

Myanmar

Overview of TB control system

Myanmar is among the 22 high-burden countries that have strong health infrastructures. The Ministry of Health has identified TB as being second only to malaria as a health priority, and the minister himself chairs the central TB supervisory committee. The unit of management for TB control is the township, with an average population of 130 000. In some places, TB treatment is supervised by trained volunteers at rural health centres and in patients' homes.

Surveillance, planning, operations

Case finding has improved greatly in Myanmar over the past 4 years: the estimated smear-positive case detection rate by the DOTS programme rose to 73% in 2002, in excess of the 70% target. Treatment success in the 2001 cohort was 81%, about the same as it has been since 1996. The principal obstacle to reaching the 85% target is the 10% default rate. An explanation of why so many patients fail to complete treatment has not been given.

Political commitment to TB remains high, as demonstrated recently by ministerial involvement in programme reviews and participation in World TB Day. Improved funding from international donors allowed the expansion of DOTS to 15 more townships in 2003. All 324 townships are now, or will soon be, implementing DOTS provided funds from the GFATM become available in 2004. All zones will have their own TB centres by 2005. About one quarter of the total NTP staff positions remain vacant, mostly in the districts. Training of NGO staff to deliver DOTS has improved treatment supervision, IEC, and referral capabilities.

The reliability of the drug supply has been improved through support from the GDF, and a grant from the GFATM will allow the purchase of drugs during 2004 to cover 80% of patients. Drug distribution and supervisory visits to facilities were made easier following the construction of a central drug store in 2002, and the purchase of vehicles in 2003. Laboratory infrastructure (buildings, microscopes, supply of laboratory consumables) and staff training at the township laboratories have been improved, though there is still a shortage of equipment. The central reference laboratory is faced with a heavy workload, and staffing remains inadequate to carry out the supervision, training, quality assurance, cul-

ture, and drug susceptibility testing that are required.

The collaboration between the public and private health providers was expanded through pilot projects with the Myanmar Medical Association in 2003. General practitioners and health facilities outside the NTP still do not fully comply with DOTS standards, although a number of non-DOTS public health facilities reported to the NTP for 2001, this was not the case for 2002. Some funding from the GFATM is devoted to social franchising to encourage private clinics to implement DOTS.

As yet, there is no TB/HIV coordinating body, nor is there a surveillance system to measure HIV prevalence among TB patients. Guide-

PROGRESS IN TB CONTROL IN MYANMAR

Indicators

| | |
|--|------------------|
| • Treatment success 2001 cohort | 81% |
| • DOTS detection rate, 2002 | 73% |
| • NTP budget available, 2003 | 18% ^a |
| • Government contribution to NTP budget, including loans, 2003 | 6% |
| • Government contribution to total TB control costs, including loans, 2003 | NA |
| • Government health spending used for TB, 2003 | NA |

Constraints to achieving targets

- Delay in receipt of GFATM funds
- Shortage of TB clinics, laboratory equipment, microscopy centres, and vehicles at central and peripheral levels
- Insufficient numbers and training of technical, supervisory, and managerial staff, particularly with respect to quality assurance of laboratory services, logistics, supervision, data management, and epidemiology
- Lack of community awareness about TB and available services
- Poor access to diagnosis and treatment in remote areas

Remedial actions needed

- Finalization of GFATM grant agreement
- Purchase vehicles and laboratory equipment, and refurbish clinics
- Appoint staff to suspended posts, and create new posts
- Train technical staff, supervisors, and managers
- Comprehensive IEC strategy to expand community awareness of TB
- Improve access to diagnosis in remote areas by opening new diagnostic centres; introduce mechanisms for sending sputum samples or slides to laboratories
- Scale-up successful initiatives with NGOs, private health care providers, and the HIV programme

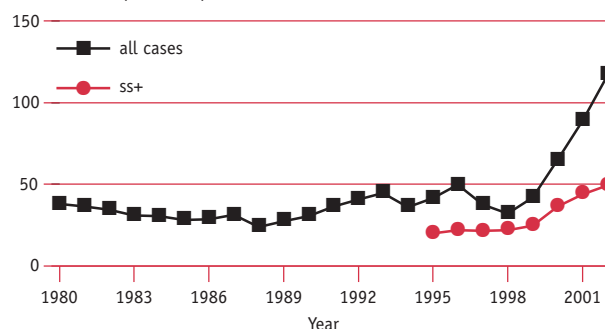
^a Once the GFATM agreement is finalized, this will be 100%.

