Ninth Meeting of the Subgroup on Public-Private Mix for TB Care and Control and Global Workshop on engaging large hospitals

Bangkok, Thailand
28-30 August 2013

Stop TB Partnership

World Health Organization
Ninth meeting of the Subgroup on Public–private mix for TB care and control and Global workshop on engaging large hospitals

Meeting Report

Bangkok, Thailand
28-30 August 2013
Acknowledgement

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## Abbreviations

<table>
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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>Global Fund</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<tr>
<td>HBC</td>
<td>high TB-burden country</td>
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<tr>
<td>HIV/AIDS</td>
<td>human immunodeficiency virus/acquired immunodeficiency syndrome</td>
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<tr>
<td>ISTC</td>
<td>International Standards for Tuberculosis Care</td>
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<td>KNCV</td>
<td>Royal Netherlands TB Foundation</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MDR-TB</td>
<td>multidrug-resistant tuberculosis</td>
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<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
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<tr>
<td>NTP</td>
<td>national tuberculosis programme</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>The US President's Emergency Plan for AIDS Relief</td>
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<tr>
<td>PP</td>
<td>private provider</td>
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<tr>
<td>PPM</td>
<td>public–private mix</td>
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<tr>
<td>PPM Subgroup</td>
<td>Subgroup on Public–Private Mix for TB care and control</td>
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<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>The Union</td>
<td>International Union against Tuberculosis and Lung Disease</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WHA</td>
<td>World Health Assembly</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>XDR-TB</td>
<td>extensively drug-resistant tuberculosis</td>
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</table>
1. Introduction

Engaging all care providers in TB care and control through public–private mix (PPM) approaches and promoting the International Standards for Tuberculosis Care (ISTC) are among the core components of WHO’s Stop TB Strategy. Strengthening health systems through the involvement of all relevant health-care providers outside the national TB programmes (NTPs) is essential to meet the TB-related Millennium Development Goal and reach the targets for tuberculosis (TB) control set out in the Global Plan to Stop TB 2006–2015. The Stop TB Partnership Subgroup on Public–Private Mix for TB Care and Control (PPM Subgroup), hosted by the Global TB Programme of the World Health Organization (WHO) has been instrumental in assisting countries to enhance collaboration among diverse public, private, voluntary and corporate care providers to improve access to high-quality TB care to all who need it.

At the first meeting of the Subgroup in November 2002, generic regional and national strategies for PPM were developed and endorsed. The second Subgroup meeting reviewed the growing PPM evidence base emerging from numerous PPM initiatives, and broadened the scope of PPM to include the involvement of public sector providers not yet linked to NTPs. The third Subgroup meeting identified barriers and enablers for scaling up PPM for TB care and control and endorsed the global guidance document on engaging all care providers in TB care and control. The fourth meeting specifically focused on PPM for TB care and control in Africa. It examined how successful PPM approaches within Africa could be scaled up and how approaches in other regions could be adapted to African settings. The fifth meeting reviewed the global and regional progress on PPM and identified barriers to scaling up PPM and ways to address them. While the sixth meeting discussed practical tools to accelerate PPM scale up, the focus of the seventh meeting was on mainstreaming PPM as an important approach to address global deceleration of TB case notifications. The eighth Subgroup meeting showcased PPM progress in the countries within the World Health Organization’s (WHO) Western Pacific region and discussed ways to engage individual formal and non-formal private providers through innovative approaches such as, for example, social franchising.
The ninth meeting of the PPM Subgroup and the associated workshop on hospital engagement, was supported by the TB CARE I Program of the United States Agency for International Development (USAID). The meeting was organized in Bangkok, Thailand, from 28-30 August 2013. The meeting overviewed global progress to-date, discussed ways to accelerate PPM scale up and prepared for PPM mainstreaming within the post-2015 TB strategy. With a view of drawing attention to the possibility of substantially enhancing TB case notifications while also improving TB management among people with TB presenting to large hospitals, a workshop on the unfinished business of effective engagement of large hospitals in TB care and control was organised in conjunction with the ninth PPM Subgroup meeting. The evidence generated from documented field projects was presented and discussed. The participants made field visits to examine first-hand some working examples of effective hospital engagement in TB care and control in Bangkok.

This report summarizes the proceedings of the ninth meeting and workshop. The objectives and expected outcomes are presented in Section 2. Section 3 briefly outlines the presentations and discussions at the meeting. The agenda and list of participants are presented in the appendices. The meeting presentations are available online at: www.who.int/tb/careproviders/ppm/ninth_ppm_subgroup_meeting.
2. Objectives and expected outcomes

2.1 Objectives

Ninth PPM Subgroup Meeting
1. To review and discuss global progress on PPM for TB care and control.
2. To discuss future strategies to accelerate expansion and enhance impact of engaging all care providers through PPM in the context of the proposed post-2015 TB strategy.

Global Workshop on Engaging Large Hospitals
3. To discuss ways to engage large hospitals to enhance case notifications and improve TB management.
4. To make field visits to selected large hospitals in Bangkok to better understand approaches to hospital engagement in TB care and control.

2.2 Expected Outcomes

Ninth PPM Subgroup Meeting
1. A review of global progress on PPM and its contribution to TB care and control.
2. Outlines of future strategies to enhance attention to PPM before and beyond 2015.

Global Workshop on Engaging Large Hospitals
3. A review of country approaches and experiences in engaging large hospitals in TB care.
4. Field visits for enhanced understanding of internal coordination and external linkages for improving management of people with TB presenting to large hospitals.
3. Summary of presentations and discussions

3.1 Day 1
The introductory session provided an overview of global and regional progress on PPM. This was followed by a special session with a focus on the South-east Asia region. The WHO office of the South-east Asia region outlined the PPM expansion strategy in the region. Three countries from this region: Thailand, Indonesia and Myanmar highlighted their progress in engaging various care providers and presented their PPM strategies and plans. This was followed by a panel discussion on partner approaches and activities for PPM, and their perspectives on the future. The day closed with a dynamic debate on regulation and collaboration. An overview of the various sessions on the first day are provided below.

