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)
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

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

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**“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

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**MDG 6 TB target achieved**

<table>
<thead>
<tr>
<th>Year</th>
<th>Incidence Rate per 100,000 population</th>
<th>Mortality Rate per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>18% drop since 2000</td>
<td>47% decline since 1990</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Incidence Rate per 100,000 population</th>
<th>Mortality Rate per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>140</td>
<td>20</td>
</tr>
<tr>
<td>2000</td>
<td>20</td>
<td>2</td>
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</table>

MDG 6 TB target achieved

In 2014, the global target of a 50% reduction in TB incidence and a 75% reduction in TB mortality was achieved. However, a huge burden of deaths and suffering remains. In 2014, 1.5 million people died of TB, and 9.6 million people fell ill with TB.

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**Surpassing MDGs and other targets**
in the Western Pacific Region

9.6 million people fell ill with TB in 2014, and there were 1.5 million deaths. In the Western Pacific Region, 1.6 million people fell ill with TB in 2014, and there were 88,000 deaths.

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**TB burden in the Western Pacific Region**

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimate number of TB (all forms)</td>
<td>1.6 million (85 per 100,000)</td>
</tr>
<tr>
<td>Estimated number of deaths due to TB*</td>
<td>88,000 (4.8 per 100,000)</td>
</tr>
<tr>
<td>Multidrug-resistant TB</td>
<td>71,000</td>
</tr>
<tr>
<td>HIV-associated TB</td>
<td>31,000</td>
</tr>
</tbody>
</table>

*Excluding death due to TB-HIV co-infection

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**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

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

Growing evidence on a huge private sector drug market

TB drugs in the private sector market

Need for more sensitive diagnostics
The End TB Strategy
Draft Regional Framework for Action

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”

Governance
For Health
Universal Health Coverage
Health system capacity
• Quality & safety
• Efficiency
• Equity
• Accountability
• Sustainability and resilience

Health governance
Sustainable development and growth
Non-health sector policies & actions

Funds
Revenue (Resources for health)
Health policies, system & services
Health outcomes
Disease control in the SDG era
• Disease control efforts:
  — should support system building
  — should be supported by bold systems
• System efficiency, equity and sustainability
• Strong governance
• Multisectoral engagement

Efficient and coherent service delivery

Health development model in the context of Sustainable Development

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

SDG
2020
2025
END TB
2030
2035

Reduction in number of TB deaths
35% 75%
90% 95%
Reduction in TB incidence rate compared to 2020
20% 50%
80% 90%
TB affected individuals having access to health care within 0% 0%
0% 0%
0% 0%

Projected acceleration of TB incidence decline to target levels

Optimize current tools, pursue universal health coverage and social protection

Current global trend: -2%/year

Average -17%/year

-10%/year by 2025

Introduce new tools: a vaccine, a new prophylaxis & treatment regimen, a PoC test

The End TB Strategy: 3 pillars and 4 principles

PILLAR 1
Ending poverty, reducing inequalities and promoting health
PILLAR 2
Building and supporting health systems
PILLAR 3
Intensified research and development

Government leadership and accountability, with monitoring and evaluation
Building strong-wealth with civil society and communities
Protecting and promoting human rights, ethics and equity

Adaptation of the strategy and targets at country level, with global collaboration.
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 44th RCM in Oct 2015**

**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

**Changes in TB incidence between 1994-2013**

**Key areas elaborated**
- People centered care → Principle
- Co-morbidity management
- Link with ageing societies
- TB care financing in the context of UHC
- WPPO’s policy framework on sustainable funding for priority health programmes
- Social protection floor
- ILO Recommendation R202
- Social determinants
- HIV & Urban TB control

**Paradigm shift in TB control**
- Elimination of catastrophic costs / Harmonization with UHC schemes
- Free diagnosis and drugs (in-kind provision)
- Supervised drug intake
- Supportive supervision and community-based support
- Patient-centred care
- Examples:
  - “free diagnosis & treatment” → UHC & social protection
  - DOT → Patient-centred care

**Changes in TB incidence between 1994-2013**

**Estimated incidence (per 100 000)**
- Estimates from Global TB Database
Evolution of the TB control components along with an epidemiological spectrum

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: PHTI/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
- 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

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

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
Thank you!
Country Presentations

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

<table>
<thead>
<tr>
<th>Country</th>
<th>Population</th>
<th>TB burden 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>15 million</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Estimates of TB burden 2014**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Number (thousands)</th>
<th>Rate per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality (excluding HIV-TB)</td>
<td>8.6 (5.3–12)</td>
<td>58 (41–78)</td>
</tr>
<tr>
<td>Mortality (HIV-TB only)</td>
<td>0.8 (0.3–1.5)</td>
<td>5.1 (4.1–6.1)</td>
</tr>
<tr>
<td>Prevalence (includes HIV-TB)</td>
<td>104 (87–120)</td>
<td>468 (455–580)</td>
</tr>
<tr>
<td>Prevalence (includes HIV-TB only)</td>
<td>66 (54–66)</td>
<td>310 (303–318)</td>
</tr>
<tr>
<td>Incidence</td>
<td>12.4 (9.9–15)</td>
<td>12.10 (2–15)</td>
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</tbody>
</table>

