses	3 605
Total cases notified	**141 957**

Among 138 352 new and relapse cases:
36 301 (26%) cases aged under 15 years; male:female ratio: 1.6

Reported cases of RR-/MDR-TB 2014

	NEW	RETREATMENT	TOTAL[b]
Cases tested for RR-/MDR-TB	10 295 (24%)	15 166 (117%)	26 240
Laboratory-confirmed RR-/MDR-TB cases			3 495
Patients started on MDR-TB treatment[c]			1 537

TB/HIV 2014

	NUMBER	(%)
TB patients with known HIV status	56 133	(40)
HIV-positive TB patients	6 412	(11)
HIV-positive TB patients on co-trimoxazole preventive therapy (CPT)	4 666	(73)
HIV-positive TB patients on antiretroviral therapy (ART)	5 749	(90)
HIV-positive people screened for TB	54 178	
HIV-positive people provided with IPT	2 997	

Treatment success rate and cohort size

	(%)	COHORT
New cases registered in 2013	(87)	135 614
Previously treated cases registered in 2013	(71)	7 147
HIV-positive TB cases, all types, registered in 2013		
RR-/MDR-TB cases started on second-line treatment in 2012	(79)	443
XDR-TB cases started on second-line treatment in 2012		

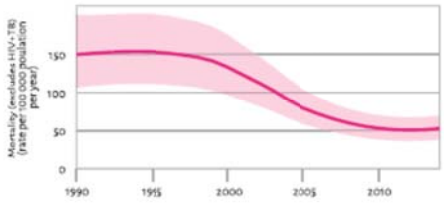
Laboratories 2014

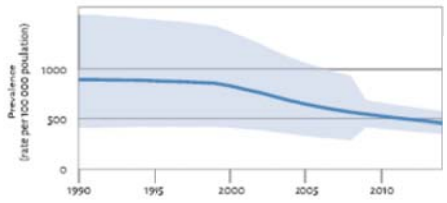
Smear (per 100 000 population)	0.9
Culture (per 5 million population)	0.3
Drug susceptibility testing (per 5 million population)	0.2
Sites performing Xpert MTB/RIF	38
Is second-line drug susceptibility testing available?	Yes, outside country

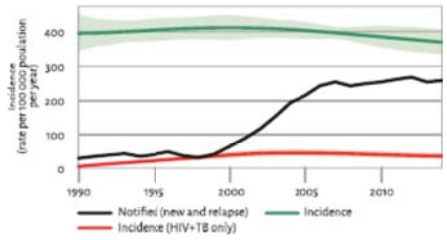
Financing TB control 2015

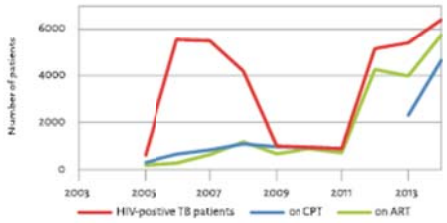
National TB programme budget (US$ millions)	36
% Funded domestically	11%
% Funded internationally	67%
% Unfunded	22%

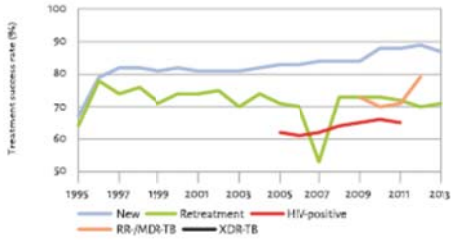
Data are as reported to WHO. Estimates of TB and MDR-TB burden are produced by WHO in consultation with countries.
[a] Ranges represent uncertainty intervals.
[b] Includes cases with unknown previous TB treatment history.
[c] Includes patients diagnosed before 2014 and patients who were not laboratory-confirmed as having RR-/MDR-TB.

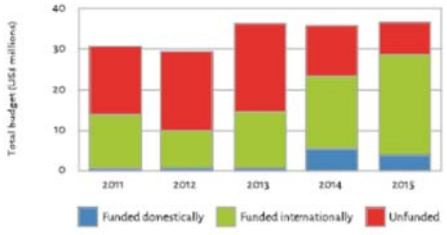












Data for all years can be downloaded from www.who.int/tb/data

Philippines ■ Population 2014 **99 million**

Estimates of TB burden[a] 2014

	NUMBER (thousands)	RATE (per 100 000 population)
Mortality (excludes HIV+TB)	10 (9–11)	10 (9.1–11)
Mortality (HIV+TB only)	0.08 (0.055–0.11)	0.08 (0.06–0.11)
Prevalence (includes HIV+TB)	410 (360–470)	417 (367–471)
Incidence (includes HIV+TB)	290 (250–320)	288 (254–324)
Incidence (HIV+TB only)	2.5 (2–3.2)	1.6 (2–3.2)
Case detection, all forms (%)	85 (76–97)	

Estimates of MDR-TB burden[a] 2014

	NEW	RETREATMENT
% of TB cases with MDR-TB	2 (1.4–2.7)	21 (16–29)
MDR-TB cases among notified pulmonary TB cases	4 600 (3 300–6 300)	6 500 (4 700–8 700)

TB case notifications 2014

	NEW[a]	RELAPSE
Pulmonary, bacteriologically confirmed	52 991	6 277
Pulmonary, clinically diagnosed	139 950	
Extrapulmonary	4 161	

Total new and relapse	**243 379**
Previously treated, excluding relapses	24 057
Total cases notified	**267 436**

Among 97 578 new and relapse cases:
12 191 (12%) cases aged under 15 years; male:female ratio: 1.8

Reported cases of RR-/MDR-TB 2014

	NEW	RETREATMENT	TOTAL[b]
Cases tested for RR-/MDR-TB	4 415 (5%)	20 196 (67%)	27 287
Laboratory-confirmed RR-/MDR-TB cases			3 000
Patients started on MDR-TB treatment[c]			2 680

TB/HIV 2014

	NUMBER	(%)
TB patients with known HIV status	53 354	(20)
HIV-positive TB patients	108	(<1)
HIV-positive TB patients on co-trimoxazole preventive therapy (CPT)	20	(19)
HIV-positive TB patients on antiretroviral therapy (ART)	53	(49)
HIV-positive people screened for TB	5 995	
HIV-positive people provided with IPT		

Treatment success rate and cohort size

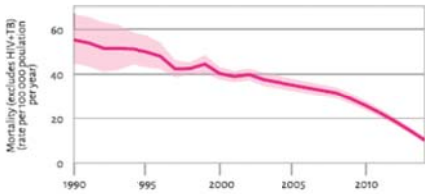
	(%)	COHORT
New and relapse cases registered in 2013	(90)	216 250
Previously treated cases, excluding relapse, registered in 2013	(86)	2 924
HIV-positive TB cases, all types, registered in 2013		
RR-/MDR-TB cases started on second-line treatment in 2012	(43)	1 798
XDR-TB cases started on second-line treatment in 2012	(10)	10

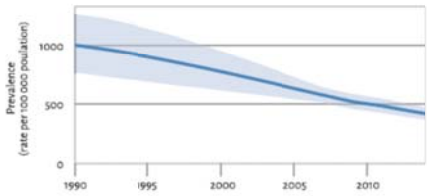
Laboratories 2014

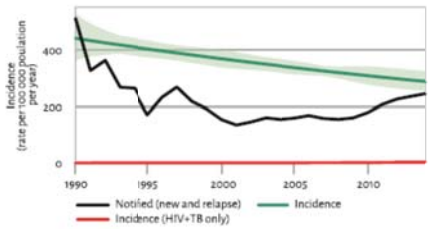
Smear (per 100 000 population)	2.6
Culture (per 5 million population)	1.1
Drug susceptibility testing (per 5 million population)	0.2
Sites performing Xpert MTB/RIF	84
Is second-line drug susceptibility testing available?	Yes, in country

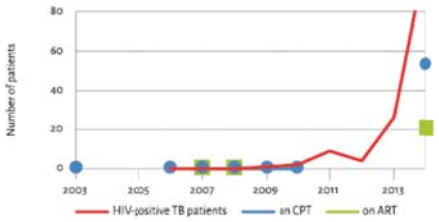
Financing TB control 2015

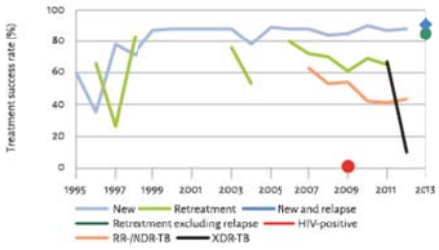
National TB programme budget (US$ millions)	106
% Funded domestically	23%
% Funded internationally	39%
% Unfunded	37%

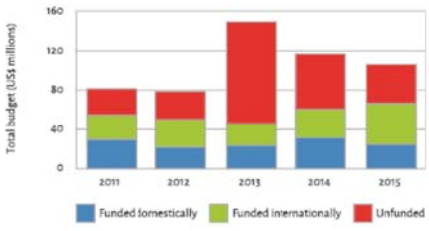












Data are as reported to WHO. Estimates of TB and MDR-TB burden are produced by WHO in consultation with countries.

[a] Ranges represent uncertainty intervals.
[b] Includes cases with unknown previous TB treatment history.
[c] Includes patients diagnosed before 2014 and patients who were not laboratory-confirmed as having RR-/MDR-TB.

Data for all years can be downloaded from www.who.int/tb/data

Thailand ■ Population 2014 **68 million**

Estimates of TB burden[a] 2014

	NUMBER (thousands)	RATE (per 100 000 population)
Mortality (excludes HIV+TB)	7.4 (3.9–12)	11 (5.7–18)
Mortality (HIV+TB only)	4.5 (2.3–7.4)	6.6 (3.4–11)
Prevalence (includes HIV+TB)	160 (110–220)	236 (161–326)
Incidence (includes HIV+TB)	120 (61–190)	171 (90–276)
Incidence (HIV+TB only)	15 (7.8–24)	22 (12–36)
Case detection, all forms (%)	59 (36–110)	

Estimates of MDR-TB burden[a] 2014

	NEW	RETREATMENT
% of TB cases with MDR-TB	2 (1.4–2.8)	19 (14–25)
MDR-TB cases among notified pulmonary TB cases	1 100 (780–1 600)	1 100 (800–1 500)

TB case notifications 2014

	NEW[b]	RELAPSE
Pulmonary, bacteriologically confirmed	34 394	1 969
Pulmonary, clinically diagnosed	21 115	0
Extrapulmonary	10 244	0

Total new and relapse	**67 722**
Previously treated, excluding relapses	3 896
Total cases notified	**71 618**

Among 34 394 new cases:
119 (<1%) cases aged under 15 years; male:female ratio: 2.5

Reported cases of RR-/MDR-TB 2014

	NEW	RETREATMENT	TOTAL[b]
Cases tested for RR-/MDR-TB	4 370 (13%)	2 209 (18%)	9 580
Laboratory-confirmed RR-/MDR-TB cases			506
Patients started on MDR-TB treatment[c]			

TB/HIV 2014

	NUMBER	(%)
TB patients with known HIV status	50 670	(71)
HIV-positive TB patients	6 831	(13)
HIV-positive TB patients on co-trimoxazole preventive therapy (CPT)	4 359	(64)
HIV-positive TB patients on antiretroviral therapy (ART)	4 691	(69)
HIV-positive people screened for TB		
HIV-positive people provided with IPT		

Treatment success rate and cohort size

	(%)	COHORT
New and relapse cases registered in 2013	(81)	65 867
Previously treated cases, excluding relapse, registered in 2013	(66)	1 812
HIV-positive TB cases, all types, registered in 2013	(67)	7 665
RR-/MDR-TB cases started on second-line treatment in 2012		
XDR-TB cases started on second-line treatment in 2012		

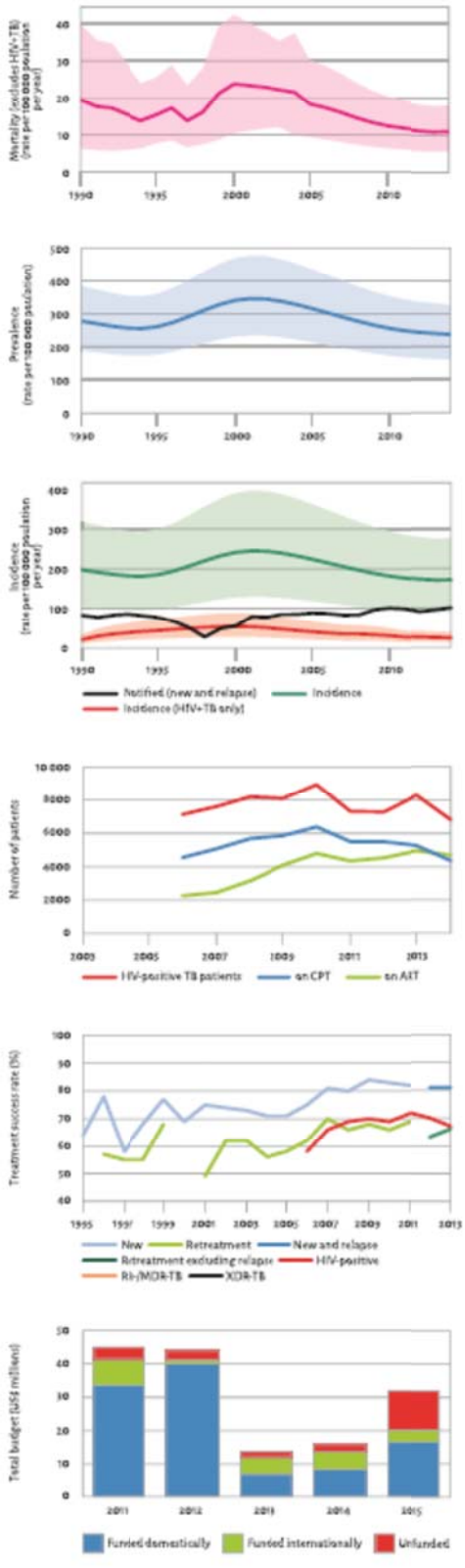
Laboratories 2014

Smear (per 100 000 population)	1.3
Culture (per 5 million population)	3.9
Drug susceptibility testing (per 5 million population)	1.5
Sites performing Xpert MTB/RIF	14
Is second-line drug susceptibility testing available?	Yes, in country

Financing TB control 2015

National TB programme budget (US$ millions)	32
% Funded domestically	52%
% Funded internationally	11%
% Unfunded	37%

Data are as reported to WHO. Estimates of TB and MDR-TB burden are produced by WHO in consultation with countries.
[a] Ranges represent uncertainty intervals.
[b] Includes cases with unknown previous TB treatment history.
[c] Includes patients diagnosed before 2014 and patients who were not laboratory-confirmed as having RR-/MDR-TB.