Session I: Opening
The meeting was opened by the Honourable Permanent Secretary from the Ministry of Public Health in Thailand- Dr Narong Sahametapat, the WHO Representative for Thailand- Dr Yonas Tegegn and the Director of the WHO Global TB Programme- Dr Mario Raviglione. Following the opening remarks, the two new chairs of the PPM Core Group – Dr Evan Lee from Eli Lilly and Dr William Wells from USAID presented their vision for the PPM Subgroup going forward. The outgoing chair of the PPM Subgroup-Dr Phil Hopewell from the American Thoracic Society (ATS) was thanked for his decade of outstanding chairmanship.
Following this, the agenda and objectives of the Subgroup meeting and associated workshop on hospital engagement were outlined and discussed. A brief introduction to PPM was presented, including the evolution of PPM, PPM models and key resources.

**Figure: The public-private mix model**

![Image](image_url)

**Session II: Global, regional and country progress**

*Global progress*

The first presentation in this session overviewed global progress in PPM countries. Data and analysis from the PPM section in the 2013 Global TB report was presented:

- In 2013, 73 countries reported summary data to WHO, and data for 29 of these countries (including 14 HBCs) were presented (see Table 1).
- In most of these countries, PPM initiatives contributed about 10% to 40% of total notifications.
- Considering that the private medical sector in Africa is much smaller compared with that in Asia, the contribution of private-for-profit and not-for-profit providers in Ethiopia, Kenya, Nigeria and the United Republic of Tanzania is noteworthy.
- Progress in parts of Asia is also noticeable – almost every fourth case in Indonesia and the Philippines was notified by non-NTP care providers in 2012.
- Large public sector hospitals have contributed sizeable proportions of cases in China and Indonesia as well as in the Philippines, and engagement of large hospitals is one of the major strategies required to improve detection and notification of TB cases.
- In the European Region and the Region of the Americas, contributions to case notifications from public sector providers outside the purview of the Ministry of Health, such as social security organizations and prison health services, are relatively large.
Table 1. PPM contribution to notifications of TB cases in 29 countries, 2012

<table>
<thead>
<tr>
<th>Country</th>
<th>Type of care providers</th>
<th>Number of TB cases notified by public NTP care providers</th>
<th>Number of TB cases notified by private care providers</th>
<th>Contribution to total notifications of TB cases in 2012 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AFRICAN REGION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Diverse private providers</td>
<td>–</td>
<td>17,133</td>
<td>12</td>
</tr>
<tr>
<td>Ghana</td>
<td>Diverse non-NTP public and private providers</td>
<td>1,107</td>
<td>832</td>
<td>13</td>
</tr>
<tr>
<td>Kenya</td>
<td>Private clinics and hospitals, and prisons</td>
<td>817</td>
<td>10,364</td>
<td>12</td>
</tr>
<tr>
<td>Lesotho</td>
<td>Diverse private providers</td>
<td>–</td>
<td>1,044</td>
<td>10</td>
</tr>
<tr>
<td>Nigeria</td>
<td>Public non-NTP and NGO hospitals and private clinics</td>
<td>14,066</td>
<td>8,121</td>
<td>24</td>
</tr>
<tr>
<td>Swaziland</td>
<td>Diverse non-NTP public and private providers</td>
<td>1,489</td>
<td>841</td>
<td>33</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>Private facilities and faith based organizations</td>
<td>–</td>
<td>13,734</td>
<td>22</td>
</tr>
<tr>
<td><strong>REGION OF THE AMERICAS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>El Salvador</td>
<td>Diverse non-NTP public and private providers</td>
<td>761</td>
<td>50</td>
<td>40</td>
</tr>
<tr>
<td>Peru</td>
<td>Social security organizations and other non-NTP public providers</td>
<td>6,576</td>
<td>–</td>
<td>22</td>
</tr>
<tr>
<td><strong>EASTERN MEDITERRANEAN REGION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Afghanistan</td>
<td>Private clinics, hospitals, laboratories and pharmacies</td>
<td>1,362</td>
<td>2,128</td>
<td>12</td>
</tr>
<tr>
<td>Egypt</td>
<td>Health insurance organizations, NGOs and other public non-NTP providers</td>
<td>1,993</td>
<td>213</td>
<td>26</td>
</tr>
<tr>
<td>Iran (Islamic Republic of)</td>
<td>Health insurance organizations, prisons, military and private care providers</td>
<td>1,205</td>
<td>3,189</td>
<td>40</td>
</tr>
<tr>
<td>Iraq</td>
<td>Diverse non-NTP public and private providers</td>
<td>2,693</td>
<td>2,938</td>
<td>65</td>
</tr>
<tr>
<td>Pakistan</td>
<td>Private clinics and hospitals</td>
<td>925</td>
<td>56,363</td>
<td>21</td>
</tr>
<tr>
<td>Sudan</td>
<td>Diverse private and non-NTP public providers</td>
<td>450</td>
<td>1,475</td>
<td>10</td>
</tr>
<tr>
<td>Syrian Arab Republic</td>
<td>Diverse private and non-NTP public providers</td>
<td>175</td>
<td>2,400</td>
<td>86</td>
</tr>
<tr>
<td>Yemen</td>
<td>Public hospitals including university, military and police hospitals, prisons and private hospitals</td>
<td>3,486</td>
<td>–</td>
<td>35</td>
</tr>
<tr>
<td><strong>EUROPEAN REGION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>Diverse non-NTP public and private providers, and prisons</td>
<td>673</td>
<td>1,620</td>
<td>58</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>Diverse non-NTP public providers and prisons</td>
<td>1,549</td>
<td>–</td>
<td>24</td>
</tr>
<tr>
<td><strong>SOUTH-EAST ASIA REGION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bangladesh</td>
<td>Diverse private, non-NTP public and NGO providers</td>
<td>2,429</td>
<td>14,934</td>
<td>10</td>
</tr>
<tr>
<td>India</td>
<td>Diverse private, non-NTP public and NGO providers</td>
<td>13,572</td>
<td>3,533</td>
<td>–</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Public and private hospitals</td>
<td>77,376</td>
<td>5,432</td>
<td>25</td>
</tr>
<tr>
<td>Myanmar</td>
<td>Diverse private, non-NTP public and NGO providers</td>
<td>8,999</td>
<td>26,879</td>
<td>23</td>
</tr>
<tr>
<td>Nepal</td>
<td>Diverse private providers</td>
<td>–</td>
<td>5,366</td>
<td>15</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>Diverse non-NTP public and private providers</td>
<td>5,004</td>
<td>415</td>
<td>60</td>
</tr>
<tr>
<td>Thailand</td>
<td>Diverse non-NTP public and private providers</td>
<td>1,532</td>
<td>1,267</td>
<td>4.6</td>
</tr>
<tr>
<td><strong>WESTERN PACIFIC REGION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>China</td>
<td>General public hospitals</td>
<td>3,684</td>
<td>–</td>
<td>44</td>
</tr>
<tr>
<td>Philippines</td>
<td>Private clinics and hospitals</td>
<td>11,804</td>
<td>36,744</td>
<td>24</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>Diverse non-NTP public and private providers</td>
<td>3,404</td>
<td>4,724</td>
<td>8.0</td>
</tr>
</tbody>
</table>
The activities undertaken by the PPM Subgroup partners and secretariat over 2012-2013 were also outlined. This included: (1) inclusion of PPM in the post-2015 TB strategy (2) updating of the ISTC (3) designing guidance and tools for engagement of corporate sector, pharmacies and hospitals (4) specific technical assistance to countries like Myanmar, Nepal and Cambodia (5) inclusion of the PPM component in joint program reviews and (6) collating and analyzing PPM data from 73 countries for the Global TB Report. The potential of hospital engagement was also discussed with reference to the WHO/CIDA initiative to engage large hospitals towards early and full case finding.

