Report of the Meeting of the DOTS Expansion Working Group

Engaging Professional Associations in TB Control

15 October, 2008
Palais des Congrès, Paris, France
Engaging professional associations in TB control

Report of the ninth annual meeting of the DOTS Expansion Working Group

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Acknowledgements

The DOTS Expansion Working Group (DEWG) Secretariat would like to acknowledge all those who have contributed to the DEWG meeting 2008. In particular, we would like to thank Dr Chakaya, Chair DEWG; the various presenters who shared their experiences in engaging all care providers in TB control and the role of professional associations; the NTP Managers of the 22 TB High Burden Countries, professional association representatives, the patient and community representatives, and other members of the DEWG who actively contributed to the group work and discussions on the way forward.

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The meeting was financially supported by the Stop TB Partnership and the Global Health Bureau, Office of Health, Infectious Disease and Nutrition (HIDN), US Agency for International Development through TB CAP.

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Dedication

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

We shall all miss him immensely.
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<th>Description</th>
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<tr>
<td>ATS</td>
<td>American Thoracic Society</td>
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<tr>
<td>DEWG</td>
<td>DOTS Expansion Working Group</td>
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<tr>
<td>DOTS</td>
<td>the basic package that underpins the Stop TB Strategy</td>
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<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>HIV/AIDS</td>
<td>human immunodeficiency virus/acquired immunodeficiency syndrome</td>
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<td>IMA</td>
<td>Indian Medical Association</td>
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<td>IMPACT</td>
<td>Indian Medical Professional Associations Coalition against TB</td>
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<td>ISR</td>
<td>Indonesian Society of Respirology</td>
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<tr>
<td>ISTC</td>
<td>International Standards of Tuberculosis Care</td>
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<td>KAPTLD</td>
<td>Kenya Association against TB and Lung diseases</td>
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<td>KNCV</td>
<td>Royal Netherlands TB Association</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MDR-TB</td>
<td>multidrug-resistant tuberculosis</td>
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<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
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<tr>
<td>NTP</td>
<td>national tuberculosis control programme, or equivalent</td>
</tr>
<tr>
<td>PCTC</td>
<td>Patient Charter for Tuberculosis Care</td>
</tr>
<tr>
<td>PP</td>
<td>private provider</td>
</tr>
<tr>
<td>PPM</td>
<td>public–private mix</td>
</tr>
<tr>
<td>PPM Subgroup</td>
<td>Subgroup on Public–Private Mix for TB Care and Control</td>
</tr>
<tr>
<td>RNTCP</td>
<td>Revised National TB Control Program (India)</td>
</tr>
<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>TBCAP</td>
<td>Tuberculosis Control Assistance Programme</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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</table>
1. Introduction

The Stop TB Partnership has seven Working groups that all function in synergy. Members of the DOTS Expansion Working Group (DEWG) include representatives of the 22 countries with the highest burden of TB (HBCs), national TB control programmes (NTPs), technical and donor agencies, experts, and patient and community representatives. The four DEWG subgroups address: public-private mix (PPM); advocacy, communication and social mobilization (ACSM); childhood TB; and TB and poverty (Fig. 1).

The annual meetings of the DEWG are organized in conjunction with the annual conference of the Union to review progress in the HBCs and focus on key issues of importance to global TB control. Its meeting in 2008 focussed on sensitizing and mobilizing leaders of health professional associations to contribute to TB control in collaboration with NTPs.

The Stop TB Strategy of the World Health Organization (WHO) envisages the engagement of all care providers, through public-public and PPM approaches, using the International Standards of Tuberculosis Care (ISTC) as a tool. While countries have made considerable progress in initiating and scaling up PPM approaches, systematic efforts to engage health professional associations have yet to be undertaken. In several countries professional associations are effective conduits to reach and influence their members’ practices. The launch of ISTC in 2006 was followed by the initiation of pilot initiatives to promote their use through professional associations in selected countries (including India, Indonesia, Kenya, Mexico and the United Republic of Tanzania). The enthusiastic response to these initiatives by NTPs and professional associations prompted the DEWG to use "engaging professional associations in TB control" as the theme for its ninth annual meeting.

For the first time in the history of global TB control, TB programme managers and representatives of professional associations from the HBCs shared a common platform and exchanged ideas for working together towards a common purpose: controlling TB globally.
2. Objectives

The objectives of the meeting were as follows:

1. To sensitize leaders of professional associations on TB control, the WHO Stop TB Strategy and the ISTC.
2. To share experiences on engaging professional associations in TB control in diverse country settings.
3. To provide a platform for exchanging ideas among NTP managers and leaders of professional associations for the implementation of the ISTC.
4. To discuss ways to enable professional associations to contribute to national and global efforts to control TB.