Data for all years can be downloaded from www.who.int/tb/data

TB Statistics of Non-High Burden Countries (2014)

			Nepal		Korea		Taiwan		Japan	
Population (1000)			28		50				127	
Incidence (Estimate)	include. HIV	Number	44	39 - 50	43	41 - 46			23	20 - 26
		Rate	158	139-178	86	81-91			18	16 - 21
	HIV+ only	Number	1.5	1.2 - 1.9	0.51	0.44 - 0.59			0.099	0.089 - 0.12
		Rate	5.4	4.2 - 6.7	2.6	2.2 - 3.0			<0.1	<0.1-<0.1
Mortlity		Number	5.3	3.7 - 7.1	1.9	1.8 - 2.1	609		2.2	2.2 - 2.3
		Rate	19		3.8	3.6 - 4.1	2.6		1.8	1.7 - 1.8
Case detection Rate (%)					93	88 - 99			84	75 - 96
MDT-TB (%)		New			2.7	2.1 - 3.4	3.2		0.7	0.42 - 1.1
		Retreatment	15	10 - 23	14	10 - 19	8.2		9.8	7.1 - 13
		Survey year	2,011		2,004		2005 - 2011		2,002	
Case notification	New & Relapse	Number	35,277		40,190		11,326		19,615	
		Rate	125		80		48		15	
	New, Pulm, bacteriol confirmed		15,947		18,784				12,120	
	New, Pulm Clincal		8,445		9,350				2,061	
	New, Extrapulmonary		8,583		6,987				4,255	
Treatment success (2013 Cohort)		%	91		82		65		54	
		Cohort size	33,877		40,794				15,941	

Note : For Taiwan the data are for 2014 for notification, 2013 for mortality, and 2012 for Treatment results.
For Nepal, Korea and Japan figures are based on Global Tuberculosis Report 2015 (WHO).

Presentation and discussion of activities of partnerships

Cambodia Anti-TB Association
Cambodia

About CATA (1)

1. **Background:**
   Cambodia Anti-Tuberculosis Association(CATA), a local NGO established in 2003, as a TB professional association of individual and institution committed to contribute to the fight against TB in Cambodia.

2. **Vision:**
   Make Cambodia free from TB and Lung Disease.

Stop TB Partnership JAPAN

Asian National Stop TB Partnership Forum
"Community people's roles in End TB Strategy in Asia"
United Nation University, Tokyo, Japan
14 and 15 March, 2016

Dr. Khloeung Phally
Mr. Chry Monyrath

About CATA (2)

3. Mission

Coordinate and advocate for TB free Cambodia and ensure social and community enabling environment through:

- Promoting the institution and the individual to involve in Stop/End TB strategy
- Information sharing, research and capacity building
- Promoting the quality of effective prevention, early detection and treatment of Tuberculosis and Lung disease
- Strengthening the effective enforcement of relevant laws, policies and guidelines.

TB Burden in Cambodia

- Cambodia is still one of the 22 HBC with TB in the world
- Incidence rate of TB all forms in 2014 is 390/100,000*.
- Prevalence rate of TB all forms in 2014 is 668/100,000*.
- Prevalence rate of Sm+ for age 15 and over in 2011 is 272/100,000.
- Death rate 58/100,000*

* Global report 2015

About CATA (3)

4. Goal

Strengthening the coverage and quality of TB services by increasing commitment of the institution and the individual and promoting the social and community environment.

Current Projects

Project Name	Coverage Area
Public-Private Mix-DOT in Factory (work place)	14 Factories, Phnom Penh
Active Case Finding among Elderly and other Vulnerable Communities	12 Operational Districts in 8 Provinces.

TB Control in Factory (2)

2. Current Methods:

- Trained peers to conduct peer contact activities.
- Conduct follow up (FU) meetings with peers
- Refer suspected TB case from factory to public health center
- Implement DOT in factories (work place)

(1)
TB Control in Factory (PPM-DOT)

TB Control in Factory (3)

3. Results:

- 14 garment factories were implemented.
- 11,553 workers were contacted by peer educators (11 months).
- 12 sessions of FU were conducted
- 108 TB suspects referred to HC (11mths).
- 10 TB cases registered (5s+, 4s- and 1EP) for treatment by DOT in factory (11 months).

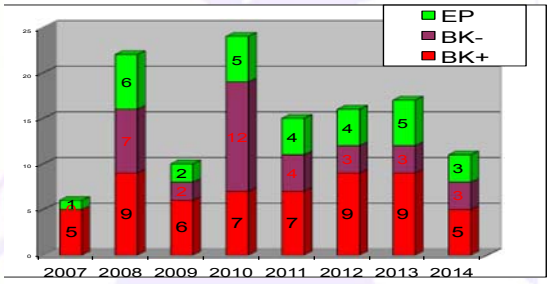
TB Control in Factory (1)

1. Background:

- Factories, the poor ventilated settings where thousands of workers work and share room air are at high risk for TB
- Patients with TB symptoms may receive symptomatic treatment at the factories as factory clinics support only primary health care, leading to diagnostic delay.
- Untreated, some one with chronic TB may face being dismissed from employment due to frequent absenteeism , and bring additional hardship to the vulnerable family.

TB Control in Factory (4)

4. Cases notified by TB types/years



TB Control in Factory (5)

5. Lesson Learnt:

- Lack of awareness raising activity, the discrimination among workers might be not reduced leading to less number of referral
- Limited budget for FU meeting with Peers is the cause of less peers' activity.
- TB patients can work regularly during the course of treatment(in the exception of 1st month therapy of smear positive cases).
- In congregated settings, one case treated can prevent hundreds of co-workers from TB

Active Case Finding (2)

2. Methods:

- Active case finding using mobile teams equipped with a chest x-ray (CXR) and Xpert machine in 12 Operational Districts.
- 1 to 2 weeks before field operation, each health centre was visited for one day by the team:
  - Volunteers performed door to door **symptom screening** prior to CXR screening day.
  - TB suspects with a positive **CXR were then tested by Xpert** MTB/RIF assay
  - TB cases were registered and put on **treatment**
- Elderly were primarily targeted.
- Project yield and TB notification data were analysed to assess impact on treatment initiation.

(2)
Active Case Finding
Among Elderly & Other
Vulnerable Community

Active Case Finding (3)

3. Results (1):

Indicators	Year 1 (2014)			Year 2 (2015)		
	Annual Planned Target	Achieved Target	%	Annual Planned Target	Achieved Target	%
1) #of people screened	113735	68846	61%	57810	56996	99%
(2) #of TB suspects	21840	11995	55%	16830	16043	95%
(3) #of people tested by TB X ray.	18055	11650	65%	15810	12147	77%
(4) #of TB suspects tested by Gene Xperts.	3276	2520	77%	3478	2084	60%
(5) #of people confirmed as SS +/B+ (yield SS+/B+)	663	397	60%	557	334	60%
(6) #of people confirmed as TB all forms (yield all forms)	1243	1064	86%	1265	1094	86%

Active Case Finding (1)

1. Backgrounds:

- TB burden in Cambodia has decreased by > 50% by end 2015 compared to 1990 data.
- Cambodia still one of the highest TB prevalence in the world
  - Prevalence all form : 668 cases/100,000 population
  - Prevalence survey in 2011, TB burden in elderly is ≥3time higher than the general population.
  - Prevalence/Notification ratio in >55 years = 1.5
- Hypothesis: poor access to TB diagnosis and treatment

Active Case Finding (4)

3. Results (2):

- 12 operational districts visited.
- 193 health facilities visited.
- 23,797 individuals screened by CXR.
- 4,604 (19.0%) individuals were tested using the Xpert MTB/RIF assay,
- Resulting in the detection of 731 (16%) MTB-positive patients.
- Total cases : 2158 (MTB positive + others)

Active Case Finding (4)

3. Results (3): New bacteriologically-positive notifications increased +119.2% for all ages and +262.7% for those ≥55 years during the ACF quarters compared to trend expected notifications.

Changes in new Bac+ and All Forms of TB treatment initiation and reporting in 4 Operational Districts of Year 1

	Patients Detected (Project Yield)	Actual Intervention Quarter Notifications	Trend Expected Intervention Quarter Notifications	Additional Notifications	Additional Notifications to Yield Ratio
New Bac+, All Ages	319	399	182	217 (+119.2%)	68.00%
Ang Roka	35	58	24	34 (+141.7%)	97.10%
Battambong	68	115	56	59 (+105.4%)	86.80%
Kong Pisey	110	105	45	60 (+133.3%)	54.50%
Sampovmeas	106	121	57	64 (+112.3%)	60.40%
New Bac+, ≥55 Years	231	243	67	176 (+262.7%)	76.20%
Ang Roka	29	34	8	26 (+325.0%)	89.70%
Battambong	62	61	13	48 (+369.2%)	66.70%
Kong Pisey	68	71	24	47 (+195.8%)	69.10%
Sampovmeas	62	77	22	55 (+250.0%)	88.70%
All Forms of TB, All Ages	893	1,232	653	579 (+88.7%)	73.10%
Ang Roka	98	152	68	84 (+122.4%)	69.40%
Battambong	230	445	196	249 (+126.6%)	85.20%
Kong Pisey	318	344	245	99 (+40.3%)	77.00%
Sampovmeas	247	291	143	148 (+103.6%)	57.90%

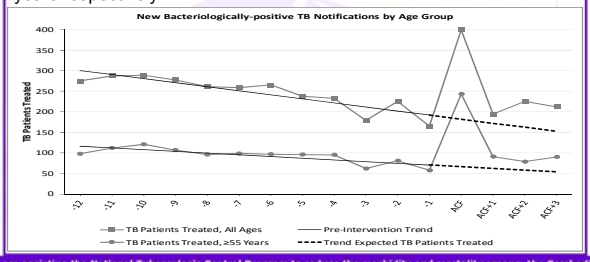
Active Case Finding (6)

4. Lesson Learnt (2):

- The conditions to replicate and expand the successful strategy are:
  - The combination of the team 1 and team 2 to work together for:
    - Increasing the number screened by CXR,
    - Saving fuel needed to supply 2 generators that operated separately.
    - Minimizing interruption of the operation due to unsafe power supply.
  - Procure a set of new CR machine to avoid interruption due to Prima console system error or broken.

Active Case Finding (4)

3. Results (4): NTP notifications in intervention period compared to expected notifications based on 3 year trend:New Bac+ notifications were +54.0% and +109.2% higher than expected for all ages and ≥55 years respectively.



Active Case Finding (7)

4. Lesson Learnt (3):

- The strategy used is likely appropriate for ACF but there are some constraints factors as following:
  - Road conditions are bad due to rainy season, causing difficulty to reach the HCs, leading to implementation time is short.
  - Elderly need to look after their grandchildren at home and sometime cannot come to HCs.
- The project screens/tests a lot of patients per day for a long period of time, so it may cause to damage the material. To avoid that and ensure the project run smoothly, CATA seeks fund to buy new equipment especially CR and X-ray machine for security.

Active Case Finding (5)

4. Lesson Learnt (1):

- The factors contributing to the success are the involvement from stakeholders and the trust to the project for its new technology, and quick diagnosis.
- The conditions for success to be continued are: 1) proper maintenance of all equipment to avoid being broken during implementation,
  2) well calculation and implementation of project's resources supplied and demand
  3) continue providing transport cost to the poor and those who live far away from HCs, and; 4) The use of communication skills and incentive provided to all stakeholders for better involvement is still key factors for success.

Active Case Finding (8)

5. Conclusion:

- ACF using mobile teams was able to increase access to TB diagnosis, especially the elderly people.
- Compare to baseline data, the intervention can detect and treat many patients who previously missed routine TB services.
- We recommend to consider targeted ACF interventions in other settings where access to diagnosis and treatment is limited.

Thank You for Your Attention

Presentation and discussion of activities of partnerships

Forum Stop TB Partnership Indonesia

Indonesia

...Indonesia...

Indonesia is the biggest archipelago in the world that consist of 17,000 islands.