Regional progress: Focus on South-East Asia

Over 40% of people with TB live in the WHO South-East Asia region. In 2011, this region had an estimated 5 million people with TB (prevalence) and 480 000 TB deaths.

PPM is crucial for this region and is a key component of the “Updated TB Regional Plan 2011-15”, given that private providers continue to be the first or alternative point of care for over 60% of TB patients, and public health care systems are overstretched. In India alone, 75% of first-line and 99% of second-line anti-TB drug sales, in dollar value, still continue to be sold outside the national TB programme.

Inter-sectoral collaboration and public-private partnerships for TB care and control have been scaled up in eight member countries: Bangladesh, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste. More than 1000 medical colleges, 25 000 private practitioners, 1800 large public and private hospitals, 250 corporate institutions, 2500 non-governmental organizations, nearly 100 faith-based organizations and over 900 prisons are now working with national TB programmes in the South-East Asia region.

In 2012, PPM contributed between 5% to 58% of all TB cases in the countries of the region. Major PPM successes in this region include:

- India declared that all providers should mandatorily notify TB and medical colleges should include this in their curricula;
- Medical associations endorsed the International Standards for Tuberculosis Care (ISTC) in most countries of the region;
- The Thai Business Coalition and Indian Business Alliance are supporting provision of TB services in workplaces;
- Large hospitals are being involved increasingly in Bangladesh, India, Indonesia and Thailand.
The challenges that pose barriers in scaling-up PPM include:

Within NTP:
- Limited ability and capacity to rapidly expand PPM;
- Limited networking and coordination between various players, especially in urban settings;
- No systematic involvement in quality assurance mechanisms;
- Weak capacity to monitor private providers including private laboratories.

Within participating sectors:
- Variable quality of diagnosis and treatment; ideological differences; guidelines not always followed;
- Reluctance to refer for diagnosis and treatment, particularly in large private hospitals;
- High costs of diagnosis and treatment, e.g. fees for follow-up visits;
- Poor patient retrieval: limited capacity to follow up within the community, weak links with community health centers and volunteers;
- Supervision by NTP staff not always well received.

The priorities for PPM in the region include: catalyzing wider PPM implementation in four countries - India, Indonesia, Myanmar and Nepal; documenting and disseminating best practice PPM examples; actively engaging with professional associations and universities for dissemination and application of the ISTC; expanding collaboration with the corporate sector; building coordination mechanisms and forums for information exchange at all levels; and organizing a regional training for national consultants and focal points on strengthening public-private partnerships.

Country progress
Three countries from the South-East Asia region - Indonesia, Myanmar and Thailand presented the progress made in scaling up PPM in their countries.

Indonesia
Indonesia has a strong and comprehensive strategy in place to engage all providers (see figure below). In 2012, around 25% of the total TB cases in the country were detected and notified by non-NTP providers. The national TB programme is working towards further scaling up PPM to reach the remaining 30%-40% of TB patients who are currently not reached with quality TB care services.
The care providers engaged in the country include, lung clinics/hospitals, public and private hospitals, private practitioners, prisons, NGOs, corporate sector, and, military and para-statal hospitals.

**Figure: Indonesia PPM model**

![Indonesia PPM model](image)

The country is currently working towards Universal Health Coverage. Efforts are underway by the national TB programme to ensure that the coverage of TB services in the Universal Health Coverage package is adequate and also covers links to the non-NTP sector.

**Myanmar**

Around one-fourth of the total TB cases in the country are detected and notified by non-NTP providers in Myanmar each year. Engaging all care providers is thus a crucial element of Myanmar’s TB care and control efforts. The national TB programme is engaging:

- general practitioners through two NGOs using schemes;
- 79 private laboratories, in addition to the 386 public laboratories;
- 23 public hospitals;
- other ministries, namely, Labour, Home Affairs and Defence.

The country’s future PPM plans include, intensifying hospital engagement - especially of newly engaged hospitals; strengthening the referral system for general practitioners; starting MDR-TB management through general practitioners, and strengthening the EQA system to ensure laboratory quality.
Thailand
There has been significant progress in engaging all care providers in Thailand. Around 3000 people with TB were detected and notified by non-NTP providers in Thailand in 2012. The PPM network in the country includes, the Bangkok Metropolitan Administration, government hospitals (at all levels), university hospitals, private hospitals, NGOs, corporate sector, prisons, military and police. However, there is significant scope for strengthening engagement of hospitals in the private sector as well as those outside the purview of the Ministry of Public Health. Currently, 80% of private hospitals do not notify TB cases to the national TB programme. An action plan to scale up involvement of all non-engaged hospitals in TB care and control has been put together by the national TB programme to address this gap.

Session III: Partner approaches and activities
This session was organized in an interactive question-and-answer format with seven partners including a community representative, to discuss PPM lessons from the past and perspectives on the future. The partners in the panel discussion included Eli Lilly, the Royal Netherlands TB Foundation (KNCV), PATH, Population Services International (PSI), the Global TB Community Advisory Board (TB CAB), TBCARE II, and the United States Agency for International Development (USAID). An overview of the key points discussed in the panel are highlighted below:

- Lessons learned from current PPM activities were reviewed, followed by deliberations on key challenges for PPM in the future.
- Insights were provided from Eli Lilly’s previous experience in getting private industry to contribute to PPM. The current PPM related activities of the Lilly MDR-TB Partnership were outlined, including future plans for PPM support.
Based on KNCV’s longstanding work on hospital engagement, the top 3 major barriers in engaging public and private hospitals in PPM expansion were discussed. This included rates of loss to follow up of TB patients treated in hospitals, weak accreditation systems, non compliance with the ISTC and the need for regulation. Strategies to make well-established partners and others beyond the TB community pay greater attention to PPM expansion were also discussed.

