JOINT WHO/GLOBAL FUND WORKSHOP

Reaching the “missing million” through enhancing private provider engagement as part of scaling up public-private mix for TB care and control in “high-impact” Asia

New Delhi, India
25-27 June 2014
Joint WHO/ Global Fund Workshop

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Meeting Report

New Delhi, India
25-27 June 2014
Acknowledgement

This report was prepared by Hannah Monica Dias, Mukund Uplekar and Diana Weil, with inputs from the rapporteurs of the meeting, Vijayashree HY.

This meeting and report is made possible thanks to the generous support and inputs of the Global Fund to fight AIDS, TB and Malaria (The Global Fund), the United States Agency for International Development (USAID) and the Eli Lilly and Company Foundation.

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WHO/HTM/TB/2014.25
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACSM</td>
<td>Advocacy, Communication and Social Mobilization</td>
</tr>
<tr>
<td>Global Fund</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>HBC</td>
<td>high TB-burden country</td>
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<tr>
<td>HDL</td>
<td>hospital DOTS linkage</td>
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<tr>
<td>HIV/AIDS</td>
<td>human immunodeficiency virus/acquired immunodeficiency syndrome</td>
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<td>ISTC</td>
<td>International Standards for Tuberculosis Care</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<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 control programme</td>
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<td>PP</td>
<td>private provider</td>
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<td>PPM</td>
<td>public–private mix</td>
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<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>
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<tr>
<td>USAID</td>
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<td>WHA</td>
<td>World Health Assembly</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>XDR-TB</td>
<td>extensively drug-resistant tuberculosis</td>
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1. Background

Delays in diagnosis leading to increased disease transmission, stagnating TB case notifications, and spread of MDR-TB are among the major challenges facing global TB control today. Care providers not linked to national TB programmes and especially private medical care providers in Asia are both a part of the problem and solution to all these challenges. Asia also has the largest burden of “missed” cases. The 2013 WHO Global TB report has identified 12 countries that account for 75% of the “missed 3 million cases” globally. High-burden countries in Asia account for over a million of these missed cases. A large proportion of these cases are likely managed outside the network of public sector services and not notified to the national TB programmes. The fact that the proportion of TB drugs sold in the private sector in Asia equal those used in public sector TB programmes, indicates that a large number of people with TB receive care in the private sector. Irrational use of diagnostics by private laboratories is also common in some countries. Furthermore, in most countries, public sector facilities such as large hospitals also contribute significantly to the burden of un-notified cases.

All Asian countries have been implementing the “engaging all care providers” component of the Stop TB Strategy. The progress however has been uneven. Countries have experienced greatest difficulties in scaling up engagement of largely unorganized private practitioners who are often the first care provider of people with TB. The attention, investments, and input on the part of public sector TB programmes to scaling up public-private mix (PPM) initiatives have been inadequate given the size and the complexity of the problem. Further, while regulations regarding mandatory case notification and rational use of TB drugs exist on paper in many countries, their enforcement is weak if not absent in most high TB-burden countries.

The global push to intensify TB case detection has also led to development of a few innovative models of engaging private providers. Social franchising models have been scaled up successfully in some settings. A newer market-sensitive, social enterprise model that incorporates use of mobile communication technology has produced impressive results in pilot projects. Another model has been successful in rational introduction of new TB diagnostics in the private sector through private laboratories. Evidence also shows that inputs into optimizing TB services in large hospitals almost always yield impressive gains in terms of increasing case notifications. The potential of the corporate sector via workplace programmes still remains largely untapped.

The knowledge and evidence-base on PPM including new working models on private sector engagement; strong attention from the Global Fund on high-impact Asia; as well as the felt-need of countries to develop ambitious, context-specific plans for countrywide expansion of PPM into national strategic plans and Global Fund “concept notes” (for Global Fund financing under the new funding model) — all provide an exceptional opportunity to
promote and expand a dual-track approach of scaling up innovative models of collaboration with all care providers, while introducing effective regulation as part of strengthening health systems. To streamline this, the Global TB Programme of the World Health Organization along with the high-impact Asia department of the Global Fund organized a joint workshop on scaling up the engagement of all care providers. The workshop focused on six high-impact Asia countries: Bangladesh, India, Indonesia, Myanmar, Pakistan and the Philippines.