The meeting was structured around five themes: (i) types of health professionals associations and examples of their involvement in TB control in various settings; (ii) strengthening health professional associations to facilitate their contribution to TB control; (iii) ways of supporting health professional associations by NTPs; (iv) promoting the Patients' Charter for Tuberculosis Care (PCTC); (v) working together to rationalize the use of anti-TB medicines. A concluding plenary session was held to allow general discussion and examine next steps.
3. Summary of presentations and discussions

3.1. Session 1: Opening session

The chair of the DEWG introduced the meeting by welcoming the participants and explaining the organization of the Working Group. The WHO Stop TB Department summarized the current status of TB control, the progress achieved to date and the challenges that lay ahead.

The TB-related targets of the United Nations Millennium Development Goals and those of the Stop TB Partnership call for progress beyond the 70/85 target set for 2005. Of the estimated global annual incidence of 9.15 million TB cases, only 5.27 million have been notified by countries in 2007. About 3-5.6 million TB cases (40%) were not accounted for.

This gap demonstrates that despite activities to expand DOTS, a substantial proportion of TB cases are either not detected, or not notified to DOTS programmes. The provisional case detection rate for 2007 is 62%, although it varies greatly among countries and regions (for example, 46% of cases were detected in the African Region compared with 77% in Western Pacific Region). During 1995-2006, there has been an increase in the rate of TB case notifications that peaked between 2003 and 2006. After 2006, this rate appeared to stagnate. Clearly, proven approaches need to be scaled up, such as, for example, PPM and new approaches identified, such as, for example, active case finding among vulnerable populations.

The treatment success rate of 85% has been achieved largely as a result of efforts in populous countries such as China and India. In other countries, this rate continues to be low.

Globally, and in most regions, the estimated rates of TB prevalence and mortality are declining, but not quickly enough to enable reaching TB related targets of the Millenium Development Goals. The overall global trend in TB incidence is declining very slowly. However, the absolute numbers of incident TB cases are expanding apace with population growth.

Building on the Stop TB Strategy, there is an urgent need to accelerate efforts in early case detection and to deliver high-quality care. A conceptual framework was presented for improved and early case detection, which schematizes the processes from TB infection to notification and addresses delays and other health systems obstacles. The framework situates the role of the components of the Stop TB Strategy in context and calls for innovative thinking as to how active and early case detection might be promoted (Figure 2).
Examples from Indonesia (Yogyakarta) and India (Mumbai and Bangalore) were cited to demonstrate that linking different providers to the NTP can generate increases in case notifications. However, globally much work remains to be done to fully scale up PPM activities; which in most countries have remained as pilot initiatives or small- to medium-sized projects. PPM activities have been scaled up fully in only a few countries. Providers in several countries are not yet linked to the NTP.

The American Thoracic Society (ATS) presented the ISTC and the role of professional associations. The meeting was recognized as a unique opportunity for bringing together NTPs and national professional associations and as an initiative to reconcile some of the differences in practices between the public and private sectors. The ISTC was discussed as an important tool for forging partnerships between the public and private sectors. The process of developing the ISTC was described, highlighting the importance of public-private partnerships in their development. Using the ISTC, collaborations between NTPs and professional associations have great potential to contribute to better care of TB patients. As part of efforts to engage all health care providers, such collaboration would enable diverse providers to use uniform standards for diagnosis, treatment and supervision of TB patients. The promotion of ISTC led by professional associations has been pilot tested in five countries: Kenya, India, Indonesia, Mexico and Tanzania. These country experiences have been documented in a handbook. The ISTC document has been translated into 10 languages.

Professional associations can assist the NTP in many ways, by:

- serving as conduits to their private
sector members for dissemination of information (such as the ISTC);
- boosting credibility to NTPs;
- providing technical assistance to NTPs in relevant areas;
- conducting training activities;
- exerting peer pressure;
- advocating for appropriate resources and policies.

The ISTC are a tool to catalyse interactions between NTPs and professional associations in the following ways, including:
- uniting public and private sectors in providing a uniformly accepted level of care for all patients with, or suspected of having, TB by describing the essential elements of TB care that should be available universally;
- providing a focus for mobilizing professional associations globally in support of NTPs;
- serving as a powerful advocacy tool to ensure that its essential elements are available;
- presenting a core for medical and nursing school curricula and for continuing medical education;
- guiding policy makers and donors.