PPM-specific advocacy efforts led by PATH at the national level in countries were presented and implications for future PPM funding in countries was discussed.

In many settings, private providers are unwilling or uninterested in engaging with PPM schemes, particularly where financial benefits of participation are unclear. PSI discussed what methods they use to address this barrier and build engagement. In addition, the advantages of using social franchising approaches for active case finding through private providers were elaborated.

Civil society engagement is vital for PPM. Discussions reviewed how patient and community perspectives could be incorporated in the design and implementation of TB strategies in countries. Good examples were shared on where partnership with civil society has resulted in greater impact, and the potential of civil society engagement for PPM.

Current efforts to engage private health providers in the mining industry to increase TB case detection were outlined. In addition, the potential of involving traditional health practitioners in PPM expansion especially in high HIV settings in Africa was discussed.

**Session IV: Debate**

The last session on the first day was a dynamic debate on the motion: “In the present context in high-prevalence countries, regulation is the only way forward to achieve large scale expansion of PPM for TB”. The debate was moderated by Dr Mario Raviglione and included speakers from Pakistan, Kenya, India and WHO on behalf of Nigeria.

Representatives of India and Nigeria presented against the motion with view points and personal experiences on the importance of collaboration to build engagement with private and non-NTP public providers in TB care and control efforts.

Representatives of Kenya and Pakistan were for the motion, and illustrated with country examples, the importance of enforced regulation to ensure that all care providers deliver high quality care and to curb the irrational use of anti-TB drugs.
The pros and cons of collaboration and regulation were debated in detail. In general, in most resource-poor countries with a high TB-burden, patients with symptoms suggestive of TB seek care from a wide array of health-care providers. These care providers, often not linked to public sector-based NTPS, may serve a large proportion of TB suspects. Evidence suggests that failure to involve all care providers used by TB suspects and patients hampers case detection, delays diagnosis, leads to inappropriate and incomplete treatment, contributes to increasing drug resistance and places an unnecessary financial burden on patients. Collaboration with all care providers is thus crucial to ensure high quality TB care for all.

Regulation was considered essential because collaboration alone is not enough to make all care providers align their practices to recommended guidelines. Evidence shows that collaboration does not guarantee notification of all cases not does it ensure rational use of TB drugs. Further, it is demanding for already burdened NTPs to engage and effectively supervise the numerous individual practitioners, formal and informal. Regulatory approaches like certification and accreditation of a sufficient number of collaborating providers and restricting non-participating providers from accessing TB drugs could ease the burden on TB programmes.

A strong case was also made for collaboration. The progress in expanding PPM so far has been achieved mostly through collaborative approaches. Regulation may be easier to enact than enforce in the current context of weak health systems in many high TB prevalence
countries. Regulation cannot be a panacea to guarantee adherence to rules by all care providers; regulation may not change people’s health seeking behaviour, it may not help raise a provider’s index of suspicion for TB, nor will it help in early diagnosis or to ensure the quality of care provided. Also, if regulation alienates the care providers by forcing all people with TB to move to the public sector, it may overburden the already overstretched TB programmes. For regulation to work, collaboration is crucial, as regulation generally works by disciplining the errant few when the majority collaborate.

The debate was followed by a lively discussion with questions from the audience on the stands taken by debaters.

The session concluded that both collaboration and regulation were important. There was consensus that scaling up PPM will require both collaboration and regulation to ensure effective engagement of the non-NTP public and private sectors.
3.2 Day 2
Global workshop on engaging hospitals in TB care and control

The Global PPM workshop on engaging hospitals was held on the second day the meeting.

A significant proportion of people with symptoms of TB visit hospitals that may be located far away from their homes, as their first or main point of care. People do so often with a belief that long-standing illnesses of serious nature are better taken care of at hospitals. Hospitals, however, are not always well placed to provide closely supervised care for patients with TB. Optimal care of TB patients in a hospital setting requires close coordination among various internal departments and strong networking with peripheral health centres. While this is essential to ensure continuum of care for TB patients, achieving it may pose distinct challenges. The workshop - through field visits, presentation of country experiences and group discussions, deliberated on ways to strengthen engagement of large hospitals for enhancing case notifications and improving TB management.

Session V: Field visits and country experiences

Field Visits
The workshop opened with field visits to three hospitals in Bangkok - King Mongkuth Military and Medical School hospital, Rajavithi Hospital and Taksin General hospital. The aim of these field visits was to help participants understand the functioning of hospitals and how they work together with the national TB programme for delivery of TB care. Following the field visits, each group presented their observations and findings in a plenary session. The overall impression of participants was that, in Thailand with Universal Health Coverage there appears to be good access to health services, and hospital-based inpatient
and outpatient services are heavily utilized. TB care is provided and results are good. The challenge now, as noted with the just concluded programme review is to maximize early information flow across health services and NTP on patients diagnosed and enable effective referral as need for full patient treatment.

*Engaging hospitals – country experiences*

**Lessons from five-country WHO/CIDA initiative**

In March 2009, WHO initiated a project in diverse country settings to help intensify TB case detection, through a grant from the Canadian International Development Agency (CIDA). The initiative was implemented in five countries in Africa and Asia: Democratic Republic of the Congo (DRC), Ghana, The Philippines, Swaziland and Viet Nam. It included a setting-specific mix of the following approaches: i) intensified hospital engagement in large cities, ii) implementation of systematic TB contact investigation, iii) screening for TB among high-risk individuals such as people living with HIV (PLHIV) and people with diabetes; and high-risk populations such as prison inmates and people living in poor urban areas. The aim of the initiative was to detect an additional 28 500 cases in the five countries. Intensified hospital engagement was the major approach in all countries that contributed to detecting majority of the target cases.

*Figure: Trends in bacteriological testing for TB and TB case notifications in hospitals in project sites, 2010 – 2012*
An overview of the interventions in each country to link hospitals was briefly presented, followed by a discussion on critical success factors, challenges and sustainability beyond the project.

