

# Public-Private Mix for TB Care and Control

Report of the Fifth Meeting of the Subgroup on  
Public-Private Mix for TB Care and Control

Cairo, Egypt  
3-5 June 2008



World Health  
Organization

**Stop TB Partnership**

# Public–private mix for TB care and control

Report of the Fifth Meeting of the  
Subgroup on Public–Private Mix  
for TB Care and Control

Cairo, Egypt  
3–5 June 2008



## Acknowledgements

We gratefully acknowledge the contribution of the WHO Regional Office for the Eastern Mediterranean for hosting this meeting.

The contributions of Samiha Baghdadi, Isabel Hall, Ebenezer Johnson, Mirette Kamal, Hala Korayem and Akihiro Seita in the organization of the meeting are much appreciated.

This report was prepared by Hannah Monica Yesudian, Mukund Uplekar, Knut Lonroth and Berthollet Kaboru.

Caroline Sorel provided secretarial assistance. The report was copy-edited by Karen Ciceri.

© World Health Organization 2008

All rights reserved.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

**This publication does not necessarily represent the decisions or policies of the World Health Organization.**

## Dedication

*This report is dedicated to the memory of **Dr. Hassan Sadiq** (1962-2008)  
National TB Programme Manager, Pakistan.*



*We all shall miss him immensely.*

# Contents

|  |           |
|--|-----------|
| Abbreviations                                      | v         |
| <b>1. Background</b>                               | <b>1</b>  |
| <b>2. Objectives and expected outcomes</b>         | <b>2</b>  |
| 2.1 Objectives                                     | 2         |
| 2.2 Expected outcomes                              | 2         |
| <b>3. Summary of presentations and discussions</b> | <b>3</b>  |
| 3.1 Overview of progress on PPM                    | 4         |
| 3.2 Progress in WHO regions                        | 5         |
| 3.3 New initiatives                                | 8         |
| <b>4. Summary of group work</b>                    | <b>12</b> |
| <b>5. Recommendations</b>                          | <b>13</b> |
| Appendix 1. PPM Subgroup Terms of Reference        | 17        |
| Appendix 2. Group work                             | 20        |
| Appendix 3. Agenda                                 | 38        |
| Appendix 4. List of participants                   | 41        |

## Abbreviations

|              |   |
|--------------|---|
| DEWG         | DOTS Expansion Working Group                                    |
| DOTS         | The internationally recommended strategy for TB control         |
| GDF          | Global Drug Facility  |
| Global Fund  | Global Fund to Fight AIDS, Tuberculosis and Malaria             |
| HBC          | high TB burden country  |
| HDL          | hospital DOTS linkage   |
| HIV/AIDS     | human immunodeficiency virus/acquired immunodeficiency syndrome |
| KNCV         | Royal Netherlands TB Association                                |
| MDG          | Millennium Development Goal                                     |
| MDR-TB       | multidrug-resistant tuberculosis                                |
| NGO          | nongovernmental organization                                    |
| NTP          | national tuberculosis control programme                         |
| PP           | private provider  |
| PPM          | public–private mix  |
| PPM Subgroup | Subgroup on Public–Private Mix for TB Care and Control          |
| TB           | tuberculosis  |
| TBCAP        | Tuberculosis Control Assistance Programme                       |
| USAID        | United States Agency for International Development              |
| WHA          | World Health Assembly   |
| WHO          | World Health Organization                                       |
| XDR-TB       | extensively drug-resistant tuberculosis                         |

# 1. Background

Engaging all care providers through public–private mix (PPM) approaches and promoting the International Standards for Tuberculosis Care are among the core components of the Stop TB Strategy. The engagement of all relevant health-care providers is essential to meet the TB-related Millennium Development Goals and reach the targets for tuberculosis (TB) control set out in the Global Plan to Stop TB 2006–2015. The Subgroup on Public–Private Mix for TB Care and Control (PPM Subgroup) has been instrumental in assisting countries to enhance collaboration among health-care providers in diverse settings. The PPM Subgroup was established by the Stop TB Partnership's DOTS Expansion Working Group in 2002. Its members include representatives from the private sector, academia, country programme managers, policy makers, field experts, international technical partners and donor agencies. Since its previous meeting (Nairobi, 12-14 September, 2006), the subgroup has been restructured and new terms of reference have been developed (Appendix 1) formalizing its structure and outlining the way forward. The previous core group has also been expanded to include new members.

The first meeting of the PPM Subgroup (Geneva, 25-26 November, 2002) set the stage for PPM and urged regions and countries to initiate and scale up PPM efforts. The second meeting (New Delhi, 3-5 February, 2004) reviewed the growing evidence-base emerging from numerous PPM initiatives and also broadened the scope of PPM to include the involvement of public sector health providers outside the scope of national TB control programmes (NTPs). The third Subgroup meeting (Manila, 4-6 April, 2005) identified barriers and enablers for scaling up and sustaining PPM and also endorsed the global PPM guidance document prepared by the Subgroup secretariat. 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 of the PPM Subgroup was hosted by the WHO Regional Office for the Eastern Mediterranean in Cairo, Egypt, on 3–5 June 2008. This report summarizes the proceedings of the meeting. The objectives and expected outcomes are outlined in Section 2. Section 3 summarizes the presentations and discussions, while Section 4 provides an overview of key topics discussed in six break-out groups. Section 5 lists the major recommendations.

## **2. Objectives and expected outcomes**

### **2.1 Objectives**

1. To review the global and regional progress on PPM for TB care and control.
2. To examine ongoing work and experiences for involving hospitals, national professional associations and corporate sector establishments in TB control.
3. To discuss recent revisions and effective ways to use the International Standards for Tuberculosis Care and the Patients' Charter for Tuberculosis Care.
4. To introduce new areas of work such as engaging all care providers in implementing collaborative TB/HIV activities and in the prevention and management of multidrug-resistant TB (MDR-TB) and extensively drug-resistant TB (XDR-TB).
5. To discuss coordination among Stop TB partners supporting regions and countries to scale up PPM.

### **2.2 Expected outcomes**

1. A review of the global and regional progress on PPM for TB care and control.
2. Identification of mechanisms and tools for engaging institutional providers (national professional associations, hospitals and corporate sector health services) in TB control.
3. Recommendations for the Subgroup's future work including those related to collaborative TB/HIV activities and prevention and management of MDR-TB and XDR-TB.

### 3. Summary of presentations and discussions

The inaugural session overviewed global and regional progress on PPM implementation. Presentations and discussions in the six subsequent sessions covered all the areas set out in the meeting objectives. The discussions are summarized below.



Opening session of the Fifth Subgroup Meeting

#### 3.1 Overview of progress on PPM

##### 3.1.1 Global progress

The meeting reviewed and discussed the progress made globally in engaging all care providers in TB control. According to the 2008 WHO global report on TB control, 16 of the 22 high TB burden countries (HBCs) had a focal person responsible for managing PPM-related activities in the central unit of the NTP and had undertaken a situation assessment for PPM implementation; 14 had developed national operational guidelines for PPM and 8 had developed training material for private providers (Figure 1). The number of HBCs scaling up PPM interventions more than tripled between 2005 and 2007, from 4 to 14 countries. Currently, more than 16 countries have PPM components in their approved Global Fund grant applications. There is now a wealth of experience from numerous evaluations of small to medium sized PPM initiatives. However, in the absence of

inclusion of PPM-related data in the routine recording and reporting systems in most countries, the precise contribution of PPM implementation to national and global progress in TB control is not yet known.

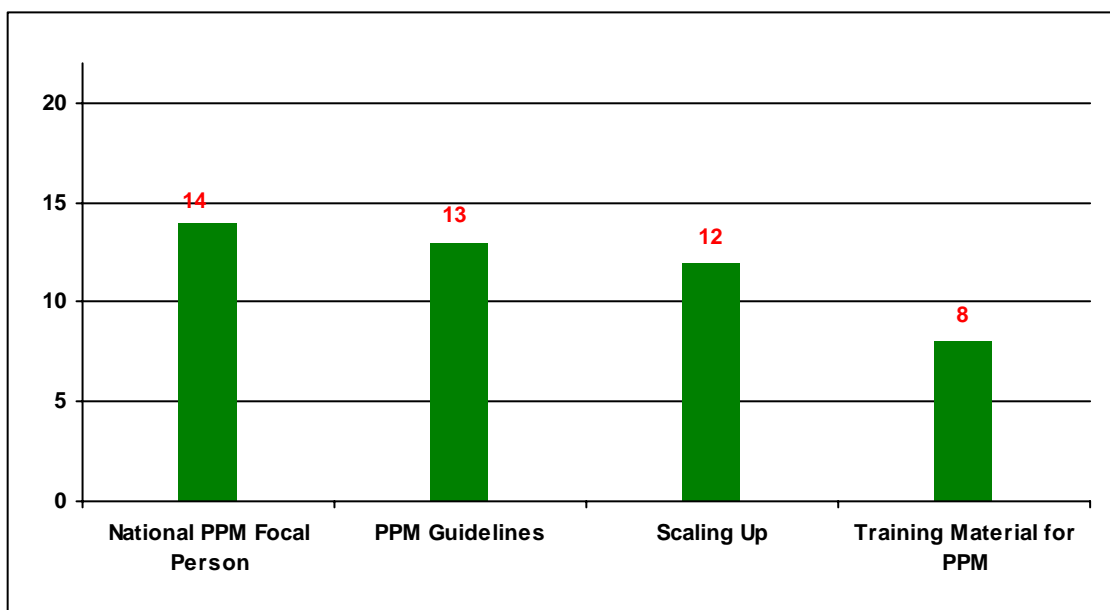


Figure 1. Public-private mix resources and progress in TB control in 22 high-burden countries, 2007

Source: *Global Tuberculosis Control: surveillance, planning, financing. WHO Report 2008. Geneva, World Health Organization, 2008 (WHO/HTM/TB/2008.393).*

### 3.1.2 Activities of the Subgroup Secretariat and partners

The Subgroup secretariat continued to provide technical assistance to countries during the period under review. Countries that received technical assistance on PPM specifically or as part of broader review missions included Bangladesh, Burkina Faso, China, Gambia, Ghana, India, Indonesia, Malawi, Mexico, Nepal, Nigeria, Pakistan, the Philippines and Viet Nam.

