The Stop TB Partnership Indonesia is a partnership group comprising of diverse organizations and individuals who have the common commitment to deal with the problems of Tuberculosis. Partners can be an individual or the organization leaders who have the power in advocacy. Their main goal is to contribute in supporting the government on TB control in their regions.

Tuberculosis (TB) remains a major global health problem. In 2012 an estimated 8.6 million people developed TB and 1.3 million died from the disease (including 320,000 deaths among HIV-positive people). The number of TB deaths is unacceptably large given that most are preventable.

WHO Global Tuberculosis Report 2013 and accompanying supplement countdown to 2015 assess progress have been made towards the 2015 targets and top priority actions are needed to achieve and/or move beyond them for TB care and control.

These five priority actions required to accelerate progress towards the 2015 targets include:

1. Reach the missed cases
2. Address MDR-TB as a public health crisis
3. Accelerate the response to TB/HIV
4. Increase financing to close all resource gaps
5. Ensure rapid uptake of innovations

The South-East Asia Region (SEAR) and Western Pacific Region (WPR) collectively accounted for 58% of the world’s TB cases in 2012¹. Half of the High Burden Countries (HBCs) are in South-East Asian, Western Pacific and Eastern Mediterranean region (EMR) i.e. 11 out of the 22 HBCs.

The 1st Forum of National Partnerships to Stop TB in SEA, WP and EM regions was held on 22-23 November 2012 at Seoul, Republic of Korea. During that meeting Indonesia as one of the successful country in partnership proposed to host the 2nd Forum of National Stop TB Partnership meeting in 2014.

The 2nd Forum of national partnerships working in TB care in the SEA, WP and EM regions focussed on the urgency to find, treat and cure the ‘missing cases’ through the involvement of the private sector and wider communities. Organized on the 3-4 March 2014 and financially supported by the Stop TB Partnership Indonesia, the Forum represented a platform for representatives from 13 governments, NGOs, private sector and national partnerships from Afghanistan, Bangladesh, Cambodia, China, India, Indonesia, Japan, Nepal, Pakistan, Philippines, South Korea, Thailand and Vietnam, to meet and discuss how they can overcome their challenges in properly addressing TB.

Theme: “Amplify and sustain our TB successes”

Objectives:

- To share current situation, practices and challenges in engaging a wide range of stakeholders and partners in TB programmes
- To discuss and develop concrete actions to endorse of the Regulation on TB Control in every country through the Top Leader decree
- To discuss and agree on proper engagement of private sector (as health care deliverers and business partners) in TB programmes

¹ WHO, Global Tuberculosis Report 2013
Proceedings:

DAY 1: 3rd March 2014

A. Opening Ceremony:

- Guests and participants from the 13 participating countries are welcomed and agenda for the meeting is introduced. Chair of the Stop TB Partnership Forum – Indonesia, Mr Arifin Panigoro, delivered the welcome speech.

- Mr Panigoro welcomes all participants and states it is a pleasure to host the event. He reiterates that TB is a problem that all has been dealing with for a long time and continues to be a huge challenge. Based on the WHO report, Indonesia is among the 22 high burden countries. The problem is aggravated due to limited finances and there is need for commitment from the government and private sector. He emphasises the importance of engaging various stakeholders in the fight against TB and stresses that collaboration has become an important part in TB care and control. With complex challenges such as increasing number of cases, emergence of MDR-TB, high risk factors such as diabetes mellitus patients in TB and smoking, and insufficient financial capability of country funding makes this challenge even harder. Strong commitment and serious efforts from all stakeholders will help achieve the goals and targets. The need for high level decree to release country dependency on international funding and attain sustainability through domestic sources. He suggested that national Partnerships should collaborate with each other, for example STBP Japan collaborated on a project for community engagement with the Indonesia Partnership; as such joined efforts could accelerate achievement of the common goal.

- WHO Representative to Indonesia, Dr Khanchit Limpakarnjanarat recollects the aim of the meeting which is to share experience and successes of national partnerships and appreciates the Stop TB Partnership Indonesia for hosting the multi country event and financing it. There has been major progress made in the 20 years in TB control but there remain top priorities that still need to be addressed. He shared key facts of the disease and it is not acceptable to have deaths due to TB. WHO suggests 5 priorities towards 2015 target of MDGs:
  i. List the missed cases, ensure diagnosis and treatment
  ii. Address MDR-TB as a public health crisis i.e. diagnosis, treatment and capacity building, need to collaborate among partners of various stakeholders
  iii. Accelerate the response to TB-HIV co-infection. Increase ART coverage of co-infected patients to 100%
  iv. Increasing financing to poor resource gap of 2 billion USD per year in low and middle income countries.
  v. Ensure rapid uptake of innovations as strategies or tools in policy.
  
  These can be achieved by development and adoption of the new strategy will help accelerate the fight against TB. There is current need in the wider contribution from various Public Private Partners, from different ministries, sectors, media, etc. He hopes the outcome of the meeting would be to understand and broaden the need for partnerships which is crucial for TB care and control.