After successful implementation of project activities, total hospital notifications increased from about 2000 per year across the five sites before the project to about 12,000 per year in 2012. The documented number of people tested for TB with a bacteriological test increased in all sites, and the average increase was roughly fourfold (see figure).

Documentation of referrals for treatment and feedback to confirm treatment initiation demonstrated that the losses after referral were very large at baseline in the two Asian countries (the Philippines and Viet Nam). These losses were substantially reduced by the end of the third project year through improved communication between hospitals and the primary health care facilities to which they were making referrals. Treatment success rates among those started on treatment in hospitals were similar to those reported by the NTP.

This project helped to describe a baseline situation in which hospitals were not engaged. It then demonstrated that it is possible to proactively engage hospitals and align their services to national guidelines and in turn to improve detection of TB cases and notification to NTPs. The key components of success in engaging hospitals were: political commitment; dialogue between NTP, MoH departments dealing with hospitals, hospitals managers and clinicians; and, dedicated and accountable staff for internal and external coordination.

**China: Country experience on engaging hospitals**

The new model of engaging hospitals in MDR-TB care in China was presented. The model was piloted in 4 cities in China covering a population of 21 million people. The baseline assessment period was January 2006-October 2009 and the intervention period was 2011.

The pilot project had excellent outcomes. Strong linkages between the Centers for Disease Control in China and hospitals led to increased case-finding of people with MDR-TB by 650% between the baseline and intervention periods. There was also a drop in time-to-diagnosis by 88%, drop in cost of hospitalization by 44%,
drop in out-of-pocket payment from 70% to 24%, and drop in cost per hospital day for MDR-TB treatment by 40%.

In addition, an overview was provided on the health reform process in China and how TB care-including hospitals managing TB patients are being integrated in this.

**India: Country experience on engaging hospitals**

Medical college hospitals in India are key providers of health care including for TB, as well as for imparting education. An overview of the Indian model and process of engaging medical college hospitals was presented. To facilitate the engagement of medical college hospitals in the country, India's Revised National TB Control Programme (RNTCP) set up taskforces at the national, regional and state level to provide the necessary human resources and logistics support to implement and coordinate activities. The RNTCP also provided at no cost to the institutions, laboratory consumables and supplies, drugs as well as funds for civil works for upgrade of infrastructure where required. Funds for salary of medical officer in-charge of a DOTS clinic was also provided to each medical college. The medical college hospitals were expected to provide space for the microscopy and DOT centre within the hospital, undertake diagnosis and treatment of TB and drug-resistant TB, designate faculty members to supervise the functioning of the centre and arrange sensitization and training of hospital staff jointly with respective district-level programme staff.

In 2012, 90% (315) of all medical colleges in the country were engaged by the RNTCP in delivery of TB services. Approximately 13% of the new smear positive TB cases in the country in 2012 were notified by medical college hospitals. Further, around 26 000 MDR-TB patients and 209 XDR-TB patients were detected and treated at medical college hospitals between end 2007 and early 2013.

**Kenya: Country experience on engaging hospitals**

The experience of Moi Teaching and Referral Hospital, in Eldoret, Kenya in TB care and control was presented. TB service delivery in the hospital is coordinated by a working group of TB staff. Support is provided by the national TB programme, the national AIDS programme and the ASANTE Consortium (a group of North American Universities led by Indiana University). A total of 540 TB cases were detected and notified by the Moi hospital in 2012.
The hospital runs an active TB case finding program to detect TB early using, key staff to monitor and screen for cough in the hospital and local volunteers in the community. Around 305 smear positive TB patients were detected in 2012 through this program. TB screening is also undertaken at the HIV clinics in the hospital. The hospital also implements collaborative TB/HIV activities and provides care for MDR-TB patients.

**Session VI: Group work on hospital engagement**

Breakout groups were then organized with facilitation from area experts to discuss four critical elements for hospital engagement: (1) Effective coordination within hospitals; (2) Effective linkages between hospital and external peripheral centres; (3) Essential inputs needed from NTPs – at all levels to facilitate engagement; (4) Essential inputs needed from beyond NTPs, e.g. ministry of health, other ministries, government.

The groups presented outcomes from discussions at a plenary session at the close of the workshop.

Essential inputs needed from the NTP: For NTPs, setting up collaboration is beset with barriers both inside and outside hospitals. Making the more powerful departments responsible for hospitals within and outside Ministries of Health (MoH) cooperate in TB control is not easy. Inside hospitals, interacting with busy, high-profile clinicians indifferent to public health consequences of their actions is problematic, while outside hospitals, establishing referral links with peripheral health centres to achieve the continuum of care for patients from distant regions is complex.
Commitment of the hospital management and willingness and capacity on the part of the NTP to support hospitals are important prerequisites to begin implementation. This may be facilitated by involvement of an intermediary organization such as the hospital association or a local NGO. A situation assessment should be first conducted – led by the NTP – to understand the working of the hospital with regards to managing TB patients-this should be led by the NTP. The tasks related to TB care that the hospital could undertake should be spelt out. Hospital management may take a considered decision to simply refer all TB suspects or diagnosed TB cases to health centres for treatment and follow up. Some hospitals may take on the responsibility of managing only those patients who reside in the vicinity and decide to refer the rest to peripheral health centres. Depending on the hospital policy, resources required to streamline TB management may need to be assessed by the NTP. Plans for any reorganization of services may then be prepared in close consultation with the hospital management. Identifying champion(s) within the hospital, offering them the leadership role or training responsibilities and setting up an in-hospital coordination team could greatly facilitate further implementation.

**Essential inputs needed beyond national TB programmes:** Local collaboration between hospitals and health centres may not work or be sustained if it is not supported and supervised by higher provincial and national authorities. There should be a clear national policy mandating all health institutions in the country, including hospitals, to follow national guidelines based on the International Standards for TB Care. The problems of co-ordination arise because often, within the ministries of health, different departments may be responsible for health centres and hospitals and other ministries such as the ministry of social welfare or of education may be responsible respectively for hospitals run by social insurance organizations or academic institutions. It is therefore important to constitute national and provincial mechanisms to help set up, support and supervise linkages between hospitals and health centres and sustain them. Also models from Latin America and elsewhere exist on establishing cross ministry coordination (social security, justice, military, transport, etc.).