The Stop TB partners have also been active in the development of specific approaches to help scale up PPM. For example, the American Thoracic Society, as part of the Tuberculosis Coalition for Technical Assistance, has been spearheading the work on dissemination and promotion of the International Standards through national professional societies and associations. Pilot projects on their implementation have been initiated in India, Indonesia, Kenya, Mexico and the United Republic of Tanzania. A user guide and training modules have been developed. KNCV is leading the work on developing guidance for engaging hospitals in TB control. WHO has been working on synthesizing evidence on approaches to engage informal providers and traditional healers. The Subgroup secretariat, in collaboration with the Joint United Nations Agency on HIV/AIDS (UNAIDS), the International Labour Organization (ILO), the World Economic Forum (WEF) and the

Stop TB Partnership secretariat, has also been working on developing an evidence-base on ways to engage businesses and the corporate sector in TB care and control.

During the year under report, the Secretariat, in collaboration with the TB/HIV and drug-resistance unit of the Stop TB Department, contributed to the development of a protocol to initiate non-programme provider engagement in collaborative TB/HIV activities. This protocol will be pilot tested by the Union in the Asian and African settings and also made available on the World Wide Web for broader use.

At the second meeting of the global task force on XDR-TB, the PPM Subgroup secretariat was invited to present its perspective on engaging all care providers in TB control in the prevention and management of MDR-TB and XDR-TB through PPM approaches. The core group of the MDR-TB working group subsequently recommended close collaboration with the PPM Subgroup to initiate and expand work in this area.

A PPM operational planning workshop was organized in Cairo on 25–28 February 2007 for 11 countries from the African and Eastern Mediterranean regions. Two international consultant training courses on PPM were held in Sondalo, Italy on 11–18 April 2007 and 14–19 April 2008.

In order to raise awareness and also provide a resource for PPM-related information, a new PPM web site and a knowledge management system (the PPM Learning Laboratory) was launched in 2007. This new tool (the PPM Learning Laboratory) is designed to serve as a platform for information-sharing on PPM. It is a site in a format similar to Wikipedia that fosters and invites discussion from contributors on topics of current interest relevant to engaging all care providers in TB care and control.

### **3.2 Progress in WHO regions**

Representatives from the WHO Regional Offices for Africa, the Americas, the Eastern Mediterranean, South-East Asia and the Western Pacific presented overviews of regional progress on PPM implementation.

#### **African Region**

Formal PPM initiatives are in place in 14 African countries, of which seven (Burundi, Liberia, Malawi, Mali, Mozambique, Senegal and Sierra Leone) have Global Fund support for PPM activities. Of the 9 HBCs, 6 have completed situation assessments for PPM implementation, five have appointed a PPM focal point in the NTP, one has developed national PPM guidelines and three are in the process of developing them. PPM targets over the next five-year period include implementing PPM initiatives in major cities of at least all nine HBCs by 2009, in 34 countries by 2010 and in all countries by 2013.

### **Region of the Americas**

PPM activities in the Americas are primarily focused on engaging the non-NTP public sector providers such as public health insurance, prisons, military and police. Of the six priority countries (Bolivia, Brazil, the Dominican Republic, Ecuador, El Salvador and Mexico), four have initiated situation assessments for PPM implementation in pilot areas and all have appointed a national PPM focal point in the NTP. All six priority countries have PPM activities in place, and four countries (Colombia, Guatemala, Paraguay and Uruguay) have plans to initiate PPM activities. Around 4.5% of TB cases in Bolivia, 13.2 % of TB cases in Brazil and 12.3% of TB cases in the Dominican Republic were detected in the private sector. 23.3% of TB cases in the Dominican Republic and 3.3% of TB cases in Bolivia were treated in the private sector. Regional priorities for 2008–2009 include scaling up PPM to the national level in five countries (Bolivia, Ecuador, the Dominican Republic, Brazil and Mexico); carrying out situation assessments in four additional countries (Columbia, Paraguay, Guatemala and Uruguay); promoting the adoption of the International Standards and the Patients' Charter; promoting inclusion of PPM activities in national TB plans and Global Fund proposals; conducting PPM training workshops; strengthening PPM advocacy efforts; and providing PPM-related technical support to countries.

### **Eastern Mediterranean Region**

Of the 22 countries in the region, seven (Afghanistan, Egypt, Pakistan, Somalia, Sudan, the Syrian Arab Republic and Yemen) have conducted situation assessments on PPM implementation, six countries have established task forces for PPM and developed PPM operational guidelines, while eight countries have designated PPM focal points at central level. The other countries were reported to have PPM activities on a small scale, mainly within the public sector, such as, for example, prisons, health insurance institutions and academia. In 2007, around 74% of the diagnosed smear-positive cases in the Lebanon and 47% of the diagnosed smear-positive cases in the Syrian Arab Republic were referred by the private sector. The region was the first to launch the WHO-recommended revised recording and reporting system for all its countries in 2007. Regional priorities in 2008–2009 include conducting situation assessments for the remaining countries; establishing task forces and focal points for PPM for the countries; initiating pilot projects in the countries; analysing the results and enhancing documentation of PPM initiatives using the recording and reporting system.

### **South- East Asia**

All the HBCs in the region (Bangladesh, India, Indonesia, Myanmar) with the exception of Thailand have conducted a situation assessment, appointed a focal person in the NTP and developed PPM operational guidelines. All countries except the Democratic People's Republic of Korea and Myanmar have secured support from the Global Fund for expanding PPM activities. Myanmar has secured financial support for PPM from several bilateral donors through the country-specific "Three Disease Fund". In India, 262 medical colleges, more than 17 695 private practitioners, over 2946 nongovernmental organizations (NGOs) and 150 corporate houses were involved in TB

control; in Thailand, around 60 private hospitals were implementing TB activities; in Indonesia, all lung clinics and 37% of large hospitals were involved in TB control, while in Bangladesh 90% of TB services were delivered through NGOs. The Myanmar Medical Association engaged 526 general practitioners in 23 townships and referred 20.27% of sputum smear-positive cases diagnosed in the country. Regional priorities in 2008–2009 include: increasing documentation of ongoing PPM initiatives; active engagement with professional associations and teaching institutions in dissemination and use of the International Standards; establishing mechanisms to facilitate information exchange at all levels (between public–public and public–private) in countries; expanding collaboration with the corporate sector; providing assistance to countries in developing clear PPM strategies and operational guidelines based on lessons learnt (Bangladesh, Sri Lanka, Thailand); supporting pilot projects in Bangladesh and Thailand; and organizing a regional training workshop for national focal points on strengthening public–private partnerships.

### **Western Pacific Region**

PPM is a priority for four countries in the region (Cambodia, China, the Philippines and Viet Nam). In China and Viet Nam, a PPM focal point has been appointed and PPM taskforces established. In all the priority countries, the International Standards have been translated into local languages and disseminated. All the priority countries have developed or are in the process of developing PPM operational guidelines. The Philippines has longstanding PPM for MDR-TB initiatives in place. Around 5660 TB suspects were referred from PPM sites in Cambodia and 535/19 421(2.7%) smear-positive cases in the country were diagnosed through these referrals. In the Philippines, 115 PPMD units were installed covering 28 million population, over 3000 private physicians were trained and 11% additional cases were identified in the country through the PPM approach. Case detection increased by 18% in PPM pilot areas in Ho Chi Minh City (Viet Nam); however, an initial default of 58% was observed among patients referred by private practitioners to NTP diagnostic centres. In addition, poor treatment outcomes were attributable to anti tuberculosis drugs being made available only in the public sector. Regional priorities include supporting development of standardized training materials for PPM, strengthening linkages with hospitals in certain countries and promoting the International Standards.

## **3.3 New initiatives**

### **3.3.1 Involving all health-care providers in the response to MDR-TB and XDR-TB**

MDR-TB/XDR TB is an area that requires special attention. The 4th WHO report on anti tuberculosis drug resistance in the world estimated that 489 139 MDR-TB cases emerged in 2006 and that the global proportion of resistance among all cases was 4.8%. The second meeting of the WHO Task Force on XDR-TB (Geneva, April 2008) recommended that countries involve all health-care providers in the global response to MDR-TB and XDR-TB. To date, few PPM initiatives are in place for MDR TB management. The Philippines is an exceptional case in point, where management of MDR-TB was initiated by the private sector. Bangladesh is implementing MDR-TB

management through an NGO. Efforts are being made to establish a collaborative group on PPM MDR-TB with a mandate to document best practices and models, develop a framework for PPM MDR-TB based on WHO guidelines and conduct pilot testing of PPM MDR-TB in key settings.

### **3.3.2 Engaging all health-care providers in collaborative TB/HIV activities**

As part of a project supported by the Tuberculosis Control Assistance Programme (TBCAP), WHO along with the Union and other partners, has initiated work on extending collaborative TB/HIV activities to care providers not linked to NTPs. A systematic review of published and unpublished literature on private sector involvement in collaborative TB/HIV activities was undertaken and two expert consultations were organized. The second consultation developed an implementation protocol to help set up collaborative TB/HIV activities by a wide spectrum of public and private providers. The Union will adapt and use the protocol to implement pilots in two countries (India and Namibia). The meeting extensively discussed this issue. The protocol was found to be particularly useful for countries that had not yet initiated PPM TB/HIV activities.



### **3.3.3 Involving informal providers in TB control**

According to one estimate by WHO, up to 80% of the population in Africa uses traditional healers for health care. A review of evidence on informal provider engagement indicated that 10–58% of TB patients approached informal providers for TB services. Various initiatives, such as the Bangladesh village doctor model and the engagement of traditional healers in Burkina Faso, India and South Africa, demonstrate the applicability of engaging informal providers in key tasks such as suspect identification, referral, treatment supervision and increasing community awareness. Engaging these providers effectively could potentially help programmes to increase case detection, reduce diagnostic delays, improve equity in access to TB care, contribute to community TB care and support patients to enhance treatment adherence.

Barring a few working examples, the issue of involving informal providers and traditional healers has not yet been systematically addressed. More country-based work is needed in this area to first determine their current role and then identify ways to engage them effectively in TB care and control.

