

# **TB Control activities and Success factors and Challenges for monitoring and Evaluation of the Management of LTBI in Cambodia**

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# Outline of the Presentation

- Burden of TB in Cambodia
- TB Control Infrastructure
- NTP achievements
- Major Funding Sources
- NTP Challenges
- Summary
- LTBI

# 1. Burden of TB in Cambodia

- Cambodia is still one of the 30 HBC with TB in the world (population: 15 million)
- Incidence Rate\* of all forms of TB for 2014: 390/ 100,000 pop.  
(~ 60,000 cases/year) \*WHO Global TB Report 2015
- Prevalence Rate of all forms\* of TB for 2014: 668 / 100,000 pop. \*WHO Global TB Report 2015  
**NTP had achieved the MDG target for this indicator (4 years before schedule)**
- Prevalence Rate of Sm+\* for > 15 y in 2011: 272/ 100,000 pop. (\*Based on the final result of Prevalence Survey 2011); -it was 437 /100,000 pop. in 200 2: first Prevalence Survey.  
**reduction of 38% in 9 years---an average of 4.2 % per year, quoted in WHO 2012 and UN MDG report 2013 as a best example**
- Death rate\*: 58/100,000 pop \* WHO Global TB Report 2015  
**NTP has alos achieved the MDG target for this indicator (4 years before schedule)**
- Pop infected with TB ? 40-50% ???
- HIV Sero-prevalence among TB Patients : **2.5%** in 1995, **12%** in 2003, **10%** in 2005, **7.8%** in 2007 and **6.3%** in 2009
- PLHIV: ~70,000( 0.6%),with > 80 % on RT
- Estimate of MDR-TB burden in Cambodia (WHO Global TB Report 2015)
  - Percentage of TB cases with MDR-TB among new smear positive= 1.4%
  - Percentage of TB cases with MDR-TB among re-treatment cases= 11%

## 2. TB Control Infrastructure

- Central level-CENAT
  - Hq for the National TB Program with Technical Bureau (30 staff)
  - Referral TB/Chest Hospital\* (130 beds)
  - National TB Reference Laboratory
- Provincial level (25)
  - Provincial TB Supervisors (2 per province)
  - All Provincial Referral Hospitals with TB services
- Operational District level (OD TB Supervisors)
  - Referral Hospitals with TB services : all
  - Health Centres with TB services= 1089
  - TB Microscopic Centres = 215
  - HCs with Community DOTS= 861
- Total =1,314 health facilities are providing TB services which includes the 5 National Hospitals including Referral TB/Chest Hospital under CENAT, all in Phnom Penh

# 3. NTP Achievements

- DOTS started in 1994, until 1998 DOTS services only available at the hospital level; HC DOTS began in 1999; but massive HC DOTS expansion started in late 2001 and by end of 2004, all HCs had DOTS services
- Cases notified increased drastically since the start of HC DOTS expansion. Currently ,cases notified seems to be peaking for TB all forms, but declining for sm+ TB cases.