**Case detection, all forms (%)**

- 72% (6–80)

**Estimates of MDR/TB burden 2014**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Number</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>New MDR/TB cases with MDR-TB</td>
<td>1.4 (0.7–2.3)</td>
<td>1.1 (0.7–2.3)</td>
</tr>
<tr>
<td>MDR-TB cases among notified pulmonary TB cases</td>
<td>30/160 (18%)</td>
<td>200 (73–400)</td>
</tr>
</tbody>
</table>

**TB case notifications 2014**

- Pulmonary, bacteriologically confirmed: 168 cases (445)
- Pulmonary, clinically diagnosed: 286 cases (709)
- Extrapulmonary: 312 cases (141)

**Total new and relapse**

- Previously treated, excluding relapses: 679 cases
- Total cases notified: 1,393 cases

**Among all new and relapse cases**

- 12,050 (90%) cases aged under 15 years, male/female ratio 1.2

**Reported cases of RR/MDR-TB 2014**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Number</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases tested for RR/MDR-TB</td>
<td>645 (5%)</td>
<td>1,326 (57%)</td>
</tr>
<tr>
<td>Laboratory confirmed RR/MDR-TB cases</td>
<td>110</td>
<td></td>
</tr>
<tr>
<td>Patients started on MDR-TB treatment</td>
<td>110</td>
<td></td>
</tr>
</tbody>
</table>

**TB/HIV 2014**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB patients with known HIV status</td>
<td>91.6% (91)</td>
</tr>
<tr>
<td>HIV-positive TB patients</td>
<td>933 (3)</td>
</tr>
<tr>
<td>HIV-positive TB patients on antiretroviral therapy (ART)</td>
<td>938 (98)</td>
</tr>
<tr>
<td>HIV-positive people screened for TB</td>
<td>3,504</td>
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<tr>
<td>HIV-positive people provided with IPT</td>
<td>901</td>
</tr>
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</table>

**Treatment success rate and cohort size**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Number (cohort)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New and relapse cases registered in 2013</td>
<td>555 (56)</td>
</tr>
<tr>
<td>Previously treated cases, excluding relapse, registered in 2013</td>
<td>700</td>
</tr>
<tr>
<td>HIV-positive TB cases, all types, registered in 2013</td>
<td>933 (3)</td>
</tr>
<tr>
<td>RR/MDR-TB cases started on second-line treatment in 2012</td>
<td>110</td>
</tr>
<tr>
<td>XDR-TB cases started on second-line treatment in 2012</td>
<td>101</td>
</tr>
</tbody>
</table>

**Laboratories 2014**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Number per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>smear</td>
<td>1.4</td>
</tr>
<tr>
<td>culture</td>
<td>1.3</td>
</tr>
<tr>
<td>drug susceptibility testing per 100,000 population</td>
<td>1.0</td>
</tr>
<tr>
<td>sites performing Xpert: MTB/RIF</td>
<td>37</td>
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<tr>
<td>second-line drug susceptibility testing available</td>
<td>8</td>
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</tbody>
</table>

**Financing TB control 2015**

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<thead>
<tr>
<th>Disease</th>
<th>Number (USD)</th>
<th>% Funded domestically</th>
<th>% Funded internationally</th>
</tr>
</thead>
<tbody>
<tr>
<td>National TB programme budget</td>
<td>31</td>
<td>31%</td>
<td>47%</td>
</tr>
<tr>
<td>Unfunded</td>
<td>42%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Estimates of TB burden 2014

<table>
<thead>
<tr>
<th>NUMBER (thousands)</th>
<th>RATE (per 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality (includes HIV/TB)</td>
<td>100 (80–120)</td>
</tr>
<tr>
<td>Mortality (HIV/TB only)</td>
<td>22 (11–33)</td>
</tr>
<tr>
<td>Prevalence (includes HIV-TB)</td>
<td>1.600 (1.303–2.000)</td>
</tr>
<tr>
<td>Incidence (includes HIV-TB)</td>
<td>1000 (700–1400)</td>
</tr>
<tr>
<td>Incidence (HIV-TB only)</td>
<td>65 (40–90)</td>
</tr>
<tr>
<td>Case detection, all forms (%)</td>
<td>35 (22–48)</td>
</tr>
</tbody>
</table>

### Estimates of MDR-TB burden 2014

<table>
<thead>
<tr>
<th>NEW</th>
<th>RETREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of TB cases with MDR-TB</td>
<td>1.9 (0.9–2.3)</td>
</tr>
<tr>
<td>MDR-TB cases among notified pulmonary TB cases</td>
<td>1100 (700–1600)</td>
</tr>
<tr>
<td>TB case notifications 2014</td>
<td></td>
</tr>
<tr>
<td>NEW</td>
<td>RELAPSE</td>
</tr>
<tr>
<td>Pulmonary, bacteriologically confirmed</td>
<td>109.3</td>
</tr>
<tr>
<td>Pulmonary, clinically diagnosed</td>
<td>101</td>
</tr>
<tr>
<td>Ex-pulmonary</td>
<td>19.6</td>
</tr>
</tbody>
</table>

### Total new and relapse

| 32.2 B+6 | 1.7 |

### Total cases notified

| 32.4 B+9 |

### Among 32.4 B+9 new and relapse cases:

23.7% of cases aged under 15 years, male:female ratio 1:4.