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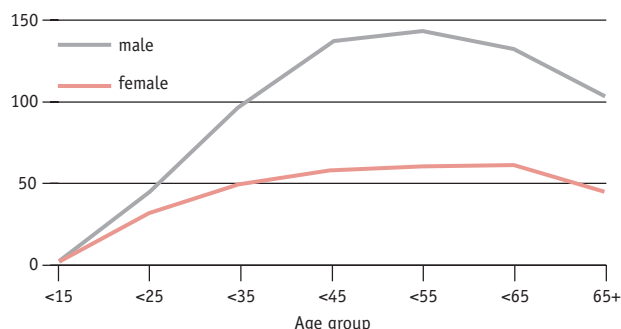
| LATEST ESTIMATES ^a | | TRENDS | 1999 | 2000 | 2001 | 2002 |
|---------------------------------------|-------------------|---|------|------|------|------|
| Population | 48 852 483 | DOTS population coverage (%) | 64 | 77 | 84 | 88 |
| Global rank (by est. number of cases) | 22 | Notification rate (all cases/100 000 pop) | 42 | 65 | 89 | 117 |
| Incidence (all cases/100 000 pop) | 154 | Notification rate (new ss+/100 000 pop) | 24 | 36 | 44 | 49 |
| Incidence (new ss+/100 000 pop) | 68 | Detection of all cases (%) | 26 | 40 | 57 | 76 |
| Prevalence (ss+/100 000 pop) | 83 | Detection of new ss+ cases (%) | 34 | 51 | 63 | 73 |
| TB mortality per 100 000 pop | 26 | DOTS detection of new ss+ (%) | 34 | 51 | 62 | 73 |
| % of adult (15-49y) TB cases HIV+ | 11 | DOTS detection of new ss+/coverage(%) | 53 | 66 | 74 | 82 |
| % of new cases multi-drug resistant | 1.5 | DOTS treatment success (new ss+, %) | 81 | 82 | 81 | — |

Notification rate (per 100 000 pop)

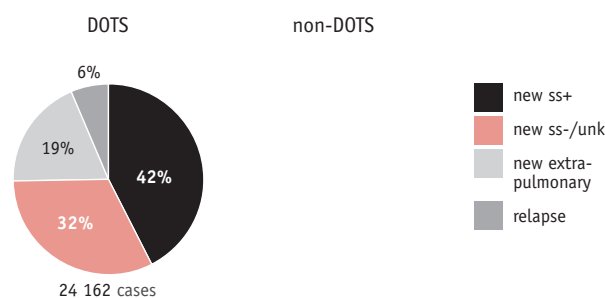
Notification (all cases) = 57 012 in 2002



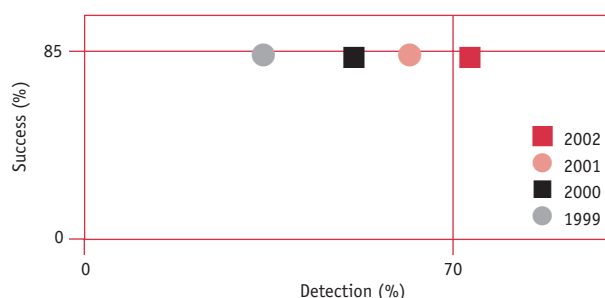
Notification rate by age and sex (new ss+)^b



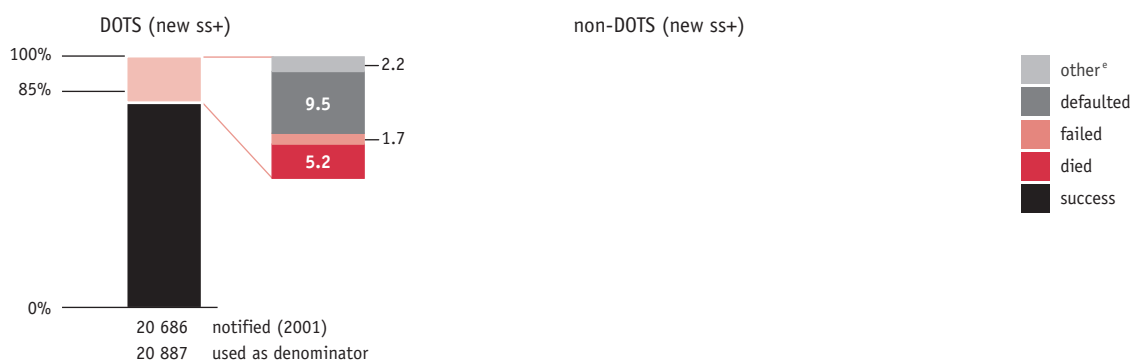
Case types notified^c



DOTS progress towards targets^d



Treatment outcomes^e



Notes

ss+ Indicates smear-positive; ss-, smear-negative; pop, population; unk, unknown.

