EIGHTH TB CONTROL MEETING FOR THE PACIFIC ISLAND

22–24 November 2016
Denarau, Fiji
Eighth TB Control Meeting for the Pacific Island
22–24 November 2016
Denarau, Fiji
MEETING REPORT

THE EIGHTH TB CONTROL MEETING FOR THE PACIFIC ISLANDS

Convened by:

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REGIONAL OFFICE FOR THE WESTERN PACIFIC

and

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NOTE

The views expressed in this report are those of the participants of the Eighth TB Control Meeting for the Pacific Islands and do not necessarily reflect the policies of the conveners.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for Member States in the Region and for those who participated in the Eighth TB Control Meeting for the Pacific Islands in Nadi, Fiji from 22 to 24 November 2016.
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KEYWORDS:

Tuberculosis – prevention & control / Programme management / Programme planning / Pacific Islands
SUMMARY

The Eighth TB Control Meeting for the Pacific Islands was jointly organized by the World Health Organization (WHO) and the United Nations Development Programme (UNDP). More than 80 participants from 20 Pacific island countries and areas (PICs) attended the three-day meeting, including representatives from government, civil society, key affected populations, academia and development partners. The focus was on the Regional Framework for Action on Implementation of the End TB Strategy in the Western Pacific, 2016–2020, endorsed at the 66th session of the Regional Committee. Implementing the End TB Strategy in the PICs poses unique challenges including geographical access and communication difficulties, marked differences in country context, limited capacity in human resources for health, high costs of health-care delivery, and varying implementation capacity. To address these challenges, governments and development partners should work together closely to build health system capacity to fulfil the objectives of tuberculosis (TB) care and prevention and to avoid the disease-specific top–down (or vertical) approach. It is also noted that addressing the TB epidemic requires systems approaches as well as partnerships across sectors and institutions. The meeting featured thematic sessions on some of the high priorities: preventing and controlling the disease among high-risk populations, addressing drug-resistant TB, strengthening research and innovation, and applying patient-centred care and social protection.

The objectives of the meeting were:

1. to review the progress of TB control since the last meeting and identify the challenges to strengthen TB control in the Pacific;
2. to discuss ways the PICs can adapt and implement the Regional Framework for Action on Implementation of the End TB Strategy in the Western Pacific, 2016–2020; and
3. to identify priority actions required at the regional and national levels to facilitate the implementation of the specific areas of the Regional Framework with a focus on people-centred care, universal health coverage and social protection, and cross-country cooperation to address TB among migrants.

Recommendations for Member States

Members States are encouraged to consider the following:

(1) To adopt the End TB Strategy into their national policies, pursue the goal and targets, and implement the Regional Framework for Action by engaging a wide range of governmental and nongovernmental stakeholders.
(2) To conduct patient cost studies to establish a baseline against a global target on zero catastrophic cost due to TB.
(3) To maintain sufficient domestic financial flows to deliver essential public health functions and services for TB care and prevention.
(4) To develop and implement strategies to address TB among identified high-risk populations in local settings. Specific attention needs to be paid to increase coverage of contact investigation and improve initiation, completion and reporting of TB-preventive treatment among child contacts.
(5) To work together to improve international information exchange to ensure the continuity of TB care including patient referral and outcome monitoring.
(6) To continue to improve national capacity to manage drug-resistant TB with proper and timely testing of patients with presumptive drug-resistant TB and effective communication and coordination with the Pacific TB Laboratory Initiative (PATLAB), the multidrug-resistant TB (MDR-TB) help desk and the second-line drug stockpile.

(7) To continue to prioritize operational research to improve TB care and prevention, in collaboration with partners.

(8) To review the current practices and system to identify actions to improve patient-centredness of TB services.

(9) To strengthen community engagement including empowering and collaborating with patients and families, as well as strengthening community-based service delivery.

**Recommendations for WHO, UNDP and partners**

WHO, UNDP and partners are requested to do the following:

(1) To continue to promote the *End TB Strategy* and support Member States to implement the Regional Framework for Action.

(2) To support designing, implementing and analysing the data of patient cost studies.

(3) To support analysing TB control financial situation and to support national advocacy efforts.

(4) To support countries and areas to design and implement specific strategies for TB high-risk populations including technical support to design rationale active case-finding activities.

(5) To promote tools to facilitate efficient international information exchange on TB patients such as a directory of national TB programmes (NTPs), standard operating procedures, multilingual fact sheets and Internet-based solutions.

(6) To continue to collaborate to secure critical regional mechanisms, including PATLAB, the MDR-TB help desk and the second-line drug stockpile, to ensure access to quality TB diagnosis and care for all people in the Pacific.

(7) To support countries and areas to develop operational research capacity.

(8) To finalize the guidance document on people-centred TB care and support countries and areas to implement the proposed actions (WHO).

(9) To enhance the engagement of civil society and community representatives in future meetings.
1. INTRODUCTION

1.1 Background

In response to the Sixty-Seventh World Health Assembly endorsement of the new global TB strategy, WHO in the Western Pacific Region has translated this strategy into possible actions in the *Regional Framework for Action on Implementation of the End TB Strategy in the Western Pacific, 2016–2020*, which was endorsed at the 66th session of the Regional Committee (WPR/RC66.R3). The Regional Framework outlines actions by governments and all partners to provide patient-centred care, pursue policies and systems that enable prevention and care, and drive research and innovations needed to end the tuberculosis (TB) epidemic in line with the Sustainable Development Goals (SDGs). It also calls for building strong national systems for prevention and care for TB through whole-of-government and whole-of-society approaches.

Pacific island countries and areas (PICs) face specific challenges for TB care and prevention. These include difficulties in ensuring universal access to quality TB care for all people, especially for high-risk and vulnerable populations, such as children and older people, people living in poor communities and remote islands, and people with co-morbidities and other risk factors, particularly HIV, diabetes and tobacco use. Establishing a robust drug management system and an effective laboratory network are continuing challenges with the additional threat posed by drug-resistant TB. In October 2014, the Seventh TB Control Meeting for the Pacific Islands was organized with participation of representatives from 20 countries and areas. The meeting discussed these common challenges and confirmed the need to continue strengthening subregional approaches such as the Pacific TB Laboratory Initiative (PATLAB) and the WHO stockpile of the second-line drugs (SLDs) for TB.

To follow up the previous meeting and the momentum built by the Regional Committee resolution, it was a critical moment to convene a meeting with TB programme managers across the PICs, from high, intermediate and low TB burden settings, to discuss priority actions to operationalize the Regional Framework for Action. This is also a platform to strengthen coordination between all relevant stakeholders who provide technical and financial support for TB control in the Pacific.

1.2 Meeting organization

The Eighth TB Control Meeting for Pacific Islands Countries in the Western Pacific Region was held from 22 to 24 November 2016 in Denarau (Nadi), Fiji.