This report summarizes the proceedings of the workshop. The objectives are presented in Section 2. Section 3 briefly outlines the presentations and discussions at the meeting, while the fourth section lists the major conclusions and next steps. The agenda and list of participants are presented in the appendices. The meeting presentations are available online at: http://www.who.int/tb/careproviders/ppm/meetings/en/.
2. Objectives

The objectives of the workshop were to:

- Examine innovative approaches to engage private practitioners in diverse country-settings and ways to sustain, replicate and scale up these approaches
- Examine regulatory approaches to help scale up public-private mix for TB care and control
- Review and enhance specifics of public-private mix interventions in the national strategic plans and concept notes of high-impact Asia countries for the Global Fund’s new funding model
3. Summary of presentations and discussions

The workshop was opened by Urban Weber, Department Head for High Impact Asia at The Global Fund, Khurshid Alam Hyder, the TB Regional Adviser for the WHO Office for South-East Asia and Mukund Uplekar from the Global TB Programme in Geneva. Meeting presentations can be accessed [here](#).

**Session 1:**
The first session provided an overview of the meeting objectives and agenda. This was followed by a presentation from the Global Fund to Fight AIDS, TB and Malaria (the Global Fund) on its new funding model and its relevance for PPM. A WHO presentation then highlighted the case of the missed 3 million and called for strategic action. The last presentation in this session reviewed the key outcomes of an USAID/World Bank meeting held in Washington DC in May 2014, on sustainable financing of private sector engagement for TB care.

**The new funding model and its relevance to PPM**
During the past decade, the Global Fund has become the largest external funder of TB programmes, providing over US$ 3.5 billion in funding for TB since 2002. The Global Fund has a new funding model to facilitate effective investments and to reach as many people affected by the diseases as possible. The new funding model aims to ensure predictable funding for those countries with a high disease burden and low ability to pay, and aims to incentivize better performing interventions.

To apply for financing through the new funding model, countries or partners need to develop a strong concept note through dialogue with key stakeholders in the country. The private sector is a key actor in this dialogue and representatives must be engaged in prioritization of country needs and concept note development.

The new funding model offers various opportunities throughout the application and implementation process for the engagement of all care providers in TB prevention, care and control. PPM is included as a common intervention for streamlining across all core modules.
Scaling up PPM to reach the “missing million” in high-impact Asia: a strategic approach

An overview of the new post-2015 Global TB Strategy was presented. PPM is a key component in the new strategy, and is critical for the world to achieve the ambitious post-2015 targets of ending the global TB epidemic. Two major barriers block progress in TB care and control: reaching the 3 million missed cases and bringing down TB incidence.

About 3 million people are “missed” each year by health systems and many therefore do not get the TB care that they need and deserve. Nearly half of these missed TB cases are in Asia. The majority of these people with TB first go to the private sector, often seeking care from multiple providers in their journey to access TB treatment, such as drug sellers, private practitioners, hospitals etc. Unfortunately the TB management practices of these providers are rarely aligned with national or international standards, and they don’t notify people under their care to national health systems for lack of information, incentives or tools. Furthermore out of pocket expenses to access care in the private sector places a heavy financial burden on TB patients. Engaging all care providers is therefore critical to ensuring these missed patients are reached with quality care.

In addition, regulation in countries regarding mandatory case notification and rational use of TB drugs is largely not enforced or absent.

All this points to the need for a strategic approach to PPM scale up especially in the Asian context. A proposed strategy mix is highlighted below – based on successful country experiences and innovative pilot models:

1. Strengthen NTP / MOH capacity and optimize investments to help scale up PPM
2. Optimize and expand engagement of large hospitals and institutions such as NGOs and medical colleges
3. Consider entrusting private practitioner engagement to "intermediaries organizations" through: Social franchising / Social enterprise / Similar indigenous approaches / professional associations
4. Mobilize and support business sector for workplace TB programmes
5. Enact and/or enforce regulatory approaches
   • Mandatory case notification
   • Rational drug sale and use
   • Certification / Accreditation / Designation systems
6. Engage communities and CSOs to enable their demand for and support quality TB care

Sustainable financing of private sector engagement for TB care: Report from the Washington meeting

In May 2014, a three-day working meeting was co-convened by the United States Agency for International Development (USAID) and the World Bank, in collaboration with the Stop TB Partnership’s subgroup on PPM.