#### **3.3.4 Public-private partnerships: coordination of technical assistance**

Engaging all care providers is now a core component of WHO's Stop TB Strategy and an essential element of the Global Plan. Various partners now incorporate PPM approaches into the TB-related technical assistance they provide to countries. Although this increasing support for PPM is encouraging, there is a need for harmonization of PPM-related technical assistance to countries and sharing of experiences. This would facilitate coordination, and improve coverage and consistency of the support given to countries, as well as reduce the risk of duplication. Tools such as TBTEAM are now available to facilitate increased coordination among partners.

#### **3.3.5 Engaging patients and communities to expand PPM**

The meeting participants included representatives of patients and communities. The Patients' Charter, which was drafted with contributions from over 800 patients, expresses the hopes and needs of the heart of the TB community, and outlines their rights and responsibilities. This charter was presented and discussed at the meeting as an ideal tool to mobilize and educate patients and the community in TB control. The patient ought to be at the core of all PPM efforts and activities. Engaging patients, their families and the community in TB control is essential for the success and sustainability of TB control efforts. In tandem with the International Standards, the Patients' Charter provides a framework for patient-centred care.

#### **3.3.6 Mobilizing national professional associations for TB control**

National professional associations in many settings are a powerful ally of NTPs to effectively reach and link private clinicians in a systematic manner. The International Standards, which have been successfully piloted in countries such as India, Indonesia, Kenya, Mexico and the United Republic of Tanzania, has evolved into a valuable tool to mobilize and engage professional associations in TB control. The Indian Medical Professional Associations Coalition against Tuberculosis and professional associations across Indonesia, Kenya and Mexico have endorsed, widely disseminated and promoted the International Standards.

During the Union Conference in 2008, the DOTS Expansion Working Group (DEWG) will organize a meeting to sensitize and mobilize leaders of national professional associations for active collaboration in TB control. The American Thoracic Society, in collaboration with WHO, will launch a project specifically designed to mobilize professional associations at this meeting.

### **3.3.7 Hospital DOTS linkage (HDL)**

In many settings, hospitals manage a large proportion of TB cases. Based on recommendations from the previous Subgroup meeting, KNCV in collaboration with other partners spearheaded the development of guidelines to involve hospitals in TB control efforts. These draft guidelines were presented at the meeting; a separate break-out group then extensively reviewed the draft document and provided their inputs during the group work session.

### **3.3.8 Corporate sector involvement in TB control**

Businesses are increasingly participating in health-care interventions in general, as part of their corporate social responsibility agenda, and in TB and HIV control in particular, in response to workforce depletion and losses to company productivity caused by the co-epidemic. Successful models of corporate sector initiatives in TB control from Bangladesh, Philippines and India were presented at the meeting. Engaging the business sector was outlined as a win-win arrangement for NTPs, businesses, workers and communities. For NTPs, involving the business sector is advantageous in reaching the larger workforce and, in some cases the community, minimizing diagnostic delays, standardizing TB care and combining resources (infrastructure, human resource and management skills) to meet targets and provide TB care to all. For businesses, engaging with NTPs is advantageous in saving costs (absenteeism and retraining), increasing productivity and improving their social reputation.

As part of a TBCAP-supported project, WHO and the WEF Global Health Initiative plus other partners are currently documenting TB control initiatives engaging the workplace with the help of a corporate self assessment tool. A global consultation with businesses, business coalitions and relevant stakeholders will be organized in 2009 to review, synthesize the evidence base and develop a framework to assist in and promote corporate sector involvement in TB control.

### **3.3.9 Measuring PPM contributions to TB control**

Most countries now have a wide array of PPM activities in place that contribute to TB control. Although there is a wealth of experience from numerous evaluations of small to medium sized PPM initiatives, measurement of PPM contribution on a national scale has not been possible in most settings. The Eastern Mediterranean Region has made some progress in measuring PPM contribution through the WHO-recommended revised recording and reporting system. Figure 2 below graphs initial output. The system is still under development. Regular collection of PPM-related information through the routine recording and reporting system is important for monitoring the progress of the PPM component of the Global Plan, as well as for planning, budgeting and advocating future PPM activities in countries.

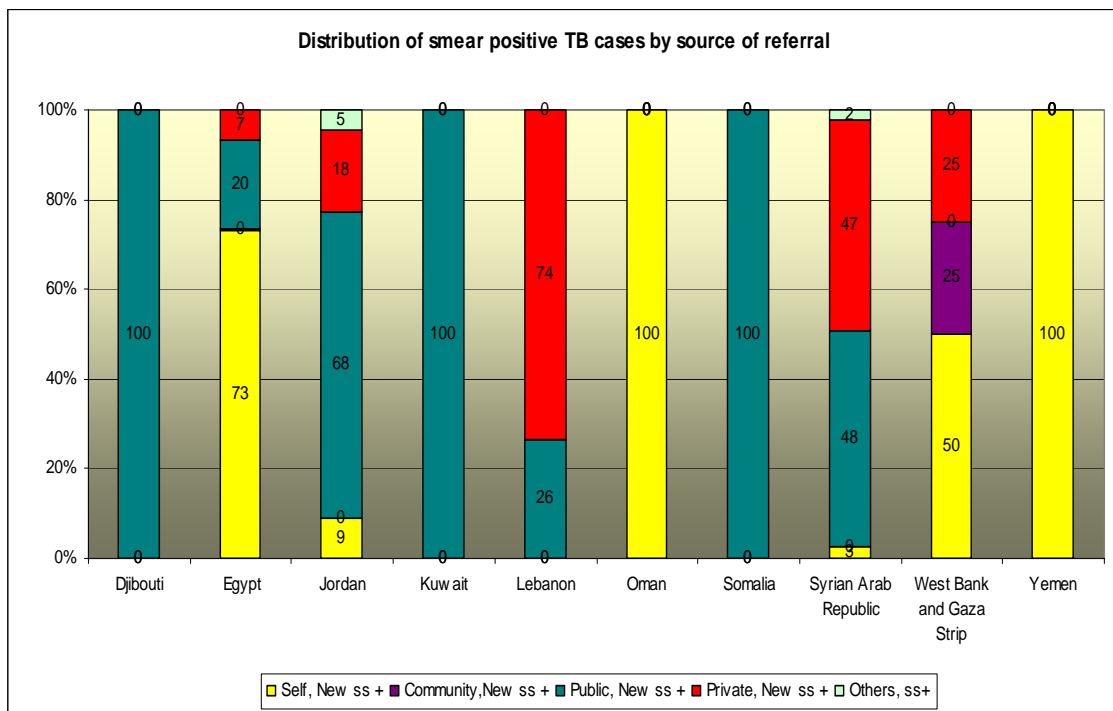


Figure 2. Data generated from the recording and reporting system,  
Eastern Mediterranean Region, 2008

## 4. Summary of group work

On the second day, break out groups were organized to discuss six major themes: mobilizing national professional associations for TB control; hospital DOTS linkages; corporate sector involvement in TB control; coordination of technical assistance for PPM; measuring PPM contributions to TB control; and engaging patients and communities to expand PPM. Each group was provided with primers containing background information, key discussion points and outcomes expected from the group work. The primers and output from the group work are presented in Appendix 2.

## 5. Recommendations

After two days of presentations, discussions and work on key topics in several groups, the Subgroup made the following recommendations:

### 5.1 To the Stop TB Partnership's Coordinating Board and Working Groups

- (i) In view of: a) decelerating global TB case detection; b) the necessity of engaging all care providers to achieve global TB control targets; c) enhanced resources accessible to countries for this purpose; d) increasing needs for technical assistance; and e) extension of the PPM concept to strengthen TB/HIV and MDR-TB control, mainstream PPM approaches into DOTS Expansion Working Group's priorities and incorporate them into the work agenda of TB/HIV and MDR-TB Working Groups.
- (ii) To monitor implementation of the PPM component of the Global Plan, encourage countries to a) implement the WHO-recommended revised recording and reporting system; b) report regularly on the contribution of PPM to case detection and treatment; and c) through periodic surveys, document effects on diagnostic delays and costs of TB care, especially among poor and vulnerable populations
- (iii) Facilitate rapid scale up of interventions to engage all care providers by advocating countries to incorporate the PPM component into funding applications, including those for the Global Fund.
- (iv) Support efforts of the PPM Subgroup to engage international corporate and business sector groups to strengthen TB control in general and in ensuring delivery of high-quality TB care to the working populations and beyond.
- (v) Encourage participation of patient and community representatives in planning and implementation across interventions for global TB care and control.

### 5.2 To Ministries of Health (National TB control programmes)

#### National situation assessment

- (i) Undertake baseline and periodic situation assessments using the national situation assessment tool to help determine strategies to initiate and expand involvement of all relevant health-care providers in TB care and control.

#### Health professionals' associations

- (ii) Engage national and sub national associations of all relevant health professionals, such as medical doctors, paramedics, nurses, pharmacists, informal providers and traditional healers, in planning and implementation of TB control activities. The

International Standards for Tuberculosis Care serve as an effective vehicle for their engagement.

- (iii) Foster and facilitate the formation of coalitions of health professional associations to provide a broad base of support within countries.

Involving hospitals in TB control

- (iv) Intensify efforts to engage hospitals in proper management of TB including, where relevant, TB/HIV and MDR-TB. For this purpose, use working examples of hospital involvement in TB control in diverse country settings and the guidance to be available on involving hospitals in TB control

Business and corporate sector engagement

- (v) Collaborate with the national business and corporate sector groups to ensure proper TB management and reporting of TB patients from among the organized and unorganized workforce, their families and communities. Tap resources and expertise available within the business and corporate sector institutions to strengthen TB care and control.

Patient and community engagement for PPM interventions

- (vi) Ensure patient and community representation and participation in the national PPM coordinating body and at sub national levels (where activities are ongoing).
- (vii) Translate into local languages, facilitate dissemination and promote use of the Patients' Charter for Tuberculosis Care by all health-care providers, community organizations and patients through appropriate approaches and channels.
- (viii) Through appropriate channels, inform communities about public and non-public high-quality TB care services available locally, and engage with community and patients organizations throughout in the process from planning to evaluation of PPM interventions.