^a See Methods for data sources.

^b The sum of cases notified by age and sex is less than the number of new smear-positive cases notified for some countries.

^c Non-DOTS is blank for countries which are 100% DOTS, or where no non-DOTS data were reported.

^d DOTS progress towards targets: DOTS detection rate for given year, DOTS success rate for cohort registered in previous year.

^e "Other" includes transfer out and not evaluated, still on treatment, and other unknown.

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Budget estimates, existing funding, and budget gaps for fiscal year 2003, US\$ millions

| | REQUIRED FUNDING | EXPECTED FUNDING | | | | FUNDING GAP |
|---|------------------|------------------|----------|------------|----------|-------------|
| | | GOVERNMENT | LOANS | GRANTS | OTHER | |
| NTP budget | | | | | | |
| Drugs | 0.5 | 0.05 | — | 0.5 | — | — |
| Dedicated staff working exclusively for TB control | 0.5 | 0.3 | — | 0.2 | — | — |
| New activities to raise case detection and cure rates | 0.8 | — | — | 0.8 | — | — |
| Buildings, equipment, vehicles | 3.0 | — | — | 3.0 | — | — |
| All other line items | 0.3 | — | — | 0.3 | — | — |
| TOTAL NTP BUDGET | 5.1 | 0.3 | — | 4.8 | — | — |
| Costs not covered by NTP budget ^a | | | | | | |
| Hospital stay | NA | NA | — | — | — | — |
| Clinic visits for DOT and monitoring | NA | NA | — | — | — | — |
| TOTAL COSTS NOT COVERED BY NTP BUDGET | NA | NA | — | — | — | — |
| TOTAL TB CONTROL COSTS | NA | NA | — | — | — | — |

— Indicates zero; NA, not available

^a WHO estimates, data not provided by the NTP

lines for treating TB patients infected with HIV have been developed, and efforts are being made to educate the private practitioners who treat these patients. Collaborative activities between TB and HIV/AIDS control programmes have been tested by the MoH in 1 of 52 districts, and the NTP will deliver ART therapy as soon as funds from the GFATM become available. Myanmar conducts DRS surveys within the framework of the WHO/IUATLD global project on anti-TB drug resistance surveillance.

Partnerships

An NICC ensures coordination among donors, with IUATLD and WHO leading external technical support to the country. Three national NGOs – the Myanmar Maternal and Child Welfare Association, the Myanmar Red Cross Society, and the Myanmar Medical Association – provide direct obser-

vation of treatment for DOTS patients. Financial support is provided by the Myanmar government, WHO, UNDP, GDF, JICA, and JATA. Some additional bilateral donors are now providing financial support to the country, but not yet for TB control. A proposal to the GFATM for TB control has been approved and funding should begin in 2004.

Budgets and expenditures

Total expenditure by the NTP in fiscal year (from April) 2002 was US\$ 1.2 million. Most of this expenditure was for drugs, with drugs worth US\$ 0.4 million supplied by the GDF and an additional US\$ 0.5 million contributed by various donors including JICA, IUATLD, and WHO.

The budget for 2003 was much higher, at US\$ 5.1 million, most of which was for purchase of vehicles

and laboratory equipment. While this budget was much higher than expenditures for 2002, it was anticipated that the budget would be fully funded following a successful application to the GFATM. Of the US\$ 5.1 million, US\$ 4.2 million was anticipated from the GFATM, US\$ 0.6 million from other donors, and US\$ 0.3 million from the government. However, as of January 2004, the grant agreement with the GFATM had not been finalized. The NTP therefore continued to rely on low levels of funding in 2003. If GFATM funds become available soon, the budget shown in the table should apply to fiscal year 2004. As in previous years, no reliable estimates could be made for TB control costs beyond the NTP budget, due to difficulties in converting costs from local currency to US\$ values.