**Internal coordination:** In order to ensure that every person with suspected TB presenting to the hospital is screened and all TB patients are properly diagnosed and treated according to national guidelines or international standards, close internal coordination is required. Often, departments, other than chest medicine, internal medicine and the outpatient department (which may be variously labeled in different settings), need to be closely engaged. These departments include, the general administration services to address issues related to patient
flows and infection control; laboratory services to ensure quality-assured microscopy; and radiology services for chest X-ray facilities. All other departments will also need to be oriented to enable identifying TB cases of all types that may be managed in the hospital.

Involving specialists, clinicians and nurses in TB control efforts should be possible through promotion of the International Standards for TB Care. To create peer pressure so that the standards are put into practice, national associations of health professionals should be mobilized. Hospital specialists may respond more positively to the Practical Approach to Lung Health than to focusing only on TB care. Once clinicians and nurses are convinced, then achieving internal coordination among hospital departments and external networking with peripheral health facilities might remain mainly managerial issues.

**External networking:** Setting up a functioning network with peripheral health centres where patients diagnosed in the hospital would be received for supervised treatment would be the most important aspect of hospital engagement. Some of the important elements of a working external network should include: development of standard operating procedures (SOPs) on patient referral and feedback; staff training related to SOPs; preparation and distribution of relevant forms and registers; adequate supply and logistics support; periodic meetings for cross-checking data from hospitals and health centres and for preparation of quarterly reports; and jointly agreed monitoring and supervisory routines.
3.3 Day 3

Session VII: International Standards for TB Care and PPM Expansion

ISTC – Highlights of the upcoming 3rd revision
The session was opened with an overview of the process underway to update the ISTC. The third edition of the ISTC is expected to be launched on World TB Day in March 2014. The main updates in this edition include, the incorporation of rapid molecular tests into diagnostic evaluation in line with WHO recommendations, and broadening of the criteria for antiretroviral therapy (ART) in line with WHO recommendations.

ISTC for PPM expansion – Indonesia experience
In Indonesia, ISTC has been used as a key tool to engage pulmonologists and hospitals in TB care and control. Between 2010 and 2013, 97 pulmonologists and 61 hospitals in three provinces have been engaged using the ISTC. Improvements in quality of care and TB notifications were reported as key outcomes of using the ISTC as a tool for PPM in the country.

Session VIII: PPM for MDR-TB and other innovations

Is the private sector prepared to engage in MDR-TB management? – findings from the Philippines
In the Philippines, the enrolment of MDR-TB patients increased four times in 2011 compared to 2010. Despite this progress, the number of MDR-TB cases notified in 2011 represents 19% of estimated caseload (among notified) in the Philippines. The national TB programme therefore undertook an assessment in collaboration with the WHO regional office for the Western Pacific to assess if the private sector could be engaged in detecting and managing MDR-TB patients.

The assessment indicated that there is significant potential and benefit to engaging the private sector, to manage MDR-TB cases and boost the rational use of anti-TB drugs. Detailed findings are available in the meeting presentation (see link at the end of this section.)
Social enterprise model and technology boost to improving TB care delivery

An overview of the social enterprise models for TB care delivery and diabetes management currently being rolled out in two Asian megacities- Dhaka, Bangladesh; and Karachi, Pakistan, were presented. This initiative is being led by Interactive Research & Development (IRD), with support from TBREACH and UNITAID.

The initiative uses process and technology innovations in communications, mass screening algorithms, behavioral economics and rapid diagnostics such as Xpert MTB/Rif, Computer Aided Detection 4 TB (CAD4TB), HbA1c Analyzer (diabetes point-of-care test), and desktop spirometry. A business approach underpins the initiative which includes a mix of free TB and paid non-TB services. The verbal screening tools used in identifying people suspected of having TB in the initiative, include questions on diabetes- as diabetes triples the risk of developing TB.

In 2011 and 2012, nearly 6000 TB cases were detected in Dhaka and Karachi using this model. The initiative is a pathfinder and demonstrates potential to improve standards of lung health and diabetes care in the private sector. This model is being set up for implementation in Jakarta, Indonesia.

Panel discussion on PPM for MDR-TB and other innovations

Initiative for Promoting Affordable Access to Quality TB Diagnostics (IPAQT) in Indian Private Sector – early experiences

In June 2012, the government of India took the unprecedented step of banning the import, manufacture, distribution and sale of antibody-based TB serodiagnostic tests, in line with the WHO recommendation that such tests should not be used to diagnose TB. Unfortunately, this ban created a gap in the private market that allowed other suboptimal tests to gain market share, especially since TB diagnostics recommended by WHO were considered too expensive and well beyond the reach of the typical TB patient. To overcome this market
shortcoming, the Initiative for Promoting Affordable, Quality TB Tests (IPAQT) in India was launched in March 2013.

IPAQT is a consortium of 42 private diagnostic laboratories supported by not-for-profit stakeholders (examples include the Clinton Health Access Initiative and the McGill International TB Centre). It has established agreements with Cepheid Inc, Hain LifeScience, and Becton, Dickenson and Company that allow access to concessional prices for Xpert MTB/RIF, first-line line probe assays, and liquid culture in the private sector, which is normally excluded from negotiated pricing agreements. Participating laboratories must abide by several conditions: they need to be accredited to assure quality; they must report confirmed cases to the Revised National TB Control Programme (RNTCP); they must adhere to a ceiling price when charging patients; and they must refrain from using any tests that are not recommended by WHO or the RNTCP.

Together, there are approximately 50 member laboratories, 3500 franchisee laboratories, and 40 installed bases participating in IPAQT, with over 10 000 specimen collection centres across India, thus increasing access to rapid, accurate and affordable diagnostics for patients seeking care in the country's extensive private sector.