Engaging all care providers in collaborative TB/HIV activities/PPM for TB/HIV

- (ix) Consider adapting and using the draft protocol available to initiate and/or scale up collaborative TB/HIV activities in partnership with health-care providers not linked to TB and/or HIV control programmes.

Measuring contribution of collaborating care providers to TB control

- (x) To assess progress and help refine PPM strategies, determine and report regularly on the contribution of all collaborating health-care providers to TB case detection and treatment, along the lines of the new WHO recommended revised recording and reporting system. Document periodically the effect of PPM implementation on diagnostic delays and costs of care to poor people and vulnerable populations.

Funding PPM scale up

- (xi) To help set up and facilitate rapid scale up of activities to engage all care providers in TB control, incorporate a PPM component in all funding applications including those of the Global Fund and encourage civil society groups to include it in their applications.

**5.3 To the PPM Subgroup Secretariat and Stop TB partners**

Coordination of technical assistance

- (i) Taking into consideration the experiences so far and using the new TBTEAM structure, coordinate and share responsibilities among Subgroup partners for technical assistance to countries and for implementing the following recommendations:

Support for development of Global Fund proposals

- (ii) Through available country support mechanisms, assist country programmes and civil society groups in incorporating the PPM component into their Global Fund applications.

Mobilizing professional associations

- (iii) Using available international and national fora and mechanisms, facilitate dialogue and encourage collaboration between NTPs and national associations of relevant health professionals, to strengthen TB care services across health-care providers, within and outside NTPs. Promote the International Standards as a tool for such collaboration.

Involving hospitals in TB care and control

- (iv) Incorporating feedback received from the Subgroup and following input from the MDR-TB and TB/HIV working groups, revise the draft guidelines on involving hospitals in TB control.

Business and corporate sector involvement in TB control

- (v) In collaboration with the Global Health Initiative of the World Economic Forum, the Global Business Coalition and NTPs, a) document working examples and synthesize evidence-base on ways to undertake TB control in workplaces and beyond b) facilitate collaboration between NTPs and the business sector to strengthen TB control in general and at workplaces in particular.

Engaging all care providers in TB/HIV collaborative activities

- (vi) Facilitate use of the available protocol to initiate and/or scale up collaborative TB/HIV activities in partnership with non-programme health-care providers.

Engaging relevant care providers in MDR-TB prevention and management

- (vii) Collaborate with the MDR-TB Working Group to help identify and address issues related to engaging relevant non-programme care providers in MDR-TB prevention and management.

Measuring PPM contribution

- (viii) Prepare a guiding document and provide assistance to countries to help implement the WHO-recommended recording and reporting system, to be able to measure and report regularly on the contribution of PPM to key TB care and control.

Informal care providers

- (ix) Develop and synthesize an evidence-base and facilitate sharing of experiences on engaging informal providers and traditional healers in TB care and control

Patient and community engagement

- (x) Collaborate with the country-level subgroup of the Advocacy, Communication and Social Mobilization Working Group to help identify and promote ways to use the Patients' Charter through all care providers and to inform communities on availability of TB care within and outside NTPs.

# Appendix 1

## **PPM Subgroup Terms of Reference**

### **Terms of Reference for the Subgroup:**

- To actively promote systematic engagement of all health care providers in TB control in line with the International Standards, the Stop TB Strategy and the Global Plan.
- To discuss and provide guidance on developing global, regional, country-specific strategies aimed at involving all care providers in implementation of TB control activities
- Coordinate with other working groups and subgroups of the Stop TB Partnership
- To offer platforms to share ideas and experiences related to PPM implementation and development including the meetings of the Subgroup
- To identify resources to support PPM related documentation and research and assist in global coordination for technical assistance related to PPM.
- To assist the development of tools for PPM planning and implementation at the country level
- To assist in developing training material, tools and programmes and advocacy strategies on PPM
- To review progress in PPM implementation on global, regional and country level.
- To promote widely PPM as a comprehensive approach to engage all health care providers in TB control, as well as for delivery of other public health interventions and for general strengthening of the capacity of health systems to utilize the full potential of available health care providers.
- To assist in development and implementation of a research agenda related to PPM.

### **The Core Group of the PPM Subgroup**

#### **Terms of reference:**

To oversee and steer the work of the Subgroup

- To hold face to face meetings around the annual Union conferences and the PPM Subgroup meetings and participate in teleconferences organized by the Subgroup secretariat as and when needed
- To advise the secretariat in developing PPM strategic framework and work plans
- To set the agenda and assist in the organization of Subgroup meetings
- To support the Secretariat in coordinating and monitoring PPM activities and progress

#### **Membership:**

The Core Group will have "permanent" and "non-permanent" members. On the lines of the core group of the DEWG, the permanent members will represent major institutions and constituencies engaged in global TB control. Non-permanent members will be added to seek expertise in specific areas and will be replaced periodically. The current core group members and secretariat will

prepare a list of potential core group members. The Chair will present it to the wider Subgroup for approval.

| <b>Core Group members</b>   |                              |
|---|------------------------------|
| <b>Chair of the PPM Subgroup:</b> Phil Hopewell, ATS                                    |                              |
| <b>Secretariat:</b> Mukund Uplekar, Knut Lonroth, Berthollet Kaboru and Monica Yesudian |                              |
| <b>Name</b>   | <b>Organization</b>          |
| Noor Ahmed  | NTP Manager, Pakistan        |
| Jerhemia Chakaya  | KAPTLD                       |
| Case Gordon   | World Care Council           |
| Shaloo Puri Kamble  | WEF                          |
| Vishnu Kamineni   | The Union                    |
| Michael Kimmerling  | Gorgas TB Initiative         |
| Wang Lixia  | NTP Manager, China           |
| P.K Mitra   | GLRA                         |
| Ben Nwobi   | NTP Manager, Nigeria         |
| Akihiro Okahado   | JATA                         |
| Hamid Salim   | Damien Foundation Bangladesh |
| Guy Stallworthy   | GATES Foundation             |
| Thelma Tupasi   | Makati Medical Center        |
| Lynn Vianzon  | NTP Philippines              |
| Cheri Vincent   | USAID                        |
| Jan Voskens   | KNCV                         |

### **The Secretariat of the PPM Subgroup**

- To coordinate activities of the Subgroup and prepare the strategic framework and work plans
- To plan and help organize global PPM Subgroup meetings every 12-18 months, and Core group meetings at least twice yearly
- To prepare and disseminate reports of the meetings of the Subgroup
- To maintain the minutes of the meetings of the Core group
- To monitor progress of the Subgroup and the development of PPM globally
- To participate in the meetings/teleconferences of the Core group of the DEWG
- To report on PPM progress to the, Core group, Subgroup, DEWG (and its Core Group) as well as the Stop TB Coordinating Board

**Members of the Secretariat:** The Secretariat is housed within the World Health Organization's Stop TB Department. The staff working in the PPM team in WHO, Geneva, are the members of the Subgroup Secretariat.

## Appendix 2

### **Group 1: Mobilizing professional associations and promoting the International Standards for Tuberculosis Care**

#### **Group Work Summary**

This group deliberated on the prerequisites for mobilizing national professional associations and practical steps for NTPs to engage them in TB control efforts. The group emphasized that professional organizations could be excellent partners in shouldering the burden of programmes in engaging and monitoring the private sector.

#### **Key recommendations to the NTP:**

- NTPs could sensitize professional associations on TB care using the International Standards as a tool.
- Professional associations should be involved in policy formulation, preparation and dissemination of national guidelines.
- NTPs should in collaboration with professional associations support continuous medical education programs, trainings, journals, workshops and research.
- Professional associations could be involved in certification and accreditation of private providers.

#### **Key recommendations to the PPM Subgroup:**

- PPM subgroup should have adequate representation from professional associations.
- It should provide guidance and technical assistance to NTPs to engage professional associations.
- Create a forum where professional associations can interact and exchange experiences and ideas.
- PPM subgroup should develop tools for monitoring, evaluation and indicators for measuring the contribution professional association engagement.

The participants also discussed the DOTS Expansion Working Group (DEWG) meeting to be organized at the Union Conference in Paris which will focus on enhancing collaborations between national programmes and professional associations. The group made a suggestion to include two additional items to the agenda- developing national coalitions of professional associations and the role of international professional associations.

## **Primer for Group 1**

**Facilitator:** R V Asokan

The International Standards for TB Care, launched in 2006, have been effectively used as a tool to engaging professional associations in TB control in some countries. While the International Standards has greatly helped as a rallying point to help mobilize professional societies and associations, its translation into improved TB management practices among their members is yet to be documented. Taking into account the country-experiences so far, this group should discuss ways to expedite effective collaboration for TB control between national TB programmes (NTPs) and national associations of health professional.

This year's DOTS Expansion Working Group meeting to be organized at the Union conference in Paris will focus on enhancing collaboration between professional associations and NTPs. The group should also discuss and suggest ways to make optimum use of this opportunity. The provisional agenda of the Paris meeting would be made available to the group.

### ***Background material***

- Presentation on engaging professional associations
- Country experiences of relevant group members

### ***Discussion points***

- What role do professional associations currently play in TB care and control in different contexts?
- How can NTPs support involvement of professional associations in TB control? What assistance would NTPs need for this purpose?
- How can professional associations mobilize their members and engage them in TB control? What support would they need for this purpose?
- How to engage associations of informal providers / traditional healers?
- How to ensure that promotion of the International Standards results in improved TB management practices among health practitioners?
- What role the PPM Subgroup could play in speeding up effective collaboration between NTPs and professional associations?