It also comprises administratively of :

- 34 Provinces-416 districts and 98 cities-7,094 subdistricts-8,412 hamlets and 74,093 villages

forum Stop TB Partnership Indonesia

presented during

"THE ASIAN NATIONAL
STOP TB PARTNERSHIP FORUM",
14 and 15 March 2016,
Tokyo, Japan

prepared by:

Drg Mariani Reksoprodjo & Dr Fibriani Manan

...Indonesia...

Current result :

Stop TB Partnership is only available in :

- 1 city in west java province
- 1 city and 2 districts in east java province
- 4 districts in south Sulawesi Province

Based on those data, it is significantly obvious that "our homeworks" remain so many to accomplish.

Indonesia

Area : 1,913,578.68
Population : 254,826,034

Systematic Presentation

1. Name and Legal Corporate Status
2. Short History
3. Relationship with Other Organizations
4. Members:
   Membership, Current Members

...Systematic ...

5. Purposes
6. Activities
7. Current Challenges

Name and Legal Corporate Status

Name: FORUM STOP TB PARTNERSHIP INDONESIA (FSTPI)

Status: Meanwhile, it remains temporarily as a Forum. Chairman of FSTPI is attempting to make the FSTPI a legal organization and formally registered to the Ministry of Legal and Human Rights, Republic of Indonesia

... History...

- Address of Secretariat: Jalan Sultan Iskandar Muda No. 66A
  Kebayoran Lama Utara
  Jakarta Selatan
  DKI Jakarta, Indonesia

  Phone / Fax: +62 21 739 74 94
  Website: www.stoptbindonesia.org
  Twitter: @StopTBIndonesia
  Facebook: StopTBIndonesia

- 3 -4 March 2014: Host for The 2nd Forum of National Stop TB Partnership in South-East Asia, West Pacific and East Mediterranian Region

  This meeting was attended by 13 out of 14 invited countries (Myanmar regretted to come) and they were:

Short History

- **30 May 2013:** FSTPI was officially established and launched in Jakarta.
  This is a partnership group consisting of diverse organizations and individuals who have similar commitment in dealing with TB problems

- **October 2013:** Operational Guideline on FSTPI was published

... History...

- → SEA: India, Bangladesh, Thailand Nepal and Indonesia
- → WP: China, Philippines, Cambodia, Vietnam, South-Korea and Japan
- → EM: Pakistan and Afghanistan

...RELATIONSHIP...

5. Professional Organizations
   - *Indonesian Medical Doctor Association*
   - *Indonesian Internist Association*
   - *Indonesian Lung Doctor Association*
   - *Indonesian Pediatric Association*
   - *Indonesian Public Health Educators Association*
   - *Indonesian National Nurses Association*
   - *Indonesian Pharmacists Association*
   - *Indonesian Midwives Association*
   - *Indonesian Blood Transfusion Technician Association*
   - *Indonesian Medical Laboratory Technology Expert Association*

RELATIONSHIP WITH OTHER ORGANIZATIONS & MEMBERS: *MEMBERSHIP, CURRENT NUMBER*

Based on the List of FSTPI members at central level, there are 54 members that consist of:

1. Government Group
   - *Ministry of Health*
   - *Coordinating Ministry of Human Development and Culture*
   - *Ministry of Legal and Human Rights*
   - *Ministry of Defense*
   - *Ministry of Manpower and Transmigration*
   - *Centre of Health of National Army*
   - *Centre of Medical and Health of Police Department*

...RELATIONSHIP ...

6. Health Service Group
   - *Indonesian Hospital Association*
   - *Indonesian Primary HealthCare Facilities and Clinics Association*
   - *Gunung Sahari Clinical Laboratory*
7. Academician Group
   - *Faculty of Public Health, University of Indonesia*
8. University Students Group
   - *Asian Medical Students Association (AMSA Indonesia)*
   - *Centre for Indonesian Medical Students Activities (CIMSA)*
   - *Students Executive Board of Facultiy of Public Health, University of Indonesia*

...RELATIONSHIP...

2. State Owned and Private Companies Group
   - *BPJS (Universal Health Coverage) of Manpower*
   - *BPJS (Universal Health Coverage) of Health*
   - *Indonesian Entrepreneurs Association*
3. Development Partners Group
   - *WHO Indonesia*
   - *USAID*
   - *DFAT*
   - *KNCV*
   - *FHI 360*
4. CSO Group
   - *9 CBO*
   - *7 FBO*

PURPOSES

- **The main goal is to contribute in supporting the government on TB control**
- **The Forum is expected to be able to assist in overcoming the burden of national TB problem.**
- **In TB control, it will be difficult to do it if each group exercises it without good cooperation and coordination, as it can lead to the less optimal result.**

Activities

1. Quarterly plenary meeting
2. Facilitated meeting for developing national strategic plan on TB
3. Facilitated PHO/DHO/CSO to establish the forum Stop TB Partnership
4. Upload any news related TB / FSTPI into website
5. Share information to all of members (from Union, WHO, Global Stop TB Partnership)

...Current Challenges...

4. **Only around 30% of hospitals that have conducted Hospital DOTS Linkage.**
5. **Very limited budget allocated for TB Control from central and local governments.**
6. **Inappropriate TB facilities**
7. **Lack of understanding of community on TB**

...Activities...

6. Will Establish 5 working group in the forum :
   - Public communication
   - Advocacy
   - Community
   - Health service
   - Resource Mobilization

Current Challenges

1. **High Incident Rate and Prevalence Rate in Indonesia (based on the result of survey of 2013-2014)**
   - **Incidence Rate: 403 / 100,000 population**
   - **Prevalence Rate: 660 / 100,000 population**

   Total Population in Indonesia: ± 250 million

2. **TB-related Issues:**
   - **The quality of DOTS should be improved**
   - **TB – MDR**
   - **TB-HIV**
   - **TB-DM**
   - **TB-with bad smoking habit**

3. **a. Recording and Reporting System for private physician are not yet formulated**
   b. ISTC is not yet fully functioning


KICK OFF
KICK OFF
FORUM STOP TB PARTNERS
INDONESIA
Jakarta, 30 Mei 2013

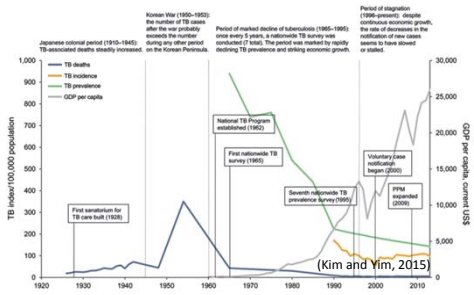

Thank you!


Partnership
Indonesia
2nd FORUM OF NATIONAL STOP TB PARTNERSHIP IN SOUTH-EAST ASIA,
WEST PACIFIC AND EAST MEDITERRANEAN REGIONS

Presentation and discussion of activities of partnerships

Stop TB Partnership Korea
Korea

<History of Korean TB situation>



(Kim and Yim, 2015)

INTRODUCTION OF STOP TB PARTNERSHIP KOREA

Hongjo Choi, MD. PhD
(KNTA, KIT)

Name and legal corporate status

- Name : STOP-TB Partnership Korea(STBK)
- Legal corporate Status : None
  - Secretariat of STBK was installed under Korean National TB Association in 2009

Table of Contents

Short history

<Progress>

2008. 3 : Announcement of establishment / operation plan of the STOP-TB Partnership KOREA by the Ministry of Health and Welfare and Korean Center for Disease Control

2009. 6 : Establishment of the STBK's Secretariat under Korean National Tuberculosis Association

2010. 3 : Formal registration as the national cooperation partner of WHO Stop TB Partnership

2010. 12 : STBK inaugurated with 19 partners
(Chairperson : Sook Mi Son, , Member of National Assembly)

2012. 11 : Hold 1st forum of national to stop western pacific & south-east asia regions

2015. 9 : Appointment 2nd chairperson, Myung Yeon Kim, Member of National Assembly

2016. 3 : 44 organizations and almost 60,000 individual partner take part in

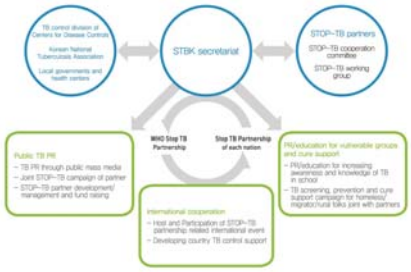
Relationship with other organizations

<STBK Organization Chart>

Members: Membership, Current number

Relationship with other organizations

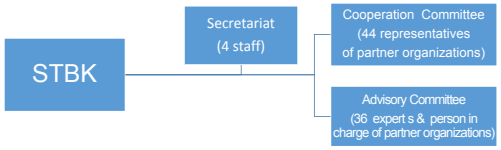
<Business Implementation System>



Purposes

- TB prevention education and support for the vulnerable, particularly, migrants and homeless people
- Development and promotion of tuberculosis elimination projects among underdeveloped countries and exchange programs for global & National STOP-TB Partnership
- Establishment of cooperative system to raise social awareness and participation into the domestic and global plan to stop TB.

Members: Membership, Current number



Activities

<Advocacy>

TV Documentary production for Improving TB Awareness

A commemorative event on the "World TB day"

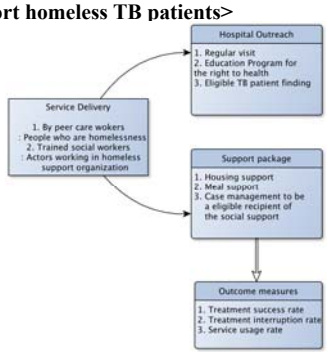
Activities

<Advocacy>

Policy forum to support efficient TB patient care

Monthly webzine publication and e-mail service

<Pilot programs to support homeless TB patients>



Activities

<Advocacy>

Appoint the representatives of 12 national communities as foreign TB honorary ambassador

Production of various IEC materials

Activities

<Education>

Health lecture for TB high risk group such as the immigrants, homeless

STOP-TB Camp for youth

Activities

<Support for The Vulnerable population>

Providing free TB X-ray screening joint with TB related partners during multicultural festival for the immigrants

Providing treatment expense for MDR-TB Patients

Activities

<International Cooperation>

Project for Korea-Mongolia Anti-TB Collaboration in Ulaanbaatar

1st forum of national to stop TB western pacific & south-east Asia regions

Current challenges

- Development and vitalization of various tuberculosis eradication activities joint with partners to support NTP
- Improvement of sustainability STOP-TB Partnership Korea through developing unique fundraising method besides government aid
- Participating in active international tuberculosis eradication movement through the reinforcement of global cooperation capability by developing specific cooperation project and reinforcing link with other national partnership

Presentation and discussion of activities of partnerships

MYANMAR MATERNAL AND CHILD WELFARE ASSOCIATION
Myanmar

This presentation includes;

- Brief information about MMCWA
- MMCWA's participation in community based TB care activities
  - *Self-reliance Approach*
    - ✓Target areas
    - ✓Methodology
    - ✓ Achievements
  - *Project Approach*- CBTBC Project in collaboration with National TB Program(NTP) and Global Fund(Round-9)
    - ✓Target areas
    - ✓Methodology
    - ✓Achievements and challenges

4

Asian National Stop-TB Partnership Forum

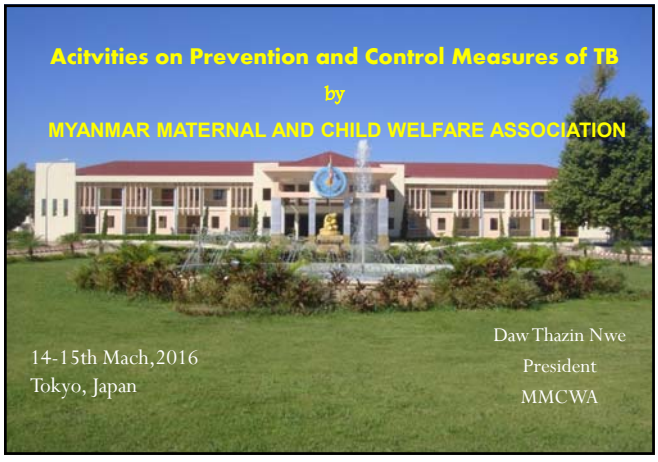
Tokyo, Japan 14-15th March, 2016

Profile of MMCWA

- **Myanmar Maternal and Child Welfare Association**
  Established since 30th April 1991
  (according to law No: 21/90 – November 9th, 1990)
- **Non-profit Voluntary Organization**

5

5



Mission Statement

The Myanmar Maternal and Child Welfare Association is a voluntary organization dedicated to serve the Myanmar Society in promoting the health and well-being of mothers and children with the aim to improve the quality of life of the people.

6

6

Objective

To carry out activities related to development of health, education, economic and social aspects of beneficiaries with priority to the grassroots level residing in wards and villages.

7

MMCWA Organizational Structure

Central Council

↓

Central Executive Committee

↓

State and Regional, NPT Council Area Supervisory Committees(15)

↓

District Supervisory Committees(72)

↓

Township Associations (330)

↓

Branch Associations (Wards/Villages) (22063)

Members of MMCWA- > 12millions

8

MMCWA activities in line with its objectives

1. Health Activities
2. Educational Activities
3. Economic Activities
4. Social Activities

9

Health Activities

10

Provision of Community based health care services

Health Education	Programme for Congenital Defect
Prevention and Control of Communicable diseases	Eye Care Activities
Programme for Chronic Non-communicable diseases	Environmental Health
Safe motherhood programme	Anti Tobacco activities
Nutrition Progamme	Programme for Traditional Medicine
Immuization programme	Capacity Building Programme

11

Prevention and control of communicable diseases (HIV/AIDS, Malaria, TB, Leprosy, other infectious d/s..)