**Session IX: PPM preparedness for the post-2015 strategy**

**PPM in the Post-2015 TB Strategy**

An overview of the draft post-2015 Global TB Strategy was presented. The vision for the draft post-2015 tuberculosis strategy is “a world free of tuberculosis”; also expressed as “zero deaths, disease and suffering due to tuberculosis”. The goal is to end the global TB epidemic. The Strategy framework includes milestones for 2025 and targets for 2035, underpinned by four key principles: government stewardship and accountability, with monitoring and evaluation; strong coalition with civil society organizations and communities; protection and promotion of human rights, ethics and equity; and adaptation of the strategy and targets at country level, with global collaboration. The framework includes three main pillars:

1. Integrated, patient–centered care and prevention
2. Bold policies and supportive systems
3. Intensified research and innovation
**Figure: Draft post-2015 Global TB Strategy framework**

| **VISION:** | A world free of tuberculosis  
|            | – zero deaths, disease and suffering due to tuberculosis |
| **GOAL:**  | End the global tuberculosis epidemic |
| **MILESTONES FOR 2025:** | – 75% reduction in tuberculosis deaths (compared with 2015);  
|            | – 50% reduction in tuberculosis incidence rate  
|            | – (less than 55 tuberculosis cases per 100 000 population)  
|            | – No affected families facing catastrophic costs due to tuberculosis |
| **TARGETS FOR 2035:** | – 95% reduction in tuberculosis deaths (compared with 2015)  
|            | – 90% reduction in tuberculosis incidence rate  
|            | – (less than 10 tuberculosis cases per 100 000 population)  
|            | – No affected families facing catastrophic costs due to tuberculosis |

**PRINCIPLES:**

1. Government stewardship and accountability, with monitoring and evaluation
2. Strong coalition with civil society organizations and communities
3. Protection and promotion of human rights, ethics and equity
4. Adaptation of the strategy and targets at country level, with global collaboration

**PILLARS AND COMPONENTS**

1. **INTEGRATED, PATIENT-CENTRED CARE AND PREVENTION**
   
   A. Early diagnosis of tuberculosis including universal drug susceptibility testing; and systematic screening of contacts and high-risk groups
   
   B. Treatment of all people with tuberculosis including drug-resistant tuberculosis; and patient support
   
   C. Collaborative tuberculosis /HIV activities; and management of co-morbidities
   
   D. Preventive treatment of persons at high-risk; and vaccination against tuberculosis

2. **BOLD POLICIES AND SUPPORTIVE SYSTEMS**

   A. Political commitment with adequate resources for tuberculosis care and prevention
   
   B. Engagement of communities, civil society organizations, and public and private care providers
   
   C. Universal health coverage policy; and regulatory frameworks for case notification, vital registration, quality and rational use of medicines, and infection control
   
   D. Social protection, poverty alleviation and actions on other determinants of tuberculosis

3. **INTENSIFIED RESEARCH AND INNOVATION**

   A. Discovery, development and rapid uptake of new tools, interventions, and strategies
   
   B. Research to optimize implementation and impact, and promote innovations
PPM is placed as a key component of pillar 2, and can be enhanced through the integrated model of care envisioned in pillar 1, the bold policies such as Universal Health Coverage and mandatory case notification in pillar 2, and research for new tools to facilitate care in pillar 3.

The post-2015 Global TB Strategy is ambitious and aims to accelerate the response to the TB epidemic. The engagement of all care providers is vital to achieve the targets set by the strategy and to end the TB epidemic.

**Panel Discussion: Advocacy to address policy bottlenecks and mainstream PPM**

There has been significant progress in scaling up PPM over the past decade. However, to further scale up engagement of all care providers, there is urgent need for PPM advocacy.

A big advocacy push for PPM would help: expand political commitment, increase collaboration, help strengthen capacity and accountability in countries to implement PPM, and maximize resources/investment opportunities for PPM including with the Global Fund.

Experiences from the Eastern Mediterranean region, Afghanistan and Pakistan were shared-highlighting key successes which could be replicated in other settings.

An advocacy matrix was presented and participants were requested to brainstorm on what advocacy actions could be taken at the national, regional and global levels to promote PPM.

**Closing**

The meeting was closed by the two co-chairs of the PPM Subgroup.
### Appendix 1.

**Agenda**

#### 28 August 2013

**Ninth meeting of the Subgroup on PPM for TB Care and control**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Chair</th>
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<tbody>
<tr>
<td>8:30 - 9:00</td>
<td>Registration</td>
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<tr>
<td>9:00 - 9:10</td>
<td>Welcome by WHO Representative, Thailand</td>
<td>Yonas Tegegn</td>
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<tr>
<td>9:10 - 9:20</td>
<td>Address by the Representative, Ministry of Public Health, Thailand</td>
<td>Thavatchai Kamoltham</td>
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<td>9:20 - 9:30</td>
<td>Address by Director, WHO Global TB Programme</td>
<td>Mario Raviglione</td>
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<tr>
<td>9:30 - 9:45</td>
<td>Comments by outgoing Chair and incoming Co-Chairs</td>
<td>Phil Hopewell, Evan Lee, William Wells</td>
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<td></td>
<td><strong>COFFEE 09:45 – 10:15</strong></td>
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<tr>
<td>10:15 - 10:30</td>
<td>Background, objectives, declarations of interest and agenda</td>
<td>Mukund Uplekar</td>
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<td>10:30 - 11:00</td>
<td>Discussion</td>
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<tr>
<td>11:00 - 11:15</td>
<td>Global Overview</td>
<td>Hannah Monica Dias</td>
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<tr>
<td>11:15 - 11:30</td>
<td>Regional Overview – Southeast Asia</td>
<td>Khurshid Alam Hyder</td>
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<tr>
<td>11:30 - 11:45</td>
<td>Country perspective – Thailand</td>
<td>Chawetsan Namwat</td>
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<td>11:45 - 12:00</td>
<td>Country Perspective – Indonesia</td>
<td>Dyah Mustikawati</td>
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<td>12:00 - 12:15</td>
<td>Country Perspective – Myanmar</td>
<td>Thin Thin Nwe</td>
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<td>12:15 - 12:30</td>
<td>Discussion</td>
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<td></td>
<td><strong>LUNCH 12:30 – 13:30</strong></td>
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<tr>
<td>13:30 – 13:40</td>
<td>Eli Lily</td>
<td>Evan Lee</td>
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<td>13:40 – 13:50</td>
<td>KNCV</td>
<td>Jan Voskens</td>
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<td>13:50 - 14:00</td>
<td>PATH</td>
<td>SS Lal</td>
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<td>14:00 - 14:10</td>
<td>PSI</td>
<td>Petra Stankard</td>
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<td>14:10 - 14:20</td>
<td>TB CAB</td>
<td>Blessi Kumar</td>
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<td>14:20 - 14:30</td>
<td>URC</td>
<td>Thulani Mbatha</td>
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<td>14:30 – 14:40</td>
<td>USAID</td>
<td>William Wells</td>
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<tr>
<td>14:40 – 15:00</td>
<td>Discussion</td>
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<td></td>
<td><strong>COFFEE 15:00 – 15:30</strong></td>
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<tr>
<td>15:30 - 15:40</td>
<td>Speaker for the motion</td>
<td>Ejaz Qadeer</td>
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<td>15:40 - 15:50</td>
<td>Speaker against the motion</td>
<td>Joshua Obasanya</td>
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<td>15:50 - 16:00</td>
<td>Speaker for the motion</td>
<td>J M Chakaya</td>
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<td>16:00 - 16:10</td>
<td>Speaker against the motion</td>
<td>RV Asokan</td>
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<tr>
<td>16:50 - 17:00</td>
<td>Briefing on field visits to hospitals in Bangkok</td>
<td>Yuthichai Kasetjaroen</td>
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29 August 2013
Global Workshop on Engaging Hospitals in TB Care Control