In order to mobilize professional associations to foster effective collaboration with NTPs and the private sector, the ATS and partners plan to develop a professional society network, provide technical assistance for work plan development, and mobilize resources for effective collaborations with NTPs.

Patients should be at the centre of all TB control activities. Issues related to their involvement, individually and through associations, were widely discussed. Patients’ representatives from various countries including South Africa, the Democratic Republic of Congo, India, Ecuador stressed the importance of promoting the PCTC, which encompasses the rights and responsibilities of patients. Developed through a participatory, consultative process, the PCTC is a rights-based tool that allows providers and NTPs to respond to patients, and for NTPs to understand their responsibilities with respect to TB care. It is thus essential that the ISTC and PCTC go hand in hand in promoting high quality, comprehensive TB care. The PCTC is an integral part of the Stop TB Strategy (under the component of empowering communities and people with TB). The need of first translating the PCTC document and then using it by care providers was discussed. A handbook is being developed for such use, adopting a participatory approach and will be placed on a website (www.patientcharter.org).

3.2. Session 2 Sharing of country experiences

Representatives from Cambodia, India, Indonesia, Kenya and Mexico presented their country experiences.

India

The private sector in India is huge. It is estimated that 75% of TB patients first seek
care in this sector. The Indian Medical Association (IMA) has a well organized structure with a presence across almost all states and districts of India. It has about 170,000 members. The IMA is contracted by the Revised National TB Control Program (RNTCP) to provide training on DOTS to private physicians. Based on pilot experiences in the state of Kerala, the IMA is scaling up this project in six other states, supported by the RNTCP through a grant from the Global Fund to fight AIDS, Tuberculosis and Malaria. The training is tailored to accommodate the specific needs and limited availability of private physicians. Further, the IMA may provide a sustainable institutional mechanism for systematic PPM activities targeting medical practitioners.

Key characteristics of the IMA’s approach include:

- viewing private providers primarily and essentially as professionals, not as money seeking private providers.
- using non-financial incentives, such as certification, accreditation and professional development as strong motivating factors, which are considered to be more important than the small financial compensation provided by the schemes developed by the RNTCP

- one-to-one peer sensitization has proven more effective than group sensitization but is resource intensive.
- the ISTC are used as a tool for imparting knowledge and defining the quality of TB care. Practitioners wanting to provide services consistent with the ISTC are then trained and linked to the RNTCP.

Facilitated by the Central TB Division of the Ministry of Health and Family Welfare and the WHO Country Office, the IMA collaborated with other professional associations with relevance to TB control. This resulted in the formation of the Indian Medical Professional Associations Coalition against TB, a network of professional associations with a common aim of controlling TB.

Only about 1% of the profession is currently involved in the national programme. Increasing this involvement to 10% will have a significant impact – and this is the initial target of the IMA. In addition to sensitization and training activities, the journal of the IMA (JIMA) publishes important articles on national TB control. In 2008 alone, the IMA reached out to
55 000 practitioners, sensitized more than 15 000 practitioners, and started over 130 DOT centres and four RNTCP-designated microscopy centres.

The challenges of collaboration include:
- the slow and complicated process of converting private clinics into DOT centres;
- transportation of sputum samples;
- supervision and quality assurance by the RNTCP;
- referral and feedback mechanisms;
- consensus on treatment regimens;
- public health responsibilities of private physicians concerning notification of cases and use of second-line anti-TB medicines.

**Indonesia**

TB care is currently standardized in Indonesia within the public health sector network. In the private sector, substandard care for TB is common. Sputum smear testing is underutilized in hospitals and private practice, with many physicians using other tests (serology test, PCR, X-ray, etc.). Treatment regimens vary considerably in private practice. The need for a tool to bridge the NTP with professional associations, private sector and hospitals is urgent.

The process of promoting the ISTC in Indonesia started in 2005 and was led by chest specialists and the Indonesian Society of Respirology. The ISTC were introduced through key opinion leaders and the scientific committees of professional associations and endorsed in 2006 by the Indonesian Society of Respirology and the Indonesian Medical Association. There are ISTC task forces within the professional associations. Two-day workshops organized in provinces to further familiarize professionals with the ISTC include topics on epidemiology of TB, standards of diagnosis and treatment, public health responsibilities, multidrug-resistant TB (MDR-TB), TB/HIV and role of chest X-ray.