The meeting brought together TB, health financing and public-private partnership experts to identify the essential elements for the sustainability, growth and future relevance of PPM efforts. The goal was to improve the sustainability of private sector engagement in TB control by bringing together innovations in service delivery models and financing.
USAID made a presentation on the outcomes of the meeting and its relevance to discussions in the workshop. Some highlights are presented below:

- A range of strategies are needed to finance various context-specific PPM models in TB, and new mechanisms represent a significant opportunity. Sustainability of such financing relies in part on the incorporation of TB and PPM into domestic health financing streams. Currently, the predominant source of financing for PPM is input-based domestic and donor financing, but countries are increasingly exploring output or results-based financing (RBF) and financing via health insurance agencies. Social protection programs can also supplement with patient enablers. A range of tools and schemes are needed that can be adapted to produce the optimal PPM for each country’s context. Whatever mix of financing is used, pooling of the financial resources is a critical step to reduce complexity and standardize service packages.

- A variety of entities and mechanisms can organize providers and enforce quality control.

- Existing PPM achievements have used the dual concepts of the NTP as steward of health standards and quality, and an intermediary as an organizing force for individual private providers. These concepts of standards and an organizing entity remain intact, but there are an increasing number of ways to implement them. Standards and quality can be strengthened by linking to accreditation and reimbursement schemes (e.g., when TB is covered by a national health insurance scheme), or by demanding certain outputs under RBF. The organizing of providers (and further quality control) can be mediated by social businesses, social franchises, and organizations that change business incentives by altering market dynamics.

- Within PPM schemes, there is an increasing need to integrate health services, both for efficiency and cost savings. Linking TB programs with high volume and/or high-income generating health services can help to improve access to care, expand TB control efforts and cross-subsidize TB care.

- The use of incentives and enablers should be considered to encourage participation in PPM. For this strategy to be effective, the field will need more information about provider microeconomics and motivations to design verifiable and reliable incentive systems.

Effective engagement of the private sector requires TB control programs to look outwards – not only to other healthcare providers, but also to experts in healthcare financing, market dynamics, business planning, and other areas that are essential for a new generation of PPM work. Countries were invited to review and the outcomes of the Washington meeting and consider innovative mechanisms to scale up PPM.

**Session 2: Approaches to engage private practitioners**

**Q and A: Approaches and challenges to scaling up**

The second session began with a “question and answer” panel where country representatives shared experiences on the progress made in scaling up PPM and the related challenges of implementing some PPM components.

- In Bangladesh there has been extensive training and capacity building of private sector providers, and enforcement of notification has met with some success. Challenges include lack of capacity to cover the vast and unregulated private sector, suboptimal
engagement of the Bangladesh Medical Association and inadequate support and supervision of private practitioners engaged in PPM.

- In India, individual private practitioners are being involved for diagnosis and treatment via PPM schemes and through collaboration with the Indian Medical Association. Private Provider Interface Agency (PPIA) model is being implemented in Mumbai to strengthen private practitioner engagement. Efforts are also ongoing to involve informal practitioners. They are encouraged to refer TB suspects to the NTP.

- Engaging all care providers in Indonesia is underpinned by a strong PPM strategy. Collaboration with the Indonesian Society of Respirology (PDPI) in engaging private practitioners has met with major success. Implementation of mandatory notification is in the pipeline.

- In Myanmar, engagement of private practitioners is done via 3 PPM schemes. Incentives are provided to practitioners for referring TB cases to the NTP. However challenges remain, the supervision and monitoring of practitioner activities is inadequate, in addition practitioners refuse to undertake recording and reporting.

- In Pakistan, the most successful model is NGO engagement to reach private practitioners. Efforts were also made to engage solo general practitioners in TB through social franchising. However this model was not replicate as it was human resource intensive. There is a lack of regulation for private practitioners, and need for simplified PPM reporting tools.

- In the Philippines, private practitioners refer TB cases to the NTP and receive financial incentives. Free drugs are provided by the programme.

Discussions following country remarks highlighted the need to ensure financial sustainability of PPM especially for those which were predominantly funded externally. Particular mention was made to the social franchising model of Myanmar. It was discussed, even after successful implementation of this model for more than ten years, there were challenges with funding, which called for attention of sustainability.