### *Expected output*

- Key recommendations to NTPs on how to engage with professional associations for TB control
- Key recommendations to the PPM Subgroup on facilitating collaboration between NTPs and professional associations
- Ways to assess the effectiveness of use of the International Standards by professional associations
- Suggestions on the DEWG Paris meeting agenda

### **Group 1 - Members**

| <b>Name</b>        | <b>Organization</b>                              |
|--------------------|--|
| Al Hasen Mysoun    | NTP, Syrian Arab Republic                        |
| Asokan RV          | Indian Medical Association                       |
| Bergström Karin    | WHO,HQ   |
| Burhan Erlina      | Indonesian Respiriology Association              |
| Del Granado Mirtha | WHO, Regional Office for the Americas            |
| Du Melle Fran      | NTP, Cambodia                                    |
| Eang Mao Tan       | National Center for TB and Leprosy Control       |
| Hopewell Philip    | Division of Pulmonary and Critical Care Medicine |
| Muhgazi Ghada      | WHO, Syrian Arab Republic                        |
| Nwobi Benjamin     | NTP, Nigeria                                     |
| Seyer Julia        | The World Medical Association                    |
| Suleh Andrew       | Kenya Medical Association (KMA)                  |

## **Group 2: Hospital DOTS Linkages**

### **Group Work Summary**

This group discussed the various issues and challenges of involving hospitals in TB control efforts. The need for good incentives to encourage hospital referral and notification were extensively discussed. The draft HDL guidelines developed by KNCV and partners was reviewed and suggestions were made by the group to simplify the document, link the document with the existing guidelines for PPM and to include short sections on Infection control, TB/HIV and MDR TB. It was recommended that the revised draft be then sent out for review to a wider audience including end users such as hospitals and NTPs.

## Primer for Group 2

**Facilitator:** Jan Voskens

The difficulty of engaging hospitals in DOTS implementation is faced by most countries. Effective engagement of hospitals often presents the dual problem of "internal coordination" among hospital departments to which TB symptomatics and cases often present (such as the outpatients, radiology, laboratory, internal medicine, family medicine, and chest medicine) as well as "external coordination" between hospitals and peripheral health facilities from where patients are often referred to hospitals and to which patients are often sent back after diagnosis. There have been some successful examples of hospital-DOTS linkage (HDL).

As a part of TBCAP project and based on country experiences, draft guidelines on HDL have been put together. The draft will be made available to the participants of this break out group, prior to the meeting and group work.

### ***Background material:***

- Draft HDL guidelines
- Presentation on HDL

### ***Discussion points:***

- Issues and challenges of involving hospitals in TB control
- Summary comments on HDL guidelines including the terminology, the content, the presentation, and adequacy of the evidence
- Comments on HDL guidelines incorporating issues such as TB/HIV, MDR TB and infection control
- Recommendation to the Subgroup on next steps with regards to the HDL guidelines

### **Expected outcomes**

- Recommendations to NTPs on involving hospitals in TB control
- Comments on the draft HDL guidelines
- Recommendations on the next steps on HDL guidelines

## Group 2 - Members

| Name               | Organization   |
|--------------------|--|
| Abu-Saad Refaat    | Azhar University, Egypt                              |
| Al Domainy Khadija | Ministry of Public Health, Yemen                     |
| Awe A              | WHO, Nigeria   |
| Chakaya Jeremiah   | Kenya Medical Research Institute                     |
| Chin Daniel        | Gates Foundation -- China Office                     |
| Farghaly Ayman     | Chest Specialist (Army), Egypt                       |
| Kilicaslan Zeki    | Chest Diseases Dept, Istanbul University             |
| Uplekar Mukund     | WHO,HQ   |
| Wei Xiaolin        | Nuffield Centre, University of Leeds, United Kingdom |
| Voskens Jan        | KNCV Tuberculosis Foundation                         |
| Zignol Matteo      | WHO,HQ   |

## **Group 3: Corporate Sector Involvement**

### **Group Work Summary**

Businesses are increasingly participating in health care interventions as part of their corporate social responsibility agenda and in response to losses in company productivity and bottom-line caused by epidemics such as TB and HIV. The corporate sector can be a powerful ally to NTPs given their access to the working population and, in some cases, the community. This group first shared experiences on their own country experiences of engaging with the corporate sector and then deliberated on concrete steps for NTPs and the Subgroup to engage and promote the engagement of the corporate sector in TB control efforts.

### **Key recommendations to NTPs**

- First promote corporate sector engagement internally within the ministry of health to get internal buy-in.
- Collaborate with intermediaries such as business associations/coalitions to share the burden of coordinating with and monitoring these providers.
- Involve businesses in Global Fund proposals, especially in the dual-track financing proposals, to ensure funding for these initiatives.
- Encourage company involvement in TB control efforts outside the workplace by reaching out to workers' families and the local community, and utilize the capacity of trade unions for community engagement.
- Initiate advocacy efforts to engage companies in TB control efforts.

### **Key recommendations to PPM Subgroup**

- Document existing corporate sector models.
- Facilitate dissemination and follow up of the corporate self-assessment tool as part of a global mapping exercise and to build up an evidence base.
- Coordinate with the ILO and other agencies/partners working in this area.
- Identify and draw lessons from other disease programmes that are engaging the corporate sector and/or piggyback existing mechanisms (for example: HIV in the workplace programmes).
- Develop practical guidance on corporate sector engagement for NTPs and businesses in collaboration with the Global Health Initiative of the World Economic forum and the Global Business Coalition.

### **Primer for Group 3**

**Facilitator:** Shaloo Puri

Health services for the organized workforce are often provided, fully or partly, by their employers. However, the current contribution or the potential participation of businesses/the corporate sector in TB control, especially in HBCs, has not yet been properly assessed. Some successful initiatives in Africa and Asia illustrate the significant role the corporate sector can play in TB control efforts. These working examples, however, have not been well documented. Guidelines for TB control in the workplace have already been prepared jointly by WHO and ILO but are not adequately supported by ground experiences in country settings. In order to prepare an evidence-base of working models of corporate sector involvement in TB control in diverse settings, WHO has begun documenting selected country experiences. Summaries of site visits to Bangladesh and Philippines will be made available to the members of this group.

To help gather a sufficient number and variety of corporate sector experiences, a corporate self-assessment tool has also been developed, tested and revised. This will also be made available to the group.

A synthesis of country experiences could help provide the evidence-base for the current guidelines and also offer options to NTPs to choose from. Logically, this should be undertaken in close collaboration with business sector groups such as the Global Health Initiative of WEF and the Global Business Coalition. The expectation from this group would be to advise NTPs and the PPM Subgroup on how best this task can be achieved.

#### ***Background material***

- Presentation on corporate sector efforts in TB control
- Case Studies from Philippines and Bangladesh
- Self-assessment tool for businesses to evaluate their contribution to TB control

#### ***Discussion points:***

- Ways in which the corporate sector can contribute to TB control
- NTP approaches to address the issue of corporate sector involvement?
- Who could facilitate NTPs - business sector collaboration? How?
- How can the self-assessment tool be put to use?

### *Expected outcomes*

- Recommendations to the PPM subgroup on building the evidence base and proposing options to NTPs
- Recommendations on collaborative partnership among GHI, GBC and the PPM Subgroup
- Initial steps that NTPs should take to begin engaging with the corporate sector

### **Group 3 - Members**

| <b>Name</b>              | <b>Organization</b>               |
|--------------------------|-----------------------------------|
| Abdel Halim Mohammad     | PPM Focal Person, MoH, Egypt      |
| Awal Miah Abdul          | NTP, Bangladesh                   |
| Conway Shaun             | Re-Action Consulting, London      |
| Egami Youriko            | WHO, Pakistan                     |
| El Wagie Hashim Suleiman | NTP, North Sudan                  |
| Gad Omayma               | HIO Focal Person, MoH, Egypt      |
| Gumuslu Feyzullah        | NTP, Turkey                       |
| Islam Akramul            | BRAC Health Programme, Bangladesh |
| Kamble Puri Shaloo       | GHI                               |
| Lasu Hickson             | NTP, South Sudan                  |
| Mehta Firdosi            | WHO, Indonesia                    |
| Sitienei Joseph          | NTP, Kenya                        |
| Yesudian Monica          | WHO,HQ                            |

## Group 4: Measuring PPM contribution to TB control

### Group Work Summary

This group extensively discussed indicators for countries to monitor PPM contribution, practical steps for countries to pilot and fully implement a system to record and report on PPM contributions and the need for advocacy to promote PPM monitoring on a national level. The key indicators suggested by the group for measuring PPM contributions are outlined in the table below.

| Global Indicators  | Assessing PPM contribution to MDR-TB   | Assessing PPM contribution to TB/HIV   |
|--|--|--|
| Number and proportion of non-programme facilities involved in: <ul style="list-style-type: none"> <li>– Referring suspects</li> <li>– Diagnosing TB cases</li> <li>– Managing TB patients</li> </ul> | Number or proportion of private and public non-NTP providers involved in MDR diagnosis and treatment according to international (WHO, Union) standards | Participation of non-programme provider representatives in TB/HIV coordinating body  |
| Number and proportion of notified cases diagnosed by non-programme providers   | Number or proportion of DST conducted by private and public non-NTP labs   | Number or proportion of non-programme TB diagnostic centers that offer VCT   |
| Number and proportion of notified cases managed by non-programme providers   | Number or proportion of second line treatments managed by private and public non-NTP providers   | Number or proportion of TB cases diagnosed in private sector who receive VCT   |
|  |  | Among those under care of non-programme providers, the number or proportion of people testing positive for HIV who are screened for TB |

Table 1: Indicators for measurement of PPM contribution

The group discussed the progress made by the Eastern Mediterranean Region in measuring PPM contribution. The group recommended that all regions initiate similar recording and reporting systems so that in the next PPM subgroup meeting all regions could report back on the contributions made by PPM at country level. The group recommended to the PPM Subgroup that efforts be initiated to develop a guidance document to assist countries in measuring the impact of engaging all care providers. With regard to advocacy the group recommended increased coordination and organization of consultations between the public and private sector to highlight the importance of monitoring PPM contribution and also to ensure ownership of the process from both sides.

## **Primer for Group 4**

**Facilitator:** Dr. Hassan Sadiq

Most countries now have a wide array of providers that contribute to TB control. Their contributions include, for example, referral of TB symptomatic, collection of sputum smear samples, smear microscopy, culture and DST, diagnosis of TB, diagnosis of HIV, DOT or other ways of supervision, absentee retrieval, drug management, record maintenance, etc.

The standard reporting by NTPs on TB control progress and programme implementation does not normally include specific information about contributions of diverse providers to TB control.

There is a wealth of experience from numerous evaluations of small to medium size PPM initiatives on how to evaluate PPM. However, these experiences have not yet been translated into guidance for countries scaling up PPM on how to continuously monitor PPM on a national scale.