- Dr Lucica Ditiu, Executive Secretary of Global Stop TB Partnership presents “Out of the comfort zone in thinking of TB” and urges interactive discussions in order to discuss issues or challenges and their solutions. She congratulates the Stop TB Partnership Indonesia under the Chairmanship of Mr Panigoro for taking the leadership in organizing this meeting showing a true example of what the private sector can do if we engage them for TB care and control.
The regions hold most of the important countries in relation to burden on TB and this meeting is important to reach out to private sector and communities for their involvement in TB care and control. There is hope to get more attention from the government and ministers to prioritise TB in various countries of the regions. Dr Ditiu speaks that the hope of reducing TB incidence from 125/100K to 10/100K with the 2% rate of decline per year we have now, we will only reach the goal by 2180, hence we need to accelerate the work if we want to see a more significant decrease in the Incidence rate in our lifetime or our children's lifetime. There are 1.3 m TB deaths per year with 40% in SEA. 8.6m TB cases were estimated in 2012 (same as 2007) but countries reported 5.7m i.e. about 3m are missing cases- could it be the private sector? Providing care not following the NTP – we need additional efforts to find them.

There are about 450,000 new cases of MDR-TB but only 77000 reported and put on treatment. XDR-TB a new challenge which is estimated at 10% of MDR-TB cases. Advocacy efforts are needed to get attention of Ministry of Health and Ministry of Finance by using the data or figures to grab their attention. There are funding gaps of 2 billion with the biggest gap in the African region. There is a 150 million funding gap in SEA. Interaction is needed with private sector to bridge gaps.

Dr. Ditiu appreciates the hand tree logo made by the organizers which shows we can achieve more by joining hands.

- Deputy for Health, Population and Family Planning of Coordinating Ministry for People's Welfare, Republic of Indonesia, Dr. Emil Agustiono wishes an interactive and good meeting, appreciates the organizing committee and guests who have come. TB is a multi-sector disease. There is need to show TB as a public health crisis like an emergency situation for which a response is needed to reduce the incidence and encourage treatment. Exploring finance to ensure this response is crucial and need to absorb and explore contribution of all stakeholders in the countries of SEARO, EMRO regions. Working together, strengthening the partnership for global community will accelerate our efforts. All departments should be endorsed to finance efforts for TB care and support of the national program or Ministry of Health. TB control should be included in the National Development plan and be part of the economic and social welfare department plans as well. He thanked all on behalf of Government of Indonesia, wishing all a good meeting and officially opens the event by hitting the bell/gong together with Pak Arifin Panigoro, Prof. Tjandra Yoga Adhitama, Lucica Ditiu and Dr. Khanchit Limpakarnjanarat.

- The Minister of Health, Republic of Indonesia: Dr. Nafsiah Mboi congratulates and thanks Stop TB Partnership Indonesia for organizing the event with support from various partners and attendees from many countries which she cites as a good example of true partnership initiative. The event indicates recognition of the progress the country has made in TB Control for example the achievement of 90% of cure rate with a fall in mortality rate from 53 to 27 /10000K population in Indonesia; all was made possible by support of partners. Problem is the limited community access with good quality services. There are multiple challenges with financial gaps which led to the introduction of a social health insurance scheme which could address this challenge. On 1st Jan 2014 Indonesia national social health insurance scheme is launched , a total of 117m people will benefit from the scheme bringing TB services in the reach of all. In the years of the DOTS strategy we have successfully treated 56 million patients and saved 22 million lives worldwide. While it is a good achievement we can do better to accelerate progress and address fundamental challenges.
like MDR-TB and TB-HIV. **Innovations are to be put in practice and opportunity to call on partnerships in an organized way to fight the epidemic of TB.** Dr. Mboi also mentioned the post 2015 Global TB strategy and encourages its adoption through advocating country governments. The strategy is based on 3 principles; i. Integrated approach ii. Supportive system and iii. Research. The strategy may have ambitious targets but they can be achieved in a strategic and systematic way. She ends her talk by encouraging all participants to **use this meeting as a launching pad for new efforts in improving national, regional, local and international level TB Care and control services.**

- **Mr Osamu Kunii – Head Strategy, Investment & Impact Division of The Global Fund** spoke on GF TB Investment. He shares that GF contributes 75% of international funding for TB control amounting to 4.7 billion USD and of that 16 % is in the South Asia region. There has been an increase in trend for TB disbursing from 2003 to 2013. The TB budget is distributed under the various heads like diagnosis and treatment (33%); Supportive environment (19%), MDR-TB (14 %), HSS (14 %) M&E, OR (7%); community TB and high risk groups (6%), TB-HIV (4%) and Engaging with other providers (3 %). Achievements include supporting more than 1000 programs in 140 countries supporting major progress in TB control like decline in incidence rate, prevalence and mortality, supporting the scale up of DOTS, MDR-TB and innovative approaches like public-private mix, Gene Xpert and MDR-TB scale up. However there are challenges that need to be addressed like the missing cases, the slow decline in TB incidence, matching expanded diagnostic capacity for MDR-TB to effective treatment, low ART coverage among HIV infected patients, funding gaps, suboptimal involvement of private sector and engagement of civil society in KAP in TB. What is needed to move forward is reaching the missing cases and effective treatment, addressing MDR-TB as a public health crisis, involving all stakeholders including private sector and civil society in TB, increase financing to close all resource gaps including domestic financing and ensure rapid uptake of innovations.

**Country wise presentations:**

- **Afghanistan:** Team shared a few key epidemiological facts of the TB program in the county (see table)
  Progress and achievements included:
  - Policy documents and related guidelines/SOPs developed and training packages implemented.
  - Revision of NTP National Strategic Plan for the year 2013-2017
  - Establishing Culture facilities in NRL and RRL
  - MDR TB management started at central level
  - Development and expansion of TBIS, TB information system nation wide
  - Expansion of Stop TB Partnerships in main provinces including TB Patient Association
  - TB Cross Border Coordination launched between Afghanistan and Pakistan, and
  - Operational research on TB & Gender, accuracy of TB data for the country.