Concern was raised that civil society’s involvement is not seen as a priority in PPM strengthening in countries. It was emphasized that civil society is an important partner in engaging all care providers and should be involved in country PPM activities.

Panel discussion:

**Productive ways of engaging private practitioners and finding the missing million**

A panel discussion with international and country partners was held on productive ways of engaging private practitioners in reaching the missed million people with TB.

- PSI presented its social franchising model in Myanmar and the success they have had in engaging private providers and pharmacies. Both financial and non financial incentives and enablers were vital to support the engagement of providers. The challenges in provider engagement were also highlighted – including increased workload, inadequate diagnostic facilities, remote location of private clinics hindering collaboration, complexities of private clinics run by public providers and vertical programs created by different donors.
Social business models for engaging the private sector were presented next. The outcomes of implementing the social business model in Karachi, Dhaka and Jakarta with support from the TBXpert project and TBREACH was shared. While the pilot initiatives show good progress in case detection, challenges remain in taking these models to scale. The challenges include, high capital investment costs, conflict between public health and business priorities, reaching regional consensus on branding and further investments to integrate multiple diseases into the model to generate sustainable revenues for social business.

PATH then made a presentation on the Private Provider Interface Agency (PPIA) model in Mumbai. PPIA is designed to strengthen the capacity of networks of private health care providers in the Municipal Corporation of Greater Mumbai (MCGM) to ensure early and accurate diagnosis of tuberculosis (TB) cases through effective TB case management. The aim of the agency is to improve TB diagnosis and treatment to ultimately improve case notification and treatment success for TB patients who seek health care from private-sector providers that are not linked to the Revised National Tuberculosis Control Programme (RNTCP) run by the public health system.

The agency is underpinned by an innovative model with six main features: a network approach; maintenance of PP’s patient management autonomy; an incentive scheme; presence at the zone and ward levels; adoption of new information and communication technology (ICT); and use of fast, accurate diagnostic tools. Central to this approach is changing private providers’ behaviors by mobilizing, incentivizing, and developing capacity of PPs to provide early and accurate diagnosis of TB cases and effective TB case management.

A presentation was made by the Indonesian Society of Respirology (PDPI) on using the International Standards for TB Care as a tool for engaging the private sector in Indonesia. PDPI is implementing a PPM project to engage private pulmonologists in the national TB
control programme, using the ISTC. The objectives of the project are to ensure all TB patients are managed according to the ISTC and to ensure all TB cases found through PDPI are reported to the National TB Programme. Between 2010 and 2013 over 10 000 TB cases were detected in 3 provinces and managed by pulmonologists through the PDPI project. The project will be expanded to 4 new provinces in the coming year.

**Session 3: Regulatory approaches to help scale up PPM**

**Pursuing regulatory approaches – country example**

The third session opened with a presentation on regulatory approaches and their enforcement in the Indian context. The success of India in curbing the sale of serological tests through a government ban and in collaboration with IPAQT was highlighted. IPAQT – the Initiative for Promoting Affordable Quality TB tests is a consortium of private diagnostic laboratories supported by not-for-profit stakeholders such as the Clinton Health Access Initiative and the McGill International TB Centre in India to ensure that, high quality TB tests are used for TB diagnosis, diagnostics are affordable to patients and that diagnosis is linked to treatment via the RNTCP. IPAQT helped inform laboratories of the serological test ban and also ensured that serological tests were not used by their network of laboratories.

India has also made notification of TB cases mandatory in the country. To facilitate reporting India has created a web-based recording and reporting system - Nikshay. The system is still in its early stages but TB cases are increasingly being notified through it. Regulation on sale of anti-TB drugs over the counter also exist, but enforcement of the law needs to be strengthened. Lastly consumer protection laws exist to protect patients from malpractice. These laws have not yet been applied to TB in India as is the case in Indonesia.

**Session 4: Plenary on enforcing regulatory approaches**

**Group Work and plenary**

Participants then broke out into 6 groups to review various TB regulatory approaches such as: mandatory case notification, curbing irrational drug use, certification and accreditation of providers. Groups listed current situation in countries, actors and actions required beyond NTPs, human resource requirements within and beyond NTPs and financial resources required. The groups then presented an overview of their discussions at the plenary session.