### Reported cases of RR/MDR-TB 2014

<table>
<thead>
<tr>
<th>NEW</th>
<th>RETREATMENT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases tested for RR/MDR-TB</td>
<td>1258 (97%)</td>
<td></td>
</tr>
<tr>
<td>Laboratory-confirmed RR/MDR-TB cases</td>
<td>845 (87%)</td>
<td></td>
</tr>
<tr>
<td>Patients started on MDR-TB treatment</td>
<td>9503</td>
<td></td>
</tr>
</tbody>
</table>

### TB/HIV 2014

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB patients with known HIV status</td>
<td>15,674 (60)</td>
</tr>
<tr>
<td>HIV-positive TB patients</td>
<td>21,800 (10)</td>
</tr>
<tr>
<td>HIV-positive TB patients on antiretroviral therapy</td>
<td>553 (91)</td>
</tr>
<tr>
<td>HIV-positive TB patients on anti-TB therapy</td>
<td>664 (98)</td>
</tr>
<tr>
<td>HIV-positive people screened for TB</td>
<td></td>
</tr>
<tr>
<td>HIV-positive people provided with IPT</td>
<td></td>
</tr>
</tbody>
</table>

### Treatment success rate and cohort size

<table>
<thead>
<tr>
<th>NEW</th>
<th>COHORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previously treated cases excluding relapse, registered in 2013</td>
<td>94 (1.0)</td>
</tr>
<tr>
<td>HIV-positive TB cases, all types, registered in 2013</td>
<td>2,438</td>
</tr>
<tr>
<td>RR/MDR-TB cases started on second-line treatment in 2012</td>
<td>423</td>
</tr>
<tr>
<td>XDR-TB cases started on second-line treatment in 2012</td>
<td>11</td>
</tr>
</tbody>
</table>

### Laboratories 2014

- Gene (per 100,000 population): 2.2
- Culture (per 1 million population): 0.4
- Drug susceptibility testing (per 5 million population): 0.3
- Xpert MPD MTB/RIF: 71
- In second-line drug susceptibility testing available? Yes, in-country

### Funding TB control 2014

- National TB programme budget ($US millions): 112
- % funded domestically: 13%
- % funded internationally: 56%
- % unfunded: 31%

---

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

- Numbers represent uncertainty intervals.
- The prevalence of bacteriologically confirmed TB was 5.1 (4.2–6.0) per 100,000 population, the prevalence of CLINICALLY diagnosed TB (i.e., smear-negative and culture-negative TB), including all extra-pulmonary cases (i.e., an additional 1.6 per 100,000 population, i.e., prevalence rate of extra-pulmonary TB is subsumed in the clinically diagnosed category) was 6.7 (5.3–8.2) per 100,000 population.
- Includes cases with unknown previous TB treatment history.
- Includes patients diagnosed before 2014 and patients who were not laboratory-confirmed.
Estimates of TB burden* 2016

<table>
<thead>
<tr>
<th>NUMBER (thousands)</th>
<th>RATE (per 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality (includes HIV-TB)</td>
<td>28 (20-37)</td>
</tr>
<tr>
<td>Mortality (HIV-TB only)</td>
<td>4.1 (3.6-4.5)</td>
</tr>
<tr>
<td>Prevalence (includes HIV-TB)</td>
<td>2.60 (1.96-3.09)</td>
</tr>
<tr>
<td>Incidence (includes HIV-TB)</td>
<td>2.00 (1.80-2.20)</td>
</tr>
<tr>
<td>Incidence (HIV-TB only)</td>
<td>1.05 (0.65)</td>
</tr>
<tr>
<td>Case detection, all forms (%)</td>
<td>70 (64-76)</td>
</tr>
</tbody>
</table>

Estimates of MDR-TB burden* 2014

<table>
<thead>
<tr>
<th>NEW</th>
<th>RETREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of TB cases with MDR-TB</td>
<td>5.3 (1.4-1.8)</td>
</tr>
<tr>
<td>MDR-TB cases among notified pulmonary TB cases</td>
<td>4,600 (3,500-7,200)</td>
</tr>
</tbody>
</table>

TB case notifications 2014

<table>
<thead>
<tr>
<th>NEW</th>
<th>RELAPSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonary, bacteriologically confirmed</td>
<td>42,618</td>
</tr>
<tr>
<td>Pulmonary, clinically diagnosed</td>
<td>37,935</td>
</tr>
<tr>
<td>Extrapulmonary</td>
<td>14,103</td>
</tr>
</tbody>
</table>

Total new and relapse 139,658
Previously treated, excluding relapses 3,460
Total cases notified 143,118

Among 118,352 new and relapse cases:
94,301 (80%) cases aged under 15 years; male:female ratio 1.6

Reported cases of RR/MDR-TB 2014

<table>
<thead>
<tr>
<th>NEW</th>
<th>RETREATMENT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases tested for RR/MDR-TB</td>
<td>10 (95) (2.4%)</td>
<td>15,166 (117%)</td>
</tr>
<tr>
<td>Laboratory-confirmed RR/MDR-TB cases</td>
<td>3,495</td>
<td></td>
</tr>
<tr>
<td>Patients started on MDR-TB treatment</td>
<td>1,577</td>
<td></td>
</tr>
</tbody>
</table>