This meeting was convened for national TB programme managers, TB coordinators and laboratory technicians/focal persons across the PICs. The meeting aimed to discuss priority actions to operationalize the Regional Framework.

1.3 Meeting objectives

The objectives of the meeting were:

1) to review the progress of TB control since the last meeting and identify the challenges to strengthen TB control in the Pacific;

2) to discuss ways the PICs can adapt and implement the *Regional Framework for Action on Implementation of the End TB Strategy in the Western Pacific, 2016–2020*; and
3) to identify priority actions required at the regional and national levels to facilitate the implementation of the specific areas of the Regional Framework with a focus on people-centred care, universal health coverage and social protection, and cross-country cooperation to address TB among migrants.

1.4 Participants

A total of 46 participants from the national TB programme (NTP) of 20 PICs attended the three-day meeting. Also present in the deliberations were 7 temporary advisors and 9 observers representing the technical partners, academia, civil society and TB patient representatives. The Stop TB team from the WHO Regional Office for the Western Pacific and Division of Pacific Technical Support, along with the Global Fund Principal Recipient/United Nations Development Programme (UNDP) team, facilitated the meeting.

2. PROCEEDINGS

2.1 Opening

Dr Subhash Yadav, WHO Fiji, welcomed the participants to the meeting. Mr Philip Davis, Permanent Secretary for Health and Medical Services, Fiji, delivered the opening address. Dr Nobuyuki Nishikiori, WHO Regional Office for the Western Pacific, communicated the message from Dr Shin Young-soo, WHO Regional Director. Mr Bakhodir Burkhanov, UNDP, also addressed the participants, reminding them of the TB goals in the SDGs. All the dignitaries wished the participants a successful and productive meeting to achieve the SDGs for TB.

Dr Nishikiori discussed the outline and objectives of the meeting. The programme and agenda is available in Annex 1. All participants introduced themselves and office bearers were nominated. A list of participants is available in Annex 2.

2.2 Session 1: Overview

Dr Nishikiori introduced the Regional Framework for Action on Implementation of the End TB Strategy in the Western Pacific, 2016–2020. Although TB control efforts have achieved milestones in the last decade and half, many other challenges still need to be addressed. These include: missed and unreached patients, insensitive diagnostics, TB among high-risk and vulnerable populations, financial burden of TB patients and families, missed opportunities for diagnosis and enrolment of multidrug-resistant TB (MDR-TB) patients, and limitations in health-care systems.

The End TB Strategy and its Regional Framework for Action have opened up a new era of TB care and prevention. The Strategy emphasizes transforming TB care and prevention in all countries with people-centeredness as a core principle; modernizing TB services in diagnosis, treatment and prevention for all people; and enhancing inter-country collaboration to achieve the TB goals. Implementing the Strategy and its Regional Framework for Action is difficult in the PICs because of communication challenges, geographically scattered islands, marked differences in country context, limited capacity in human resources for health, high costs of health-care delivery and varying implementation capacity in many of the countries. To cater for these challenges, it is strongly recommended that the development partners work with governments to avoid the vertical disease-based approach as the TB epidemic requires partnerships across sectors and institutions.
Dr Maisoon Elbukhari Ibrahim, UNDP Pacific, presented the Global Fund grant management systems and role of UNDP as a principal recipient, progress towards targets and indicators, and opportunities under the Global Fund grant for the 11 PICs. As ending the TB epidemic requires partnerships, all of the stakeholders around the table have a role to play. This meeting would therefore strengthen coordination and complementarities between all stakeholders providing technical and financial support for TB care and prevention in the Pacific.

2.3 Session 2: Country and area presentations

All the NTP representatives presented the status of TB control services in their respective countries and areas. The presentations were based on a preformatted template covering aspects of: TB epidemiology, national strategic plan for TB, TB programme performance, laboratory network, programmatic management of drug-resistant TB, systematic screening (active case finding) for active TB and latent TB infection (LTBI), cross-border TB collaboration, childhood TB, financing for TB control, universal health coverage and social protection, and activities/system to improve people-centredness of TB care.

American Samoa
TB services are well established and cater to all presumptive cases among Samoans and expatriates from Asian countries, cannery workers and diabetics. A low TB burden country with four cases in 2015 and two TB cases to date in 2016. All contacts of TB cases are assessed and provided with LTBI treatment.

Cook Island
The overall burden of TB is low and the number of TB cases diagnosed has decreased over the last decade. Most TB cases diagnosed among immigrants from neighbouring high-burden countries. TB services are provided to all through the government health system.

Fiji
It is a moderate TB burden country with good case notification and treatment outcome rates. TB services are incorporated into the health system and directly observed treatment (DOT) provision is ensured through community worker involvement. TB control services are decentralized to peripheral health institutions. A phased introduction to TB diagnosis based on GeneXpert and detection of rifampicin resistance is ongoing.

French Polynesia
TB services are well established and free, which has resulted in lowering of prevalence and mortality of TB over the years. Smear microscopy is used for the diagnosis of TB and sputum samples are sent to the reference laboratory in France for culture and drug-susceptibility testing (DST).

Guam
TB notifications continued to fall until 2013 but later increased due to detection of more TB cases among the immigrant population. A recent spurt in diagnosis of four new MDR TB cases linked to local as well as migrant populations with irregular treatment history has posed challenges in procurement of SLDs for drug-resistant TB treatment.
Kiribati
It is one of the very high TB burden countries. The majority of TB patients are diabetics and smokers that complicate the management of TB cases. Notification of TB cases has increased over the last few years from 354 in 2011 to 516 in 2015 with a 15 – 24 years age group carrying the highest burden of TB.

Marshall Islands
It is among the high TB burden island countries in the Pacific and has been notifying an increasing number of cases over the last decade. Laboratory diagnosis has strengthened with availability of the GeneXpert instrument as well as digital X-ray machines. Active screening for TB is planned in Ebeye Island.

Federated States of Micronesia
It is one of the high TB burden countries with low TB/HIV co-infection and low MDR-TB cases. Good treatment outcomes are reported for all forms of TB. The highest number of TB cases is in Chuuk State where MDR-TB cases have also been reported previously.

Nauru
It is a low TB burden country and about 5–10 TB cases are notified on average per year. TB services are well managed by the public health division and RON Hospital. A major concern is TB among the refugee populations who are mainly from the high-burden countries in Asia and Africa.

New Caledonia
It has an efficient TB control programme and the TB incidence has been decreasing over the years.

Niue
It remains with no/zero TB cases from 2006 to 2016. TB services are very well aligned with the general health system. The biggest challenge is the high burden of TB among the migrant population who are screened for TB infection and disease on a regular basis and treated for LTBI.