Therefore, we still have very little information about the actual contribution of PPM to the achievement of TB control indicators on national, regional and global level.

A new recording and reporting system for TB control was developed in 2006-2007, which includes some advice on how to monitor PPM on national and sub-national level. However, it does not include practical guidance on how to ensure effective collection, analysis and reporting of data. Furthermore, very few countries seem to have taken up the recommended approach to PPM monitoring.

### ***Background material:***

- Presentation of measuring PPM
- List of PPM evaluation indicators from the "PPM Guidance Document"
- Selected parts of the new recording and reporting system

### ***Discussion points:***

- What should be the key PPM indicators that countries should monitor continuously (e.g. to be reported at the 6<sup>th</sup> PPM Subgroup meeting in 2009)
- What are the practical steps that countries need to take to start pilot and fully implement a system to record and report on PPM?
- What advocacy is needed to promote PPM monitoring on national level?
- How to assess PPM contribution to care and prevention of MDR-TB and TB/HIV collaborative activities?

***Expected outcomes***

- Draft recommendations to countries on the practical steps involved in ensuring that PPM implementation and PPM contribution to TB control is monitored continuously

**Group 4 - Members**

| <b>Name</b>         | <b>Organization</b>                                    |
|---------------------|--|
| Gninafon Martin     | NTP, Benin   |
| Jin Kim Hee         | Korean Institute of TB                                 |
| Lagahid Jaime       | Director, Infectious Disease Office,<br>Philippines    |
| Lonroth Knut        | WHO, HQ  |
| Munim Aayid         | WHO, Sudan   |
| Ottmani Salah       | WHO, HQ  |
| Saade Mtanios       | NTP, Lebanon   |
| Sadiq Hassan        | NTP, Pakistan  |
| Salaniponi Felix    | Director, National TB Programme<br>Secretariat, Malawi |
| Stallworthy Guy     | Bill & Melinda Gates Foundation                        |
| Tenorio Alfonso     | University of Cauca, Colombia                          |
| Talukder Shafiullah | WHO, Bangladesh  |

## **Group 5: Coordination of technical assistance among partners**

### **Group Work Summary**

Recognizing the lack of information available on the PPM activities of partners and the risk of duplication of technical assistance to countries, this group expressed the need for more communication and coordination among partners and with NTPs. TBTEAM was highlighted as an excellent tool to facilitate this coordination and partners were encouraged to regularly use the tool. The group further suggested that countries be categorized based on PPM needs and assistance be provided to them on that basis. PPM was also seen as an instrument in facilitating health systems strengthening (HSS) and the group recommended that HSS consultants be involved in PPM missions as appropriate. Finally the group recommended that PPM be streamlined into all the components of the Stop TB Strategy to avoid fragmented approaches.

## **Primer for Group5**

**Facilitator:** Dr. Vishnu Kamineni

### **The Issue:**

In response to increasing interest in PPM in regions and countries, several organizations are involved in providing technical support to countries for PPM at different stages (planning, piloting, implementation, monitoring/evaluation and scaling-up).

Although communication between these actors exists, there is need for increased coordination and sharing of experiences. This would further improve coverage and consistency of the support given to countries, and reduce the risk of unnecessary duplication.

A first good response to this is the TBTEAM which has been set up as a network linking organizations and individual consultants involved in technical assistance on TB control. Still, there are no clear mechanisms linking partners providing technical assistance for PPM.

### **Background material**

- Presentation material
- List of current and planned future (2008-09) technical assistance on PPM by the different organizations

### **Points for discussion**

- What are the different technical partners providing technical assistance to countries on?
- Are there gaps in terms of geographical regions not being provided enough support by partners? How to address these gaps?
- Any overlap in TA between organizations?
- What are the options for improving future coordination among partners?

### **Expected outcomes:**

- Matrix showing ongoing and planned technical assistance on PPM, by partner organization
- Draft recommendations on future coordination mechanisms among partners suggested

## Group 5 - Members

| Name               | Organization   |
|--------------------|--|
| Aziz Mohamed Abdel | The Global Fund                                      |
| Elliott Megan      | Population Services International                    |
| Kamineni Vishnu    | The Union  |
| Massaut Sara       | KNCV Tuberculosis Foundation                         |
| Mitra P K          | German Leprosy & TB Relief Association India         |
| Nathanson Eva      | WHO, HQ  |
| Nkhoma Wilfred     | WHO Regional Office for Africa                       |
| Ohkado Akihiro     | Japan Anti-Tuberculosis Association                  |
| Salaniponi Felix   | National TB Programme Secretariat, Malawi            |
| Seita Akihiro      | WHO Regional Office for the Eastern<br>Mediterranean |
| Vincent Cheri      | U.S. Agency for International Development            |

## **Group 6: Patient and community perspectives in PPM**

### **Group Work Summary**

This group discussed the various elements of engaging patients and communities in PPM activities. They highlighted the need for patient and community representation and participation in national and sub-national PPM taskforces/coordinating bodies. The subgroup was requested to promote the Patients' Charter hand in hand with the International Standards in all relevant documents, conferences, forums, trainings and workshops, assist in the translation of the Charter into local languages and also support the development of a user guide for the Charter. The group also recommended that assistance be provided to patient and community groups in countries to develop and apply for Global fund support through the dual-track financing mechanism.

## Primer for Group 6

**Facilitator: Case Gordon**

Patients have always been at the centre in PPM philosophy and strategies. The basic ground for PPM is indeed that patients with TB symptoms seek for help from many sources of care, including public and private providers operating outside NTPs. Thus, bringing these providers closer with NTPs for more case notification and better quality of care in the private sector is aimed to improve access to quality care for the benefit of the patients. As PPM strategies develop to include more and more categories and types of providers and institutions, and expand into newer and more complex areas such as MDR and XDR-TB and TB/HIV, it is important that patient and community perspectives are adequately addressed.

The Patients' Charter for Tuberculosis Care is an excellent tool that communities as well as providers could use to inform TB patients of their rights and responsibilities. We need to know better how the Charter can be introduced within PPM and how to measure its effectiveness. NTPs should incorporate patient and community perspectives into PPM implementation for two clear reasons: in areas where PPM is being implemented, informing patients and communities on increased access to care at places of their convenience and in areas where other providers exist, NTP facilities are hard to reach and yet PPM is not being implemented, creating demand for PPM to involve other providers so that patients can seek care from providers of their choice.

### Background material

- Presentation by Case Gordon
- Patient Charter for Tuberculosis Care

### Points for discussion

- Ways and mechanisms for patient and community involvement in PPM initiatives
- Patients' Charter as part of tools to be disseminated and promoted in PPM approaches: Who should do this? How and when?
- Need for tools and indicators to measure community and patient involvement in PPM approaches

### Expected outcomes

- Ways to use the Patients' Charter in PPM approaches
- Ways to enhance patient information on PPM and to create demand for services expanded through PPM
- Recommendations to the Subgroup on incorporating patient' perspective in PPM approaches

## Group 6 - Members

| Name                        | Organization                                  |
|-----------------------------|---|
| El Tilib Husham Ali Ibrahim | Ministry of Health, Khartoum                  |
| Baghdadi Samiha             | WHO Office for the Eastern Mediterranean      |
| Gordon Case                 | World Care Council                            |
| Hamid (Salim)Abdul          | Damien Foundation Bangladesh                  |
| Inaba Keiko                 | WHO South Sudan                               |
| Kaboru Berthollet           | WHO,HQ  |
| Kumar Blessina Amulya       | Community Health Nurse                        |
| Ledoux Fogu                 | TB/HIV Advocate, Cameroon                     |
| Malmborg Rasmus             | Norwegian Heart and Lung Patient Organization |
| Nyasulu Ishmael             | WHO, Malawi                                   |
| Velebit Lana                | WHO,HQ  |

## Appendix 3

### Agenda

| 03 June 2008  |  |                                |
|---|--|--------------------------------|
| <i>Session 1: Introduction</i>                      |  | <i>Chair: Jaouad Mahjour</i>   |
| 8:30 - 9:00   | <b>Registration</b>  |                                |
| 9:00 - 9:10   | Opening address by the Regional Director                                     | RD, WHO EMRO                   |
| 9:10 - 9:20   | PPM Subgroup Chairman's address  | Phil Hopewell                  |
| 9:20 - 9:25   | Workshop Objectives and Agenda   | Samiha Baghdadi                |
| 9:25 - 9:40   | Global PPM progress report   | Mukund Uplekar                 |
| 9:40 -10:00   | <b>Discussion</b>  |                                |
| <i>10:00 – 10:30 <u>Coffee</u></i>                  |  |                                |
| <i>Session 2: PPM progress in the WHO Regions</i>   |  | <i>Chair: Cheri Vincent</i>    |
| 10:30 - 10:45                                       | Regional Office for Africa   | Wilfred Nkhoma                 |
| 10:45 - 11:00                                       | Regional Office for the Americas   | Mirtha Del Granado             |
| 11:00 - 11:15                                       | Regional Office for the East. Mediterranean                                  | Samiha Baghdadi                |
| 11:15 - 11:30                                       | Regional Office for South-East Asia  | Firdosi Mehta                  |
| 11:30 - 11:45                                       | Regional Office for the Western Pacific                                      | Pieter van Maaren              |
| 11:45 - 12:15                                       | <b>Discussion</b>  |                                |
| <i>12:15 – 13:30 <u>Lunch</u></i>                   |  |                                |
| <i>Session 3A: Perspectives and new initiatives</i> |  | <i>Chair: Felix Salaniponi</i> |
| 13:30 - 13:45                                       | PPM for TB control: donor perspective  | Cheri Vincent                  |
| 13:45 – 14:00                                       | Engaging all care providers: civil society perspective and new opportunities | Case Gordon                    |
| 14:00 – 14:30                                       | <b>Discussion</b>  |                                |
| 14:30 - 14:45                                       | Involving informal providers in TB control                                   | Berthollet Kaboru              |