TB/HIV 2014

<table>
<thead>
<tr>
<th>NUMBER (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB patients with known HIV status</td>
</tr>
<tr>
<td>HIV-positive TB patients</td>
</tr>
<tr>
<td>HIV-positive TB patients on co-trimoxazole preventive therapy (CTPT)</td>
</tr>
<tr>
<td>HIV-positive TB patients on antiretroviral therapy (ART)</td>
</tr>
<tr>
<td>HIV-positive people screened for TB</td>
</tr>
<tr>
<td>HIV-positive people provided with IPT</td>
</tr>
</tbody>
</table>

Treatment success rate and cohort size

<table>
<thead>
<tr>
<th>(%)</th>
<th>COHORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>New cases registered in 2013</td>
<td>15,164</td>
</tr>
<tr>
<td>Previously treated cases registered in 2013</td>
<td>7,147</td>
</tr>
<tr>
<td>HIV-positive TB cases, all types, registered in 2013</td>
<td>7,147</td>
</tr>
<tr>
<td>RR/MDR-TB cases started on second-line treatment in 2012</td>
<td>443</td>
</tr>
<tr>
<td>XDR-TB cases started on second-line treatment in 2012</td>
<td>443</td>
</tr>
</tbody>
</table>

Laboratories 2014

| Smear (per 100 000 population) | 0.9 |
| Culture (per 5 million population) | 0.3 |
| Drug susceptibility testing (per 5 million population) | 0.3 |
| Xpert performing Xpert MTB/RIF | 58 |
| Is second-line drug susceptibility testing available? | Yes, outside country |

Financing TB control 2015

| National TB programme budget (US$ millions) | 56 |
| % Funded domestically | 11% |
| % Funded internationally | 89% |
| % Unfunded | 22% |

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

For all years can be downloaded from www.who.int/tb/data
### Estimates of TB burden* 2014

<table>
<thead>
<tr>
<th>NUMBER (thousands)</th>
<th>RATE (per 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality (includes HIV+TB)</td>
<td>10 (9 – 11)</td>
</tr>
<tr>
<td>Mortality (HIV+TB only)</td>
<td>0.18 (0.16 – 0.20)</td>
</tr>
<tr>
<td>Prevalence (includes HIV+TB)</td>
<td>473 (455 – 503)</td>
</tr>
<tr>
<td>Incidence (includes HIV+TB)</td>
<td>2.0 (1.8 – 2.2)</td>
</tr>
<tr>
<td>Incidence (HIV+TB only)</td>
<td>2.2 (2.0 – 2.4)</td>
</tr>
</tbody>
</table>

### Estimates of MDR-TB burden* 2014

| % of TB cases with MDR-TB | 2.1 (1.9 – 2.3) |
| MDR-TB cases among notified pulmonary TB cases | 4600 (4300 – 4900) |

### TB case notifications 2014

<table>
<thead>
<tr>
<th>NEW</th>
<th>RELAPSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonary, bacteriologically confirmed</td>
<td>12,991</td>
</tr>
<tr>
<td>Pulmonary, clinically diagnosed</td>
<td>39,950</td>
</tr>
<tr>
<td>Extrapulmonary</td>
<td>4,161</td>
</tr>
</tbody>
</table>

### Total new and relapse

23,379

### Previously treated, excluding relapses

8,057

### Total cases notified

31,436

Among 97,228 new and relapse cases:

- 12,191 (45%) aged under 15 years, male:female ratio 1:8

### Reported cases of RR / MDR-TB 2014

<table>
<thead>
<tr>
<th>NEW</th>
<th>RETREATMENT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases tested for RR-MDR-TB</td>
<td>4475 (52%)</td>
<td></td>
</tr>
<tr>
<td>Laboratory-confirmed RR (MDR-TB cases)</td>
<td>3,900</td>
<td></td>
</tr>
<tr>
<td>Patients started on MDR-TB treatment†</td>
<td>6,680</td>
<td></td>
</tr>
</tbody>
</table>

### TB/HIV 2014

<table>
<thead>
<tr>
<th>NUMBER (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB patients with known HIV status</td>
</tr>
<tr>
<td>HIV-positive TB patients</td>
</tr>
<tr>
<td>HIV-positive TB patients on co-trimoxazole preventive therapy (CDT)</td>
</tr>
<tr>
<td>HIV-positive TB patients on antiretroviral therapy (ART)</td>
</tr>
<tr>
<td>HIV-positive people provided with IPT</td>
</tr>
</tbody>
</table>

### Treatment success rate and cohort size

<table>
<thead>
<tr>
<th>(%)</th>
<th>COHORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>New and relapse cases registered in 2013</td>
<td>216,820</td>
</tr>
<tr>
<td>Previously treated cases, excluding relapse, registered in 2013</td>
<td>2,954</td>
</tr>
<tr>
<td>HIV-positive TB cases, all types, registered in 2013</td>
<td>1,798</td>
</tr>
<tr>
<td>HIV-TB cases started on second line treatment in 2013</td>
<td>10</td>
</tr>
</tbody>
</table>