Health Education

- IEC dissemination
- Mass Media
- Community health talks
- Outreach round table talks

- Early Case Detection
- Referral
- Support for care and treatment

12

Educational Activities

13

Formal Education

Stationary Support to needy students

School Enrollment Week–Community Mobilization

Educational activities

1. Early Childhood Development Centre (ECCD)
2. Participation in mobilization for School enrollment week
3. Stationeries, Uniforms and Financial Assistance for Formal Education
4. Adult Literacy
5. Evening classes

14

Non-formal Education

3-R Classes

Continuous Learning Initiative for Adult Literacy

17

Early Childhood Care and Development (ECCD)

Activities

- *Establishing holistic development from transition period of the children*
- *Creating opportunities for income generation for mothers*
- *Provision of parenting education*
- *Pre-school Teacher training*

In 2014,
Number of Pre-school - 730
Children (male) - 12349
(female) - 15317

Number of Day Nursery - 39
Children (male) - 574
(female) - 738

- Libraries – 12873 numbers
- Community learning Centre – 3260 numbers

Provided Books to Libraries

Economic Activities

19

Social Activities

22

Income Generation Programme

1. Provision of vocational training courses(VCT) on sewing, knitting, cooking etc.
2. Micro-credit small loan scheme
3. Financial assistance for small household farming, agriculture and small scale home industries
4. Finding Job Opportunities

Micro-credit small loan scheme

20

Social activities

- Elderly Care Program (Home based care services for physical & psychosocial well-being)
- Bringing social support to orphanages and vulnerable group
- Maxillofacial correction to promote self esteemed for cleft children
- Promoting and assisting civic duty and cultural heritage for future generation
- Risk management and rapid response in time of disaster

23

Training on Embroidering Tapestry

Training on Basic Computer Skills

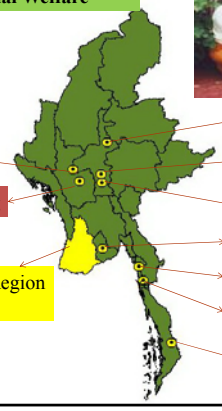
MMCWA participation in Elderly Care Activities

Approaches

1. **Self reliance Approach -by MMCWA (Central) /State & Regional /Township MCWA supervisory committees**
2. **Project Approach (MMCWA+DSW) (MMCWA Funding)**

II. Home-based care for elderly project- MMCWA+ Dept; of Social Welfare

Total -35 townships



2007 Chauk

Yaynanchaung

2011 Ayarwaddey Region 26 townships

Amayapuya

Tatkone

Leiway 2010

Dawbon

Tanphyuzayat

Malamyaing

Myeik

Collaborating Agencies of MMCWA

Government sector

1. Ministry of Health
2. Ministry of Education
3. Ministry of Social Welfare
4. Ministry of Internal Affairs

International

1. WHO
2. UNICEF
3. IPPF
4. UNFPA
5. UNAIDS
6. JOICFP
7. GGA

28

Conducting Home Based Medical Care

Provision of eye care for elderly

MMCWA Community Based TB Care Activities

29

Participation in relief matters at the effected area of disasters

Donation for Flooded Townships in Kalay and Tamu

Preparation Dignity Kits for Disaster-risk areas at MMCWA HQs

27

Approaches

1. Self reliance Approach
   -by MMCWA (Central)/State & Regional / Township MCWA supervisory committees

2. Project Approach
   (MMCWA+NTP)
   (Global Fund Round-9 Funding)

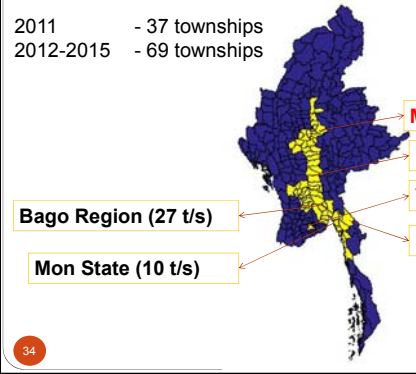
MMCWA Self reliance TB Care Activities

- Target - 15 States and Regions(330 townships)
- Methodology
  - Dissemination Health Talks on prevention of TB
  - Referral of presumptive TB cases
  - MMCWA volunteers' participation on DOTs programme

31

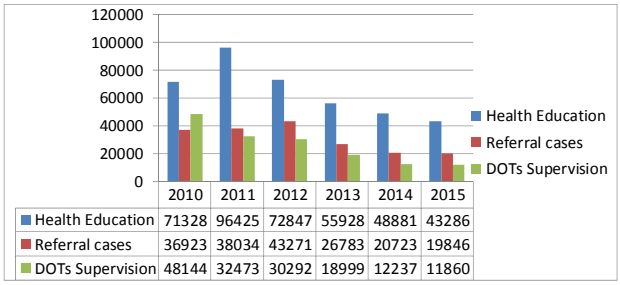
Community based TB Care (MMCWA+NTP+GF) (Townships - 69 townships)

2011 - 37 townships
2012-2015 - 69 townships



34

MMCWA Self reliance TB Care Activities(Cont;)



	2010	2011	2012	2013	2014	2015
Health Education	71328	96425	72847	55928	48881	43286
Referral cases	36923	38034	43271	26783	20723	19846
DOTs Supervision	48144	32473	30292	18999	12237	11860

32

Activities

(1) Central Training of trainers on Community TB Care (Naypyitaw) (x 2 days) (1 volunteer/tsp)

(2) Township Multiplier Training for Community volunteer on DOTS (x 2 days) (30 volunteer/tsp)

(3) TB case finding and/or treatment activities at community level

(4) Community education session

(5) Half yearly evaluation meeting for community volunteer at respective township level

36

- (6) Central Annual Evaluation Meeting at MMCWA HQ (Yearly)
- (7) Refresher Training for community volunteers at MMCWA HQ (once in 3 year)

Supervision

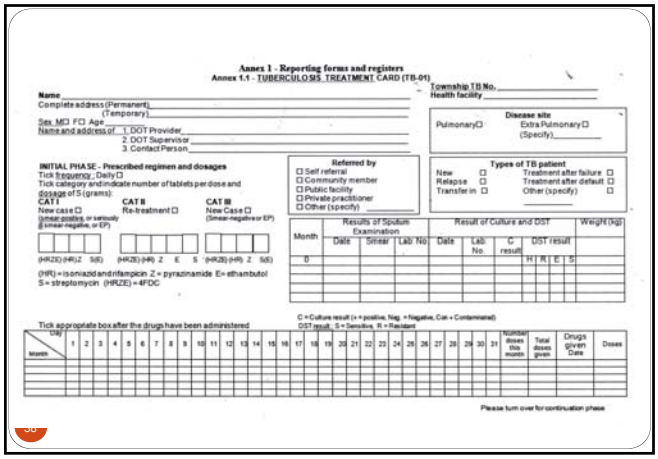
(1) Supervision from Central to State/Regional level
- *One visit per year to the respective State/Regions*

(2) Supervision from Districts to Townships level
- *One visit per year to the respective townships*

37

Annual Evaluation Meeting

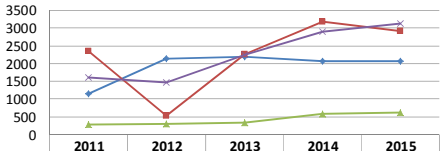
40



Annex 1 - Reporting forms and registers
Annex 1.1 - TUBERCULOSIS TREATMENT CARD (TB-01)

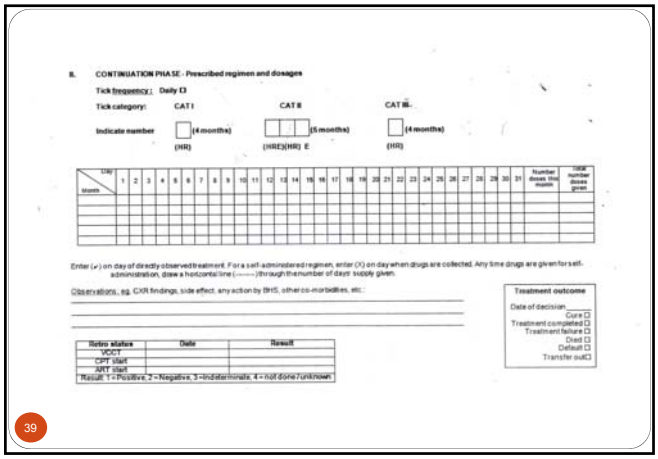
38

Indicators



	2011	2012	2013	2014	2015
No. of community volunteer trained	1147	2139	2190	2070	2069
No. TB suspected cases referred by community volunteers	2357	531	2255	3177	2921
No. of TB patients detected and put on treatment	282	298	344	589	615
No. of health talks conducted at community lavel	1606	1468	2251	2905	3126

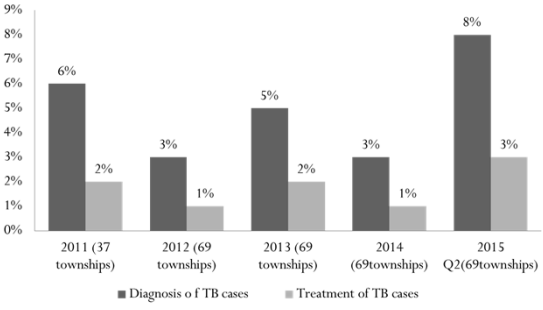
41



II. CONTINUATION PHASE - Prescribed regimen and dosages

39

MMCWA contribution to National TB Program(NTP)



Source; NTP

Supervision from Central to Mon State

43

	Strengths
1	MMCWA Volunteers reach to the gross-root level
2	Volunteers are enthusiastic and energetic in finding new cases and referral
3	MCWA Volunteers participate in Home-based Care for providing DOTS
4	Community participation are active; - Interested in Health Talks on TB preventive and control measures

	Challenges
1	Supervision from District to township level reports are not receiving regularly.
2	Attrition within the ToT volunteers
3	Reporting system sometimes weak, not received in time.
4	Need patient support and transportation fees for patients

Supervision from Central to Mandalay Region

44

Volunteerism

Performing an act of kindness , freely giving of talent, time, effort for the simple fulfillment of community expectations.

Training of Trainers(ToT) Refresher Training

45

Presentation and discussion of activities of partnerships

Japan-Nepal Health & TB Research Association

Nepal

Scenario:2015

- Major Public Health Problem
- Priority I Programme of the Government

Population	: 27 million
Incidence rate (all TB cases)	: 163 /100,000
Prevalence rate (all TB cases)	: 241/ 100,000
Mortality rate	: 20/100,000
TB patients co-infected with HIV	: 2.4%
Proportion of MDR-TB	
New cases	: 2.2%
Previously treated cases	: 16%

Regd. No.: 961/064/065 SWC No.: 24717

जापान - नेपाल स्वास्थ्य तथा क्षयरोग अनुसन्धान संस्था

JAPAN-NEPAL HEALTH & TUBERCULOSIS RESEARCH ASSOCIATION (JANTRA)

In collaboration with RIT/JATA

Ram Sharan Gopali (MPH)
Executive Director

Who we are.....?

JANTRA is a non-profitable, public service oriented non-government organization

JANTRA is affiliated with Research Institute of Tuberculosis/Japan Anti-Tuberculosis Association

JANTRA is a member of Nepal TB Control-Network

Basic Facts of Nepal

Nepal is a landlocked country located in the WHO South Asian region at the edge of the Himalaya mountains between India and the Peoples Republic of China

Area	147,181 Sq. km
Region	5
Zone	14
District	75
Treatment Centre	1140
Sub-treatment	2907
Microscope Centre	554
Gene-Xpert Center	22
MDR Centre	13
MDR Sub-Cen.	71

Mission

To franchise in the prevention/control of Tuberculosis, Public Health and Social Development issues in Nepal.

Areas of Intervention;

- Policy and Advocacy at all level
- Community System Strengthening (CSS)
- Knowledge Management
- Partnership and networking (Nationally & Internationally)

Our Steps for…….