Commonwealth of the Northern Mariana Islands
Overall TB prevalence and mortality is decreasing over time, but challenges still remain among the high-risk groups such as household contacts (adults and children) and diabetics. No MDR-TB case has been reported, but a presumptive case highlighted the challenges, especially in securing funds for procurement of SLDs, referring specimens for culture and DST, performing contact investigation, and ensuring patient privacy and workplace ethics. The LTBI treatment protocol has been established for high-risk groups and treatment for LTBI is planned with rifampicin for four months in place of isonicotinylhydrazide (INH) for nine months. Frequent travel and transfer of TB cases among the immigrant population proves a challenge in TB control efforts.

Palau
Notification of TB cases has increased over the years and it is considered as one of the high TB burden countries. GeneXpert is available locally to detect Mycobacterium tuberculosis (MTB) complex and rifampicin resistance. In addition, Diagnostic Laboratory Services (DLS) in Hawaii does culture and DST for all first-line TB drugs to confirm resistance to INH and rifampicin. TB among migrant workers is a challenge.
Samoa
It is a low TB burden country with decreasing incidence and mortality rates as well as high treatment success rate. TB is mainly notified among older age groups.

Solomon Islands
It has achieved the Millennium Development Goals and TB prevalence and mortality rates fell by 78% and 85%, respectively, relative to 1990 figures. In 2014, the treatment success rate was 85%. Solomon Islands has identified urban informal settlers, children and prisoners as highly vulnerable populations for TB. The GeneXpert instrument is available in the National Reference Laboratory; an additional one was procured for the Western province and is being installed. Community-based contact tracing and treatment is planned for TB patients on treatment in the continuation phase.

Tokelau
No TB case was notified in the last year.

Tonga
It is a low TB burden country with decreasing trends of incidence and mortality over the years. A GeneXpert instrument was procured via Global Fund support and is functioning. TB screening is undertaken on those wanting to migrate or immigrate and referred accordingly for further investigations or treatment. The focal persons for the International Health Regulations (IHR) is implementing a current cross-country referral and feedback mechanism. Integration with maternal and child health, Expanded Programme on Immunization, nutrition, HIV and other programmes is ongoing.

Tuvalu
It is a very high TB burden country with a small population. A GeneXpert instrument is available and a digital X-ray unit is planned to be procured via the Global Fund to help improve case notification and early diagnosis.

Vanuatu
It is a moderate TB burden country with decreasing trends in incidence and mortality over the years. TB services in outer islands is challenging with delays in diagnosis and treatment. Notifications from different provinces vary. The NTP has completed the development of the National Strategic Plan and updated its guidelines.

Wallis & Futuna
No TB case was diagnosed and notified in the last 4 years. The health department continues to provide TB control services.

Some of the common challenges faced by the PICs in TB control are:

- limited number of trained human resources in the clinical and public health system for management of TB prevention, care and control services;
- limited financial resources for outreach activities as well as for contact tracing;
- frequent cross-border travel and poor referral systems between countries leading to inadequate treatment of immigrant populations and lack of electronic recording and reporting systems;
- challenges in ensuring adherence to TB treatment (patients refuse to take drugs);
- nutritional challenges due to imported food products; and
- high rate of diabetes in the PICs, which makes it difficult to achieve high treatment success rates for TB; diabetes is driving the TB epidemic in the Pacific.

2.4 Session 3: Contributing to universal health coverage

2.4.1 Monitoring financial burden of TB patients (patient cost study)

One of the important milestones in the *End TB Strategy* is to achieve 0% of TB-affected families facing catastrophic costs due to TB. Lost income accounts for the bulk of these costs, especially for people belonging to low socioeconomic groups, while treatment costs for MDR-TB continue to be beyond the reach of a common TB patient. A baseline survey is needed to measure the target of the *End TB Strategy* on catastrophic cost. WHO has developed a generic research protocol and a questionnaire for TB patient cost surveys which can be accessed through the WHO website. By 2020, at least 30 high TB burden countries are expected to conduct the national TB patient cost survey. While conducting patient cost surveys, the following need to receive sufficient attention: availability of funding; contractual agreement with research partners; timely applications to ethics review committees (local and WHO); reaching a successful balance between independent assessment and NTP leadership; local adaptation of the survey instrument (including careful selection of asset ownership questions); selection of participants and carrying out of analysis (country-specific assumptions needed); study design that involves extrapolation; and long interview period. The discussion focused on the need for WHO to support all the countries and the need to take into consideration the cultural norms of the country.

2.4.2 Enhancing social protection to improve TB care

Enhancing social protection to improve TB care is incorporated under pillar 2 and objective 4 in the *End TB Strategy*. Social protection has four functions: preventative, protective, promotive and transformative. National social protection should at least ensure the access to essential health care and basic income security for children, for persons in active age who are unable to earn sufficient income and for older persons.

The NTP can ensure a social protection mechanism to support patients and families affected by TB through (1) conducting TB patient cost surveys to estimate and understand the distribution of different cost components disaggregated by important stratifiers; (2) identifying disadvantaged populations facing catastrophic costs based on survey results, (3) identifying relevant social protection interventions to meet the needs of TB patients and their families; and (4) informing health-care workers and patients about existing social protection schemes.

The discussion focused on possible advantages of social protection and the creation of a holistic approach towards social protection by including other stakeholders such as community-based organizations, nongovernmental organizations and other ministries.

2.4.3 Financing TB care and control in the context of universal health coverage

Financing health care is increasingly challenging in the region. These challenges are attributed by: changing demographic structures and disease patterns, high expectations from the public, and reduction in external funding for health and difficulties in the transition to domestic financing. The NTPs of lower-middle-income countries were 63% domestically funded, 16% internationally funded and 22% unfunded in 2015.

While increasing domestic funding to the health sector is critical, strengthening domestic financing institutions and improving coordination and efficiency are equally important. In many countries, the transition from donor funding to domestic financing is happening in parallel with the overall health
system reforms. However, the progress made in communicable disease control can only be maintained with a sustainable health system through a whole-of-system approach. Discussion under this subitem emphasized the importance of integrating and collaborating with other programmes such as noncommunicable diseases for future funding possibilities.

2.5 Session 4: TB control among high-risk populations

2.5.1 Introduction
Addressing TB among high-risk populations is key in TB care and prevention. A two-pronged approach for TB care and prevention should be followed: basic TB services through the primary health care network and targeted/tailored services for high-risk groups. For targeted/tailored services for high-risk groups, it is critical to ensure universal access to TB diagnosis, to perform intensified and systematic screening for TB and address specific needs of the groups. TB risk and vulnerability and limited access to health care are two dimensions to consider when mapping and prioritizing risk groups. For vulnerable and marginalized groups, it is important to increase equitable access to quality TB care and prevention. Increasing case detection, reducing transmission through early detection and mitigating institutional amplifiers should be the focus in high-risk TB groups.