### Laboratories 2014

- Smear (per 100,000 population): 2.6
- Culture (per 1 million population): 1.1
- Drug susceptibility testing (per 5 million population): 0.2
- 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): 106
- % Funded domestically: 23%
- % Funded internationally: 37%
- % Unfunded: 40%

---

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

* Ranges represent uncertainty intervals.
† Includes cases with unknown previous TB treatment history.
‡ Includes patients diagnosed before 2013 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)

<table>
<thead>
<tr>
<th></th>
<th>Nepal</th>
<th>Korea</th>
<th>Taiwan</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (1000)</td>
<td>28</td>
<td>50</td>
<td></td>
<td>127</td>
</tr>
<tr>
<td><strong>Incidence (Estimate)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>include. HIV</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>44</td>
<td>39-50</td>
<td>43</td>
<td>41-46</td>
</tr>
<tr>
<td>Rate</td>
<td>158</td>
<td>139-178</td>
<td>86</td>
<td>81-91</td>
</tr>
<tr>
<td><strong>HIV+ only</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>1.6</td>
<td>1.2-1.9</td>
<td>0.51</td>
<td>0.44-0.59</td>
</tr>
<tr>
<td>Rate</td>
<td>5.4</td>
<td>4.2-6.7</td>
<td>2.6</td>
<td>2.2-3.0</td>
</tr>
<tr>
<td><strong>Mortality</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>5.3</td>
<td>3.7-7.1</td>
<td>1.9</td>
<td>1.8-2.1</td>
</tr>
<tr>
<td>Rate</td>
<td>3.8</td>
<td>3.6-4.1</td>
<td>2.6</td>
<td>1.8-1.8</td>
</tr>
<tr>
<td><strong>Case detection Rate (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New</td>
<td>19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retreatment</td>
<td>15</td>
<td>10-23</td>
<td>14</td>
<td>10-19</td>
</tr>
<tr>
<td>Survey year</td>
<td>2,011</td>
<td>2,004</td>
<td>2005-2011</td>
<td>2,002</td>
</tr>
<tr>
<td><strong>Case notification</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New &amp; Relapse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New, Pulm, bacterial confirm</td>
<td>15,947</td>
<td>18,784</td>
<td>12,120</td>
<td></td>
</tr>
<tr>
<td>New, Pulm Clinical</td>
<td>8,445</td>
<td>9,350</td>
<td>2,061</td>
<td></td>
</tr>
<tr>
<td>New, Extrapulmonary</td>
<td>8,583</td>
<td>6,987</td>
<td>4,255</td>
<td></td>
</tr>
<tr>
<td>Treatment success</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2013 Cohort)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>91</td>
<td>82</td>
<td>65</td>
<td>54</td>
</tr>
<tr>
<td>Cohort size</td>
<td>33,877</td>
<td>40,794</td>
<td></td>
<td>15,941</td>
</tr>
</tbody>
</table>

**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.

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.

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.

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
Current Projects

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Coverage Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public-Private Mix-DOT in Factory (work place)</td>
<td>14 Factories, Phnom Penh</td>
</tr>
<tr>
<td>Active Case Finding among Elderly and other Vulnerable Communities</td>
<td>12 Operational Districts in 8 Provinces.</td>
</tr>
</tbody>
</table>

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)

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 (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.

Active Case Finding (3)

3. Results (1):

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Year 1 (2014)</th>
<th>Year 2 (2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual Planned Target</td>
<td>Achieved Target</td>
</tr>
<tr>
<td># of people screened</td>
<td>11350</td>
<td>11945</td>
</tr>
<tr>
<td># of TB suspects</td>
<td>21840</td>
<td>16165</td>
</tr>
<tr>
<td># of people tested by TB X-ray.</td>
<td>3276</td>
<td>2520</td>
</tr>
<tr>
<td># of people confirmed as SS+/B+ (yield SS+/B+)</td>
<td>663</td>
<td>397</td>
</tr>
<tr>
<td># of people confirmed as TB all forms (yield all forms)</td>
<td>1240</td>
<td>1094</td>
</tr>
</tbody>
</table>

Active Case Finding (4)

3. Results (2):
• 12 operational districts visited.
• 193 health facilities visited.
• 23,797 individuals screened by CXR.
• 4,804 (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 (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.

![Graph showing New bacteriologically-positive TB Notifications by Age Group](image)

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 (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:
    - 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 (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.
Thank You for Your Attention
Presentation and discussion of activities of partnerships

Forum Stop TB Partnership 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

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It also comprises administratively of:

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

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

**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

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

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

Phone / Fax: +62 21799 1494

Website: www.stopindonesia.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 Mediterranean Region

Operational Guideline on FSTPI was published

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

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

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

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

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

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 Faculty of Public Health, University of Indonesia

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
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
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

6. Will Establish 5 working group in the forum:
   - Public communication
   - Advocacy
   - Community
   - Health service
   - Resource Mobilization
Thank you!
Presentation and discussion of activities of partnerships

Stop TB Partnership Korea

INTRODUCTION OF STOP TB PARTNERSHIP KOREA

Name and legal corporate status

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

Table of Contents

1. Name and legal corporate status
2. Short history
3. Relationship with other organizations
4. Members: Membership, Current number
5. Purposes
6. Activities
7. Current challenges

<History of Korean TB situation>

Name and legal corporate status

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

Short history

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

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.