**Session 5: Some essentials of PPM expansion**

The second day opened with presentations on PPM scale up, measurement, corporate sector engagement and PPM for MDR’TB management.

**Translating PPM concepts into activities and budgets**

The first presentation overviewed experiences of the TBREACH initiative of the Stop TB Partnership. The initiative promotes early and increased TB case detection using innovative approaches especially in poor, underserved and vulnerable groups. The costs and impact in terms of people with TB reached were presented. Reaching the missed million should be a key part of Global Fund interventions in countries.
Measuring contribution of PPM to TB care and control
The importance of measuring the impact of PPM in countries was highlighted. Country experiences from India, Indonesia and Pakistan was highlighted. It was emphasized that in addition to cases detected, indicators should include reduction of delay in access to care, decreasing out-of-pocket expenses for patients and cost effectiveness.

Strategies to engage the business sector
The potential of engaging workplaces in TB prevention, treatment and care efforts still remains largely untapped, with only small initiatives in some countries such as Bangladesh, Cambodia, China, Kenya, India, Philippines, and South Africa. On the other hand, there are many examples of workplace HIV programmes, however only a few of them include activities to reduce the burden of TB. A survey conducted jointly by the International Labour Organization (ILO) and the World Health Organization (WHO) revealed that 57% of 21 000 workplaces did not address TB within their HIV workplace programmes. The presentation overviewed the need to scale up engagement of the corporate sector in countries with a high burden of TB (especially in Asia) and outlined guiding principles to help initiate and scale up involvement of the business sector in TB prevention, treatment and care.

A frame work on PPM for programmatic management of drug-resistant TB
Although encouraging progress has been made in engaging non-NTP providers in basic TB care and control activities, there has been to date limited progress in engaging non-NTP health care providers in DR-TB management. Globally in 2012, an estimated 3.6% of new tuberculosis (TB) cases and 20% of previously treated cases have multi-drug resistant TB (MDR-TB). An estimated 450,000 MDR-TB cases emerged worldwide in 2012. Despite slow progress, management of DR-TB is still a big challenge, with globally in 2012, only 5% of new bacteriologically-confirmed TB cases and 9% of those previously treated for TB tested for DR-TB, and only 28% of the 300,000 estimated MDR-TB patients detected amongst the notified pulmonary TB cases. Among the detected MDR-TB cases, 92% were started on treatment. The gap between diagnosis and treatment is however growing rapidly in many countries as a result of the recent rapid expansion in diagnostic capacity, with a growing number of diagnosed MDR-TB and rifampicin resistant TB (RR-TB) patients being placed on "waiting lists for treatment". Greater efforts are needed to achieve universal access to care for MDR-TB, as targeted by 2015 in the Global Plan to Stop TB and the 2009 World Health Assembly resolution. Engaging all relevant health care providers in the management of DR-TB cases is one of the important interventions to achieve that goal. The presentation outlined the structure of a framework document under development by WHO on PPM for programmatic management of drug-resistant TB.

Session 6 & 7: Enhancing PPM component of national strategic plans

Group Work and plenary
The participants were divided in country groups to discuss how PPM components in national strategic plans (NSPs) and Global Fund Concept notes could be enhanced to ensure accelerated scale up of PPM. Countries filled in a template of current and planned PPM interventions in National Strategic Plans/Concept Notes along with estimated financial and human resource requirements. Building on this countries listed targets up to 2017 for PPM on contribution to case notification private and non-NTP care providers. Countries then

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1 Multidrug-resistant TB (MDR-TB): resistant to at least rifampicin and isoniazid.
developed a strategic matrix on how current/planned PPM interventions could be strengthened to reach the targets set. The strategic matrix and targets will be used by countries to strengthen their existing NSPs and concept notes, or those to be developed (Indonesia). The table below presents the PPM targets developed by the six countries:

<table>
<thead>
<tr>
<th>Bangladesh</th>
<th>Current and potential contribution to case notification by private (for profit and non-profit) care providers</th>
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<td>Current and potential contribution to case notification by private (for profit and non-profit) care providers</td>
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<td>Disaggregated data not collected for non-NTP public sector care providers</td>
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4. Conclusion and next steps

The workshop was perceived as being of great value by all the participating countries and partners. A major outcome of the workshop was the template developed by each country group to enhance the PPM components of country national TB strategic plans and/or Concept Notes for the Global Fund applications. The template outlined concrete actions and deliverables with human and financial resource implications. Countries also set case notification targets expected to be achieved through PPM expansion.