2.5.2 TB and noncommunicable diseases
Diabetes is one major noncommunicable disease that causes vast complications in TB patients. Approximately 45% of adult Pacific islanders with TB also have diabetes. TB–diabetes co-morbidity is greater among the older age group (61–69 years followed by 50–60 years). Diabetes cases in the Pacific are 2.2 times (60%) more likely to remain culture-positive after 60 days of treatment and less likely (84%) to complete TB treatment as per the evidence. TB–diabetes co-infection cases are 2.3 (16% vs 7%) times more likely to die during TB treatment. A 27% reduction has been noted in TB deaths in the Pacific from 2009 to 2014.

To control TB, it is important to break the disease silo and start collaboration with other sectors and diseases. The focus should be the patient not the disease.

2.5.3 Situation and challenges in TB contact investigation and the management of latent TB infection
In 2012, WHO issued recommendations for investigating contacts of persons with infectious TB in low- and middle-income countries to assist NTPs in developing and implementing case finding among people exposed to infectious TB.

A brief survey questionnaire on contact tracing was shared to all the countries prior to the meeting. Of the 13 countries that responded to the survey, 10 (77%) have a TB contact tracing policy included in the national TB guidelines. Children less than 5 years of age (92%), people living with HIV infection (85%), contacts of index cases with MDR- or extensively drug-resistant TB (XDR-TB) (92%) and people with diabetes (85%) are priority contacts for screening. Chest X-ray (77%) is used as part of the initial screening for contacts, and qualified health-care workers (69%) supervise preventative therapy.

The facilitating factors for TB contact tracing is its inclusion in manual, human resources, trained staff, finances, acceptability by the community, incentives and enablers, transportation of patients to the hospital, outreach and a small population that is easily traceable. The major barriers to TB contact tracing in most of the PICs are inadequate numbers of trained personnel including physicians to rule out TB, lack of knowledge among health-care workers, lack of transport, shortages of purified protein
derivative (PPD) solution, geography, stigma, cost and availability of chest X-ray facilities, and funding.

2.5.4 Designing and evaluating active TB case-finding activities/Screen TB: an online tool for prioritization and strategy selection
Well-designed active case-finding (ACF) activities improve case finding among people with high risk for TB and/or who have limited access to health care at a justifiable cost. They also make it possible to find TB patients who would not have been detected, contribute to early detection and treatment which subsequently reduce transmission and disease burden in the communities, and increase public/community awareness on TB. However, ACF can: deprive resources with poor yield, promote the wrong impression that ACF is more important than the routine; increase unsuccessful treatment; increase stigma and adverse social impacts on patients, families and communities; deteriorate the imbalance in resource allocation between priority health issues; damage comprehensiveness of the health services; and be a risk of over-diagnosis and -treatment. In designing ACF, it is important to ensure essential quality TB services in place, careful prioritization and strategy selection, regular monitoring and evaluation, and a strategy to address patient needs and care delivery.

ScreenTB is an online tool for risk-group prioritization and strategy selection. The tool was developed as part of the 2015 WHO guidance on operationalizing the Principles and recommendations for systematic screening for active TB (2013). The tool is meant to serve only as an aid in prioritizing risk groups for screening and choosing screening algorithms. ScreenTB is available for use at: https://wpro.shinyapps.io/screen_tb/

2.5.5 Ebeye active case-finding project
The primary objective of the Ebeye ACF screening is to detect active TB early, reduce poor treatment outcomes and reduce TB transmission by shortening the duration of infectiousness. The principles for the Marshall Islands TB screening is to establish capacity to scale up quality TB care for new cases, create “one-stop” TB screening for those without TB, provide a reduction in TB cases and improve ACF, allow for shoulder-to-shoulder work with external experts and employ best technology available (GeneXpert MTB-RIF).

2.5.6 Multisectoral approach to address social determinants: Health in All Policies and whole-of-society approaches
The multisectoral approach to address social determinants is incorporated under pillar 3 of the End TB Strategy. The social determinants of health are the conditions in which people are born, grow, live, work and age, and the structural drivers of those conditions, such as the distribution of power, money and resources. Social determinants of health are mostly responsible for health inequities. Addressing them, while working towards universal health coverage, will contribute to the improvement of health outcomes.

Health in All Policies is a tool that addresses the social determinants. It comprises six steps: establish the need and priorities for Health in All Policies; assess and engage other sectors; foster a common understanding between sectors; identify supportive structures and processes; enhance community participation; and ensure monitoring, evaluation, reporting and accountability.

The role of TB programmes is to fortify the monitoring systems that provide disaggregated data to assess inequities; undertake advocacy to strengthen commitment to address the social determinants of TB; actively participate in national efforts to fight poverty and improve living conditions; and ensure that TB programmes foster equity in access and financial protection for the poor.
2.5.7 Community-based active case finding: a Fiji perspective

The algorithm used in Fiji for community-based ACF is based on selecting populations followed by symptomatic screening, digital chest X-rays and sputum collection. The lesson learnt to improve community-based ACF is to have trained staff (standard operating procedures, reading chest X-rays), financial allocation for active case (project implementation plans), committed transport, community awareness-priming (communication strategy), integrated services with primary health care and primary health services.

During community-based ACF it was found that in Fiji, symptomatic screening is a poor tool and chest X-rays have a high possibility of over-diagnosis and overuse of GeneXpert. To achieve success, it is important to follow a strict methodology with good data management (poor selection of communities dilutes impact). The future for community-based ACF in Fiji is to create a one-stop service where diagnosis, registration and treatment initiation for TB is done within a working day.

2.5.8 Migration and TB

The presentation pointed out significant challenges in TB control among migrant populations in terms of TB prevention, diagnosis, care mobility and legality. These groups are exposed to a wide diversity of risks. To monitor migrants’ health, it is important to design a TB surveillance system that is inclusive of migrant populations, and TB epidemiological and cohort data should be analysed to monitor the burden of TB and outcomes of treatment in migrants. Key determinants of migrant TB are the volume of the travelling population and rates of travel, along with the efficiency and accessibility of travel.

There is a web-baed platform to facilitate international information exchange for referral and contact investigation. ERS/WHO TB Consilium between the European Respiratory Society (ERS) and WHO started as a web-platform for case consultation (seek expert advice) now with a new function of transborder case referral (send a case to a national TB focal). This web-based platform can be accessed through: www.tbconsilium.org

During discussion some of the points raised were to develop planned departure, strengthen seafarers’ referrals, have TB focal point in Pacific and strengthen immigration act. WHO is willing to support any initiative by any of the countries planning to develop standard operating procedures for international referral and commutation.