Activities

<Advocacy>

TV Documentary production for Improving TB Awareness

A commemorative event on the “World TB day”
<Advocacy>
- Policy forum to support efficient TB patient care
- Monthly webzine publication and e-mail service

<Advocacy>
- Appoint the representatives of 12 national communities as foreign TB honorary ambassador
- Production of various IEC materials

<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

<Pilot programs to support homeless TB patients>
<Education>
- Health lecture for TB high risk group such as the immigrants, homeless
- STOP-TB Camp for youth

<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

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

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.
**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.

---

**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 - > 12 million

---

**MMCWA activities in line with its objectives**

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

---

**Health Activities**

1. Health Activities
   - Prevention and Control of Communicable diseases
   - Immunization programme

2. Educational Activities
   - Health Education
     - IEC dissemination
     - Mass Media
     - Community health talks
     - Outreach round table talks
     - Early Case Detection
     - Referral
     - Support for care and treatment

3. Economic Activities

4. Social Activities

---

**Provision of Community based health care services**

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

---

**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
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

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

Non-formal Education

- 3-R Classes
- Continuous Learning Initiative for Adult Literacy

Early Childhood Care and Development (ECCD)

- 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
In the Economic Activities section, the document outlines the Income Generation Programme, which includes:

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

In the Social Activities section, the document highlights Social activities involving:

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

The document also mentions MMCWA participation in Elderly Care Activities and outlines Approaches:

1. Self-reliance Approach (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

2010
- Leikway

2011
- Ayarwaddey Region
- 26 townships

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

MMCWA Community Based TB Care Activities

Conducting Home Based Medical Care
Provision of eye care for elderly

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

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

MMCWA Self reliance TB Care Activities (Cont.;)

<table>
<thead>
<tr>
<th>Year</th>
<th>Health Education</th>
<th>Referral cases</th>
<th>DOTs Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>71,328</td>
<td>36,923</td>
<td>48,144</td>
</tr>
<tr>
<td>2011</td>
<td>96,425</td>
<td>38,034</td>
<td>48,881</td>
</tr>
<tr>
<td>2012</td>
<td>72,847</td>
<td>43,271</td>
<td>32,473</td>
</tr>
<tr>
<td>2013</td>
<td>55,928</td>
<td>26,783</td>
<td>30,292</td>
</tr>
<tr>
<td>2014</td>
<td>48,881</td>
<td>20,723</td>
<td>18,999</td>
</tr>
<tr>
<td>2015</td>
<td>43,286</td>
<td>19,846</td>
<td>12,237</td>
</tr>
</tbody>
</table>

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

- Mandalay Region (26 t/s)
- Naypyitaw (3 t/s)
- Yangon Region (1 t/s)
- Bago Region (27 t/s)
- Mon State (10 t/s)
- Kayin State (2 t/s)

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
• (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

---

Annual Evaluation Meeting

---

Indicators

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of community volunteer trained</th>
<th>No. TB suspected cases referred by community volunteers</th>
<th>No. of TB patients detected and put on treatment</th>
<th>No. of health talks conducted at community level</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>1147</td>
<td>2357</td>
<td>282</td>
<td>1606</td>
</tr>
<tr>
<td>2012</td>
<td>2139</td>
<td>531</td>
<td>298</td>
<td>1468</td>
</tr>
<tr>
<td>2013</td>
<td>2190</td>
<td>2255</td>
<td>344</td>
<td>2251</td>
</tr>
<tr>
<td>2014</td>
<td>2070</td>
<td>3177</td>
<td>589</td>
<td>2905</td>
</tr>
<tr>
<td>2015</td>
<td>2069</td>
<td>2921</td>
<td>615</td>
<td>3126</td>
</tr>
</tbody>
</table>

---

MMCWA contribution to National TB Program (NTP)

Source(NTP)
Supervision from Central to Mon State

Supervision from Central to Mandalay Region

Training of Trainers (ToT) Refresher Training

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

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

Thank You
Presentation and discussion of activities of partnerships

Japan-Nepal Health & TB Research Association
Nepal

Scenario: 2015

- Major Public Health Problem
- Priority 1 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%

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

<table>
<thead>
<tr>
<th>Area</th>
<th>147,181 Sq. km</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region</td>
<td>5</td>
</tr>
<tr>
<td>Zone</td>
<td>14</td>
</tr>
<tr>
<td>District</td>
<td>76</td>
</tr>
<tr>
<td>Treatment Centre</td>
<td>1140</td>
</tr>
<tr>
<td>Sub-treatment</td>
<td>2907</td>
</tr>
<tr>
<td>Microscope Centre</td>
<td>554</td>
</tr>
<tr>
<td>Gene-Xpert Center</td>
<td>22</td>
</tr>
<tr>
<td>MDR Centre</td>
<td>13</td>
</tr>
<tr>
<td>MDR Sub-Cen.</td>
<td>71</td>
</tr>
</tbody>
</table>

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

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, NGOs/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

Current Projects

- Urban TB Control
- TB REACH Wave 4
- Post Disaster Recovery Project

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

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

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 Volunteer Trust Fund
- Support for poor TB patients who are not eligible in public social protection scheme
- Logistic management support