## 2013

- Smear positive TB cases : 14,082
- All Forms of TB 39,055

## 2014

- Smear positive TB cases : 12,165
- All Forms of TB 43,738

## 2015

- Smear positive TB cases : 10,280
- All Forms of TB: 35,638

*Cure rate has been maintained over 90% for the last decade*

*10 years 2004-2013:cases notified under NTP : All forms; 379,819*

*Sm+ : 178 ,538 ----->*

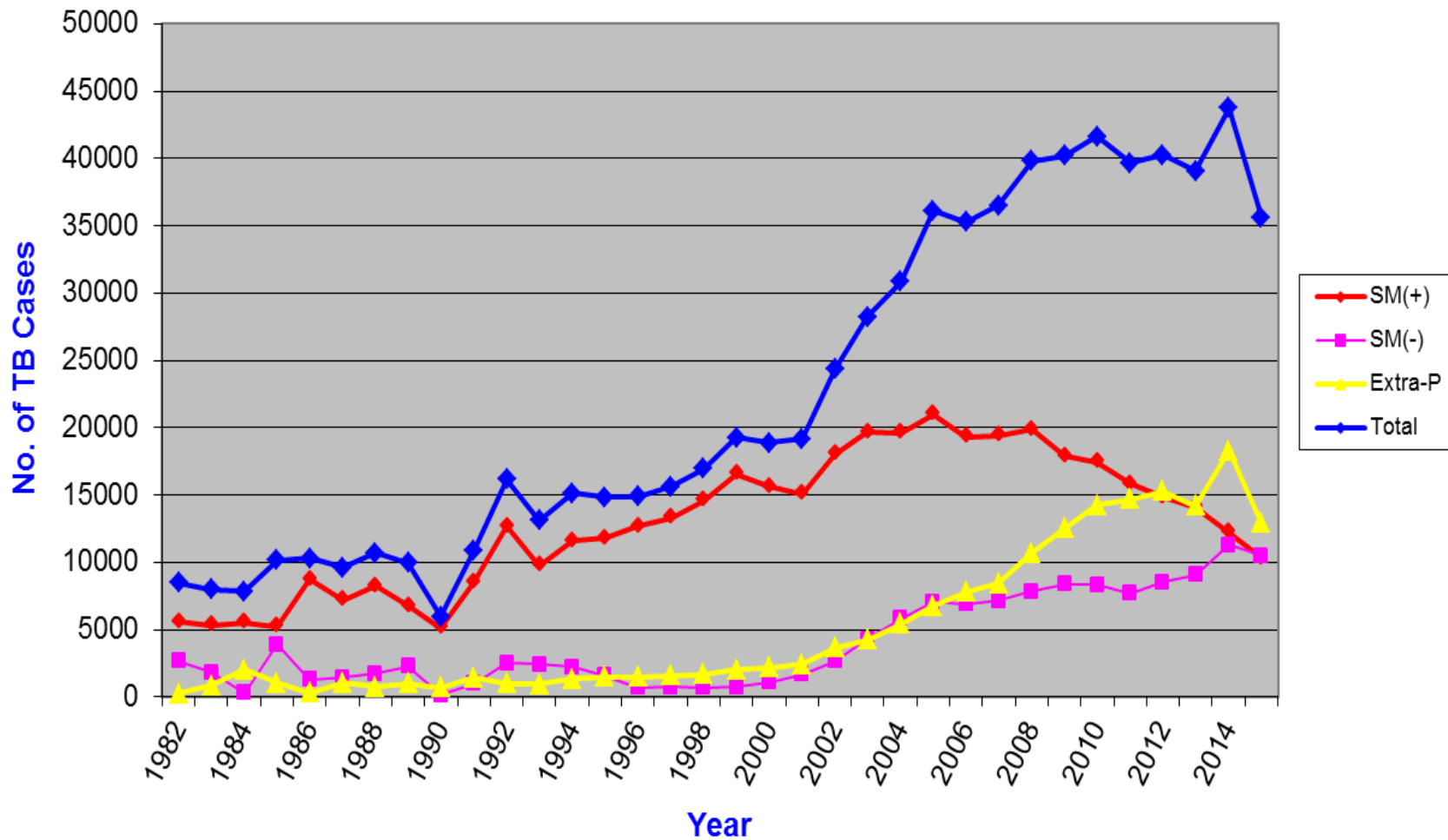
*prevalence reduced by 4-5% per year*

***MoH received award from USAID: a “Champion in Global fight against TB” in March 2014 and CENAT/NTP received JICA recognition award in September 2014***

- **Community DOTS** (since 2002): : 503 HCs by end of 2008, , 827 in 2012 ,816 by 2013 and **577** by April **2014** and **861** in 2015
- **TB/HIV Activities** (since 2003), by the end of 2008- 74 ODs, and by the end of 2011- **all ODs.Now,all ODs**  
*% of referral cases from both sides increased from around 40 % in 2007 to more than 50% (53%) in 2008 and over 70 % in 2009 and over 80% since 2011*
- **PPM-DOTS** (since 2005): currently in 8 provinces and 27ODs by 2014. **Currently, no this activities.**
- **TB in prison** ( since 2005) : currently in 26 prisons
- **MDR-TB** (since late 2006): 11 treatment sites: **56** cases in 2011, **110** in 2012, and **121** cases in 2013 and 110 cases in 2014, and 75 cases in 2015
- **TB in Children:** Cases increased from **1600** in 2007 to **2500** in 2008 and **3853** in 2009 and **4,100** in 2010 and `~ 5,700 in 2011 **and over 6,000** in 2012 , **7,000** cases in 2013, **11,973** in 2014 and **6,857** in 2015.