Sensitization to the ISTC is followed by several activities for endorsement. An abridged version has been published in the local language and disseminated to 25 provinces. The ISTC are further disseminated at annual meetings and sessions on continuing medical education and in journal articles. The ATS has provided technical support to the initiative, and WHO and KNCV have facilitated many activities.

A baseline study conducted in 2007–2008 will enable future evaluation of the impact of the ISTC.

Lessons learnt from Indonesia indicate that:
- involving key opinion leaders is very important,
- promoting the ISTC is easy because of their evidence base and clinical orientation;
- the ISTC can be a bridge between the NTP and professionals;
- the NTP can outsource socialization and roll out of the ISTC to professional associations.
Kenya

Kenya faces an HIV-associated TB epidemic with a very high burden of TB. 51% of TB services are provided by the public sector. The PPM initiative in Kenya has so far targeted private hospital association and private medical providers (at least MBChB). There are plans to involve other non-medical cadres such as clinical officers, nurses, pharmacists as well as informal providers, including drug shops and traditional healers, through the use of DOTS representatives.

The Kenya Association for the Prevention of TB and Lung Disease (KAPTLD) is leading the initiative in the five largest urban settings, with a total of 88 DOTS centres. Nairobi, the most important site with a large private medical sector, is where one fifth of TB cases occur and where most of these private providers are operational. A substantial number of unqualified private providers have yet to be engaged.

Anti-TB medicines are widely available on the market in Kenya. The need for engaging the private sector, using the ISTC, will contribute to:

- standardized TB management practices in the private sector;
- affordable and quality-assured anti-TB medicines in the private sector;
- accelerated DOTS implementation to achieve WHO-recommended TB control targets;
- matching available resources to TB control needs (against the background of an increasing urban TB disease burden with a vibrant health sector in the cities).

Since 1997, the process of involving the private sector has been "outsourced" to KAPTLD through an agreement with the NTP. KAPTLD has been implementing the initiative in collaboration with other medical professional associations (such as the Kenya Medical Association and the Kenya Association of Private Hospitals), with private physicians as the initial target group.

The collaboration began in 1999, with the NTP providing medicines to treat about 1500 patients in the private sector. The formal consensus meeting and adoption of the ISTC took place only in 2007. Efforts to involve training institutions in integration of the ISTC into curricula have been under way since 2008. The strategy for disseminating the ISTC in Kenya has since evolved gradually. The pictures in the original document have been replaced by local Kenyan pictures. Each month, one standard is printed and distributed to collaborating physicians in the form of a monthly newsletter, enabling its easy
familiarization and in-depth knowledge. The PCTC is disseminated to all patients attended to by private physicians via patients’ packs supplied to the private sector, which are collected at registration. In future, it is planned to use the ISTC to accredit health facilities.

Mexico

National guidelines on TB control in Mexico have been available since 1993 and are revised every fifth year, but they are not followed by many providers. An assessment of the nature (quantity and quality) of care provided within the private sector found that there was lack of operational research on the issue, and no data were available on treatment outcomes of patients and the cost of services for TB patients. Linkages between official and private services were found to be weak, and an effective reporting system from private health services was absent. Mexico has been a pilot country for the ISTC. A public-private alliance is now under way that builds on a clear task allocation scheme. Political commitment for this initiative is noticeable. Other opportunities include agreements with the national associations of schools of medicine and nursing, pharmacies, private hospitals; with the National University (UNAM) and with two chains of national private laboratories. There is also large potential to involve traditional indigenous healers in Mexico.

The Mexican Standards for TB care, inspired by the ISTC, have been adopted by the Ministry of Health. An instrument to measure the level of involvement of public–private health providers in Mexico has been developed. The PCTC has been made available and is being disseminated. Next steps include the dissemination of the Mexican Standards to all relevant government ministries. There is political will and it is a good opportunity.

Cambodia

Two-thirds of Cambodians with TB symptoms first seek care outside the public sector. In 2005, the PPM initiative began engaging the private sector in TB control. The PPM strategy and guidelines were developed. The Cambodian experience illustrates an interesting model of collaboration between the NTP and the association of pharmacists. Cambodia launched this initiative in 2005. The process involved the following steps:
- identifying and engaging the professional association (the Pharmacists Association of Cambodia);
- reviewing and revising national recording and reporting forms;
- developing standardized referral tools;
- formulating IEC and training curricula;
- developing Memorandum of Understanding agreements.