Afghanistan partnership has a wide range of partner from multiple sectors including UN organizations, bilateral agencies, ministries, parliament, patient groups, civil society and many
private business corporations. The partnership has prepared a concept note for NFM of GFATM for 2015-2017 with budget for expanding of the partnership in 34 provinces. The advocacy role of the partnership for political commitment is highly successful as there are members from Parliament who engaged in TB and some members of the board include high levels of Government including two present Ministers and the Chair is an ex Vice president of Afghanistan who is now the Director of Human Rights. There has been good achievement in spite of the law and order situation and this need to be continued with support from the WHO and other partners.

- **Bangladesh:** Bangladesh is ranked number 6 in the 22 high burden countries for TB. It has shown much success in exceeding the targets of treatment success rate and has achieved the case detection rate of 70% with a decrease from 76 to 45/100,000 per year of TB deaths. There are challenges like sustaining the achieved success by maintaining quality services, addressing extra pulmonary TB, Paediatric TB and sputum negative cases, scaling up of PPM, PMDT and cPMDT, strengthening of ACSM and health system strengthening. These challenges can be met by increasing and sustaining finances to extent diagnostic facilities like geneXpert and availability of technology; effective public and civil society engagement and research and development. Majority of funding for TB comes from the GFATM with limited finds from the NTP. Role of the Partnership in mobilizing resources include;
  - Human resource – Training, collaboration, other resource management, employee motivation, etc.
  - Financial need for MDR through PMDT & cPMDT, EP, investigations
  - Physical – Facility extension, technology importation, logistics etc.
  - Information- Guidelines development, leaflets, annual reports, research findings etc.
  - Time- Proper coordination in diagnosis, follow up and overall management

- **Cambodia:** Cambodia has the second highest prevalence rate among the 22 high TB burden countries. The country has made much progress in meeting their targets with the case detection rate of 66% and a treatment success rate of 93% much more that the target of 85%. The treatment outcome is high but there is low case finding including MDR-TB so they have developed approaches to improve case finding using the routine system, awareness campaigns and active case finding using mobile teams especially for high risk populations and vulnerable groups. Financial requirement for a year is 30 million but only 8 million is available at present. About 90% of patients receive treatment from the government and ministerial order of 2011 ensures self-regulation by pharmacist association not to sell anti TB drugs over the counter. Challenge of involving major hospitals will be stepped up by government in 2014.

- **China:** China follows the DOTS strategy which is centralized consisting of free diagnosis and treatment, in addition an incentive mechanism giving subsidy for referrals, DOTS provision and tracing patients and transport fee for poor patients in project areas. Challenges of addressing vulnerable groups like prisoners and floating population, TB-HIV co infection and MDR-TB are being looked into. China has a new model for TB service delivery whereby designated hospital will be in charge of diagnosis and treatment for patients instead of TB dispensaries. Funds for TB control were increased from 0.13 billion in 2001 to 1.4 billion in 2013. Registration ratio of active pulmonary TB patients was raised from 39.0/0.1million to 73.6/0.1million from 2001 to 2005; and then kept
stable around 75.0/0.1 million. A declining tendency was observed from 2008 to 2011. China works with many international partners who offer wide range of support from capacity building, communication materials, health promotion and training and exploring new innovations and tools. However the TB epidemic is still serious with China ranking 2nd among the 22 high burden countries and the reported incidence of 74/100000 was ranked 2nd among 37 communicable diseases in 2010. A survey showed an estimated 5 million active pulmonary TB cases with difference in prevalence rates per area, the proportion of patients without any symptom is high, cases are higher in older age groups and MDR-TB rate is 8.32% and XDR-TB rate is 0.68%. To add to these challenges there is insufficient funds as provider related funding rely on external funds, patient related package is very basic, there is no funds to support MDR after the GFATM – patients would have to pay 30% of their TB care and there is no transportation fee nor psychology support. The new health system reform however represents a major window of opportunity to advance TB control in China, improve quality of drugs and bold policies and research and development for new diagnostics as way forward to enter a new era in MDR TB control.

- **India:** India has ¼ of the global burden with a mortality rate of 22/100 000 population, prevalence rate of 230/100 000 and incidence rate of 176/100 000. Case notification rate remains the same in spite of India declaring TB a notifiable disease in 2012. The national TB program in the 11th five year plan have achieved more than their planned targets and have moved into the 12th five year plan with the theme of "Universal access for quality diagnosis and treatment for all TB patients in the community with a target of reaching the unreached". Targets of the 12th plan will include early detection and treatment of about 8.7 million patients. 200 000 MDR-TB patients with special focus on marginalized, hard to reach populations, high risk and vulnerable groups. To achieve this the NTO sub-district management unit are proposed to be aligned with the National Rural Health Mission blocks, increase in infrastructure and man power at all levels, development of diagnostic and free treatment for DR-TB and HIV co-infected patients, urban TB control is to be aligned with urban health mission and revised financial norms of the NGO-PP schemes. The 12th FYP has 75% funding from the Government of India. Civil society in India is however largely dependent on international donors and do not receive much from domestic sources with the exception of the NGO-PP schemes. The areas of priority for India would be to find the missing cases of about 800,000 expected to occur but not diagnosed or not notified to the program, for which there is an urgent need to involve private healthcare providers, also DR-TB is a serious threat added to which financial constraints for addressing these priorities. Many stakeholders from private sector, communities and the national partnership supports the national TB program through various activities like trainings of medical practitioners, medical colleges, pharmacists, rural healthcare providers, hospital managers, media, school children, workplace interventions etc. advocacy among communities, parliamentarians, TB patient networks among a few. The national partnership plans to advocate for increase of funding to civil society through domestic sources and through the CSR components of private companies, it also plans to identify and train a pool of TB spokespersons who will liaise directly with the TB parliamentary forum for political commitment.