2.6 Session 5: Programmatic Management of Drug-Resistant TB (MDR TB)

2.6.1 Global and regional situation of drug-resistant TB

The growing problem of MDR-TB challenges TB control globally and in the region with WHO revising the list of 30 high burden countries post-2015. In 2015, 83 000 MDR/rifampicin-resistant TB cases have been estimated to occur among notified TB cases. Only 17% of them were detected and initiated on second-line treatment in 2015. With a 52% success rate, similar to the global level, treatment outcomes of MDR-TB remain problematic. Differing situations with respect to treatment outcomes in countries were discussed. Patient-centred services for MDR-TB need to be enhanced. In most high burden countries in the region, the Global Fund has remained a major source of funding for programmatic management of drug-resistant TB. Challenges include inadequate diagnosis for drug-resistant treatment due to insufficient funding, high out-of-pocket costs, human resource constraints and poor coordination. Some non-health system barriers such as geographical difficulties and stigma are also still common.
2.6.2 WHO MDR-TB guidelines update 2016, shorter regimen, new drugs and active drug safety monitoring and management

The WHO MDR-TB guideline update 2016 recommends: shorter MDR-TB treatment regimen; regrouping of SLDs for TB based on updated evidence on effectiveness and safety; composition of longer/individualized MDR-TB regimens; and elective partial lung resection surgery along with recommended MDR-TB regimen. A meta-analysis showed that the treatment success of shorter MDR-TB regimen is higher (84%) compared to individualized/longer regimens (62%). A shorter MDR-TB regimen is recommended in patients with rifampicin-resistant TB or MDR-TB, not previously treated with SLDs for TB and resistance to fluoroquinolones and second-line injectable agents was excluded or considered highly unlikely. For a longer regimen, at least 5 effective TB medicines are recommended during the intensive phase. Elective partial lung resection (lobectomy or wedge resection) may be used alongside a recommended MDR-TB regimen.

The WHO has approved and recommended two new drugs: bedaquiline (BDQ, in 2012) and delamanid (DLM, in 2014) to be added to a WHO-recommended regimen in adult patients with pulmonary MDR-TB. Delamanid can also be added to longer regimens in children and adolescents (6–17 years) with MDR- or rifampicin-resistant TB who are not eligible for the shorter MDR-TB regimen. Specific conditions such as proper selection of patients, adherence to the principles of designing a WHO-recommended MDR-TB regimen, treatment under close monitoring, patient-informed consent and active pharmacovigilance should be considered prior to implementation of bedaquiline and delamanid.

The active drug safety monitoring and management is the active and systematic clinical and laboratory assessment of patients on treatment to detect, manage and report suspected or confirmed drug toxicities. It applies to TB patients on MDR-TB treatment with new medicines (e.g. bedaquiline, delamanid), novel regimens (e.g. MDR-TB shorter regimen) and XDR-TB regimens composed of multiple repurposed drugs (e.g. clofazimine, linezolid). There is a possibility of serious adverse events by these drugs. There are three levels of monitoring: (1) core package – requiring monitoring for and reporting of all serious adverse events; (2) intermediate package – includes serious adverse events as well as adverse events of special interest; and (3) advanced package – includes all adverse events of clinical significance.

2.6.3 Practical challenges in managing drug-resistant TB in the Pacific

In the Pacific, drug-resistant TB cases are increasing. They require longer, more complex treatment regimens; use SLDs, which have a higher toxicity; and have a significantly lower treatment success rate. To manage drug-resistant TB, it is essential to strengthen the routine directly observed treatment short course (DOTS) programme and to have capacity to respond to a case, timely case detection/diagnosis, a multidisciplinary management approach and prompt access to SLDs and technical support (laboratory and clinical). Treatment adherence, need of effective infection control and management of contacts are some of the major challenges.

The Pacific Clinical Support Network “DR-TB help desk” has been established to provide advice on management of complex and drug-resistant TB cases. It is important that the network provide a high standard of up-to-date advice. However, the network faces the challenge of maintaining the help desk over the longer term.

2.6.4 MDR-TB case in Guam: lessons learnt

In Guam, an increase of 58% in TB cases has been noted from 2013 to 2015. These were mostly imported. Currently, for the MDR-TB cases in Guam on treatment, the approximate medication costs is US$ 1500 per workday. Each case requires about 10 times as much time from the clinician and
programme staff compared to non-MDR-TB cases. Depending on the type of TB (TB, rifampicin-resistant TB, MDR-TB, pre-XDR-TB and XDR-TB), the cure rate decreases while the cost of treatment increases.

In summary, MDR-TB management is expensive and must include MDR prevention for the household contacts and pay attention to INH resistance, especially in patients who have diabetes.

2.6.5 PATLAB coordination

PATLAB was established in 2004 with the primary objectives to improve and maintain the quality of TB laboratory services in PICs through external quality assessment, and to support PICs in the diagnosis and management of drug-resistant TB.

The microscopic challenges are that: several PICs submit smears for blinded rechecking over nine months after completion of the quarter, a high (at least 25%) proportion of poor quality specimens, incomplete workload, data and classification of errors in the Pacific lot quality assurance sampling (LQAS) handbook is not consistent with the global version. The microscopy recommendation is that, Pacific TB reference laboratories must work with PICs to ensure that slides for blinded smear rechecking are sent within one month of completion of each quarter, PICs must ensure that adequate funding is available for shipment, and the reference laboratories must work with PICs to provide relevant laboratory data for all four quarters in a timely manner. There has to be a concerted effort to improve patient education for sputum collection and to use the global classification of errors for LQAS.

For GeneXpert, it is recommended that TB presumptive cases, especially those at high risk of TB, receive Xpert testing as part of the initial diagnostic workup, any Xpert rifampicin-resistance should be rechecked immediately by testing of another specimen to confirm initial finding and an Xpert rifampicin-resistance (R-R) must be confirmed by rpoB sequence analysis. The NTPs and national reference laboratories must ensure that sufficient funding is available to enable specimens from patients with a confirmed Xpert MTB/rifampicin-resistant tests are shipped rapidly, reliably and safely to the relevant pharmacology and toxicology research laboratory. All the PICs are recommended to use the template provided for data collection for Xpert (provided by the PATLAB Coordinator in 2015). The drug susceptibility testing for specimens with a rifampicin-susceptible result from Xpert testing should not be sent for phenotypic DST unless there is a strong clinical and/or epidemiological indication to do so.

To improve the quality of sputum, it is recommended that hospital staff be educated and additional time spent with patients explaining the procedures of collecting good sputum samples. Also, a standard and clear information on sputum collection should be developed.

2.6.6 Access to second-line probe assay (SL-LPA)

HIV and TB co-infection has become a major issue in recent years globally, while MDR/XDR is posing major threat to the community. The WHO recommended newer molecular diagnostic assays available for TB diagnosis/resistance testing such as Line Probe Assay, GeneXpert, TB-LAMP (Loop mediated isothermal amplification), sequencing/mutation analysis and genotyping.