During the three-years implementation period, pharmacists referred 9447 patients, of whom 4509 attended DOTS services and 844 were diagnosed with TB. This initiative enjoys strong support from the Pharmacists Association, which organizes many consensus building meetings, workshops and meetings on monitoring and evaluation. Referrals from pharmacies in PPM areas are yielding high
percentages of smear-positive TB cases from those being evaluated. This result suggests that pharmacies are an excellent location for identification of undiagnosed cases.

The PPM plan is divided into two phases. The first phase is confined to promoting referrals from private providers. The second phase, wherein the private providers will diagnose and treat, has not yet started. Currently, 11 of 38 districts offer PPM-DOTS.

One key challenge is that about half of referrals are not reaching DOTS diagnostic centres.

**General discussion**

There was general agreement that associations of health professionals offer great potential in contributing to national and global TB control. During the discussions, it was noted that very little experience was available globally on involving associations other than those of medical doctors and pharmacists. The Bangladesh “village doctors” initiative was cited as a working example of involving informal providers in TB control.

Discussions also focused on how to involve nurses associations. The international nurses association volunteered to offer to link up with national nurses associations. In relation to discussions on incentives and fees, it was noted that in India the private practitioner is allowed to charge a consultation fee, but sputum AFB and treatment are provided free of charge to patients.
4. Concluding remarks

In his concluding remarks, the Executive Secretary of the Stop TB Partnership highlighted the need for the effective involvement of all constituencies in TB control, including the professional associations. The Partnership and its board are very supportive of the initiative to involve professional associations. TB control is not only a public sector business or responsibility, but also a collective one. There is a need for a movement against TB, and the people affected by the disease are central to this work. More work is required to fully engage the professional associations, using the ISTC, PSTC and other tools.

The Director of the WHO Stop TB Department highlighted the uniqueness of this initiative, which probably marked a first for any global disease control programme. Involving professional associations in TB control is timely and unprecedented. Achieving the TB-related Millennium Development Goals should be possible if all health-care providers were to abide by the ISTC. In addition to the medical professional associations, associations of nurses and informal providers such as traditional healers need to be engaged.
5. Next steps: supporting professional associations for work plan development

The ATS informed the participants that there is some funding available to support professional associations in developing workplans for collaboration with NTPs. Applicants should be from professional associations. The instructions for proposal development were summarized. The application should specify how the activities will be linked to other longer term plans, and whether any technical assistance will be needed. The budget should not exceed US$10,000 and a deadline for submission of proposals was set.
Annex 1: Summary of Group work

Five work groups were set up to work more in-depth on specific issues. The discussions in break-out groups focused on:

1) Types of health professionals associations, and the examples of their involvement in TB control in different settings

2) Strengthening health professional associations to enable them to contribute to TB control

3) Ways in which NTPs can support health professional associations

4) Promoting the Patient Charter for TB Care

5) Working together to rationalize the use of anti-TB drugs
Group 1. Types of health professionals associations

The group identified the following types of professionals associations as relevant to TB control.

<table>
<thead>
<tr>
<th>Medical</th>
<th>Paramedics / Alternative systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical</td>
<td>• Nurses</td>
</tr>
<tr>
<td>• Paediatricians</td>
<td>• Laboratory Technicians</td>
</tr>
<tr>
<td>• Pulmonologists</td>
<td>• Pharmacists</td>
</tr>
<tr>
<td>• Microbiologists</td>
<td>• Traditional Healers</td>
</tr>
<tr>
<td>• Public Health</td>
<td>• Village doctors</td>
</tr>
<tr>
<td>• Radiologists</td>
<td>• Alternative medicine practitioners</td>
</tr>
<tr>
<td>• FBO associations</td>
<td>• Homeopathy</td>
</tr>
<tr>
<td>• Hospital associations</td>
<td>• Social workers</td>
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</tbody>
</table>

As to whether, how, and where these associations are involved in TB care and control, the group provided an overview of diverse associations currently collaborating with NTPs in different settings. For instance, in Japan, TB related information is given to doctors by NTP through professionals’ association. China Medical Association develops guidelines to complement NTP guidelines and undertakes training jointly with NTP. In Ethiopia, physicians and paediatricians have contributed to development of guidelines. In D R Congo, the NTP has working groups which involve association representatives – medical, nurses, laboratories etc. working on issues like national treatment guidelines development. In The Netherlands, chest physicians association contributes to national TB policy development and disseminates the information to the association members. Similarly, in Australia, chest specialists association contributes to policy development and information dissemination. There is a limited role for generalists as well. Associations of informal providers are particularly active in Burkina Faso, South Africa (traditional healers) and Bangladesh (village doctors).
Group 2. Strengthening health professional associations to enable them to contribute to TB control