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
DOTS service & SPUTUM EXAMINATION (2014/2015)

<table>
<thead>
<tr>
<th></th>
<th>PBC</th>
<th>PCD</th>
<th>EP</th>
<th>Total</th>
<th>Sputum examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>89</td>
<td>15</td>
<td>110</td>
<td>214</td>
<td>274</td>
</tr>
</tbody>
</table>

Hotline Consultation

Consultation from Hotline telephone

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>66</td>
<td>78</td>
</tr>
<tr>
<td>2017</td>
<td>122</td>
<td>100</td>
</tr>
</tbody>
</table>

Case finding

Trend of Treatment Success Rate

Key Q & A of 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

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**

- **TB therapy initiation**
- **Sputum smear positive**
- **Refer to Chest Centre for culture identification**
- **Refer to Chest Centre for treatment initiation**
- **Screening**

**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**

- Male: 112341
- Female: 34656
- Total: 146997

**Post Disaster Recovery Project**

- **Thematic Program Thrust—**
  - Early TB Case finding
- **Target Beneficiaries—**
  - Internally Displaced People of Kathmandu valley and Sindhupalchok district

**Post Disaster Recovery TB Program**

- **Sep 2015- 20 Jan 2016**
- **Screening of IDPs**
- **Gene-Xpert Test**
- **Bac Positive**
- **Treatment enrollment**

**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/BOC Programme;
  - To change service seeking behavior

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

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

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

Thank you
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.)
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.

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

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
• 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.

THE TUBERCULOSIS PROJECT IN SOCIO-ECONOMICALLY URBAN AREAS IN METRO MANILA, THE PHILIPPINES
2008- June 2011
Funded by : Ministry of Foreign Affairs

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
**Interventions**

**Engagement of NGOs**

- Canossa
- Sto De Tondo Charity Clinic
- German Doctors
- PAOFI

**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

- **Payatas, Quezon City**
  - Population 2013: 129,633
  - Urban poor population: 108,063 (89%)
  - Land Area: 3.21 sq km
  - Population density (sq. Km2): 37,580

**NGO DOTS’ Contribution - Tondo, 2007 - 2012**

**NGO DOTS’ Contribution - Payatas**
Capacity Building

- Basic TB DOTS Training
- Infection Control Training
- Basic DSSM Training for Medical Technologist
- Appreciation Course for CXR
- Interpersonal Communication and Counselling
- Orientation of CHV in NTP Program
- Basic DSSM Training for Lab Assistants

Network and Linkage (ACSM Activities)

- CHV Assembly
- Orientation of CHV on Basic STI HIV and AIDS Education
- CHV Assembly
- Network and Linkage (ACSM Activities)
- Development of Recording Forms
- Monitoring Tool
**CHVs’ Contribution to DOTS Facility - Tondo, 2010-2012**

- DOTS Facility:
  - 2010: 1014
  - 2011: 1599
  - 2012: 1846

- NGO Referring:
  - 2010: 43
  - 2011: 28
  - 2012: 42

**CHVs’ Contribution to DOTS Facility – Payatas, 2010-2012**

- DOTS Facility:
  - 2010: 454
  - 2011: 898
  - 2012: 846

- NGO Referring:
  - 2010: 6
  - 2011: 22
  - 2012: 15

**Development of Policies/Guidelines**

- Monitoring and Evaluation Visits

- 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)

**Accomplishment in the two project sites**

- Engagement of NGOs (combined in both sites):
  - Number of NGOs: from 3 (2008) to 5 (2010)

- Percent contribution (combined in both sites):
  - Percent contribution of NGO DOTS to TB Cases ranged from 27.9% to 41.6% (2007 to 2012)
  - Percent community contribution to TB Cases ranged from 2.1% to 3.3% (2010 to 2012).
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)

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

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

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

Project Areas
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

<table>
<thead>
<tr>
<th>Municipalities</th>
<th>No. of TB All Forms</th>
<th>RHU Accomplishment</th>
<th>CBO Accomplishment</th>
<th>% contribution by CBO to RHU</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1130</td>
<td>83</td>
<td>7%</td>
</tr>
</tbody>
</table>

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 (?)**
Maraming Salamat po!
ありがとうございました。
Presentation and discussion of activities of partnerships

Chang-Hua TB Care Association
Taiwan

Chang-Hua TB Care Association
Taiwan

Presented by
Wei-Wen Chen
(Sally)

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, Changhua, Taiwan 2008-present

Geographic Position

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

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
  Supervisor 2012 - present

Geographic Position

你好
= こんにちは
= Hello

Geographic Position

- Capital: Taipei
- The total area of Taiwan: 36,193 km² (13,974 sq mi)
- Population: 23 million
Geographic Position
Chang-Hua county
Area: 1,074 km²
Population: 1.3 millions

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.

The First Director 2009-2014
- Name: Yi-Wen, Huang
- MD, Kaohsiung Medical University 1975-1982
- Deputy commander of central region communicable Disease Control Medical Network, CDC, Ministry and welfare since 2004~now
- Chief of Pulmonary and Critical Care Unit, Chang-Hua 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

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

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 groups who agree objectives of the Association

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

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 epidemics in Taiwan

TB Incidence by County, 1990-2013

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.