|   |   |                 |
|---|---|-----------------|
| 14:45 – 15:00   | <b>Discussion</b>   |                 |
| <b>15:00 – 15:30</b> <u>Coffee</u>  |   |                 |
| <b>Session 3B: Perspectives and new initiatives</b> <b>Chair: Guy Stallworthy</b> |   |                 |
| 15.00 - 15:15   | Involving all health care providers<br>in the MDR and XDR-TB response                           | Matteo Zignol   |
| 15:15 – 15:30   | <b>Discussion</b>   |                 |
| 15:30 - 15:45   | Involving all health care providers<br>in TB/HIV collaborative activities                       | Eva Nathanson   |
| 15:45 - 16:15   | <b>Discussion</b>   |                 |
| 16:15 – 16:30   | Advocacy tools for PPM  | Thad Pennas     |
| <b>04 June 2008</b>   |   |                 |
| <b>Session 4: New tools and guidance</b> <b>Chair: J M Chakaya</b>                |   |                 |
| 08:30 – 08:50   | Putting TB control on the business agenda: roles<br>and potential                               | Shaloo Puri     |
| 08:50 – 09:10   | Involving national professional associations in TB<br>control using the International Standards | Phil Hopewell   |
| 09:10 – 09:30   | Hospital DOTS linkage   | Jan Voskens     |
| 09:30 – 09:50   | Measuring PPM contributions   | Knut Lonnoth    |
| 09:50 – 10:30   | Introduction to group work  | Monica Yesudian |
| <b>10:30 – 11:00</b> <u>Coffee</u>  |   |                 |
| 11:00 – 12:00   | Group work in six break out groups**  |                 |
| <b>12:00 – 13:30</b> <u>Lunch</u>   |   |                 |
| 13.30 - 16:30   | Group work in six break out groups** (contd.)   |                 |
| <b>05 June 2008</b>   |   |                 |
| <b>Session 5: Plenary</b> <b>Chair: Phil Hopewell</b>                             |   |                 |

|  |  |
|--|--|
|  |  |
| 08:30 – 10:30                            | Presentation by groups and discussion                |
| <b><i>10:30 - 11:00</i></b>              | <b><i><u>Coffee</u></i></b>                          |
| <b><i>Session 6: Open discussion</i></b> | <b><i>Chair: Leopold Blanc</i></b>                   |
| 11:00 - 12:00                            | Open discussion: PPM Subgroup – the way forward      |
| <b><i>12:00 - 13:30</i></b>              | <b><i><u>Lunch</u></i></b>                           |
| <b><i>Session 7: Closing Session</i></b> | <b><i>Chair: Phil Hopewell</i></b>                   |
| 13:30 – 15:00                            | Draft Recommendations and closing                    |
| <b><i>15:00 – 15:30</i></b>              | <b><i><u>Coffee</u></i></b>                          |
| 15:30 - 16:30                            | Meeting of the <u>Core Group</u> of the PPM Subgroup |

## Appendix 4

### List of participants

#### *COUNTRY REPRESENTATIVES*

##### *AFRICAN REGION*

###### **BENIN**

###### **Dr Martin Gninafon**

Professor  
National TB Programme Manager  
Cotonou

###### **Dr Andrew Suleh**

Representative  
Kenya Medical Association (KMA)  
Nairobi

###### **KENYA**

###### **Dr Jeremiah Muhwa Chakaya**

Chief Research Officer  
Centre for Respiratory Diseases Research  
Kenya Medical Research Institute  
P.O. Box 47855  
Nairobi 00100

###### **MALAWI**

###### **Dr Felix Martin Salaniponi**

Director, National TB Programme Secretariat  
Community Health Sciences Unit (CHSU)  
Ministry of Health  
Private Bag 65  
Lilongwe

###### **Dr Joseph Kimagut Sitienei**

National TB Programme Manager  
National Leprosy & TB Programme  
Ministry of Health  
P. O. Box 20781  
Nairobi 00202

###### **NIGERIA**

###### **Mr Benjamin Chukwuemeka Nwobi**

National TB Programme Manager  
National TB & Leprosy Control Programme  
(NTBLCP)  
Department of Public Health  
Federal Ministry of Health  
No 2 Justice Sowemimo Street  
Off Jose Marti Street, Asokoro  
Abuja, Nigeria

##### *REGION OF THE AMERICAS*

###### **COLOMBIA**

###### **Dr Alfonso Tenorio**

Professor  
Department of Internal Medicine  
University of Cauca  
Carrera 11 No.18N-66  
Popayán

***EASTERN MEDITERRANEAN REGION***

**EGYPT**

**Dr Mohammad Abdel Halim**

Focal Point for TB Public Private Mix  
Ministry of Health and Population  
Cairo

**Professor Naguiba Loutfy**

Professor of Public Health  
High Institute of Public Health  
Alexandria

**LEBANON**

**Dr Mtarios Saade**

National TB Programme Manager  
Ministry of Public Health  
Beirut

**PAKISTAN**

**Dr Hassan Sadiq**

National TB Control Programme Manager  
Ministry of Health  
Federal Government TB Centre  
Islamabad

***EUROPEAN REGION***

**TURKEY**

**Dr Feyzullah Gumuslu**

National TB Programme Manager  
Ministry of Health  
Department of Foreign Affairs  
Sihhiye-Ankara

***SOUTH-EAST ASIA REGION***

**BANGLADESH**

**Dr Akramul Islam**

Programme Coordinator, BRAC Health  
Programme  
75 Mohakhali  
Dhaka-1212

**SUDAN**

**Dr Husham Ali Ibrahim El Tilib**

Officer for TB Public Private Mix  
Federal Ministry of Health  
Khartoum

**Dr Hashim Suleiman El Wagie**

National TB Programme Manager  
Federal Ministry of Health  
Khartoum

**SYRIAN ARAB REPUBLIC**

**Dr Maysoun Al Hasan**

Deputy Manager of Tuberculosis Control  
Ministry of Health  
Damascus

**YEMEN, REPUBLIC OF**

**Dr Khadija Al Dumini**

Focal Point for TB Public Private Mix  
Ministry of Public Health and Population  
Sana'a

**Professor Zeki Kilicaslan**

Istanbul University  
Istanbul Medical Faculty  
Chest Diseases Department  
Capa 34390  
Istanbul

**Dr Md Abdul Awal Miah**

Directorate – General of Health Services  
National TB Programme Manager  
Mohakhali  
Dhaka-1212

**INDIA****Dr Asokan Rajakani Vivekanandan**

Dean Hospital

Punalur 691305 - Kollam District

Kerala State

**INDONESIA****Dr Erlina Burhan**

Vice Secretary, Indonesian Respiratory

Association

Department of Pulmonology and Respiratory  
Medicine

Faculty of Medicine, University of Indonesia

Persahabatan Hospital Jakarta

JI Persahabatan Raya No.1

Rawamangun Jakarata Timur

Jakarta

***WESTERN PACIFIC REGION*****CAMBODIA****Dr Mao Tan Eang**

Director

National Centre for TB and Leprosy Control

(CENAT)

Ministry of Health

St. 278/95 Sangkat Boeng

Chamkarmorn

Phnom Penh

**REPUBLIC OF KOREA****Dr Hee Jin Kim**

Director

Department of Epidemiology

The Korean Institute of Tuberculosis

Korean National TB Association

Seoul

**PHILIPPINES****Dr Jaime Lagahid**

Director, Infectious Disease Office

National Centre for Disease,

Prevention and Control

Department of Health

San Lazaro Compound Rizal

Avenue, St. Cruz

1003 Manila

***PATIENT AND COMMUNITY REPRESENTATIVES*****Ms Blessina Amulya Kumar**

Community Health Nurse

MISBAH, 1394 Sector A

Pocket B/C Vasant Kunj

New Delhi 110070

India

**Mr Fogué Ddzutué Alain Patric****Ledoux**

TB/HIV Advocate

Positive-Generation, RéCAP and

MOCPAT

Rue Tsoungui aloa à ngoa Ekelle

P.O. Box 10087

Yaoundé 00237

Cameroon

## ***PARTNER REPRESENTATIVES***

### **AMERICAN THORATIC SOCIETY**

**Dr Philip Hopewell**

Professor of Medicine  
Division of Pulmonary and Critical Care Medicine  
San Francisco General Hospital  
Room 5K1  
San Francisco, CA 94110  
USA

**Ms Fran Du Melle**

Senior Director, International Activities  
American Thoracic Society  
1150 18th Street, Suite 900  
Washington DC, 20036,  
USA

### **BILL AND MELINDA GATES FOUNDATION**

**Dr Daniel P Chin**

Senior Programme Officer, Tuberculosis  
Bill & Melinda Gates Foundation- China Office  
Room 1201, China Resources Building  
8 Jianguomenbei Ave  
Beijing, 100005  
China

**Mr Guy Stallworthy**

Senior Programme officer  
Strategic business planning  
Bill and Melinda Gates Foundation  
1551 Eastlake Avenue East  
PO Box 23350  
USA

### **DAMIEN FOUNDATION BANGLADESH**

**Dr Md Abdul (Salim) Hamid**

Country Director and Medical Advisor  
Damien Foundation Bangladesh  
House-24, Road-18, Banani, Block-A  
Dhaka  
Bangladesh

### **EDELMAN**

**Mr Thad Pennas**

Vice President  
Global Health, Corporate &

Public Affairs  
Edelman  
1500 Broadway  
New York, NY | 10036  
USA

**Ms Taryn Brucia**

Account Supervisor  
Corporate & Public Affairs  
Edelman  
1500 Broadway  
New York, NY | 10036  
USA

### **THE GLOBAL FUND TO FIGHT AIDS, TB AND MALARIA**

**Dr Mohamed Abdel Aziz**

The Global Fund  
Chemin de Blandonnet 8  
1214 Vernier  
Geneva  
Switzerland

### **GERMAN LEPROSY & TB RELIEF ASSOCIATION**

**Dr Prasun K Mitra**

Regional Medical Co-ordinator  
German Leprosy & TB Relief  
Association  
New Delhi  
India

### **JAPAN ANTI-TUBERCULOSIS ASSOCIATION**

**Dr Akihiro Okado**

Project Leader  
The Research Institute of TB  
Japan Anti-Tuberculosis  
Association  
Matsuyama 3-1-24  
Kiyose 204-8533  
Tokyo  
Japan