- **Indonesia:** A country 4th among the 22 high burden countries has a prevalence rate of 297/100 000 population reduced from 442 in 1990, incidence rate of 185 from 206/100 000 and a 49% decline in mortality rate. Indonesia launched a National TB survey in April 2013 and is ongoing with final
results and report expected before end 2014. Although there has been significant progress in TB control however the magnitude of the disease is still high with estimates of 730,000 new cases in 2012. Funding is mainly from the Global Fund which accounts for 60-70% of funding with about 30-40% from the national budget. The Indonesian Stop TB Partnership Forum was launched in March 2013 under the chairmanship of Mr Arifin Panigoro. The declaration of Indonesian TB Partners as “kick off” of the Indonesian Stop TB Partnership was done in May 2013, it includes 9 groups and is formerly known as “The Indonesian Forum of Stop TB Partnership”. The target for the partnership by end of 2016 is to be established in 33 provinces, strengthen forum members by invitation to join, grouping the forum members into working groups and establish forum at provincial and city level. The partnership strongly encourages the issuance of the highest legal aspect i.e. Presidential Decree as the basis for TB control in Indonesia as well as in other high-burden countries and also encourages strong engagement of private sectors to join the Forum and recognizes the importance of their role in TB control.

• **Japan:** There has been a marked decline in incidence of TB in Japan over the decades from 698.4 in 1950 to 18.2 in 2010; TB cases are seen in age group of 60-90 yrs. and the ratio of foreigner / foreign born TB patients’ makes up to 37%. The Stop TB Japan was established in 2007 with the objective of promoting international and national TB control through public-private partnership. The partnership managed to promote a parliamentary federation who made recommendations on improving the TB program to the government. Some of the major activities in 2014 by the team include a meeting on planning for post MDGs, activity for high-risk groups including elders, urban poor people and tobacco and NCD and a collaborative project with the Indonesian Stop TB partnership using the medium of the Indonesian traditional shadow puppet show “Wayang-Kulit” for generating awareness on TB.

• **Nepal:** The national TB program is priority number 1 for the Government of Nepal; DOTS implemented and reached 100% public health institutional coverage in 2004. Stop TB strategy was adopted in 2006 and the present estimates includes prevalence rate of 241/100,000, the incidence rate of 163/100,000 and TB deaths 20/100,000. Childhood TB is 5.1% of cases and 2.2% of MDR among new cases and 15.4% among retreated cases. The engagement of both international and national partners began during the establishment of TBCN (Tuberculosis Control Network) in 1989 with 4 major partners i.e. JICA, WHO, NATA and LHL International and ever since have seen an increase in partners on receiving the Global Fund grant with PRs & SRs joining. This forum also addresses the challenges of recording or reporting, coordination among SRs, and avoids duplication of program activities among partners. This is also used for joint planning and M&E of activities. There is heavy reliance on Global Fund who finances about 80% of the total budget for TB. Major challenges for the TB program in Nepal are undiagnosed, mis-diagnosed and un-notified cases. Suggestions of the way forward to address various challenges include increase government budget allocation for TB for financial stability, strengthen ACSM, active case finding through expansion of Gene Xpert including mobile van, diabetic screening, piloting community DOTS to reach unreached population, strengthen PPM, promote web based information, ban over the counter sale of ATT drugs and strengthen urban DOTS to address un-notified cases, improve and expand infrastructure and undertake a prevalence survey of TB cases for proper estimation of TB cases.
• **Pakistan:** Pakistan is number 5 among high burden countries for TB with the prevalence rate of 348/100,000, incidence rate of 276/100,000 and TB deaths of 34/100,000. Partners of the NTP include NGOs (3), Provincial TB program (5) and regional TB control programs (3). There are 42 Gene Xpert machines installed in December 2013 thereby increasing case finding. The program has developed warehousing management system, TB-Drug management information system and E-surveillance for MIS for DOTS. The Stop TB partnership of Pakistan has been established to involve and empower people with TB and communities. The program has also engaged with media to create awareness and Pakistan has a celebrity as a Stop TB Ambassador. Funding for the TB program in Pakistan is heavily dependent on international funding. The country has a new national strategic plan “vision 2020” with the goal to reduce the prevalence of TB by 50% by 2015 in comparison with 2012. Some of the key priority area include missed and delayed cases of TB, insufficient allocation for TB, DR-TB, private sector involvement, TB in difficult areas and high risk groups, childhood TB, etc.