Planned PPM activities in each country included those to expand collaboration as well as enforce regulation for mandatory case notification, rational use of TB drugs and certification/accreditation systems for collaborating providers.

The workshop products will be used by each country as the basis of preparation of the PPM component of the Global Fund concept notes and/or accelerating PPM scale up in each of the six countries. WHO, the Global Fund and partners committed their support in helping countries achieve this.
# Appendix 1.
## Workshop Agenda

### 25 June 2014
Reaching the “missing million” through scaling up public-private mix in TB care and control in “high-impact Asia”

<table>
<thead>
<tr>
<th>Session I: Opening Session</th>
<th>Chair: Phil Hopewell</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>9:00 - 9:20</strong></td>
<td>Welcome and introductions</td>
</tr>
<tr>
<td><strong>9:20 – 9:30</strong></td>
<td>Meeting objectives and agenda</td>
</tr>
<tr>
<td><strong>9.30 - 9.45</strong></td>
<td>The new funding model and its relevance to this meeting</td>
</tr>
<tr>
<td><strong>9:45 - 10:00</strong></td>
<td>Scaling up PPM to reach the “missing million” in high-impact Asia: a strategic approach</td>
</tr>
<tr>
<td><strong>10:00 - 10:30</strong></td>
<td>Report from the Washington meeting (May 2014): sustainable financing of private sector engagement for TB care</td>
</tr>
</tbody>
</table>

**COFFEE 10:30 – 11:00**

### Session II: Approaches to engage private practitioners
Chair: Urban Weber

| **11:00 – 12:00** | Q and A: Approaches and challenges to scaling up | Abdul Hamid RS Gupta Dyah Mustikawati SI Thu Aung Ejaz Qadeer Lyn Vianzon |
| **12:00 – 13:00** | Panel discussion: Productive ways of engaging private practitioners and finding the missing million – 10 minutes presentation on approaches to large scale engagement of private practitioners. | P P Swe S Sahu SS Lal Erlina Burhan |

**LUNCH 13:00 – 14:00**

### Session III: Regulatory approaches to help scale up PPM
Chair: M K A Hyder

| **14:00 – 14:20** | Pursuing regulatory approaches – country example – country context | KS Sachdeva Sunil Nandraj |
| **14:20 – 14:30** | Guidance on the group work | Mukund Uplekar |
| **14:30 -15:30** | Group work I on regulatory approaches | Country teams and facilitators* |

**COFFEE 15:30 – 16:00**

### Session IV: Plenary on enforcing regulatory approaches

| **16:00 – 17:00** | Plenary on regulatory approaches – short presentations and feedback from participants | Country Reps |
## 26 June 2014

### Session V: Some essentials of PPM expansion  
**Chair:** Dyah Mustikawati

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 – 9:15</td>
<td>Translating PPM concepts into activities and budgets</td>
<td>Jacob Creswell</td>
</tr>
<tr>
<td>9:15 – 9:30</td>
<td>Measuring contribution of PPM to TB care and control</td>
<td>Knut Lonnroth</td>
</tr>
<tr>
<td>9:30 – 9:45</td>
<td>Strategies to engage the business sector</td>
<td>Monica Dias</td>
</tr>
<tr>
<td>9:45 – 10:00</td>
<td>A framework on PPM for PMDT</td>
<td>Linh Nguyen</td>
</tr>
<tr>
<td>10:00 – 10:30</td>
<td>Discussion on the session presentations</td>
<td></td>
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</tbody>
</table>

**COFFEE 10:30 – 11:00**

### Session VI: Group Work – Enhancing PPM component of NSPs  
**Chair:** Blessina Kumar

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:00 – 11:30</td>
<td>Guidance on country-specific group work</td>
<td>Mukund Uplekar</td>
</tr>
<tr>
<td>11:30 – 13:00</td>
<td>Group Work II on enhancing PPM components within NSPs/Concept Notes incorporating collaborative and regulatory approaches</td>
<td>Country Teams and facilitators*</td>
</tr>
</tbody>
</table>

**LUNCH 13:00 – 14:00**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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</thead>
<tbody>
<tr>
<td>13:00 – 15:30</td>
<td>Group Work II continued</td>
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</table>