- To enhance collaboration between TB patients, NGO' s/CSO' s, Research Institutions, Universities, Government line agencies
- To care and support for those who are infected and affected by TB, for the purpose of controlling and caring all forms of TB (TB, DR, TB/HIV)
- To reduce stigma and discrimination related with TB and its co-infection
- To improve community health through innovative models up to grassroots level by knowing the local contexts

2. Community engagement and their role

- Active case finding
- door to door visit by volunteers
- monthly meeting for TB volunteers
- School health program
- Volunteer Trust Fund
- Referral and cross referral of presumptive cases
- Tracing of loss to follow up TB patients
- Organize advocacy and social mobilization

10

Current Projects

Urban TB Control	TB REACH Wave 4	Post Disaster Recovery Project
RIT/JATA	UNOPS/Stop TB Partnership	UNOPS/Stop TB Partnership

3. Net-working and Social Protection

- Communication and social mobilization activities for factory workers and vulnerable groups
- Strengthening coordination & collaboration with partners and synergy
- Tangible & intangible support for TB patients who are in need
- Initiation of TB patients club
- Empowerment of TB patients
- Enhanced understanding on Patient Character among service stakeholders and service providers

11

1. Quality DOTS services is provided for TB patients

- Innovative DOTS and Sputum examination (8:00 AM-4/5 PM)
- Referral, cross-referral and counter referral from community and private sectors
- Operational partnership with partners and CSO's
- Capacity building of key stakeholders (Health care providers public and private), volunteers, local administrative authorities

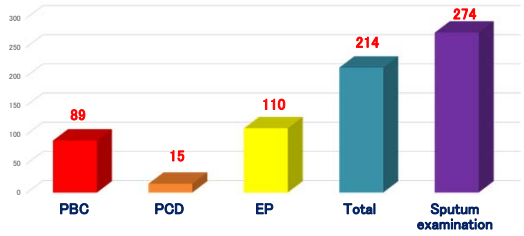
9

4. Strengthening Urban TB control

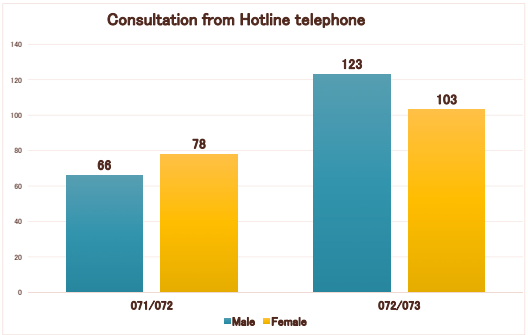
- Organizing regular meeting with stakeholders and partners
- Carrying-out joint supportive supervision with concerned stakeholders and immediate feedback mechanism
- Establishment of Volunteers Trust fund
- Support for poor TB patients who are not eligible in public social protection scheme
- Logistic management support

12

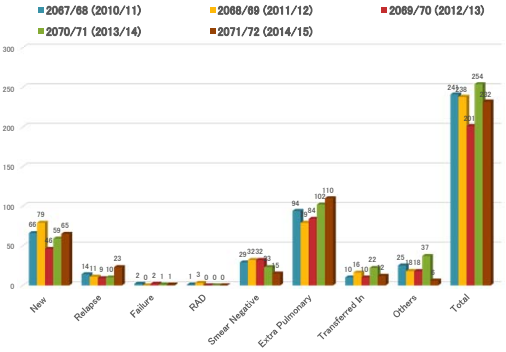
DOTS service & SPUTUM EXAMINATION
(2014/2015)



Hotline Consultation

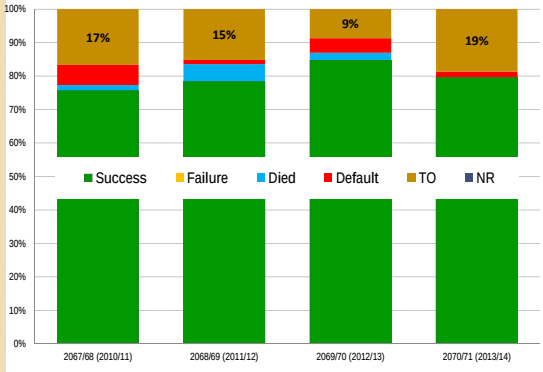


Case finding



Key Q & A of hotline consultation	Hotline Consultation
• Sign and Symptoms of Tuberculosis • Location of DOTS Centre • Venue of Microscopic Camps • Information about daily DOTS and assurance of treatment • Minor side effects • Clinic opening time	

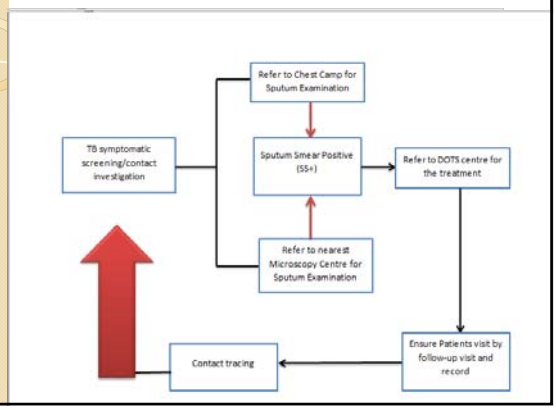
Trend of Treatment Success Rate



Systematic Screening of target populations & microscopy camps

- Community-Based;
  - TB screening/presumptive TB identification/examination/treatment enrollment and contact investigation
  - Awareness raising
- PPM
  - Strengthen cross referral mechanism
  - Refer TB suspects to microscopic camp and other laboratories
  - Collaboration with private laboratory
- Meaningful involvement and mobilization of health workers (Public and Private and volunteers)

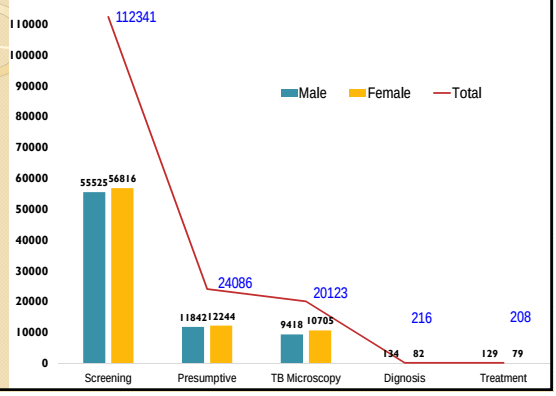
Case finding framework



Intervention

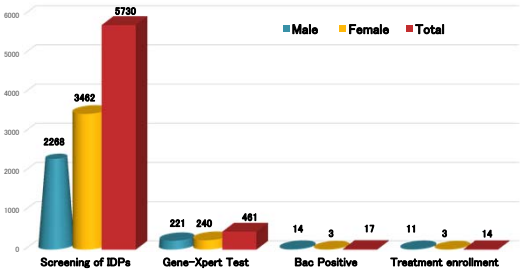
- Mapping of IDP s Camps
- Capacity building of Volunteers and key stakeholders
- Presumptive TB Case identification
- Sputum sample collection, sputum transportation & Test by Gene Xpert
- Chest Camp
- Treatment enrollment and follow up

TB REACH (WAVE 4) Achievement From July 16, 2014 to November 15, 2015



Post Disaster Recovery TB Program

Sep 2015- 20 jan 2016



Post Disaster Recovery Project

Thematic Program Thrust–

Early TB Case finding

Target Beneficiaries–

Internally Displaced People of Kathmandu valley and Sindhupalchok district

Lesson Learnt ……..

- **Support from NTP**:
  - ✓ leads to sound implementation of the planned activities
- **Proper Orientation & consistent follow-up:**
  - ✓ To continue engagement of stakeholders *(sample transportation from community to Microscopy Centre)*
- **Intensive Advocacy Programme:**
  - ✓ More partners are interested to collaborate *(local CBOs shows their interest for the collaboration)*

Lesson Learnt.....

- **Highly enthusiastic and committed volunteer;**
  - ✓ Leads to productive and sustainable programme in the community

- **Establishment of Patients club;**
  - ✓ Leads to effective contact tracing and peer education in the community

- **Consistent IEC/BCC Programme:**
  - ✓ To change service seeking behavior

Acknowledgements

- National Tuberculosis Centre
- Research Institute of Tuberculosis/JATA
- UNOPS/Stop TB Partnership
- Global Affairs, Canada
- World Health Organization
- Regional Health Directorate Office
- District (Public) Health Offices
- Urban Health Clinics
- Health care Providers (Public & Private)
- Female Community Health Volunteers
- TB Patients and Family members

Supportive Supervision & Result based monitoring

- Result based M&E and discussion with NTC

- Regular follow-up and monitoring from the RHD and respective project districts
- Project review and assessment from the TB REACH & RIT/JATA

Thank you

Issues to be address;

- Sustainability and ownership
- Compatibility of TB Program inline with Sustainable Development Goal.
- Factor affecting TB Treatment and its success; co-morbidity for instance- diabetes, malnutrition etc
- Funding gap
- Logistic, documentation and monitoring.
- Research and development ; TB and Gender, PPM, Community Engagement, UHC

Presentation and discussion of activities of partnerships

TB/HIV Research Foundation Thailand

RIT/JATA Philippines, Inc.

- Local-based NGO
- Established in 2008
- 7 staff

RIT/ JATA Philippines, Inc. Activities and Accomplishments

STOP TB Partnership Forum – Asia
March 14-15, 2016

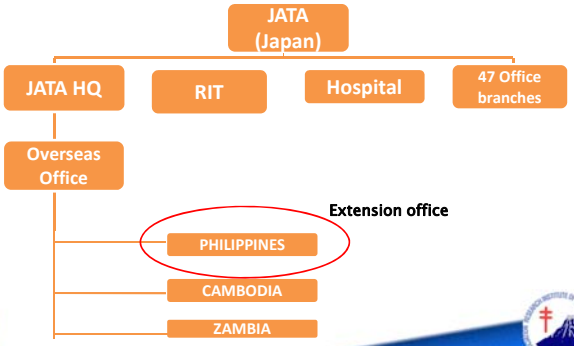
Accreditation/Membership

- Securities and Exchange Commission
- Philippine Council for NGO Certification
- NTP – Technical Working Group

About us....

Research Institute of Tuberculosis / Japan Anti-Tuberculosis Association Philippines, Inc.
(*RIT/ JATA Philippines, Inc.)*

RIT/JATA (Organizational tree)



Vision:

TB- Free Philippines

Mission:

To contribute to the NTP of the Philippines in their goal of ensuring that quality TB services are available, accessible and affordable for all TB patients.

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PhilPACT Strategies

- *Strategy 5:* Address MDR-TB, TB/HIV and the needs of vulnerable populations
- Strategy 6: Regulate and make available quality TB diagnostic tests and drugs
- *Strategy 7*: Certify and accredit TB care providers
- Strategy 8: Secure adequate funding and improve allocation and efficiency of fund utilization.

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Objective:

To improve the access of the community to quality DOTS implementation by strengthening the linkage between GOs and NGOs/private organizations

Research Institute of Tuberculosis/ Japan Anti Tuberculosis Association Philippines, Inc.

JAPAN

THE TUBERCULOSIS PROJECT IN SOCIO-ECONOMICALLY URBAN AREAS IN METRO MANILA, THE PHILIPPINES
2008- June 2011

Funded by : Ministry of Foreign Affairs

Research Institute of Tuberculosis/ Japan Anti Tuberculosis Association Philippines, Inc.

PhilPACT Strategies

- *Strategy 1: Localize implementation of TB Control*
- *Strategy 2: Monitor health system performance*
- *Strategy 3:* Engage both public and private TB care providers
- *Strategy 4*: Promote and strengthen positive behavior of communities

Research Institute of Tuberculosis/ Japan Anti Tuberculosis Association Philippines, Inc.

JAPAN

TB CONTROL AND PREVENTION PROJECT IN SOCIO-ECONOMICALLY UNPRIVILEGED AREAS IN METRO MANILA, THE PHILIPPINES
2011- June 15, 2014

Funded by : Japan International Cooperation Agency

Research Institute of Tuberculosis/ Japan Anti Tuberculosis Association Philippines, Inc.

Project Sites

District I- Tondo, Manila

POPULATION 2013	405, 125
Urban poor population	193, 746 (47.8%)
Land Area	5.64 sq km
Population density (sq. Km2)	71,831

- 10 Health Centers
- 2 NGO DOTS Facilities
- 14 NGO Referring Facilities

Engagement of NGOs

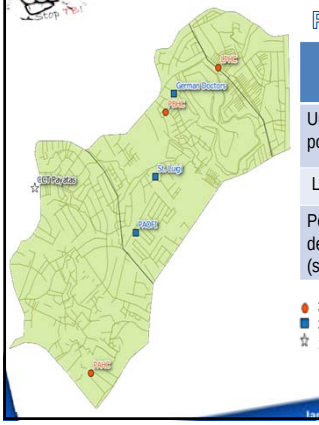
Canossa

Sto De Tondo Charity Clinic

German Doctors

Saint Luigi Orione

PAOFI

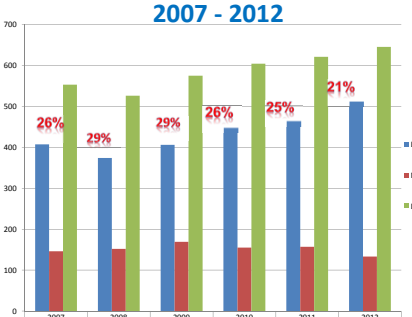


Payatas, Quezon City

POPULATION 2013	120, 633
Urban poor population	108, 063 (90%)
LAND AREA	3.21 sq km
Population density (sq. Km2)	37,580

- 3 Health Centers
- 3 NGO DOTS Facilities
- 1 Referring Facility

NGO DOTS' Contribution- Tondo, 2007 - 2012



	2007	2008	2009	2010	2011	2012
LGU	407	374	406	449	464	512
NGO	146	152	169	155	157	133
District I- Tondo, Manila	553	526	575	604	621	645

Interventions

NGO DOTS' Contribution -Payatas

	2007	2008	2009	2010	2011	2012
LGU	85	75	109	117	101	125
NGO	45	46	90	92	107	105
Payatas, Quezon City	130	121	199	209	208	230

Capacity Building

Basic TB DOTS Training

Infection Control Training

Basic DSSM Training for Medical Technologist

Appreciation Course for CXR

Orientation of CHV on Basic STI HIV and AIDS Education

CHV Assembly

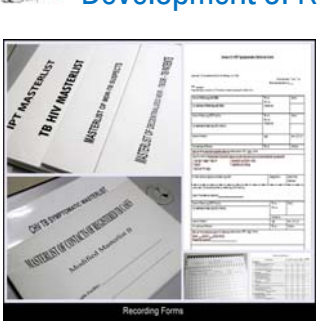
Interpersonal Communication and Counselling

Network and Linkage (ACSM Activities)

Orientation of CHV in NTP Program

Basic DSSM Training for Lab Assistants

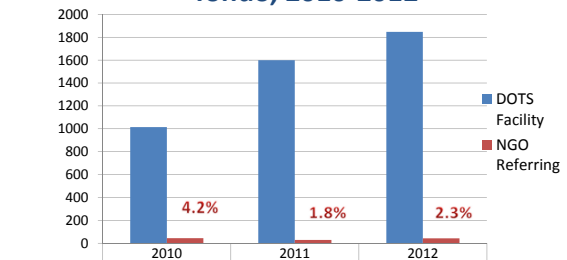
Development of Recording Forms



Recording Forms

Monitoring Tool

CHVs' Contribution to DOTS Facility-Tondo, 2010-2012



	2010	2011	2012
DOTS Facility	1014	1599	1846
NGO Referring	43	28	42

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Development of Policies/Guidelines

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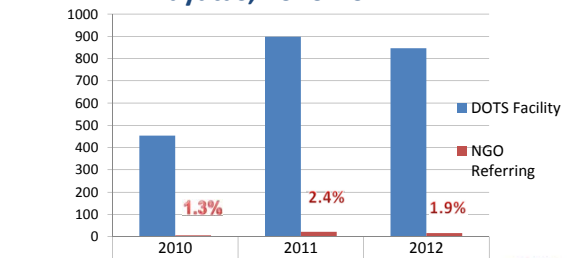
CHVs' Contribution to DOTS Facility – Payatas, 2010-2012



	2010	2011	2012
DOTS Facility	454	898	846
NGO Referring	6	22	16

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Operational Researches Conducted

- **Effectiveness of Training Course on Quality Assurance of Chest Radiography**
- **Health Care Seeking Behavior of Pulmonary TB Patients**
- **Research on Tuberculosis Diagnostic Committee (TBDC)**

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Monitoring and Evaluation Visits

Research Institute of Tuberculosis/ Japan Anti Tuberculosis Association Philippines, Inc.