• **Philippines:** Philippines achieved the MDGs as early as 2011 with a sharp decline in the prevalence rate from 1000/100,000 in 1990 to 461 in 2011, Incidence rate from 400 to 265 and TB mortality from 55 to 24. There are 35,000 missing cases due to under-reporting; cases are diagnosed but not reported and under diagnosed: patient seek care but are not diagnosed and there is poor access to healthcare. To address the former there is need to strengthen surveillance systems, establish links with full range of health-care providers and enforce legislation on notification of cases strongly. For the latter there is need for better diagnostic capacity and establishing remote smearing sites, community TB task forces to recognise symptoms of TB. The country is 4th among 27 high MDR-TB burden countries having 23% cases. Added to the challenges is a weak TB HIV collaboration at service delivery level. The Philippine Plan to control TB (PhilPACT) have 8 key strategies:
  - localize TB program implementation
  - Monitor health system performance
  - Engage both public and private TB care providers
  - Promote and strengthen positive behavior of communities
  - Address MDRTB, TB-HIV and needs of vulnerable population
  - Regulate and make available quality TB diagnostic tests and drugs
  - Certify and accredit TB care providers
  - Secure adequate funding and improve allocation and efficiency of fund utilization.
Financing of the PhilPACT is 38% from the government, 33% is foreign assisted, 14% from local government, 14% out of pocket and 1% from the national insurance. Private sector involvement initiatives to sustain TB control is public-private Mix DOTS, enhance hospital TB DOTS, strengthen internal and external referral system and quality of TB diagnosis and treatment in hospitals, programmatic management of DR-TB, TB HIV collaboration activities, TB DOTS certification and accreditation, expansion of laboratory services, community care and TB in academies. The Philippine Coalition against Tuberculosis (PhilCAT) has a membership from the government sector, professional bodies, corporates and NGOs. The Chair is from the private sector and the co-chair is from the government. Aligning activities and strategies with the direction of the NTP, recognition of efforts and contribution of partners to TB control and enhancement of existing programs are some of the objectives of the PhilCAT. Some of their achievement include development of the comprehensive unified policy and PHIC outpatient TB package in 2003, a department circular on
Operational guidelines for PPMD and creation of the NCC and RCC for PPM in 2004, the Philippine clinical practice guidelines for diagnosis & treatment of TB in adults and local TB coalition guidelines in 2006, joint statement on treatment of TB in children in 2011 and clinical practice guidelines for TB update 2014 and plan to support the revised manual of procedures of the NTP in 2014. Some of its advocacy efforts include a real life portrayal of an MDR-TB patients in primetime TV casting popular actors and actresses and spots on TV and radio for advertising on TB control and there has been advocacy for administrative order for mandatory notification of TB from private hospitals, implementing guidelines and order for hospital DOTS and a house bill has been filed in Congress making TB a national priority.

• South Korea: A brief history of TB and its control through the years beginning from 1920 to 1995 was shared. A study conducted on the TB prevalence rate vs. per capita GDP study shows that with increase in GDP the prevalence rate for TB decreases. The TB program is successful in Korea as there is strong political will, economic development, highly educated people and the introduction of rifampicin in the 1980s. The country have a TBNet which is a TB information system established in 2000 which is a web-based TB notification system and the LIS and PACS system are integrating with it. The incidence of TB from the Health insurance system shows about 80,000 TB cases on 2012. The prevalence, incidence and mortality rate have shown slight decline over from 2010 to 2012. Majority of cases are found at the private sectors majorly in general hospitals which is about 89.2 % in comparison to the 11.6% from health centres. There is a new 2020 TB control plan for Korea with the target to halve the TB incidence rate by 2015 and decrease the TB incidence rate to 20/100,000 population by 2020. The strategies proposed include early case finding to reduce transmission, treatment, prevention of TB by BCG vaccination/LTBI, monitoring through the integrated TB information system and research and development. Current issues being targeted are patient care, case finding, preventive of TB disease and TB infection. The Stop TB Partnership Korea was established in 2008 by the Ministry of Health and Welfare along with the Korean CDC with a total of 25 partner organizations and 50,000 individuals partners membership in 2014. The main objective of the partnership is to advocate on TB to the general population and expand membership, to support advocacy, health education, TB screening and treatment for TB high risk group and the vulnerable population and participate in the global stop TB campaign. Some of the partnership’s main activities are TV documentary production for improving TB awareness, commemorative events for World TB Day , health lectures for TB high risk groups such as immigrants, elderly and rheumatology patients, Stop TB youth camp for youths , a policy forum to support efficient TB patient care, providing free TB x-ray screening during multicultural events for immigrants whereby the appoint representatives of 8 national community as foreign TB honorary ambassador , a monthly webzine , IEC materials , a charity concert and organising the 1st forum of national partnerships.

• Thailand: Thailand is a high TB burden and a high HIV burden country with an incidence rate of 119 per 100 000 population, the TB/HIV incidence is 15.2/100 000 pop in 2012. Key population of TB infection are HIV/TB co infected at 2 times higher case fatality , prisoners at 5-10 times higher morbidity, elderly and migrant population. The national strategic plan 2015-2019 has the goal to reduce prevalence of TB from 159 to 120 per 100,000 pop. This will be done by ensuring universal access to standard TB diagnosis and effective treatment for presumptive Tb patient services including special populations who are at high risk of TB disease  and those living in border areas by
2019, reducing case fatality rate from TB, from a national average of 7% to 3% by 2019; or to reduce TB mortality in the general population from 14/100 000 (estimated) in 2012 to 7/100 000 by 2019 and by strengthening the leadership and strategic management capacity for TB control by 2019. The gaps to be addressed include case notification in the private sector, electronic reporting and recording; ensure success rate and DOTS, migrant issues and high risk groups of HIV, Elderly and prison. For the NSP an estimated 220 million USD is required of which only 140 million is available from the country budget needing about 80 million from a proposal to GFATM for joint TB & HIV proposal. Thailand works with some private hospitals, hotels – health program for employees, pharmaceutical company- TB free excellence award, NGOS for training on BCC, awareness raining activities to reduce stigma and discrimination, facilitating access to diagnostic services, referrals and community based DOT provision.