**COFFEE 15:30 – 16:00**

### Session VII: Plenary – Presentation of outlines for feedback

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>16:00 – 17:00</td>
<td>Brief country presentations giving brief outlines of enhanced PPM components, for feedback</td>
<td>Country Representatives</td>
</tr>
</tbody>
</table>

## 27 June 2014

### Session VIII: Plenary: Enhanced PPM components within NSPs  
**Chair:** William Wells

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:30 – 10:30</td>
<td>Final country presentations of 20 minutes each on enhanced PPM components within NSPs/Concept Notes</td>
<td>Country Representatives</td>
</tr>
</tbody>
</table>

**COFFEE 10:30 – 11:00**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:00 – 12:30</td>
<td>Final country presentations – Continued</td>
<td>Country Representatives</td>
</tr>
<tr>
<td>12:30 – 13:00</td>
<td>Next steps and wrap up</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2.
List of participants

SOUTH-EAST ASIA REGION

Bangladesh

1. Md. Abdul Hamid
   Deputy Programme Manager
   Ministry of Health & Family Welfare
   Dhaka

2. Md. Alauddin
   Civil Surgeon
   Civil Surgeon office
   Noagaon
   Bangladesh

3. Akramul Islam
   Associate Director
   Health, Nutrition and Population Program (HNPP)
   BRAC Centre
   Dhaka

4. Shayla Islam
   Senior Program Specialist
   Health, Nutrition and Population Program (HNPP)
   BRAC Centre
   Dhaka

5. Fatema Khatun
   Senior Sector Specialist
   Health, Nutrition and Population Program (HNPP)
   BRAC Centre
   Dhaka

6. Holger Sewart
   Independent Consultant
   AM Stock 9
   58762 Altina
   Germany

India

7. R.S.Gupta
   Deputy Director General (TB)
Revised National TB Control Programme
Ministry of Health and Family Welfare
Govt. of India
New Delhi

8. Kavita Singh
   Director (CCD)
   Ministry of Health and Family Welfare
   Govt. of India
   New Delhi

9. Niraj Kulshreshtha
   Addl. DDG
   PPM Focal Point
   Revised National TB Control Programme
   Ministry of Health and Family Welfare
   Govt. of India
   New Delhi

10. Sudipta Dey
    Deputy Drug Controller
    Central Drug Standard Control Organization
    FDA Bhawan, ITO
    New Delhi

11. Puneet Dewan
    The Bill & Melinda Gates Foundation
    New Delhi
    India

12. Sarabjit Chadha
    Project Director
    The Union South East Asia Office
    Qutub Institutional Area
    New Delhi
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13. Sai Praveen Haranath
    Apollo Hospital
    Hyderabad

14. Dr Narinder Saini
    Secretary General
    Indian Medical Association
    I.P.Estate
    New Delhi

15. Suresh Gutta
    National Coordinator (TB)
    Indian Medical Association
    Hyderabad
    India
16. Shamim Mannan  
National Consultant (Public Health)  
WHO-RNTCP Tech Asst, Project  
Central TB Division  
New Delhi  

17. Sushma Cornelius  
Project Director  
World Vision. Global Fund. Axshya India Project  
No.16 Pandit Pant Marg, CNI Bhawan  
New Delhi  
India  

18. Patrick Mullen  
World Bank  
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India  

19. Sayed Ghulam Dastagir  
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World Bank  
Lodi Estate  
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20. Sunita Prasad  
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Eli Lilly and Co. India (P) Ltd.  
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21. Nalini Krishnan  
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REACH  
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22. Reuben Swamickan  
USAID  
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India  

23. Harkesh Dabas  
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Clinton Health Access Initiative  
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24. Vijayashree.H.Y.  
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27. Sunil Nandraj  
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Indonesia

28. Dyah Erti Mustikawati  
National TB Programme Manager  
Ministry of Health Republic of Indonesia  
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29. Erlina Burhan  
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Department of Pulmonology and Respiratory Medicine, Faculty of Medicine, University of Indonesia  
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30. Adi Sasongko  
Yayasan Kusuma Buana (NGO)  
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31. Christopher Raymond  
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US Pharmacopeia Promoting the Quality of Medicines Program  
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32. Anny Sulistio Wati  
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33. Babay Asih Sulasih
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Myanmar