Accomplishment in the two project sites

- Engagement of NGOs (combined in both sites):
  - oNumber of NGOs from 3 (2008) to 5 (2010)
  - oNumber of NGO referring facilities: 4 (2008) to 15 (2012)
- Percent contribution (combined in both sites) :
  - oPercent contribution of NGO DOTS to TB Cases ranged from 27. 9 % to 41.6 % (2007 to 2012)
  - oPercent community contribution to TB Cases ranged from 2.1 % to 3.3 % (2010 to 2012).

Research Institute of Tuberculosis/ Japan Anti Tuberculosis Association Philippines, Inc.

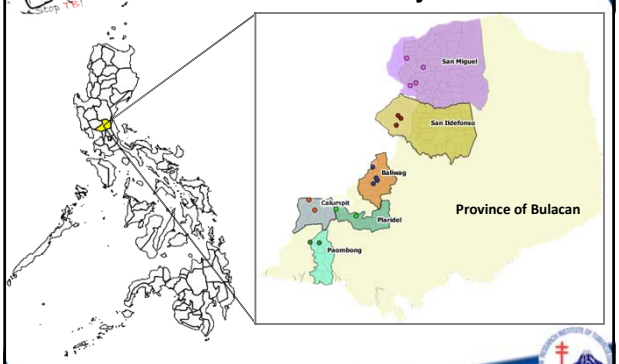
TECHNICAL ASSISTANCE SERVICES TO CAPACITATE COMMUNITY BASED ORGANIZATIONS (CBOs) AS RURAL HEALTH UNITS (RHUs) PARTNERS IN TUBERCULOSIS CONTROL
January 15, 2015 – April 30 2016

Funded by : Philippine Business for Social Progress/Innovations on Multi-Sectoral Partnership to Achieve Control of TB **(PBSP/IMPACT**)

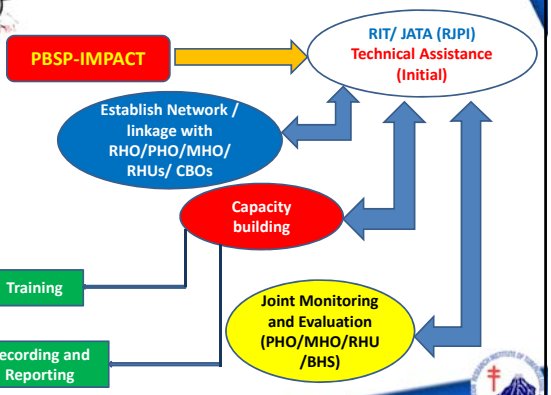
USAID FROM THE AMERICAN PEOPLE

PBSP Philippine Business for Social Progress

Project Areas



Research Institute of Tuberculosis/ Japan Anti Tuberculosis Association Philippines, Inc.



Research Institute of Tuberculosis/ Japan Anti Tuberculosis Association Philippines, Inc.

Criteria for Project site selection

- Low TB performance (LGU) because of low utilization of DOTS services by the target clients
  - Low awareness of the TB disease
  - Stigma
  - Distance and cost in going to the facility
  - Lack of public involvement
- Strong political support
- Presence of CBOs

Research Institute of Tuberculosis/ Japan Anti Tuberculosis Association Philippines, Inc.

Project Goal

- To increase the case detection rates and to improve or maintain Cure Rates in the six municipalities of Bulacan.

Research Institute of Tuberculosis/ Japan Anti Tuberculosis Association Philippines, Inc.

Roles of CBOs

- Identify and refer presumptive TB to Rural Health Units (RHUs)
- Provide TB education
- Supervise TB treatment of patients

Research Institute of Tuberculosis/ Japan Anti Tuberculosis Association Philippines, Inc.

Roles of CBOs

- Encourage contacts of TB cases undergo TB screening at health centers
- Follow-up presumptive TB (who were not able to access RHUs) and interrupters of treatment

Challenges

- **Health financing**: reduce financial burden among clients
- **Health Resources for Health**: deployment of support systems and enabling environment; keep the motivation of Community Health Volunteers
- **Essential medical products and technologies**: Balanced diagnostic and treatment supplies

Contribution of CBOs to the 6 municipalities of Bulacan

Municipalities	No. of TB All Forms		
	RHU Accomplishment	CBO Accomplishment	% contribution by CBO to RHU
	1130	83	7%

Challenges

- Service delivery: Patient- centered approach care; improvement of access to quality TB services
- Lack of funding support to continue our community-based TB activities

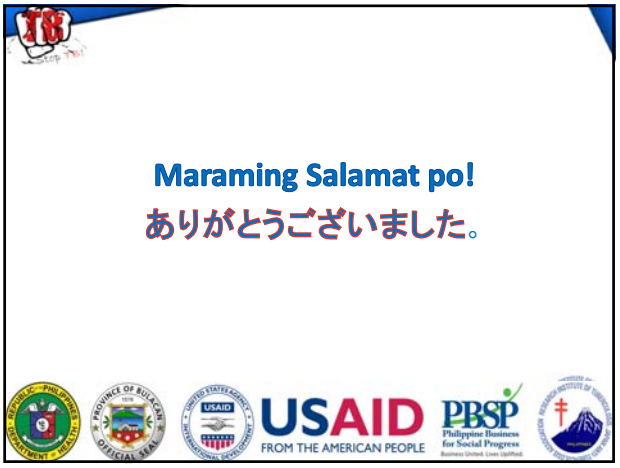
Challenges

- **Leadership and Governance**
  - Continuity of adherence to policies (municipal ordinance) and make necessary amendments if needed;
  - Continuity of supportive supervision among NGOs.
- **Health Information system**
  - Utilization of data to inform policy change

Future Directions

- TB and Universal Health Care
- TB and Tobacco
- TB and Diabetes (?)
- Promote gender equality (?)


Research Institute of Tuberculosis/
Japan Anti Tuberculosis Association Philippines, Inc.


Maraming Salamat po!
ありがとうございました。
USAID
FROM THE AMERICAN PEOPLE
PBSP
Philippine Business
for Social Progress

Presentation and discussion of activities of partnerships

Chang-Hua TB Care Association Taiwan

Wei-Wen, Chen (Sally)

- Griffith University, Queensland, Australia
  Master of Gerontology Nursing 2003-2005
- Chang-Hua TB Care Association
  Member 2014 -present
- Chang-Hua Hospital, Ministry of Health and Welfare, Changhua, Taiwan
  Secretary and research assistant, MDR TB Department 2014 - present

Chang-Hua TB Care Association Taiwan

Presented by
Wei-Wen Chen
(Sally)

Geographic Position

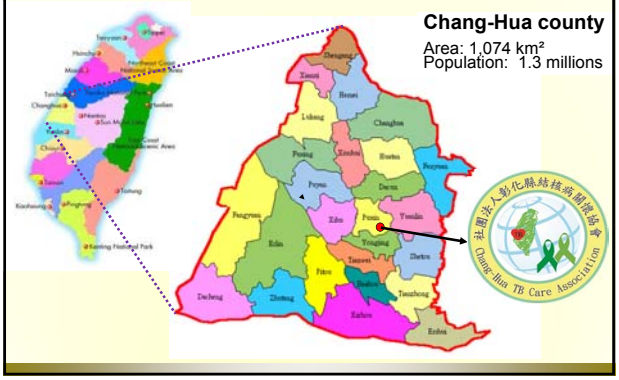
Chih Yun, Lin (Vicky)

- Fu Jen Catholic University, New Taipei City, Taiwan Department of Life Sciences 2001-2005
- Chang-Hua TB Care Association
  Supervisor 2012 -present
- Chang-Hua Hospital, Ministry of Health and Welfare, Chang-hua, Taiwan 2008-present

Geographic Position

- **Capital: Taipei**
- **The total area of Taiwan :36,193 km² (13,974 sq mi)**
- **Population: 23 million**

Geographic Position



First meeting in 2009

History

- The first non-governmental and non-profit making voluntary organization established in Chang-Hua County in March 2009 by **Dr. Yi-Wen Huang** (MD, Chief of Pulmonary and Critical Care Unit, Chang-Hua Hospital, Deputy commander of Central region communicable Disease Control Medical Network) with a view to raising public awareness against Tuberculosis (TB) and adopting preventive and curative measures towards the control of the diseases.

Present Director 2015~

- Name: **Pei-Chun, Kuo**
- RN, Master of Health Care Administration, Central Taiwan University of Science and Technology
- Clinical Registered nurse since 1997
- Supervisor of Nursing Department , Chang-Hua Hospital since 2012~now

The First Director 2009-2014

- Name: **Yi-Wen, Huang**
- MD, Kaohsiung Medical University 1975-1982
- Deputy commander of central region commu… medical network, CDC, Ministry and welfare s…
- Chief of Pulmonary and Critical Care Unit, Ch… Hospital since 2010~now
- Chief of Emergency Department, Chang-Hua Hospital since 2008~now
- Chief of Tuberculosis Department, Chang-Hua Hospital since 2007~now
- Chief of Central Region MDR-TB team, since 2004~now

Membership

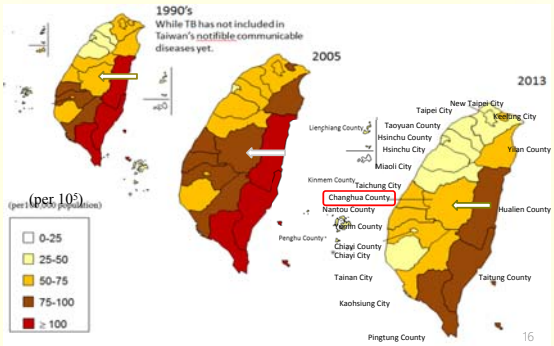
- We pursue our mission in part through an open membership policy, any individual involved and interested in the objectives of the Association may apply for membership
- The Executive Committee shall decide as to the acceptance or not of any application and similarly decide into which category the applicant shall be placed.

Membership

- For individuals: more than 20 years old and working in health care settings at Chang-Hua county or people living in Chang-Hua county
- For organizations: any associations or groups who agree objectives of the Association
- For sponsorships : people or gr… agree objectives of the Associat…

TB epidemics in Taiwan

TB Incidence by County, 1990-2013



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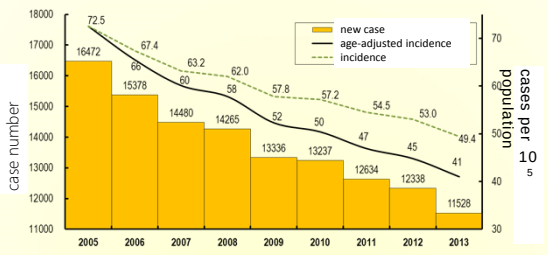
Membership

- 76 members
- Clinical staffs from hospital setting 、 community setting and DOTS.
- TB cases who completed treatments

TB Case Number and Incidence, 2005-2013



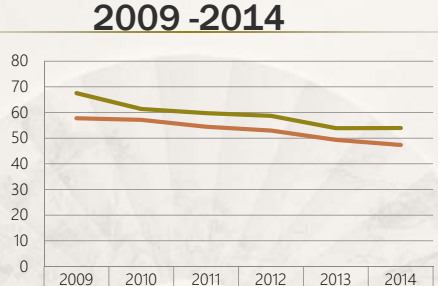
The case number and age-adjusted incidence in 2013 declined with a rate of 30.0% and 43.4% compared with 2005.