Advocacy efforts include highlighting TB in the department of disease control, public communications and involving ministers, academia and networks to join world TB day activities. Future plans include strengthening of the Bangkok TB committee, support civil society on TB activities, ensure policy on migrant health insurance and coverage and a mobile app for TB notification.

- **Vietnam**: Vietnam has about 60-65,000 new cases annually and total patients put under treatment is 100-110,000 with a success treatment rate of 80-85%. The NTP is weak and has low detection rate with treatment difficulties in remote areas. The Vietnam Stop TB Partnership was founded in June 2010 with 36 partners including Ministries, CSOs, NGOs and international organisations. The main responsibilities are to support the NTP to help improve TB detection rate and assist in TB treatment. The team has regular quarterly meetings and have advocated with Central organisations, Congress, Government and ministries, helped develop the NSP till 2013 and activities like painting contest and trainings. It also helps to assist in TB detection by implementing a circular from the MoH in February 2013 and assist in treatment through social organization volunteers and local authorities and associations. Some of the challenges are the collaboration and support given by Ministries, agencies and local authorities are not too encouraging, there are many other health programs to implement and limited financial resources being mobilised.

- **Day 1** was summarized by Dr. Suvanand Sahu, Team Leader, TB REACH, Stop TB Partnership Secretariat. Important points discussed were;
  
  **Opening ceremony**:
  - Common identified gaps in TB control were there missing cases, increase in MDR-TB and financial limitations to improve TB control.
  - There was emphasis on the need to find ‘missing cases’ through involvement of the private sector and community, Strengthening partnerships of the global community to accelerate efforts is needed and clear need sustainable financing and political commitment for TB care and control.
  
  **Country presentations**:
  - There is progress in all countries through partnerships efforts and engagement of various stakeholders.
  - Each country identified their gaps and priorities but most feel there is a need to accelerate efforts to find missing cases.
To do this there is need to involve the private sector actively and financial stability to sustain efforts made so far.

Another good suggestion is the cross country collaboration of Stop TB Partnerships for cross learning and also best practices to enhance efforts for TB care.

- Dr. Muhammad Akhtar, Medical Officer TB Programme, WHO Indonesia mentioned about the announcement of the post 2015 TB strategy by WHO most probably by end of May 2014 which is meant to change the landscape of TB control. There are financial constraints in most of the participating country so there is need to see cost of TB can be managed as the new strategy will require accelerated efforts like active case finding, roll of GeneXpert, etc.

DAY 2: 4th March 2014:

- The day began with opening remarks from the Executive Director of the GFATM Dr Mark Dybul who mentions the opportunities made available by GFATM using present tools to achieve ambitions. Resources are important and it’s unfortunately that there are not a lot of global resources for Tuberculosis. GFATM provide about 18% of external resources to countries. The expectation for middle income countries is for domestic funds for TB control. But there is too much complacency at high level and this is where the national partnerships can ensure the involvement of government and also link to the private sector to actively engage all sectors. This will be essential for moving forward in TB control. GFATM can play a catalytic role in driving political leadership and involve private sector to bring change with increasing resources but partnerships can make the change happen and keep ambitions alive.
  - Audience remark: Low share for TB may hamper progress made so far.
    - Share for TB has increased from the previous envelope. It is the countries need to look at their priorities and allocate the funds. What drives resources is not only advocacy but the results.

Group Discussions:

Group 1: Role of a wide range of stakeholders and partners in the era of post 2015 strategy and various partners from private sector (as healthcare deliverers and business partners) communities, civil society and stakeholders from other sectors beyond health.

Key observations:
- TB is not a notifiable disease in most participating countries.
- No regulation on over the counter sale of anti TB drugs
- Need to find missing cases
- Financial gaps exist in most of the participating countries
- Aggressive targets on post 2015 strategy will need serious financial and technical requirements
- Need for effective and expanded partnerships in TB control – TB partnerships are not very effective and needs to be looked at
- Heavy dependency on donor funding in particular GFATM and need to advocate for domestic sources
- Will donors/GFATM support the implementation of the post 2015 strategy? Bigger piece of pie for TB control.
- MDR-TB a huge and expensive problem so finances are needed
- Urgent need to address high risk groups (Child TB, DM, NCDs, Tobacco, gender, etc.)
- Limited Private sector engagement in spite of going about this for 10 years.
- Collaboration projects between countries a possibility –a regional partnership? Can we look at this.

Recommendations:
- Need for establishment and/or further strengthening of effective national partnerships.
- All countries must make TB a notifiable disease and pass regulation to control over the counter sale of anti TB drugs.
- Political & partnership commitment for adequate resources for TB control.
- Partnerships should support the uptake of new and innovative approaches from diagnostics to best practices.
- Partnerships demand greater assistance from WHO to achieve post 2015 targets.
- Partnerships to be interface agencies between NTP and Implementing NGOs for monitoring and evaluation.
- Inclusion and active engagement of private sector into partnerships using a separate strategy to engage them.

Audience remark: recommendations are to all stakeholders.