At this stage, there are limited data available for second-line probe assay (SL-LPA (V2)). However, the performance of genotype SL-LPA (V2) and (V1) are comparable for detection of fluoroquinolone resistance and the majority of the fluoroquinolone resistance is depicted by gyrA mutations. SL-LPA (V2) has increased sensitivity of second-line injectable drugs due to addition of the eis promoter region. The position of the mutation and information on nucleotide substitution is very relevant to
design treatment. SL-LPA does not eliminate the need for conventional phenotypic DST as SL-LPA is designated to detect fluoroquinolone and second-line injectable drug resistance from sputum only.

The presence of mutations in the specific regions does not necessarily imply resistance to all the drugs within a particular group, although specific mutations within these regions may be associated with different levels of resistance (i.e., different MIC) to each drug within the group.

2.6.7 External quality assurance for TB laboratories
The Pacific Paramedical Training Centre (PPTC) is a not-for-profit organization established in 1980 to provide training and assistance in Medical Laboratory Sciences and Blood Transfusion services of PICs and later expanded to South-East Asia. PPTC is a WHO Collaborating Centre for External Quality Assurance. A laboratory quality management system (LQMS) is a step-wise approach developed from a percentage completion score of a minimum standards checklist.

The challenges in professional practices encountered are: non-compliance to ISO standards and thus management systems, frightening automation gap between Pacific labs and those in Nez Zealand/Australia/United States of America, lack of understanding of quality concepts and desire to improve, lack of expertise/interpretative skill especially, haematology, the laboratory perception of inadequate staffing and lack of time, and failure to understand the importance and value of external quality assessment.

2.6.8 SLD stockpile: new arrangements
A regional SLM stockpile for PITs was established in 2011 by the regional partners as a mechanism designed to mitigate procurement and supply management risks and to ensure continuous availability of quality-assured SLDs for MDR-TB patients in PICs. The regional stockpile is managed by the WHO Regional Office for the Western Pacific and is hosted at the Central Warehouse/NTP in the Philippines.

The average cost of a second-line treatment course (MDR-TB) is US$ 2,600 per patient. Given the small number of MDR-TB patients, the low demand for SLDs poses specific challenges such as the risk of expiry (procured second-line medicines may remain unutilized due to low number of cases) and risk of stock-outs due to sudden increase in the number of patients.

PICs may access and obtain SLDs for MDR/rifampicin-resistant TB cases from the regional SLD stockpile without advance payment. The Global Fund Principal Recipients in PICs annually reimburse actual costs of SLDs and shipment costs related to delivery of SLDs from the regional SLD stockpile to the requesting PIC.

In discussion, it was stated that if PIC governments are committed on SLD, WHO can continue having stockpiles.

2.7 Session 6: Intensified TB research and innovation

2.7.1 TB research: Introduction
Intensified TB research and innovation is one of the important pillars (Pillar 3) of the End TB Strategy. The Structured Operational Research and Training (SORT IT) is a global initiative to build adequate and sustainable national operational research capacity to support public health programmes through collaboration between WHO/Special Programme for Research and Training in Tropical Diseases (TDR), the Union and Médecins sans Frontières (MSF). The integrated research and training is provided through this initiative on priority areas. In the Pacific, four operational research courses have been run from 2011 to 2016 and a total of 49 people have been trained: 42 (86%) have completed all three modules and passed the milestones.
There is an abundance of routinely collected data in PICs, but they are often not used to improve programme performance or influence policy and practice. This is partly due to lack of available skills to conduct research in this subregion.

2.7.2 Operational research projects in Pacific countries
The Kiribati national TB strategic plan draft (2016–2020) has dedicated one objective (Objective 3.2) with four activities to strengthen operational research. To further operation research training in Kiribati, a request for funding has been submitted to the Global Fund, government and other donors. More research is expected to be conducted in the future in collaboration with local clinicians/external advisers on TB and malnutrition/TB and diabetes.

In Solomon Islands, the study on burden of TB and treatment outcome of TB patients in urban versus rural settings has been completed. The programme is now planning to conduct TB patient cost surveys in next year. The programme is also considering operation research on policy analysis of social protection policies (literature review, tracing of people who are “lost to follow up” and to determine if costs were a reason why they were “lost”, link survey data to TB treatment outcomes, cross-country comparisons of TB patient costs, role of active TB case finding on patient costs and link to patient pathway analysis).

Vanuatu has also incorporated operational research in its National Strategic Plan for TB, 2016–2020. Three operational research studies have been conducted in the country to date. The future plan for operation research is: NTP to conduct a follow up study on knowledge, attitude and practice of TB patients and traditional healers in 2017, explore possibilities to include TB staff in regional operational research training (SPC-Union), revive and strengthen Vanuatu’s research ethics committee and network with partners and universities for collaboration in operational research.

2.7.3 TB in children
In 2015, an estimated 1 million incident TB cases occurred in children worldwide with estimated 100 000 deaths. Children get TB where adults spread the disease in areas of uncontrolled transmission. The determinant of risk is age at the time of infection. This gets greatly elevated during the first 2–3 years of life when T-cell immunity is still immature. Immune-compromised children remain at higher risk irrespective of age/immune maturity. Children aged under 1 year have the greatest risk of developing paediatric TB as well as disseminated forms of TB.

The WHO guidelines for 2014 include recommendations to use Xpert for children. The Xpert sensitivity for diagnosing TB in children is around 66%. A desk guide for diagnosis and treatment of childhood TB is being developed.

Some of the discussion points were to have good communication with paediatric departments where most of the children with TB first present. Isoniazid prophylaxis among child contacts of an index TB case has not been adequately implemented. It is important to differentiate TB lymphadenitis from the lymph node swelling due to BCG. A symptomatic child who is in contact with an infectious mother is most likely a TB case. Adherence to treatment is a major challenge in children and lot of advocacy and support to parents is needed.

2.8 Session 7: People-centred care

2.8.1 People-centred TB care and prevention
The concept of people-centred care in the overall health system was presented, in particular in the TB programme focusing on four domains: informed and empowered individuals, families and
communities; competent and responsive health-care workers; and efficient and humane health-care organization; and supportive health system.

2.8.2 Update evidence for patient care and support
To enhance TB treatment outcomes, four key interventions are needed: (1) treatment supervision (cultures and DOT (C-DOT), virtually observed treatment (VOT), self-administered treatment); (2) social support (material, psychological, patient education and staff education); (3) tracers and digital health interventions (home visit, phone call, SMS, medication monitor); and (4) mixed interventions (enhanced DOT/mixed interventions vs DOT alone or self-administered treatment). It is recommended to decentralize care for MDR-TB patients instead of centralized care.