- Active case finding started since 2005, but large scale only in 2012, 2013, 2014 and 2015
- TB lab Liquid culture started in 2011
- **Xpert MTB/RIF**: 37 machines (29 in routine services and 8 for ACF & Research)
- 2014-2020 National Strategic Plan for TB Control (final draft)
- SOP for TB in Prison; SOP for TB IC; Clinical guidelines for TB/HIV revised; Treatment guidelines revised;
- Prevalence surveys in 2002 and 2011, other surveys (HIV/TB patients 2003, 2005, 2007, 2009, Drug resistance surveys in 2001 and 2006-7)
- Joint Program Review (JPR) in 2006 and 2012

## TB Cases Notified, 1982-2015





## 4. Major Funding Sources for NTP

- Government
- GF
- USAID (including TBCARE/Challenge TB)
- US-CDC
- WHO/Stop TB partnership
- JICA/JATA
- Others ( NGOs)

# 5. Challenges

- **Resources to maintain routine services** (esp. routine DOTS ,TB/HIV , Laboratory capacity, TB in Prisons)**and expanding specific activities** ( C-DOTS , Childhood TB, Xpert MTB/RIF)
- Anti-TB drugs (SLD & childhood drugs) and Diagnostic supplies
- Annual budget for core/basic NTP need from 2014-2020: ~20 Million( Total budget need ~30 Million /year)
- Currently ,only 3 major donors: GFATM, USAID and WHO/STOP TB Partnership
- Budget allocation from GF for 2015-2017 : **15.66** Million ( around 5 .20 million per year)
- Support from USAID for 2015 ~3.5--4 Million ?( year 2016 under preparation)
- **Financial gap from 2016-2020 : may be bigger than 50% ?**
- **High prevalence, incidence and death**

## 6. Summary

- Strong political commitment & leadership
- Clear policies, strategies, guidelines, SOPs and plans
- Strong infrastructure
- Good performance
- Big financial gap in the next 5 years
- **Urgent** need for more resource mobilization

# 7. LTBI

## IPT provision-policy and practice

- Policy and Screening/diagnosing algorithms exist
- Children contact of sm+ TB, only under 5
- , service available in only 26 operational districts (26/89)

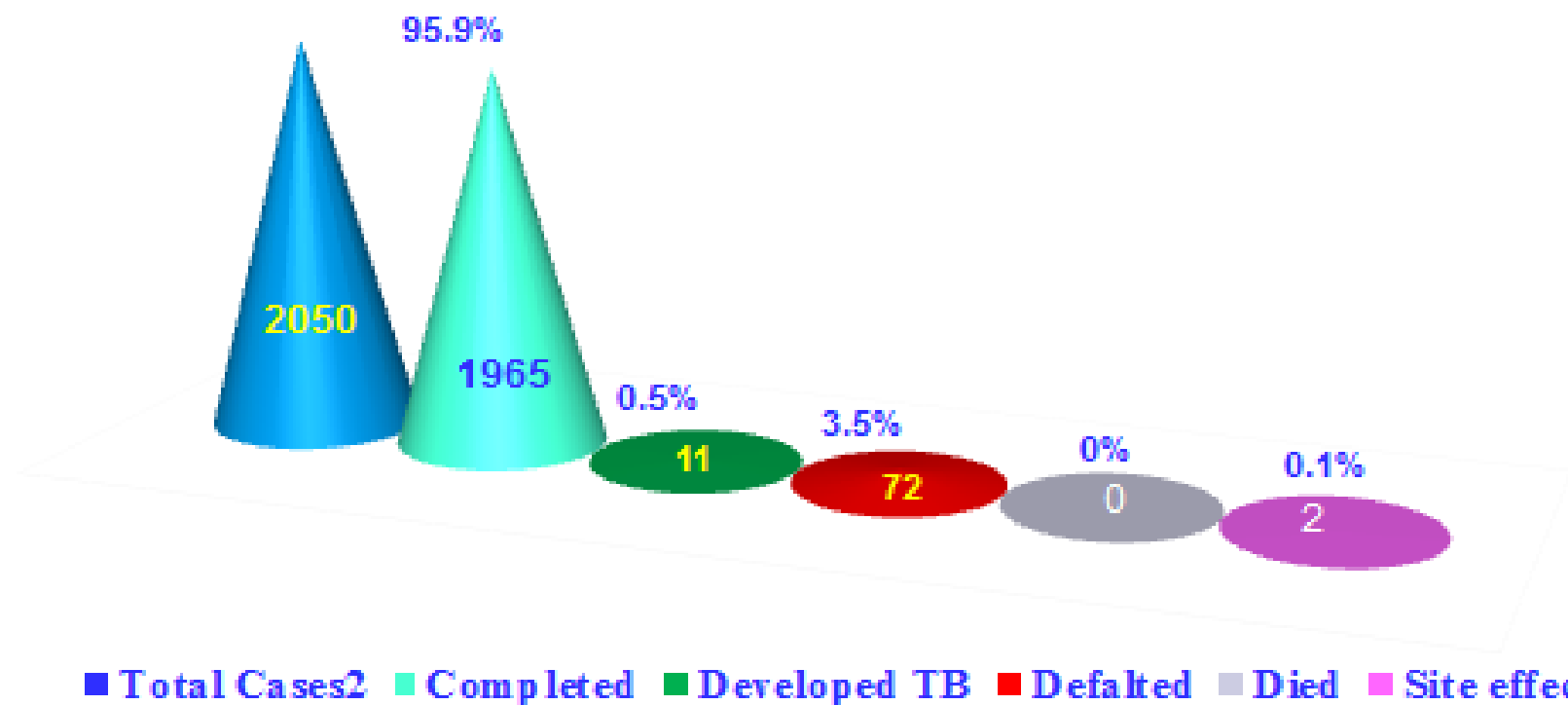
### Passive vs Active contact investigation