The group reported having extensive discussions on the aspects below:

- Facilitating transition of professional associations from clinical and academic dimensions to incorporating public health aspects in the associations work.
- Starting point: Identify possible role the professional associations can have
- Series of steps:
  - Situation analysis, identify problems
  - Think how to work together – develop interests within associations : ISTC
  - Develop objectives of collaboration
  - Process: TOR, MOU

- Need to have structure within NTP and medical associations to oversee the functions
- Unresolved issues:
  - What could be done in countries where no strong professional association exists? Should NTP initiate the collaboration?
  - What could be the approaches in countries where many associations exists – India: IMA has formed a coalition of associations for the purpose of TB control
  - Sensitivities between MOH and national medical associations
  - Lower income versus higher responsibilities with NTP collaboration

<table>
<thead>
<tr>
<th>Activities to strengthen health professional associations</th>
<th>What do the professional associations need to do for this?</th>
<th>Support, if any, required from outside?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis, situation analysis</td>
<td>Establish Task Force among different type of association; specialist – private provider – medical school</td>
<td>NTP to be the interface to initiate dialogue and provide technical and financial support; identify focal person; adapt specific tool development</td>
</tr>
<tr>
<td>Technical support in proposal writing and project design</td>
<td>Develop capacity within the professional organization</td>
<td>Training and support</td>
</tr>
<tr>
<td>Strengthen collaboration between public, private and patient initiated by NTP</td>
<td>Support patient groups to make them credible and capable partners</td>
<td>Facilitation</td>
</tr>
<tr>
<td>Networking among different associations - different disciplines</td>
<td>Sharing of interest and outcomes; an umbrella association to coordinate</td>
<td>Facilitation</td>
</tr>
<tr>
<td>Leveraging other groups such as Rotary, Red Cross</td>
<td>Enlarging the interest by the association</td>
<td></td>
</tr>
<tr>
<td>M&amp;E, impact measurement</td>
<td>Collaboration, commitment</td>
<td>Education and exposure to national M &amp; E systems</td>
</tr>
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</table>
Group 3: NTP support to health professional associations

The group reported having shared country experiences. Apparently, there is a large body of information available and that commonalities do exist among countries. It was also recognized that the NTP can play facilitative and leading role. The ISTC was seen as a key instrument in the whole process. The steps to be considered in this process are as in the table below:

<table>
<thead>
<tr>
<th>Steps</th>
<th>Human resources required</th>
<th>Possible source(s) of financial support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Needs assessment/ Situation analysis</td>
<td>NTP may consider</td>
<td>Local- Government, International- Donors; GFATM, USAID, TBCAP, JICA, CIDA Coordination</td>
</tr>
<tr>
<td>▪ Background situation</td>
<td></td>
<td></td>
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<tr>
<td>▪ Practices</td>
<td></td>
<td></td>
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<tr>
<td>▪ Use of available information/studies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Needs</td>
<td></td>
<td></td>
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<tr>
<td>2. Identification and Mapping</td>
<td>NTP may consider</td>
<td>Local- Government International- Donor; GFATM, USAID, TBCAP, JICA, CIDA</td>
</tr>
<tr>
<td>▪ Listing of organizations/ Associations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Strengthens and Weaknesses</td>
<td></td>
<td></td>
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<tr>
<td>▪ Identification of champions</td>
<td></td>
<td></td>
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<tr>
<td>▪ Context analysis</td>
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<tr>
<td>3. Steering Committee TOR</td>
<td>NTP may consider</td>
<td>Local- Government International- Donor; GFATM, USAID, TBCAP, JICA, CIDA</td>
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<tr>
<td>▪ Further mapping</td>
<td></td>
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<tr>
<td>▪ Setting strategies and guidelines; Incentives, drugs, diagnostics</td>
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<tr>
<td>▪ Defining roles and responsibilities</td>
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<tr>
<td>▪ Advocacy and resource mobilization</td>
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<tr>
<td>4. Advocacy meetings</td>
<td>Steering committee</td>
<td>Local- Government International- Donor; GFATM, USAID, TBCAP, JICA, CIDA</td>
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<tr>
<td>▪ TA; International, In-country,</td>
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</table>
5. Engagement
- Adoption of ISTC
- Guidelines/ PPM template
- Training tools
- Pre-service training
  (Curriculum review)
- Issues of sustainability
- facilitation

NTP may consider
- Outsourcing depending on opportunities
- Partnership; Professional organizations, private sector and NGOs