**Group 2: Financial stability**

Key observations:
1) In longer term, TB control financing should be the responsibility of the governments but for the interim period given the economic status of the countries, external support is extremely needed to reach post 2015 global strategy.
2) At national level, key actors should include parliament/NTP/MOH/Local government /civil societies/ women groups/CGC/private sector (business) and local donations.
3) Low priority on TB control form government ( central, state, local level) and private sectors
4) Low awareness of community thus social support, high stigma and lack of support to CBOs/CBOs
5) Need for funding due to security and geographic issues ( logistics, staff and safety)
6) GFATM plays a critical role on sustaining
7) NFM is simple and aligned with NSP

Recommendations:
- Government should allocate more budget for TB program.
- Encourage private/business sector to contribute substantial support to TB program from their CSR component.
- GFATM support and scale up of TB program to reach post 2015 targets until the country become self-sufficient to sustain the program.

Potential source of internal funding:
- Business houses
- Celebrities
- Out of pocket of rich patients
- Local donations
- Pharmaceutical
- Mass organizations, media
- CSR
- Bilateral/multilateral donors
- Medical insurances

Audience remarks:
- How to encourage private/business to contribute?
- We can look at work places like factories by creating awareness on TB; it has worked for HIV so it should work for TB as well.
- Through the CSR components of companies which is 2 % and is mandated by government. Need for advocacy to create good awareness and they will respond.

Group 3: Strengthening role of National TB Partnerships for advocacy efforts

Observations:
1. Partnerships will facilitate to come up with a unified TB program led by government
2. Empowered TB patients should be a major partner
3. Composition, influence and political commitment of the members of the partnership at country level and beyond are important. Include multiple sectors. Neither Government nor private sector can manage TB alone.
4. Mutual response for one another and understand each other’s responsibilities and limitations
5. A recognized/legalised partnership can be more effective

Recommendations:
1. Government should facilitate/promote establishment of an umbrella body including all stakeholders
   - Umbrella body should have its own governance and monitoring .Umbrella body could;
   - Role of ‘watch dog’
   - Advocate for TB program with other stakeholders
   - Get other government sectors involved
   - Advocate for TB legislation to increase for budget allocation through all ministries
   - For continual advocacy to fulfil gaps and bridge between government & non-government
2. For sustainability of National TB Program, Partnerships are needed to advocate for funds and services.
3. Involve and strengthen partners of partnership.

For private sector:
- Umbrella body should engage other private sectors to contribute
- Promote CSR e.g. in India and Thailand – partnerships should sell the importance of TB.
- Advocate private sector to implement work place policies in interest of TB patients

Audience remarks:
- We have high burden countries here and what can we do together so we can up with specific action to improve or amplify TB control?
- Streamline the recommendations of the group and come up with time bound recommendations and send to respective countries.
Collated group presentations on Recommendations

<table>
<thead>
<tr>
<th>Key word</th>
<th>Group 1</th>
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<tr>
<td>Establish &amp; Function</td>
<td>Need for establishment and/or further strengthening of effective national partnerships. Partnerships to be interface agencies between NTP and Implementing NGOs for monitoring and evaluation</td>
<td>Gov. should facilitate/promote establishment of an umbrella body including all stakeholders. Umbrella body should have its own governance and monitoring Bridge between Gov. &amp; non Gov. For sustainability for both NTP or Partnerships need to involve and strengthen partner</td>
<td></td>
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<tr>
<td>Legislate</td>
<td>All countries must make TB a notifiable disease and pass regulation to control over the counter sale of anti TB drugs</td>
<td>Gov. should allocate more budget for TB program</td>
<td>For continual advocacy to fulfil gaps</td>
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<tr>
<td>Commit</td>
<td>Political &amp; partnership commitment for adequate resources for TB control</td>
<td>Gov. should allocate more budget for TB program</td>
<td>For continual advocacy to fulfil gaps</td>
</tr>
<tr>
<td>Innovate</td>
<td>Partnerships should support the uptake of new and innovative approaches from diagnostics to best practices.</td>
<td>Encourage private/business sector to contribute substantial support to TB program</td>
<td></td>
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<tr>
<td>Involve</td>
<td>Inclusion and active engagement of private sector into partnerships using a separate strategy</td>
<td>Encourage private/business sector to contribute substantial support to TB program</td>
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<tr>
<td>Support</td>
<td>GF supports and scale up of TB program to reach post 2015 targets until the governments become self-sufficient to sustain the program</td>
<td>Gov. should allocate more budget for TB program</td>
<td>For continual advocacy to fulfil gaps</td>
</tr>
</tbody>
</table>

Way Forward: How to go from recommendations to action?
Session facilitated by Dr L. Ditiu, Dr S.Sahu and Dr M. Akhtar.
- Recommendations can be sent to ministries of countries, government, NTP, etc.

1. Establish & Function:
   - New or existing bodies/partnerships to be strengthened and recognised ensuring all stakeholders are involved.
   - In countries where there are no partnerships Stop TB can facilitate to take the issue forward.
   - Develop capacity of Partnerships - Global Stop TB Partnership to support and assist national partnerships to make a significant contribution – No specific funding from Geneva but can be looked at other sources i.e. with GF and other forums.
   - Regional partnership? - maybe it’s better to focus on national partnerships for now before considering a regional forum
   - Stop TB Partnership Secretariat should increase communication with national partnerships and advocate support of respective government to partnerships.
   - Piggy back on UNAIDS, GF and others through correspondence sent to country government. Also when attending meetings the issue can be brought up with head of states e.g. there will be a visit of GFATM and Stop TB Partnership to Pakistan in April 2014.
Advocacy is needed to bring TB as a priority in countries and should have strong internal commitment to move funds internally from donors within country. 