17

Aim/Purpose

- Support **disadvantage** and **special** groups to complete TB treatment thus reduce the chance to progress to MDR-TB
- We are a collaborative network of policy makers, health workers, researchers, people affected by TB and advocates

TB incidence rate in Chang-Hua 2009 -2014



	2009	2010	2011	2012	2013	2014
Chang-Hua	67.6	61.4	59.8	58.7	53.93	53.96
TW	57.8	57.2	54.5	53	49.4	47.36

Mission

- Assist with **disadvantage** and **special** groups(eg. homeless, HIV, drug abused, psychiatrics, alcoholics, people living alone) who has suffering with TB (MDR & pre XDR TB) : improve their lives through financial support, education, and encouragement.

Mission

- Fundraising for patients who is at low economical status or unqualified to retrieve governmental support, increase patients' motivations and adherence to complete treatment.
- The undertaking of the Research and Investigation on subjects concerning tuberculosis.
- Import & monitor new TB drug

Mission

- Home visits by clinical staff or volunteers
- Strengthening clinical education for clinical TB staff


Activities

- Regular medical allowance or food subsidies
- Provide toiletries for homeless cases




Fundraising

Challenges

* Chang-Hua county is mainly rely on urban agricultures
- Lack of TB information and knowledge
- Unable to recognized TB symptoms
- TB = Sin
* Delay hospitalization
* Short of funding

Presentation and discussion of activities of partnerships

TB/HIV Research Foundation Thailand

Chiang Rai Province

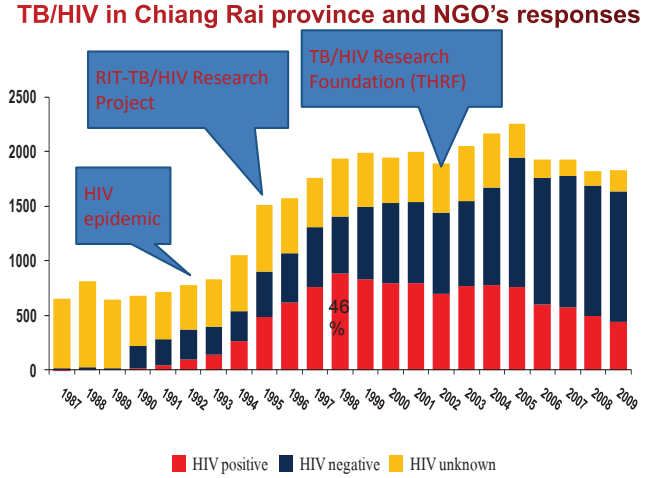
In 1993 – HIV prevalence in military conscript was 16.5% !

TB/HIV RESEARCH FOUNDATION (THRF SINCE 2002)

LOCAL WISDOM... GLOBAL KNOWLEDGE

Registered Non-profit Non-government organization in Thailand # 222/2545
http://www.tbhivfoundation.org/index.php

TB/HIV in Chiang Rai province and NGO's responses



PRESENTATION

1. About TB/HIV Research Foundation (THRF)
2. Highlight NGO's Role: The Volunteer Ladies Against TB

THRF-HISTORY (1)

- **1992,** a group of Thai and Japanese doctoral students carried out their multi-disciplinary dissertation research on TB and HIV/AIDS **(THRF Founding members)**

- Epidemiology
- Clinical and public health
- Social sciences

THRF-HISTORY (2)

- **1995** The Research Institute of Tuberculosis, Japan Anti-Tuberculosis Association (RIT/JATA) set up "TB/HIV Research Project"
- **2002** TB/HIV Research Foundation" (THRF) was officially registered as a non-profit, non-government organization

PARTNERS

THRF BOARD MEMBERS (NON-PAID)

- **President** Jintana Ngamvithayapong-Yanai, B.N. (Hons.), M.A., Ph.D.
- **Vice President** Pathom Sawanpanyalert, M.D. (Hons.), Dr.PH.
  Pacharee Kantipong, M.D.
- **Members** Petchawan Pungrassami, M.D.,Ph.D.
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  Surakameth Mahasirimongkol, M.D., M.Sc.,Ph.D.
  Oranuch Nampaisan, B.Sc. (Statistic), M.Sc.(Biostatistics)
- **Treasurer** Piyanoot Chatchawarat, B. Econ., M.Ed.,(Admin.)
- **Secretary** Sarmwai Luangjina, B.A.

14 Fulltime paid staff

Funding Policy

- No funding from tobacco and alcohol related business
- Research with pharmaceutical company is a subject of board clearance
- Pharmaceutical company can donate money to charity (but NO company logo)

Vision

Stop TB, HIV and other diseases of poverty, with the people for the people

Mission

Involving and collaborating with local, national, international research and academic institutes, policy makers, NGOs, private sectors, civil societies and vulnerable populations **(with the people)** to reduce the burden on the people affected by tuberculosis, HIV/AIDS and other diseases of poverty **(for the people)** by means of epidemiology, bio-medical, social science, operational and participatory action research.

WHAT WE DO ?

Research and projects as of December 2015 (1)

- Improvement of diagnosis by using urine test of detecting DNA fragment of Mycobacterium tuberculosis **(RIT/JATA)**
- Impact of isoniazid preventive therapy on TB morbidity and mortality: A cohort study of people living with HIV **(JATA)**
- Pharmacogenomic study of anti-tuberculosis side effects (MOPH/NIH and U.of Tokyo)
- Identification of blood transcriptional signature of active tuberculosis in Thai population (MOPH/NIH and U.of Tokyo)

Charity

Why research and charity?

- Most TB patients are poor
- Poverty cause treatment interruption and loss follow up
- Research staff are not rich!

Research and projects as of December 2015 (2)

- Ensuring treatment adherence through "CARE (Connection, Affordable, Reminder, and Enabling) Box" (Grand Challenge Canada)
- Evaluation of Rapid TB Culture and Drug Susceptibility Test through AutoMODS (Automated Microscopic Observation Drug Susceptibility) (Global Fund and National Innovation Association)
- Interventions for reducing sodium intake among patients with hypertension (Thailand Health Promotion Foundation)
- Workshops on TB in risk groups (JATA-seal funding)

We were very sick and we could not go to work. We feel so bad that our son (13 years) left the school and earned income by boxing and labor work. We do not have money to go to the hospital. Firstly, we must have foods to feed the whole family.

Photo and story credit: Sarmwai Luangjina - 2009

Human resource development and technical collaborations

- Training for community volunteers and prisoner volunteers about TB
- Member, Global Fund Thailand Country Coordinating Mechanism CCM
- Member, TB Laboratory Expert Committee, MOPH
- Technical collaboration with local NGOs, NTP/MOPH and National Health Insurance
- Field practicum in **statistics and global health** for students from universities in Thailand and School of Public Health University of Alberta, Canada

Charity

- **2007:** established a TB patient-fund (Center for Sharing) to support very poor TB patients for transportation and living expenses. (initial 3,000 US$ fund from StopTB Partnership, Geneva)
- **2009:** THRF and JATA established Volunteer Ladies Against TB to sustain the patient-fund and to support TB care

THRF

LOCAL WISDOM... GLOBAL KNOWLEDGE

Who are Volunteer Ladies Against TB?

- majority are Chiang Rai origins, age > 60 yrs, good socioeconomic status
- active in several volunteer activities not only TB activities

CHALLENGES

- Recruiting and maintaining qualified medical research and admin staff with good English command in Chiang Rai
- Limited international research funding due to being "high middle income country"
- Sustaining charity activities without budget for staff running charity activities

How did we engage Volunteer Ladies?

- Listed the existing women organizations in Chiang Rai
- Invited to the first workshop and 2 follow up workshops
- Built TB awareness by presenting TB epidemiology data
- Inspired and motivated by sharing experiences from Japanese Women Association

PRESENTATION

1. Overview about TB/HIV Research Foundation (THRF)

2. Highlight NGO's Role: The Volunteer Ladies Against TB

The Chiang Rai Ladies Volunteers Against TB

"Eradicating TB with women's hands and heart "

1. Fund raising for *"Center for Sharing"*
2. Packing daily TB drugs to ease medication
3. Visit to patients' home - supporting foods and sharing psychological support

How Volunteer Ladies support TB patients?
(data as of Dec. 2015)

1. Fund raising to support TB patient funding

- Funding increased from 3,000 US$ in 2009 to 28,040 US$ in 2015
- Total 487 patients received financial support to enhance treatment completion (279 Thai, 165 hilltribe minorities, 43 Myanmar migrants)

I was very sick and thought that I was going to die. Thanks to the volunteers bringing me back to the hospital and complete TB treatment. After my TB was cured, I was pregnant and delivered a baby. I am so happy

2. Assisting the hospital's pharmacists in packing daily dosage of anti-TB medicine to make the medication regime easier to follow for patients

77,403 packs were packed!

Photo and story credit: Chayut Kaewsitdhi and Sarmwai Luangjina 2010

3. Home visits to the extremely poor patients and patients encountering stigma and social isolation

- 90 patients were visited (67 Thai, 12 hilltribe minorities, 11 Myanmar migrants)
- All completed treatment except 3 died (TB/HIV) but died with humen touch
- Reduce stigma, tears of smile

NEXT STEP

Research to enhance "Bold Policy"

- How social protection interventions help Ending TB and contribute to social and economic development?
- Can women's hands and hearts help Ending TB

Appendix 5

Group Discussion 1: 15 March 2016 (10:15 – 11:45)

Topic: Challenges of NGO to End TB and role of women

Moderator: Nobukatsu Ishikawa

Rapporteur: Jintana Ngamvithayapong-Yanai

The moderator started the discussion by showing a list of roles of NGOs/CSOs to cover for End TB, as following:

- hard to reach groups/poor patients
- care/support to catastrophic cost
- Social protection (e.g., Stigma, discrimination)
- Universal health coverage (UHC)
- Use of community health volunteers
- Engage TB and Non-TB sectors
- Social linkage
- local authorities
- Advocacy voice for the voiceless
- Community empowerment
- Communicate/coordinate stakeholder
- Conducting research

The moderator then requested each NGO to write a top three challenges in three pieces of post-it note paper. One piece for one challenge which they think are challenges for NGO to End TB. All NGOs posted their lists on a big board. Later, the moderator created categories based on the lists presented in the Table 1. Table 2 presents challenges classified by NGO/country as discussed in the country presentations and in the document for End TB.

Table 1: The top-three free listing of perceived challenges to NGOs/CSOs to end TB

Categories of Challenges (Number)	List of challenge (country)
Challenges related to community health volunteers (5)	- How to maintain and keep volunteers actives? (Indonesia, Thailand) - Need of resource and incentives for volunteers (Indonesia, Myanmar, Philippines)

	- Case findings still low in remote area and volunteers can do more (Cambodia)
Challenges related to funding (4)	- Budget sustainability (Korea) - Limited resources, funding (Cambodia, Nepal, Philippines)
Challenges related to support to TB patients and poor patients (4)	- Addressing inequality in TB patient (Philippines) - Advocacy voice for vulnerable people (Thailand) - Need of nutrition support to patients (Myanmar) - Patient confidentiality (Taiwan)
Challenges related to patients and community awareness about TB (3)	- Need to increase TB awareness among community people (Taiwan, Thailand, Myanmar)
Challenges related to stakeholders (3)	- Lack of consensus between government and NGO (Korea) - Satisfaction for donors or satisfaction of patients? (Korea) - High expectations from stakeholders (Nepal)
Challenges related to professional care providers (2)	- Difficulty in implementing International Standard of TB care among the providers (Indonesia) - Less capacity in conducting research and development (Nepal)
Other (1)	- Migration (Cambodia)

Table 2: Challenges of NGO to End TB classified by country

Organization, Country	Challenges of NGO to End TB
Stop TB Partnership, Korea	- Budget sustainability - Lack of consensus between government and NGO - Satisfaction for donors or satisfaction of patients?
Chang-Hua Hospital / TATA, Taiwan	- Awareness of TB among community and society - Stigma and discrimination - Confidentiality of patient side, Privacy

Stop TB Partnership Indonesia	- Difficulty keeping the volunteers active - Need resources to support the volunteers - Difficulty implementing International Standard of TB care among the providers
THRF, Thailand	- TB awareness among general people - Advocacy voice for vulnerable people - Sustainability of volunteers
JANTRA, Nepal	- Limited resources - Less capacity in research and development - High expectations from stakeholders
CATA, Cambodia	- Limited fund - Case finding is still low - migration
MMWA, Myanmar	- To increase community awareness by providing more IE&C materials and community health talk - Funding for nutrition and transportation support for patients - Volunteer incentive is not enough for the targeted 330 townships for providing psycho-social support to complete treatment
RIT/JATA, Philippines	- Provision of incentive - Funding support - Addressing patients' inequality

The challenges related to "funding" was not included in this discussion session because the afternoon session will specifically discussed about fundraising. The group members shared their experiences and participated in discussion of the following issues:

1. Challenges related to community health volunteers

Turnover rate of the volunteers is common in most countries because of lack of incentives, lack of recognitions by community people, particularly recognition from people with high social and economic status. The following strategies may motivate volunteers to stay longer and increase volunteers' dignity or recognitions:

1.1 Provision of incentives including

- special right to access free health service,
- organize periodic meetings and let the volunteer to report their performance
- organize "exchange visit" so that the volunteers open their eyes to expose to other

sites

- organize training to increase TB knowledge
- provide transportation fee, award ceremony for outstanding volunteers

1.2 To enhance dignity, the volunteers should be selected by community people

Despite provision of these incentives and motivation, several participants felt the turnover rate of the volunteer is still high and require additional interventions. JUNTRA Nepal proposed “Trust fund” as an intervention motivating volunteers to actively work with dignity.