**Session V: Field visits**

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<tbody>
<tr>
<td>9:30 – 12:30</td>
<td>Field visits to Bangkok hospitals</td>
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**LUNCH 12:30 – 13:30**

**Session VI: Engaging Hospitals – country experiences**

Speaker: Jan Voskens

<table>
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<th>Time</th>
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<tbody>
<tr>
<td>13:30 – 14:00</td>
<td>Observations on the field visits by 3 groups</td>
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<tr>
<td>14:00 – 14:30</td>
<td>Lessons from five-country WHO/CIDA initiative</td>
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</table>
| 14:30 – 15:00 | Country experiences on engaging hospitals:  
|              | China                                                                     |
|              | India                                                                     |
|              | Kenya                                                                     |

Speaker: Knut Lonnroth

Speaker: Wang Lixia

Speaker: N Kulasreshtha/Sreenivas

Speaker: Achuthan Nair

Speaker: Lameck Diero

**Session VII: Group Work on Hospital Engagement**

Chair: Mao Tan Eang

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<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>15:00 – 15:10</td>
<td>Introduction to the group work</td>
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<tr>
<td>15:10 – 17:00</td>
<td>Group Work: Engaging Hospitals in TB Care and Control</td>
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<td>Group 1: Effective coordination within hospitals</td>
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<td>Group 2: Effective linkages with peripheral centres</td>
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<td>Group 3: Essential input from NTPs - central and provincial levels</td>
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<td>Group 4: Essential input from beyond NTPs - ministry of health, other ministries, government</td>
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<tr>
<td>17:00 – 18:00</td>
<td>Plenary Session</td>
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<tr>
<td><strong>Session VIII: International Standards for TB Care and PPM Expansion</strong></td>
<td><strong>Chair: Draurio Barreira</strong></td>
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<tr>
<td>09:00 - 09:15</td>
<td>ISTC – Highlights of the upcoming 3rd revision</td>
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<td>09:15 - 09:30</td>
<td>ISTC for PPM expansion – Country experiences</td>
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<td>09:30 - 09:45</td>
<td>Discussion – How best ISTC can be used for PPM scale up?</td>
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<tr>
<th><strong>Session IX: Round Table: PPM for MDR-TB and Other Innovations</strong></th>
<th><strong>Chair: Evan Lee</strong></th>
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<tr>
<td>09:45 - 10:00</td>
<td>Is the private sector prepared to engage in MDR-TB management? – findings from the Philippines</td>
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<td>10:00 - 10:15</td>
<td>Social enterprise model and technology boost to improving TB care delivery</td>
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<td>10:15 - 10:30</td>
<td>Initiative for Promoting Affordable Access to Quality TB Diagnostics (IPAQT) in Indian Private Sector – early experiences.</td>
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</table>

**COFFEE 10:30 – 11:00**

<table>
<thead>
<tr>
<th><strong>Session X: PPM preparedness for Post-2015 TB Strategy</strong></th>
<th><strong>Chair: Diana Weil</strong></th>
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<tbody>
<tr>
<td>11:00 – 11:15</td>
<td>PPM in the Post-2015 TB Strategy</td>
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<tr>
<td>11:15 - 12:15</td>
<td>Panel Discussion: Advocacy to mainstream PPM</td>
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<tr>
<td>12:15 – 12:30</td>
<td>Closing remarks</td>
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</table>

**Meeting rapporteurs:** J.M Chakaya Sreenivas Achuthan Nair Rajendra Yadav
Appendix 2.

List of participants

Country representatives

AFRICAN REGION

DEMOCRATIC REPUBLIC OF CONGO

Georges Bakaswa Ntambwe (Unable to attend)
National TB Programme
Ministry of Health
Kinshasa
Democratic Republic of Congo

Jerome Ntangu Oswanga (Unable to attend)
Ministry of Health
Kinshasa
Democratic Republic of Congo

KENYA

Jeremiah Muhwa Chakaya
Centre for Respiratory Diseases Research
Kenya Medical Research Institute
Nairobi
Kenya

Lameck Diero
Moi University/ MoiTeaching and Referral Hospital
Department of Medicine
Eldoret
Kenya

Wesley Tomno
Kenya Clinical Officers Association
Nairobi
Kenya

NIGERIA

Joshua Obasanya (Unable to attend)
National TB, Leprosy & Buruli Ulcer Control Programme
Abuja
Nigeria

Patience Osinubi (Unable to attend)
Hospital Services Department,
Federal Ministry of Health
Federal Secretariat
Abuja
Nigeria

REPUBLIC OF TANZANIA

Allan Tarimo
Ministry of Health and Social Welfare
Dar es Salaam
United Republic of Tanzania

SWAZILAND

Themba Dlamini
National TB Control Programme
Ministry of Health
Manzini
Swaziland

AMERICAN REGION

BRAZIL

Draurio Barreira
Ministry of Health
Brasilia-DF
Brazil

Eduardo Netto
Instituto Brasileiro para a Investigacao da Tuberculose/Fundacao Jose Silveria - IBIT/FJS
Salvador – Bahia
Brazil

PERU

Valentina Antonieta Alarcon Guizado
Nacional de Prevencion y control de Tuberculosis
Ministry of Health
Lima
Peru

Dante Elmo Vargas Vasquez
Hospital Nacional Hipolito Unanue
Lima
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EASTERN MEDITERRANEAN REGION

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Four useful tools for PPM planning, implementation and advocacy

"The PPM toolkit"

"The PPM Guidance Document"

"The National Situation Assessment tool"

These and other PPM documents can be downloaded from the PPM homepage at:

www.who.int/tb/careproviders/ppm

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