**KNCV TUBERCULOSIS  
FOUNDATION**

**Ms Sara Massaut**

Senior Project Officer  
PMU/TB CAP  
KNCV Tuberculosis Foundation  
PO Box 146  
2501 CC The Hague  
The Netherlands

**Dr Jan Voskens**

Senior Consultant  
International Unit  
KNCV Tuberculosis Foundation  
Parkstraat 17, The Hague  
The Netherlands

**LHL, NORWEGIAN HEART AND  
LUNG PATIENT ORGANIZATION**

**Dr Rasmus Malmberg**

Consultant International Cooperation  
LHL, Norwegian Heart and Lung  
Patient Organization  
P.O. Box 4375 Nydalen  
Norway

**NAMRU#3**

**Dr Sybil A. Tasker**

Department of Defense  
Regional Director Africa for the DOD/HIV/AIDS  
Prevention Programme for Africa  
Cairo  
Egypt

**NUFFIELD CENTRE FOR INTERNATIONAL  
HEALTH AND DEVELOPMENT**

**Dr Xiaolin Wei**

Senior Research Fellow  
University of Leeds, UK  
China Office: 2-1104, 5 Fanyu Road  
Changning District  
Shanghai - 200052  
China

**POPULATION SERVICE INTERNATIONAL**

**Ms Megan Elliott**

New Business Manager  
Population Services International  
Washington DC, 20036  
USA

**RE-ACTION**

**Dr Shaun Conway**

250 Willesden Lane, No 2  
London NW2 5RE  
United Kingdom

**THE UNION**

**Dr Vishnu Kamineni**

Technical Consultant  
India Resource Centre  
International Union Against Tuberculosis  
and Lung Disease (The Union)  
New Delhi 110013  
India

**USAID**

**Ms Cheri Vincent**

Public Health Advisor  
Global Health Bureau  
U.S. Agency for International Development  
BGH/Office of Health and Infectious Diseases  
Washington DC, 20523-3700  
USA

**WORLD CARE COUNCIL**

**Mr Case Gordon**

President  
World Care Council  
Place Pepin  
34380 Viols en Laval  
France

**WORLD ECONOMIC FORUM**

**Dr Shaloo Puri Kamble**

Head  
India Business Alliance Advisor, TB and India  
Gurgaon 122009  
Haryana  
India

## **WORLD MEDICAL ASSOCIATION**

**Dr Julia Seyer**

World Medical Association

01210 Ferney-Voltaire

France

## **LOCAL OBSERVERS**

**Professor Yousry Akel**

Professor of Chest Diseases

Elkasr - Eleini Hospital

Cairo

Egypt

**Dr Omayma Gad**

HIO Focal Person

Ministry of Health and Population

Cairo

Egypt

**Dr Ayman Farghaly**

Head of Chest Section in the Army

Ministry of Defence

Cairo

Egypt

**Dr Essam El Moghazy**

National TB Programme Manager

Ministry of Health and Population

Cairo

Egypt

## **WHO SECRETARIAT**

### **AFRICAN REGION**

**Dr Wilfred Nkhoma**

Regional Focal Point

WHO Regional Office for Africa

Brazzaville

Congo

The Office of the WHO Representative

**Mr Ishmael Nyasulu**

National Professional Officer

The Office of the WHO

Representative

Lilongwe

Malawi

**Dr Ayodele O. Awe**

National Professional Officer

Abuja

Nigeria

### **REGION OF THE AMERICAS**

**Dr Mirtha Del Granado**

Regional Adviser PAHO

WHO Regional Office for the Americas

Washington, D.C.

USA

## EASTERN MEDITERRANEAN REGION

### **Dr Samiha Baghdadi**

Medical Officer  
WHO Regional Office for  
the Eastern Mediterranean  
Cairo  
Egypt

### **Dr Amal Fawzi Bassili**

Surveillance Officer  
WHO Regional Office for  
the Eastern Mediterranean  
Cairo  
Egypt

### **Dr Youriko Egami**

Medical Officer  
The Office of the WHO Representative  
Islamabad  
Pakistan

### **Dr Zuhair Hallaj**

Special Adviser  
WHO Regional Office for  
the Eastern Mediterranean  
Cairo  
Egypt

### **Dr Jaouad Mahjour**

Director  
Control of Communicable Diseases (DCD)  
WHO Regional Office for  
the Eastern Mediterranean  
Cairo  
Egypt

## SOUTH-EAST ASIA REGION

### **Dr Firdosi Mehta**

Medical Officer  
The Office of the WHO Representative  
Jakarta  
Indonesia

### **Dr Aayid Munim**

Medical Officer  
The Office of the WHO Representative  
Khartoum  
Sudan

### **Dr Akihiro Seita**

Regional Adviser, TB  
WHO Regional Office for  
the Eastern Mediterranean  
Cairo  
Egypt

### **Dr Ghada Mohjazi**

Technical Officer  
The Office of the WHO  
Representative  
Damascus  
Syrian Arab Republic

### **Dr Keiko Inaba**

Medical Officer for TB Control  
The Office of the WHO  
Representative  
Khartoum  
Sudan

### **Dr Bashir Suleiman**

National Focal Point for TB  
WHO Liaison Office for Somalia  
in Nairobi  
Nairobi  
Kenya

### **Dr Shafiullah Talukder**

WHO Consultant  
The Office of the  
WHO Representative  
Dhaka  
Bangladesh

**WHO HEADQUARTERS**

**Dr Léopold Joseph Blanc**  
Coordinator, TBS

**Ms Karin Bergström**  
Scientist, STB/TBS

**Dr Mr Thomas Glenn**  
Journalist, STB

**Dr Berthollet Bwira Kaboru**  
Medical Officer, STB/TBS

**Dr Knut Lönnroth**  
Medical Officer, STB/TBS

**Ms Eva Nathanson**  
Technical Officer, STB/THD

**Dr Salah-Eddine Ottmani**  
Medical Officer, STB/TBS

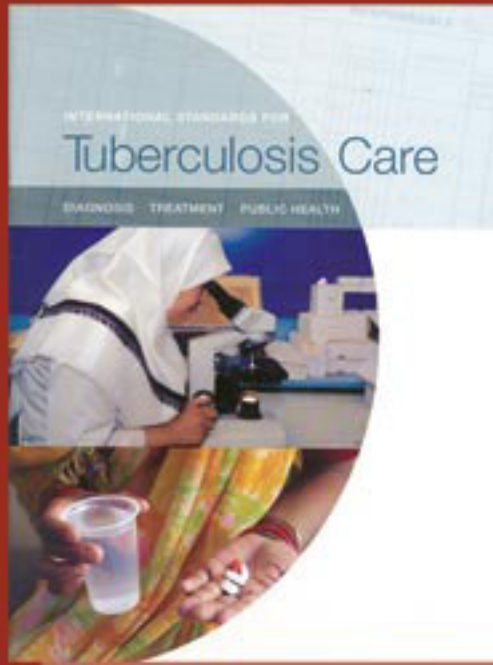
**Dr Mukund Uplekar**  
Medical Officer, STB/TBS

**Mrs Lana Velebit**  
Technical Officer, STB/TBS

**Ms Hannah Monica Yesudian**  
Technical Officer, STB/TBS

**Dr Matteo Zignol**  
Medical Officer, STB/THD

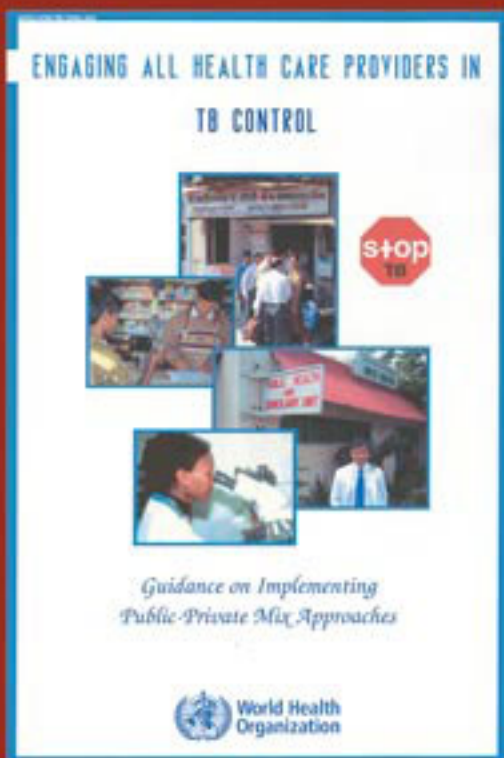
# Four useful tools for PPM planning, implementation and advocacy



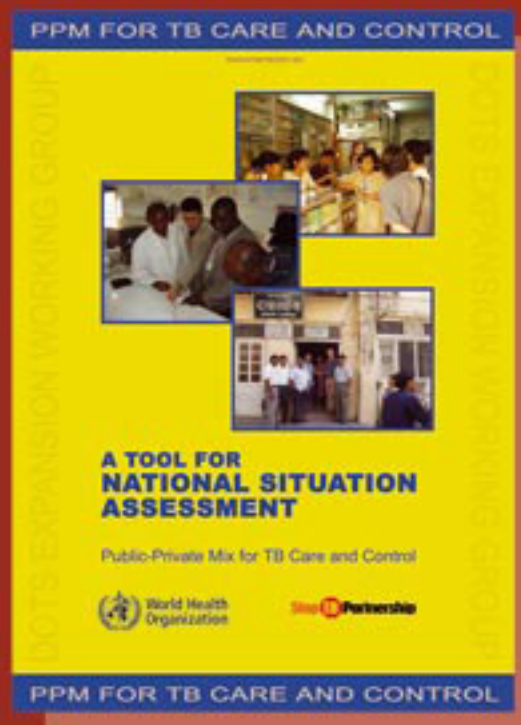
*"The International Standards for TB Care"*



*"The PPM Advocacy Brochure"*



*"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](http://www.who.int/tb/careproviders/ppm)

For further information, please contact  
Stop TB Department  
World Health Organization  
20 Avenue Appia • CH-1211 Geneva 27 • Switzerland  
Telephone +41 22 791 2111 • Facsimile +41 22 791 4199

Stop TB department website  
[www.who.int/tb](http://www.who.int/tb)