2.8.3 Community engagement
In Fiji, the community health-care workers have been utilized for patients’ and their families’ education, advocacy, reducing stigma, referring of presumptive TB cases for diagnosis, and providing treatment support to TB patients (C-DOT). Community health-care workers also contribute to decreasing catastrophic cost to TB patients. To strengthen community engagement in Fiji, community grant schemes funded through the Global Fund have been implemented. They work towards community participation in TB education and advocacy to reduce stigma (and increase volunteer the base for C-DOT) in return for small community development grants.

In Fiji, the C-DOT programme started in July 2016 targeted towards improving TB treatment outcomes and reduced mortality. C-DOT short course providers are mostly retired nurses, community health-care workers, faith-based organizations, community groups, community leaders and Red Cross volunteers.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

3.1.1 Overview
- The PICs are adopting the End TB Strategy into their national policies and implementing core components of the Regional Framework for Action at different stages.

3.1.2 Contributing to universal health coverage
- Considering the epidemiological situation and the overall health system context, it is increasingly important for NTPs to consider integrated systems approaches rather than vertical TB programme setups. The thrust towards universal health coverage under the health reforms in many countries presents greater opportunity to build robust, people-centred TB care and prevention system with sustainable domestic financing.
- The goal of zero catastrophic cost to TB patients and their families is an ambitious global target in the End TB Strategy. NTPs are encouraged to conduct patient cost studies to establish a baseline and identify interventions to achieve the target including policies for social support through multisectoral engagement.

3.1.3 TB control among high-risk populations
- TB programmes are increasingly intensifying their efforts to identify and engage vulnerable and high-risk populations such as people living with HIV, prisoners, contacts, young children, older people, diabetes patients and migrants. The planned Ebeye TB screening programme in the Marshall Islands is one such activity focusing on high density and severe TB burden.
population. The data generated through TB screening activities should be systematically analysed for further improvement of programmes.

- Most cases of TB in children occur in the TB-endemic PICs. TB programmes have already made progress in preventing, diagnosing and treating TB in children. However, within the general health services context, efforts need to be intensified to ensure comprehensive and coordinated care for a child with TB or a child who is a TB contact.
- Addressing social determinants and the vulnerability of populations will contribute not only to TB care and prevention, but also to general public health and greater equity in health. NTPs are in a good position to promote a whole-of-government approach, namely Health in All Policies, and provide concrete evidence on the impact of such an approach.
- Intercountry migrations pose a serious challenge that need to be overcome with improved communication and coordination using information exchange through available initiatives.

3.1.4 Programmatic management of drug-resistant TB

- Although the burden of drug-resistant TB remains low in the Pacific, a patient with drug-resistant TB can appear anywhere anytime. The management of drug-resistant TB has improved with critical regional support mechanisms, PATLAB, the MDR-TB help desk and the SLD stockpile. These mechanisms are clear examples of regional public goods for health and essential to ensure the access to quality TB services in the Pacific context.

3.1.5 Intensified TB research and innovation

- Many initiatives implemented to promote operational research in the region have contributed to knowledge used to inform policy decision. The PICs are encouraged to continue to prioritize operational research and build capacity to improve TB care and prevention, in collaboration with partners.

3.1.6 People-centred care

- TB prevention and care should be delivered and managed in such a way that people receive a continuum of holistic, preventive, diagnostic and treatment and care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs and expectations. Supportive treatment supervision, or DOT, is among critical means to organize and ensure patient support.
- TB programmes are increasingly using people-centred care approaches to address inequity, eliminate financial burden, and improve quality of care.

3.2 Recommendations

3.2.1 Recommendations for Member States

Members States are encouraged to consider the following:

(1) To adopt the End TB Strategy into their national policies, pursue the goal and targets, and implement the Regional Framework for Action by engaging a wide range of governmental and nongovernmental stakeholders.
(2) To conduct patient cost studies to establish a baseline against a global target on zero catastrophic cost due to TB.
(3) To maintain sufficient domestic financial flows to deliver essential public health functions and services for TB care and prevention.
(4) To develop and implement strategies to address TB among identified high-risk populations in local settings. Specific attention needs to be paid to increase coverage of
contact investigation and improve initiation, completion and reporting of TB-preventive treatment among child contacts.
(5) To work together to improve international information exchange to ensure the continuity of TB care including patient referral and outcome monitoring.
(6) To continue to improve national capacity to manage drug-resistant TB with proper and timely testing of patients with presumptive drug-resistant TB and effective communication and coordination with the PATLAB, MDR-TB help desk and the SLD stockpile.
(7) To continue to prioritize operational research to improve TB care and prevention, in collaboration with partners.
(8) To review the current practices and system to identify actions to improve patient-centredness of TB services.
(9) To strengthen community engagement including empowering and collaborating with patients and families, as well as strengthening community-based service delivery.

3.2.2 Recommendations for WHO, UNDP and partners

WHO, UNDP and partners are requested to do the following:

(1) To continue to promote the End TB Strategy and support Member States to implement the Regional Framework for Action.
(2) To support designing, implementing and analysing the data of patient cost studies.
(3) To support analysing TB control financial situation and to support national advocacy efforts.
(4) To support countries and areas to design and implement specific strategies for TB high-risk populations including technical support to design rationale active case-finding activities.
(5) To promote tools to facilitate efficient international information exchange on TB patients such as a directory of NTPs, standard operating procedures, multilingual fact sheets and Internet-based solutions.
(6) To continue to collaborate to secure critical regional mechanisms, including PATLAB, the MDR-TB help desk and the second-line drug stockpile, to ensure access to quality TB diagnosis and care for all people in the Pacific.
(7) To support countries and areas to develop operational research capacity.
(8) To finalize the guidance document on people-centred TB care and support countries and areas to implement the proposed actions (WHO).
(9) To enhance the engagement of civil society and community representatives in future meetings.
EIGHTH TB CONTROL MEETING
FOR THE PACIFIC ISLANDS
15 November 2016
Denarau, Fiji
ENGLISH ONLY
22-24 November 2016