- *TB contacts come to HC for TB screening( up to end 2014)*
  - *HC go to community and screen TB contacts ( started from around mid 2015)*
  - People living with HIV/AIDS (PLHIV) ,target mainly for new enrollees, available in all operational districts
- TB screening conducted and IPT by NAP workers, when positive ,proceed to diagnostic work up( responsibility of NTP workers)*

## Number of PLHIV and Children received IPT

	2012	2013	2014	2015
Population	14,741,000	14,962,000	15,184,000	15,405,000
PLHIV	71,600	71,400	71,160	70,000
IPT in PLHIV (target)	944	1,343	771 (1250)	954 (1194)
TB Smear (+)	14,838	14,082	12,202	10,280
IPT in Children under 5 yrs (target)	220	2,050	2,707* (2200)	989 (2400)

## IPT OUTCOME IN 2013



## Monitoring and Evaluation System of LTBI

- IPT register for children (paper system) within NTP
- PLHIV: electronic/computerized data base within NAP
- TB quarterly report for IPT register for children
- For PLHIV: generated from data base of NAP
  
- Supervision from central ,province and district
- TB/HIV working group meeting
- District quarterly meeting
- M&E quarterly workshop,NTP
- Annual TB conference and annual report,NTP

# Major Challenges for IPT

- Lack of clear and ambitious target/indicators:
  - *for both Children and PLHIV —target just set based on past implementation /resource, not much on the future direction or need ( 90%,90% ,90%,3 types of target setting approaches; Po.,Pro.,and Do.)*
  - *need to include clear denominator, i.e, number of children screened versus target ( total screenees,index cases..)...*
- Resources for implementation
  - some partners do not have priority in children( TB in children was interrupted for around 9 months)
  - big financial gap for NTP, overall
- HIS:
  - NAP data system does not capture IPT for PLHIV on ART and hesitation to start IPT among this group



- IPT in children, paper based system ,quite problematic, in-completeness, under-reporting,...
- local ownership of information vs project
- Insufficient baseline data/policy for target setting
- Other Operational challenges:
  - Reluctance from family member of children in absence of parent in IPT
  - Reluctance of Health Center staff in doing TB screening for IPT
  - transport cost to diagnostic facilities ( when positive) from community/OI-ART sites to diagnosing facilities
  - lack of fund for supervision ( 2015 ,no supervision conducted due to pending policy on DSA)
  - HR and motivation (labor intensive work)

# Conclusion & Next steps for LTBI

- System/service exists and function, but requires improvement , big gap(service/finacial) & challenges
- Revisit future directions
- Further identification of challenges and gap
- Revise future plan and intensify implementation, including research

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**Thank You**