34. Si Thu Aung
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PHILIPPINES

37. Anna Marie Celina G. Garfin
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38. Marilou A. Gecosala
NTP Nurse Coordinator
DOH Regional Office X
Phillipines
Manila

39. Amelia G. Sarmiento
Executive Director
Philippine Coalition Against Tuberculosis
Phillipines
Manila
40. Eric Camacho  
Director for Health  
Phillipine Business for Social Progress  
Manila

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Pakistan

41. Abdul Khalique Ghauri  
Senior Project Manager  
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42. Hussain Hadi  
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National Tuberculosis Programme  
Pakistan

43. Abdul Majeed Akhtar  
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44. Ismat Ara  
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Sindh, Pakistan

45. Arif Noor  
Country Director  
Mercy Corps Pakistan  
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PATIENTS AND COMMUNITY REPRESENTATIVE

46. Blessina Amulya Kumar  
Global TB CAB (Community Advisory Board)  
New Delhi, India

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47. Philip Hopewell  
Division of Pulmonary and Critical Care  
San Francisco General Hospital
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48. Fran Du Melle
   Senior Director International Activities
   American Thoracic Society
   Washington DC
   USA

ELI LILLY FOUNDATION

49. Evan Lee
    Eli Lilly Foundation
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    Switzerland

50. Maria Paola Lia
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    Eli Lilly Foundation
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    Geneva

51. Amy Israel
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    Global Health Programme
    Eli Lilly
    Chemin Des Coquelicots 16
    1214 Vernier
    Geneva
    Geneva

THE GLOBAL FUND

52. Urban Weber
    Department Head
    High Impact Asia
    The Global Fund to Fight AIDS, Tuberculosis and Malaria
    Geneva
    Switzerland

53. Mohammed Yassin
    Senior Advisor, Tuberculosis
    The Global Fund to Fight AIDS, Tuberculosis and Malaria
    Geneva
    Switzerland

54. Andreas Tamberg
    Fund Portfolio Manager, India
    The Global Fund to Fight AIDS, Tuberculosis and Malaria
    Geneva
Switzerland

55. Werner Buehler
Senior Fund Portfolio Manager, Pakistan
The Global Fund to Fight AIDS, Tuberculosis and Malaria
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Switzerland

PATH

56. S.S. Lal
TB Technical Director
HIV/TB Global Program
PATH
USA

Population Services International (PSI)

57. Petra Stankard
Population Services International
Washington D.C
USA

URC

58. Alisha E. Smith-Arthur
URC
USA

USAID

59. William Wells
USAID
USA

Stop TB Partnership

60. Suvanand Sahu
Deputy Executive Secretary
STOP TB Partnership
WHO/ HQ
Geneva

61. Jacob Creswell
Technical Officer
WHO/ HQ
Geneva

WHO Secretariat

62. Mukund Uplekar
Medical Officer
WHO/HQ
Geneva

63. Knut Lonroth
Medical Officer
WHO/HQ
Geneva

64. Hannah Monica Dias
Information Officer
WHO/HQ
Geneva

65. Linh Nguyen
Technical Officer
WHO/HQ
Geneva

WHO - WPR

66. Cornelia HENNIG
Medical Officer
STOP TB & Leprosy Elimination
Western Pacific Regional Office
Manila

WHO - Pakistan

67. Gulam Nabi Kazi
National Professional Officer
WHO Country office
Pakistan

WHO Secretariat - SEAR

68. Sreenivas Achuthan Nair
National Professional Officer - TB
WHO Country Office
India

69. Setiawan Jati Laksono
Temporary National Professional Officer
WHO Country Office
Indonesia

70. Erwin Cooreman
Medical Officer - TB
WHO Country Office
Myanmar

71. Md Khurshid Alam Hyder
Regional Adviser – TB
72. Jigmi Singay
Regional Adviser – CDC
SEARO

73. Razia N Pendse
Scientist – HIV Prevention
SEARO

74. Rui Paulo De Jesus
Regional Adviser- Leprosy
SEARO

75. Rim Kwang IL
Medical Officer – TB
SEARO

76. Caroline Bogren
Technical Officer – GDF
SEARO

77. Tanushri Mitra
Secretary – TB unit
SEARO

78. Supreet Saroha
Secretary – TB unit
SEARO