TB incidence rate in Chang-Hua

2009 -2014

2009 2010 2011 2012 2013 2014

Chang-Hua 67.6 67.4 59.8 58.7 53.9 53.06
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) to 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

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

THRF-HISTORY (1)

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

PRESENTATION

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

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

- RIT-TB/HIV Research Project
- TB/HIV Research Foundation (THRF)

HIV positive  HIV negative  HIV unknown

CHIANG RAI PROVINCE

TB/HIV Research Foundation (THRF)

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

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.
Supalert Nedsuwan, M.D., M.P.H.
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)

WHAT WE DO ?

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

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.
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)

Research and projects as of December 2016 (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)

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

Why research and charity?

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

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

- 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
**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

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**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

---

**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

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**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)

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!

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 human touch
- Reduce stigma, tears of smile

Photo and story credit: Chayut Kaewsidhi and Sarmwai Luangjina 2010

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
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>
<thead>
<tr>
<th>Categories of Challenges (Number)</th>
<th>List of challenge (country)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenges related to community health volunteers (5)</td>
<td>- How to maintain and keep volunteers actives? (Indonesia, Thailand) - Need of resource and incentives for volunteers (Indonesia, Myanmar, Philippines)</td>
</tr>
</tbody>
</table>
### 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>
<thead>
<tr>
<th>Organization, Country</th>
<th>Challenges of NGO to End TB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stop TB Partnership,</td>
<td>- Budget sustainability</td>
</tr>
<tr>
<td>Korea</td>
<td>- Lack of consensus between government and NGO</td>
</tr>
<tr>
<td></td>
<td>- Satisfaction for donors or satisfaction of patients?</td>
</tr>
<tr>
<td>Chang-Hua Hospital /</td>
<td>- Awareness of TB among community and society</td>
</tr>
<tr>
<td>TATA, Taiwan</td>
<td>- Stigma and discrimination</td>
</tr>
<tr>
<td></td>
<td>- Confidentiality of patient side, Privacy</td>
</tr>
<tr>
<td>Organization</td>
<td>Challenges</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Stop TB Partnership</td>
<td>- Difficulty keeping the volunteers active</td>
</tr>
<tr>
<td>Indonesia</td>
<td>- Need resources to support the volunteers</td>
</tr>
<tr>
<td></td>
<td>- Difficulty implementing International Standard of TB care among the providers</td>
</tr>
<tr>
<td>THRF, Thailand</td>
<td>- TB awareness among general people</td>
</tr>
<tr>
<td></td>
<td>- Advocacy voice for vulnerable people</td>
</tr>
<tr>
<td></td>
<td>- Sustainability of volunteers</td>
</tr>
<tr>
<td>JANTRA, Nepal</td>
<td>- Limited resources</td>
</tr>
<tr>
<td></td>
<td>- Less capacity in research and development</td>
</tr>
<tr>
<td></td>
<td>- High expectations from stakeholders</td>
</tr>
<tr>
<td>CATA, Cambodia</td>
<td>- Limited fund</td>
</tr>
<tr>
<td></td>
<td>- Case finding is still low</td>
</tr>
<tr>
<td></td>
<td>- Migration</td>
</tr>
<tr>
<td>MMWA, Myanmar</td>
<td>- To increase community awareness by providing more IE&amp;C materials and community health talk</td>
</tr>
<tr>
<td></td>
<td>- Funding for nutrition and transportation support for patients</td>
</tr>
<tr>
<td></td>
<td>- Volunteer incentive is not enough for the targeted 330 townships for providing psycho-social support to complete treatment</td>
</tr>
<tr>
<td>RIT/JATA, Philippines</td>
<td>- Provision of incentive</td>
</tr>
<tr>
<td></td>
<td>- Funding support</td>
</tr>
<tr>
<td></td>
<td>- Addressing patients’ inequality</td>
</tr>
</tbody>
</table>

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
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.
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-FfzHlw 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

<table>
<thead>
<tr>
<th>Organization, Country</th>
<th>Funding sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stop TB Partnership, Korea</td>
<td>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</td>
</tr>
<tr>
<td>Chang-Hua Hospital / TATA, Taiwan</td>
<td>For TATA, 80% of funding are from the president, Christmas seal. As for Chang Hua, funding are from membership, donation of members, pharmaceutical companies</td>
</tr>
<tr>
<td>Stop TB Partnership</td>
<td>Entire fund is from the Chairperson (owner of oil company)</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Organization, Country</th>
<th>Methods of fund raising</th>
</tr>
</thead>
</table>
| 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 |
| THRФ, 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 to 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 turnover 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


Staff
[Organization] Stop TB Partnership Japan, Japan Anti-Tuberculosis Association (JATA), Research Institute of Tuberculosis, JATA, Council of Japanese Women’s Anti-Tuberculosis Associations, Western Pacific Regional Office of World Health Organization
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 responses to drug-resistant TB
  - Scaling up multidrug-resistant TB control efforts while contributing to the overall health system strengthening efforts
- The End TB Strategy and its Regional Framework opened new era of TB control
- A country-level programme to "achieve health system competency"
- Prudent strategies as a core principle
- All countries to align and cooperate for regional/global TB control