Encourage collaborations between different national partnerships for joint efforts.

2. **Legislate:**

   **A. Notification of TB –**
   - In some countries TB notification has just started and it will take some time for it to take off. E.g. India and Pakistan
   - Indonesia will announce this in 2014 after preparatory work is done. PPM project to establish public information system for notification survey and the study is being assessed and lessons learnt will be scaled up. Negotiations are on for the universal health coverage to include TB.
   - Mandatory and a system to support the legislation is needed, How to implement that? **Partnerships can find out** from Government on the implementation of the order on TB notification.
   - Cambodia all providers report to NTP- no need for order.
   - Philippines are in the process of implementing the order. Linking of licensing health facilities is being looked at.
   - Bangladesh has just announced the order and templates are being worked on. PP involving private health care providers.
   - Thailand – law is not a first priority but collaboration is; Electronic system is being developed.
   - China – has a system for notifying TB as part of Communicable disease.
   - Advocate for implementation of the notification. Create an enable environment for notification through simple information and reporting systems.
   - Pilots to see what works well can be started but **resources needs to be ear marked** for implementation of the order.
   - Sharing of experience and information from other Stop TB Partnerships for best practices on implementation of the order. Flag country experience. In Romania incentives are given on number of cases notified.

   **B. Sale of over the counter anti TB drugs**
   - Cambodia: removed all anti TB drugs from the country with the exception of NTP, ICC forum discuss this issue and made official letters and submitted to Ministries
   - In countries with universal health coverage this becomes easier to implement.
   - Engage all so may need insurance coverage and work with private sector in relation to sales of Anti TB drugs.
   - Pakistan is working on a bill for the ban of OTC drugs.
   - India – has a label ‘Not to be sold without prescription’ on Anti TB drugs.
   - Regulation is important but a stringent one is needed. **Advocacy will be required** for this.
   - How to implement? Can **involve International Pharmacists Association** in this issue and make them responsible.
• Support of communication can be done from Geneva to countries and include the mentioned issues. Countries need to say what they would like to see happen to make it specific for communicating with their governments.

3. Involve: What does it take to involve private sector?

• Come up with or use terms that the private sector like to hear i.e. productivity, efficiency,
• Peer to peer communication can be a way to involve
• Invite Mr Panigoro and others like him to address private sector gathering.
• India has invited Mr Panigoro to speak in a gathering sometime in later part of the year.
• Don’t be shy to ask the private sector i.e. partnerships can write to help from business.
• Invite technical agencies like USAID, donors like BMGF, business houses, etc. around the table for discussions on possibilities.

4. Commit : Advocacy at high level for political commitment:

• Involvement of parliament, other ministers of the country besides the Minister of Health.
• Identify an ambassador to become TB advocate and spokesperson unless we have a popular person worldwide we cannot use one person, this is more of a country to country issue
• World TB Day – link TB to any day events keeps it warmed up and reminds people e.g. World Health day, International children day, etc.
• Reach out highest level of health – coordinate a meeting for feedback with right people and follow up, advocate for a presidential decree as a best possible outcome.
• This report accompanied by a letter signed by all participants highlighting important points to respective countries will help to move the mentioned issues forward with Governments.

5. Innovate:

• TB REACH initiative can fund innovations on what has been done and how successful it has been. Share experiences of partners.
• In the New Funding Mechanism of GFATM innovations from the TB REACH can be funded
• Invite partners to share experiences and also discuss the NFM in country.
• Call for applications to TB REACH is every year and all to look at this call.
• Contact TB REACH team, Stop TB Partnership Secretariat for innovative stories to be uploaded on website and other forums.

Recommendations:

1. Create or strengthen structures/platforms/partners/ forums/ partnerships at National level with assistance from Global Stop TB partnership in order to ensure that there are effective, efficient and inclusive structures engaged in TB control in countries.
2. Actively engage the private sector to contribute substantially to support TB control through any or all of the mechanisms, advocacy, constructing business case and funding.
3. Ensure a national enabling environment for TB programmes and TB control,
   a. Advocate for political commitment with a Presidential decree or similar high level declaration as a best possible outcome.
b. Establish and implement regulation of TB mandatory notifiable disease by:
   i. Advocate and develop friendly environment for TB Mandatory notification
   ii. Set up the information system to support TB mandatory notification
   iii. Piloting of the information system and roll out
b. Establish regulation to control over the counter sale of TB Drugs

Next steps:
- Report to be shared with all participants - Stop TB Partnership Indonesia
- Country participants to send Global Stop TB Partnership - Geneva, the country specific demands in relation to the following recommendations:
  - Need to strengthen and recognise national partnerships by all stakeholders
  - Advocate for notification of TB (if not present) and implementation of the order on notification
  - Need for high level political commitment on TB, advocate to high level
  - Need to invite private sector to gatherings and meetings for involving them in TB care and control
- Once received from countries, letters will be drafted for inclusion with other bodies like WHO, UNAIDS, GFATM, etc. in their country correspondence to high level officials.- Secretariat, Geneva
- Follow up by national partnerships on the letters with next steps.- National partnerships
- National Partnerships to also collect innovations and keep a lookout for call for projects from various funding opportunities like TB REACH, NFM of GFATM, other donors, etc.

Participants of the 2nd Forum of National Stop TB Partnerships in South-East Asia, West Pacific and East Mediterranean Regions, Jakarta, 3-4 March 2014.