Address by

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At the

Regional Meeting of
National TB Programme Managers and Partners of SEA

6-9 December 2011
Bangkok, Thailand

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Dr Paichit Warachit, distinguished participants, honourable guests, ladies and gentlemen;

It is my pleasure to welcome you all to the Regional Meeting of National TB Control Programme Managers and Partners in SEA.

The WHO South-East Asia (SEA) Region still bears more than one third of the "global burden" of tuberculosis. The Region has a pool of nearly 5 million cases to which more than 3 million are added each year. This is despite a more than 25% decrease in prevalence rate since 1990. Decline in TB prevalence rate in the Region has been achieved mainly due to:

- improved case findings, and
- treatment success.

This decline of TB prevalence is, therefore, contributed by the expansion of quality "DOTS" services. DOTS stands for "Directly Observed Treatment, Short-course". It is an International Strategy for TB Control. The mortality rate among TB

patients has also decreased by more than 44% during the same period. However, the absolute number of TB deaths is still close to half a million. This is mainly because of the "population momentum". With good performance in the implementation of DOTS the level of "multi-drug-resistant" (MDR) TB among newly-detected cases is low. Nonetheless, due to the large number of the total TB cases the Region accounts for an estimated 130000 MDR-TB cases. This is nearly one third of the world's estimate.

Ladies and gentlemen;

The HIV-TB coinfection is a serious problem in the SEA Region. The two related programmes, namely National TB Control and National AIDS Control programmes in most countries in the Region are jointly implementing a "comprehensive" package of interventions against this problem. This is helping them cover an estimated 600 million people. Success in TB control, to a large extent, has come from participation and involvement of a wide range of partners.

From the early 1990s, a large number of "partners" have been engaged in supporting the development and implementation of national TB control programmes. Examples of such "partners" are: private medical practitioners; international and national NGOs; public and private hospitals; medical colleges; and state enterprises etc.

This “multistakeholder involvement” has contributed to about 25% increase in case-notification and to more than 90% of the treatment success rate.

However, we need to recognize that these achievements can be successfully maintained in “the long term” only when “national health systems based on the primary health care (PHC) approach” function effectively. The primary health care approach is the key intervention to help ensure that the hard-to-reach, or the unreached populations are covered. Education and empowerment of people, individually and collectively, is the primary tool of the PHC approach. In our experience, it has also been demonstrated that in terms of “primary care in the community”, the “Practical Approach to Lung Health” (PAL) is useful in the management of TB patients as the patients ae managed through a “syndromic approach” that educates them appropriately.

The approach mentioned above is particularly useful in low-and middle-income countries. “Community-based care and services” are essential for sustained achievements in long-term TB control for the “entire population”. Tuberculosis is a disease of poverty having strong social and economic determinants. Therefore, adequate “social and economic support” to control programmes, including TB patients, is critically important for the programme’s success.

Indeed, national TB control programmes face the following challenges in medical, social and economic terms:

- difficulty faced by patients in accessing quality medical treatment;

- poverty, at the individual and family level, in particular;
- stigma, as a social barrier, to a certain extent; it prevents patients from seeking treatment;
- crowded and polluted environment that is conducive to TB transmission;
- poor nutrition that leads to low body resistance against the infection; and
- displaced population that is prone to TB infection due to various reasons.

All in all, ladies and gentlemen, at least, an estimated “one third” of TB cases remains “unreported”. Such cases are of particular concern because they perpetuate continued disease transmission in the community, pose a serious risk of drug-resistant TB that leads to difficulty in its treatment, and to high TB mortality.

Our national TB control programmes also identify the lack of “laboratory capacity”, which is essential for providing back-up to effective “diagnosis and surveillance”. This is a major constraint, among other things, to the scaling up of diagnosis and treatment of MDR-TB cases in particular.

Another important problem of ensuring uninterrupted supplies of quality second-line drugs for treatment of patients with MDR-TB is indeed proving to be a “difficult task”, especially in larger countries.

Ladies and gentlemen, national TB control programmes in our Region still need continued support from various organizations. We acknowledge the commitment of many development and technical agencies including national and international NGOs for their generous contribution to the implementation of national TB control programmes in the SEA Region.

The Global Fund to fight AIDS, TB and Malaria is now the largest funding source for TB control. The Global Drug Facility is providing essential back-up through its procurement mechanisms. As we are well aware, the long-term goal of TB control is to eliminate the disease as "a public health problem". With this perspective in view, increased and continued commitment is needed from all stakeholders and partners. In the process of implementing the control programmes with external inputs, special attention should be paid to "country capacity strengthening" in order to achieve "long-term, sustainable self-reliance".

Therefore, partners' support may be focused more on "capacity development". At the same time, we should keep in mind that in TB control "treatment of cases" is the main "control intervention". The part of health systems that deals with TB control must therefore be strengthened urgently. A national "public health specialist" should always be available to provide continuous technical back-up to the development and management of national TB control programme. TB control services should be integrated into general health-care services. As TB is a disease of poverty, the "physical, social and financial barriers" that prevent affected persons from accessing the needed care and services must be overcome.

In this context, we may need to understand that "improvement" in the "overall social and economic development" of a country will contribute importantly in its "long-term, sustained success" in TB "elimination" or "eradication". Indeed, a comprehensive and holistic package of interventions for TB control must involve "multisectoral" and "multidisciplinary" efforts. The basic issues involving the following areas must be tackled first for TB control:

- universal case detection of all forms of TB;
- introduction of new and more effective laboratory diagnosis;
- increasing access to quality DOTS services;
- effective infection control, both in and outside institutions;
- availability of quality TB drugs that are affordable to individuals, families, community and the government; and
- drugs that are accessible to all patients who need them.

In particular, the rational use of antiTB drugs must be promoted. This is another critical area of concern. National "regulatory" mechanisms must be strengthened to help ensure "quality" and "rational use" of drugs.

Distinguished participants, with regard to surroundings, certain aspects of physical and social environment help perpetuate the existence of TB disease in a population. These environmental factors must be kept in mind while planning a TB control programme for "long-term, sustained success". Even though we have been

successful in TB control through DOTS, we should think of a more comprehensive and holistic plan for long-term elimination and eradication of TB.

Ladies and gentlemen, we are here at this meeting to address our common concerns, and to plan collectively for effective implementation of various interventions including the most recent strategies towards meeting the targets set under the MDG 6, in particular. This meeting affords another platform to further promote intercountry cooperation and strengthen the commitment of all partners to reduction of the TB problem in the SEA Region.

With these words, ladies and gentlemen, I wish all of you fruitful deliberations. I also wish the meeting a successful outcome and hope that all of you have an enjoyable stay in Bangkok.

Thank you.