Local- Government
International- Donor; GFATM, USAID, TBCAP, CIDA, JICA

As conclusion, the group stressed that there is no such a thing as global blueprint for involvement of professional associations. Partnership being the key, it should recognize the learning by doing approach. There is no quick fix.
Group 4: Promoting the Patient Charter for TB Care

A number of weaknesses associated with PCTC were cited, including:
- Lack of awareness at different levels – Govt., NTP, PAs and the community
- Inconsistent application
- No guideline for implementation
- Lack of resources for quality controlled translation (for those who are not literate)
- Need for high level political commitment to ensure resources for implementation

Steps to promote the Patient Charter for TB Care

<table>
<thead>
<tr>
<th>NTP activities to promote the Patient Charter for TB Care</th>
<th>Professional association activities to promote the Patient Charter for TB Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Officially Endorse, Promote and Implement</td>
<td>PCTC can be made one of the criteria for professional regulations in order to practice</td>
</tr>
<tr>
<td>2. Need to be included in National Advocacy Programmes</td>
<td>Make information available - Inform patients regarding free care and how to access it</td>
</tr>
<tr>
<td>3. Should be seen as a tool for engaging Civil society (website: <a href="http://www.patientscharter.org">www.patientscharter.org</a>)</td>
<td>Advocate for workers in Public sector and also for return to work when culture –</td>
</tr>
<tr>
<td>4. ISTC to be used along with PCTC</td>
<td>ISTC to be used along with PCTC</td>
</tr>
<tr>
<td>5. Mechanisms for feedback/complaints from patient community</td>
<td></td>
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<tr>
<td>6. All trainings should include PCTC along with ISTC</td>
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</tr>
<tr>
<td>7. Annual NTP action plans to include PCTC and ISTC</td>
<td>Mission statements to include PCTC and ISTC</td>
</tr>
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</table>

In conclusion:
- The PCTC reflects good clinical practice and is the ideal, though this not been the case in most countries where it is not being endorsed and implemented.
- Efforts need to be made towards empowering communities to become fully engaged
- All NTP and professional associations need to make use of available resources e.g. GF, UNITAID etc.
- Involvement of Patient organizations along with PAs should be promoted.
**Group 5: Working together to rationalize the use of Anti-TB drugs**

The group made the following observations on which an intensive discussion was held:

- **Great variation in country scenarios:**
  - **One extreme:** NTP monopoly, TB drugs not available in private market, no domestic market
  - **Other extreme:** TB drugs freely available in private pharmacies with or without prescription
  - **Lack of data on magnitude, quality of prescription, quality of drugs, treatment outcomes of patients in the private sector and adverse drug reactions (ADR)**
  - **Any effort to improve rational use of drugs requires involvement beyond NTP, of the wider health systems and regulatory authorities.**
  - The group mapped the potential role of professional association along the steps of rational use of drugs: quality prescription – drug quality – quality of dispensing – quality supervision, recording and reporting (including ADR) as in the following table:

<table>
<thead>
<tr>
<th>Intervention area</th>
<th>What association</th>
<th>What action</th>
</tr>
</thead>
</table>
| Information, education, and quality of prescriptions | Medical, Pharmacy, Nurses, Paramedics, Pharmaceutical industry | - Undergraduate training  
- CME  
- Publications  
- Involved in reviews  
- Involved in programme planning  
- Restricting prescription rights to special groups |
| Quality of drugs | Pharmaceutical industry | - GMP  
- Involvement in regulation and policy |
| Quality of dispensing | Pharmacy, Medical | - Accreditation of pharmacies - correct staff with correct qualification  
- Promote dispensing only correct prescription, in full  
- Restrict dispensing to only certain pharmacies |
| Monitoring of treatment: Treatment outcomes and adverse drug reactions | Medical, Pharmacy | - Standard supervision, recording and reporting  
- ADR reporting / pharmacovigilance |

The group recognized the need for country and region-specific approaches and for better data on current situation. Also, the importance of mapping and involving wider range of professional associations and other stakeholders outside NTP to improve rational
use of drugs was highlighted. These stakeholders’ involvement in development of NTP plans, including MDR-TB national plans should be encouraged. The forthcoming MDR-TB high priority countries provides an excellent opportunity to kick-start this process.
Annex 2 : Agenda

Opening Session

Chair: Dr J.M. Chakaya, Chair of the DOTS Expansion Working Group and Vice Chair of the Stop TB Partnership Coordinating Board

09:00 - 09:15 Opening of meeting & review of objectives

This introductory presentation will provide context on the purpose of the meeting. Discussion will also include some history of the Stop TB Partnership, the DOTS Expansion Working Group and outline the need for professional associations and national TB programmes to collaborate their efforts.