2. Enhancing TB awareness

Participants shared their opinion on enhancing TB awareness as followings:

- Means and message to convey TB information to people living in remote area should be cultural sensitive.
- TB patients and their family should be involved in providing TB education to the community
- It is important to repeat TB education to every level
- Enhancing the role of peer group (TB patients group)

The moderator concluded summarizing the sessions that the roles and challenges of NGOs/CSOs are diverse and varies according to the country and organization, but key common issues such as community and patient oriented approach were discussed and shared, and this kind of sharing is a most useful to promote the spirit of stop TB partnership. For that, documentation of the success stories is important. A term of human dignity was raised particularly for community health volunteers’ motivation, but the concept could apply to all aspect of the work by NGOs/CSOs.

Appendix 6

Session 2: 15 March 2016 (13:00 – 14:30)

Topic: Fundraising for the community activities

Moderator: Jintana Ngamvithayapong-Yanai

Rapporteur: Ram Sharan Gopali

The moderator started the session by showing a short video clip on "Japan hosts 'Touch-a-boob' fundraising event" https://www.youtube.com/watch?v=pUi-FIfzHIw This is the second most viewed video clip in the YouTube for a searching keyword of "fundraising". The video shows how Japanese Foundation for AIDS Prevention (a Japanese NGO) raised US$50,000 within 24 hours with the objectives to raise HIV awareness in Japan and raise fund to support HIV prevention, treatment and care. Several Japanese porn queens voluntarily contributed to this fund raising. The participants discussed how they felt and whether or not this fundraising methodology can be applied in their countries. All participants reported this fundraising method cannot be applied because it is against law and culture in their respective countries.

Following this introductory video, the moderator presented topics for the discussion. All participants agreed with the topics. Results from the discussion are summarized as follows: Current community TB activities requiring fund include:

1. Activities directly related to patient supports include; supporting patients' transportation, providing foods to complete TB treatment, and home visit

2. Activities related to community volunteers include; support for meetings, training and allowance for volunteers

3. International community TB activities

Table 1: Current funding sources of the participants' NGOs

Organization, Country	Funding sources
Stop TB Partnership, Korea	The operational cost is funded by the government of Korea and programmatic budgets are from several funding sources such as Koica, Korean Anti-TB Association
Chang-Hua Hospital / TATA, Taiwan	For TATA, 80% of funding are from the president, Christmas seal. As for Chang Hua, funding are from membership, donation of members, pharmaceutical companies
Stop TB Partnership	Entire fund is from the Chairperson (owner of oil company)

Indonesia	
THRF, Thailand	Research funding for research activities For charity, mostly come from the volunteer ladies' fundraising
JANTRA, Nepal	For regular funding is from RIT/JATA. For project implementations are from Global Fund, Stop TB partnership, TBREACH
CATA, Cambodia	JATA, USAID, TBREACH
MMWA, Myanmar	For regular fund are from membership fee, properties (renting lands/building), running pre-school. For project are from several sources such as UNICEF
RIT/JATA, Philippines	JATA, MOFA, JICA, USAID

Participants learnt that MMWA has 12 million members and each member pay about 0.2 US$ for life-long membership and they receive a pin and a certificate to be a member.

Table 2: Fund raising methods of NGOs participating in the meeting

Organization, Country	Methods of fund raising
Stop TB Partnership, Korea	- Developing proposal for funding - Putting donation box in department store, post office and bank (obtained very small amount)
Chang-Hua Hospital / TATA, Taiwan	- Annual donation by people (Taiwanese people like donation) - Donation from pharmaceutical companies (cash and medicine) -selling Christmas seals
Stop TB Partnership Indonesia	- Organizing charity events such as cultural night, sport competition to high income people
THRF, Thailand	- Developing proposal for research funding - For charity: The volunteer ladies raise the fund by self-donation, organizing gala dinner, donation from other sources
JANTRA, Nepal	- Developing proposal for funding
CATA, Cambodia	- Organizing field visit for Japan Women Anti-TB Association - Developing proposal for funding
MMWA, Myanmar	- Donation from donors - Selling calendar and magazine
RIT/JATA, Philippines	- Developing proposal for funding

Funding from tobacco, alcohol and pharmaceutical companies

All participants recognized tobacco and alcohol as risk factors for TB. Therefore, their organizations do not accept funding from tobacco and alcohol related business. Particularly, Stop TB partnership Indonesia's mission also includes stop tobacco. Cambodia implemented TB prevention project in tobacco factory but does not receive funding from the company. As for funding from pharmaceutical companies, participants from Korea, Taiwan and Thailand reported that they accepted donation with conditions. For examples, the pharmaceutical companies can donate money to support TB activities as if they are an individual donor. Therefore, the company's logo must not appear in the product or the events funded by the pharmaceutical companies. JUNTRA, CATA and RIT/JATA Philippines have never been approached by pharmaceutical company. In addition to pharmaceutical business, Myanmar MMWA also reject funding from some baby products such as baby talcum, milk or baby food. The senior participants from RIT shared the information that pharmaceutical companies are also members of Stop TB Partnership Japan. Accepting funding from this business sector should be considered based on the conditions and context of funding proposal.

The moderator closed the session by concluding that funding is important for running NGO and implementing community activities. The discussion shows that integrity to accept or to raise funding is priority for all participants.

Appendix 7

Tokyo Statement on Community Engagement in End TB Strategy

Asian National Stop TB Partnership Forum 2016

The Asian National Stop TB Partnership Forum 2016 was held on March 14-15, in Tokyo, Japan, with the participation of a total of 18 delegates from 8 Asian countries / territories (Cambodia, Indonesia, Korea, Myanmar, Nepal, Philippines, Taiwan, and Thailand). These participants represented the non-governmental organizations (NGO) and other civil society organizations (CSO) engaged in tuberculosis control.

The missions of the Forum were;

- To enhance people's awareness of the importance of their ownership for and commitment to tuberculosis control activities,
- To promote the effective collaboration between governmental and non-governmental sectors in the fight against tuberculosis, with special reference to the potentiality of women's roles,
- To clarify the problems and challenges of tuberculosis control of each target area or community to be addressed in their action plans, and
- To advance cooperation between partners of different groups beyond country borders.

During the two-day meeting the participants shared their experiences and views of their groups, as well as those of the Women's anti-TB Association and Western Pacific Region of WHO, and had discussions over the ways to enhance respective groups' activities in the perspective of End TB Strategy. Following are the summary findings of presentations, discussions, and proposals from the forum, as agreed upon by all the participants.

Background: Paradigm shift in the fight against tuberculosis

Along with the paradigm shift from the Millennium Development Goals to Sustainable Development Goals, the global TB program has turned to End TB Strategy as endorsed in 2014. In this strategy, tuberculosis is recognized more clearly than ever as a socio-economic challenge, not merely as a medical issue, to which more engagement of communities, or non-governmental organizations, is badly needed, as claimed throughout the pillars of the strategy. Specifically, integrated, patient-centered TB care and

prevention is claimed as the fundamental element in Pillar 1. This is also stressed in the Regional Framework developed by WPRO, adapting the End TB Strategy to its regions.

Roles of NGOs in End TB Strategies: Missions, Opportunities, and Challenges

In country presentations and group discussions, the following four points were highlighted as important roles of NGOs / CSOs, each with special emphasis as supplemented in numbers 1, 2, …. . Although the roles and challenges of NGOs/CSOs are diverse and variable according to the countries and organizations, the key issues such as community and patient-oriented approach were common, and this sharing was felt as most critical in promoting the spirit of the stop TB partnership.

1) Cooperation with the government in implementing NTP

1. Supporting TB case detection through urging symptomatic subjects, or TB suspects, to visit health facilities.
2. Encouraging patients to take medications regularly.
3. Increasing the awareness and knowledge of TB among community people on various occasions to reduce the stigma, discrimination and superstition, and to take proper action against illnesses.

2) Social support of patients and families

1. Supporting, educating, and empowering patients and their family facing financial barriers through forging UHC.
2. Providing patients with food, transport, housing, etc., as important areas of patient support.

3) Advocacy

1. Advocating voices of patients and vulnerable people.
2. Increasing awareness of TB among the community.
3. Creating patients' groups, so that they have a stronger voice for claiming better service and protection, and also enhancing community awareness of TB.
4. Creating peer support groups with high capacity to support vulnerable groups (e.g., the very poor, women, children, HIV-infected or elderly persons, etc.).
5. Advocating research for TB control, especially operational researches

and researches involving community activities.

6. Engage other areas of the society/community with TB, such as education, agriculture and MCH, etc..
7. Empower health activists and volunteers o set up networks at grass-root level involving other community members

4) Women's roles and potentials

1. Gender equity should be addressed in TB care, including access to health services and knowledge of TB.
2. Women's potential in community activities should be fully recognized.

Fund raising issues

Many groups suffer from inadequate budgets, but few of them use specific schemes of their own for fund raising, e.g., Christmas-seal campaign, Calendar sales, donation box (in shops, etc.), and charity events, in addition to donations from individuals (group members and others) and companies.

Other funding sources include government programs, the Global Fund, WHO, Union, Stop TB Partnership, UNICEF, other bilateral plans (e.g., JATA, USAID, TBREACH), and charitable foundations.

Apart from the inadequacy of funds, possible concern may exist for receiving donations from pharmaceutical industries (in some countries, also other health-related businesses), to say nothing of donations from tobacco and alcohol industries.

Challenges

1. The high turn-over rate of volunteers is common, possibly due to inadequate incentives and lack of community recognition, or volunteers' dignity.
2. Incentives for volunteers may include privileged free access to health services, periodic meetings for reporting volunteers' activities, opportunities of training and exchange with other groups, awarding for outstanding performance, and provision of travel allowances.
3. Addressing patient's confidentiality or privacy.
4. In some cases, consensus between government and NGOs is not enough, and some care providers have difficulty in implementing International Standards of TB Care.
5. Low capacity of research activities, when NGO's operational research is

expected as very significant, especially in UHC and social protection schemes.

6. Documentation of success stories of community activities may be important in sharing recognition of bases of TB control such as UHC and patient-centered care.

Forum slogan

The forum decided to adopt a following slogan to be shared by member organizations as a priority message of activities.

- *Women are creators of community health through family health.*

Acknowledgement

The Forum acknowledges the contribution and efforts of the following individuals and organizations that made the meeting possible and successful. The Forum also expresses deep thanks to the observers for their kind interest in the meeting.

Participants

[Organization] Cambodia: National Center for TB and Leprosy control (CENAT), Cambodia Anti-Tuberculosis Association (CATA). Indonesia: Headquarthers of Forum Stop TB Partnership Indonesia and Stop TB Partnership Cimahi City, Korea: Korean National Tuberculosis Association (KNTA), Stop TB Partnership Korea, Myanmar: Myanmar Maternal Welfare Association (MMWA), National Tuberculosis Program, Kachin State, Nepal: Japan-Nepal Health & TB Research Association (JANTRA), Philippines: RIT/JATA, Philippines Inc. (RJPI), Taiwan: Taiwan Anti-TB Association (TATA), National Chang-Hua Hospital MDR TB Department, Thailand: TB/HIV Research Foundation (THRF), Chiang Rai Volunteer Ladies against TB

[Member] Cambodia: Khloeung Phally, Monyrath Chry, Chharvy Ringsey Keo, Indonesia: Mariani Reksoprodjo, Fitriani Manan, Korea: Seungjoon Chang, Kanghee Kim, Hong Jo Choi, Myanmar: Tha Zin Nwe, Ei Ei Chaw, Nepal: Ram Sharan Gopali, Jamuna Panthi, Philippines: Aurora G Querri, Leonardo G. Parungo Jr, Taiwan: Chih-Yun Lin, Wei-Wen Chen, Thailand: Sarmwai Luangjina, Jintana Ngamvitayapong-Yanai

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[Member] Ram Sharan Gopali, Makiko Goto, Yumi Ishikane, Nobukatsu Ishikawa, Shoji Kudo, Ayako Miyamoto, Toru Mori, Nobuyuki Nishikiori, Jintana Ngamvitayapong-Yanai Kosuke Okada, Kintaro Shibuya, Noriko Shirasu, Noriyo Shimoya, Keiji Tanaka, Tomoko Tsuji, Takeko Yamashita

Asian National Stop TB Partnership Forum 2016

Date : 14-15, March, 2016
Venue １ : 1F HALL United Nations University,
Venue ２ : Hotel New Otani
Venue ３ : Research Institute of Tuberculosis (RIT)


Summary
• Substantial achievement in TB control globally
• Remaining and emerging challenges
– TB among high-risk and vulnerable populations
– Scaling up response to drug-resistant TB
– Building sustainable TB control system while contributing to the overall health system strengthening efforts
• The End TB Strategy and its Regional Framework opened up new era of TB control
– From a vertical programme to "an essential health system competency"
– People-centeredness as a core principle
– All countries to be aligned and cooperate for regional/global TB control
World Health Organization Regional Office for the Western Pacific


Asian National Stop TB Partnersh
Mission
To function in the prevention/control of Tuberculosis Public Health and Social Development issues in Nepal
Areas of Intervention
• Policy and Advocacy at all level
• Community System Strengthening (CSS)
• Knowledge Management
• Partnership and networking (Nationally & Internationally)


Asian National Stop TB Partnership Forum 2016
Our Steps for.....


al Stop TB Partnership Forum 2016


ership Forum 2016


STOPTOBACCO


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