PROVISIONAL PROGRAMME OF ACTIVITIES

Tuesday, 22 November 2016

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<td>08:00 – 08:30</td>
<td>Registration</td>
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<tr>
<td>08:30 – 09:15</td>
<td>Opening</td>
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<td>Welcome remarks:</td>
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<td>o Permanent Secretary of Health, Ministry of Health &amp; Medical Services, Fiji</td>
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<td>o WHO Representative in the South Pacific</td>
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<td>o Country Director and Head, Regional Policy and Programme, United Nations Development Programme</td>
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<td>Meeting objectives</td>
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<td>Introduction of participants and observers</td>
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<td>Appointment of office bearers</td>
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<td>Administrative announcements</td>
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<td>09:15 – 10:00</td>
<td><strong>Group photo / coffee break</strong></td>
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<tr>
<td>10:00 – 10:30</td>
<td><strong>Session 1: Overview</strong></td>
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<td>Chair: Dr Frank Underwood</td>
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<td>Vice-Chair: Mr Felix Koakoa</td>
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<tr>
<td>10:00 – 10:30</td>
<td>The WHO End TB Strategy and Regional Framework for Action</td>
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<td></td>
<td><em>N Nishikiori</em></td>
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<td>10:30 – 10:45</td>
<td>Progress in implementing the GF multi-country grant</td>
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<td><em>UNDP</em></td>
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<td>10:45 – 11:00</td>
<td>Discussion</td>
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<td>11:00 – 12:00</td>
<td><strong>Session 2: County presentations</strong></td>
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<td>12:00 – 13:00</td>
<td><strong>Lunch</strong></td>
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<td><strong>Session 2: Country presentations (continuation)</strong></td>
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<td>Chair: Ms Eretii T. Timeon</td>
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<td>Vice Chair: Dr Nguyen Ngoc Lam</td>
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<tr>
<td>13:00 – 14:30</td>
<td>Country presentations <em>(7 minutes per country, 12 countries)</em></td>
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<td>14:30-15:00</td>
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<td><strong>Session 3: Contributing to Universal Health Coverage</strong></td>
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<td>Chair: Ms Eretii Timeon</td>
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<td>Vice Chair: Dr Nguyen Ngoc Lam</td>
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<tr>
<td>15:00 – 15:30</td>
<td>Monitoring financial burden of TB patients <em>(patient cost study)</em></td>
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<td></td>
<td><em>K Viney</em></td>
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<td>15:30 – 16:00</td>
<td>Enhancing social protection to improve TB care</td>
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<td><em>S Ahmadova</em></td>
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<td>16:00 – 16:30</td>
<td>Financing TB care and control in the context of the UHC</td>
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<td><em>N Nishikiori</em></td>
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<td>16:30 – 17:00</td>
<td>Discussion and closing of the day</td>
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**Wednesday, 23 November 2016**
### Session 4: TB control among high risk populations

Chair: Ms Gloria B. Mendiola  
Vice Chair: Mr Markleen Tagaro  

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<td>Addressing TB among high risk populations: Introduction</td>
<td>N Nishikiori</td>
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<tr>
<td>08:50 – 09:10</td>
<td>TB and non-communicable diseases</td>
<td>R Brostrom</td>
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<td>09:10 – 09:30</td>
<td>Situation and challenges in TB contact investigation and the management of LTBI</td>
<td>K Viney</td>
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<tr>
<td>09:30 – 10:00</td>
<td>Designing and evaluating active TB case finding activities/Screen TB: an online tool for prioritization and strategy selection</td>
<td>N Nishikiori</td>
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<tr>
<td>10:00 – 10:15</td>
<td>Ebeye active case finding project</td>
<td>R Brostrom</td>
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### Session 4: TB control among high risk populations (continuation)

Chair: Ms Gloria B. Mendiola  
Vice Chair: Mr Markleen Tagaro  

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<tr>
<td>10:30 – 11:00</td>
<td>Multi-sectoral approach to address social determinants: Health in All policies and whole-of-society approaches</td>
<td>S Ahmadova</td>
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<td>11:00 – 11:30</td>
<td>Migration and TB</td>
<td>K Viney/N Nishikiori</td>
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<td>Discussion</td>
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### Session 5: Programmatic Management of Drug-Resistant TB

Chair: Ms Rupihner Defang  
Vice Chair: Mr Noel Itogo  

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<td>Global and regional situation of drug-resistant TB</td>
<td>S Ahmadova</td>
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<td>13:30 – 14:00</td>
<td>WHO MDR-TB guidelines update 2016, shorter regimen, new drugs including aDSM</td>
<td>L Nguyen</td>
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<td>14:00 – 14:30</td>
<td>Practical challenges in managing drug-resistant TB in the Pacific</td>
<td>R Stapledon</td>
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<td>MDR- TB case in Guam</td>
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### Session 5: Programmatic Management of Drug-Resistant TB (continuation)

Chair: Ms Rupinher Defang  
Vice Chair: Mr Noel Itogo

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<td>PATLAB coordination</td>
<td>R Lumb</td>
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<td>15:50 – 16:10</td>
<td>Access to SL-LPA</td>
<td>S Pandey</td>
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<td>16:10 – 16:20</td>
<td>External Quality Assurance for TB Laboratories</td>
<td>Russel Cole</td>
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<td>16:10 – 16:30</td>
<td>SLD stockpile: new arrangements</td>
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<td>Discussion</td>
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Thursday, 24 November 2016

### Session 6: Intensified TB research and innovation

Chair: Ms Mareta Hauma  
Vice Chair: Dr Sosaia Ngungutau Vica Penitani

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<td>TB research: Introduction</td>
<td>K Viney</td>
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<td>08:45 – 09:15</td>
<td>Operational research projects in Pacific countries</td>
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<td>Discussion</td>
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<td>09:45 – 10:15</td>
<td>TB in children</td>
<td>B Marais</td>
</tr>
<tr>
<td>10:15 – 10:30</td>
<td>Discussion</td>
<td></td>
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<tr>
<td>10:30 – 11:00</td>
<td>Coffee / tea break</td>
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### Session 7: People-centered care

Chair: Ms Mareta Hauma
Vice Chair: Dr Sosaia Ngungutau Viea Penitani

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:00 – 11:20</td>
<td>People-centred TB care and prevention</td>
<td>K Viney</td>
</tr>
<tr>
<td>11:20 – 11:30</td>
<td>Update evidence for patient care and support</td>
<td>N Linh</td>
</tr>
<tr>
<td>11:30 – 11:50</td>
<td>Community engagement</td>
<td>Countries</td>
</tr>
<tr>
<td>11:50 – 12:15</td>
<td>Voices of community</td>
<td>Community members</td>
</tr>
<tr>
<td>12:15 – 12:30</td>
<td>Closing</td>
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<tr>
<td>12:15 – 13:30</td>
<td>Lunch</td>
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**Satellite sessions**

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<th>Time</th>
<th>Session</th>
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<tr>
<td>13:30 – 17:00</td>
<td>Global Fund Implementation Issues (current grants and plans for applications for future funding modalities)</td>
</tr>
<tr>
<td>13:30 – 17:00</td>
<td>Leprosy update</td>
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Annex 2: List of participants

EIGHTH TB CONTROL MEETING
FOR THE PACIFIC ISLANDS

WPR/DCD/STB(01)/2016/IB/2
18 November 2016

Denarau, Fiji
ENGLISH ONLY
22-24 November 2016

INFORMATION BULLETIN NO. 2

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