Dr Leopold Blanc, Coordinator, Tuberculosis Strategy and Health Systems, Stop TB Department, World Health Organization

09:15 - 09:30 Global TB control: progress and challenges

This presentation will provide a broad overview of the current status of TB control in the world and the way forward.

Dr Phil Hopewell, Professor of medicine at the University of California, San Francisco (UCSF)

09:30 - 09:45 Engaging all care providers in TB control: ISTC and role of professional associations

This presentation will examine the progress made in engaging all care providers in TB control, the beginnings and purpose of the International Standards for TB care and how health professional associations can utilize the ISTC to motivate and train their members.

Mr Case Gordon, President, World Care Council

09:45 - 10:00 Patient Charter for TB Care

This presentation provides an overview of the Patient Charter for TB care and how it can be utilized.

10:00 - 10:30 Panel Discussion

10:30 - 11:00 Coffee Break

Sharing of Country Experiences

Chair: Dr ID Rusen, Director, Tuberculosis Control and Prevention Department, International Union Against Tuberculosis and Lung Disease.

11:00 -12:15 Sharing of Experiences
Presentations in this session will share country experiences of collaboration between national TB programmes and professional associations, especially using the ISTC.

**Dr RV Asokan**, National Coordinator for TB, Indian Medical Association  
*The Indian Experience*

**Dr Erlina Burhan**, Representative, Indonesian Respiratory Association  
*The Indonesian Experience*

**Dr Joseph Sitienei**, Director, National Leprosy and Tuberculosis Programme, Kenya  
*The Kenyan Experience*

**Dr Martin Castellanos**, Director, National TB programme, Mexico  
*The Mexican Experience*

**Dr Mao Tan Eang**, Director of the National Centre for Tuberculosis and Leprosy Control (CENAT) Cambodia  
*The Cambodian Experience*

12:15 - 12:30  Panel Discussion  
12:30 - 14:00  Lunch Break

**Group Work and Conclusion**

**Chair:** Dr Phil Hopewell  
14:00 - 16:00  Group Work  
16:00 - 17:00  Plenary
Rapporteurs from each group will present the outcome of their discussion on specific topics. The groups will then take questions from the audience with guidance from the Chair.

**17:00 - 17:30  Conclusion**

Dr Marcos Espinal and Dr Mario Raviglione will share their observations at the conclusion of the meeting.

**Dr Marcos Espinal**, Executive Secretary of the Stop TB Partnership

**Dr Mario Raviglione**, Director, Stop TB Department, World Health Organization

**Dr Hiroki Nakatani**, Assistant Director-General, HIV/AIDS, Tuberculosis, Malaria and Neglected Tropical Diseases Cluster, World Health Organization.

**17:30 - 18:30  Briefing on the planned Ministerial Meeting on MDR-TB in Beijing, 2009**

Dr Hiroki Nakatani will introduce the planned Ministerial Meeting on MDR-TB in Beijing followed by a detailed briefing by Dr Mario Raviglione and Dr Paul Nunn - who coordinates WHO's work on TB/HIV and drug resistance.
Annex 3 : List of Participants

**Australia**
Mr Mark Hurwitz  
Director Thoracic Medicine  
Clinical Director-Medicine  
The Canberra Hospital

**Bangladesh**
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PPM Focal Point in NTP and  
Directorate General of Health Services

Professor Syed Akram Hussain  
Public Relation Secretary  
Bangladesh Medical Association (BMA)

Dr Asif Mujtaba Mahmud  
Associate Professor, Department of  
Respiratory Medicine, National Institute of  
Chest Disease and Hospital (NIDCH)

Dr Abdul Awal Miah  
National TB Programme Manager  
TB and Leprosy Control Programme

Dr Mahfuza Rifat  
Programme Specialist TB, BRAC

Dr Mohammad Abdul Hamid Salim  
Country Director  
Damien Foundation

**Cambodia**
Dr Mao Tan Eang  
National TB Programme Manager, Director,  
National Centre for TB and Leprosy Control

Dr Tim Bak Khim  
PPM Focal Point in NTP

Professor Sea Huong  
President, Cambodian Medical Association,  
Director of Preah Ang Dong Hospital

Mr Yim Yann  
President, Pharmacists Association of  
Cambodia (PAC)

**Cameroon**
Professor Pierre Effa  
Head, Société Camerounaise de  
Bioéthique (CBS) and Centre d’Etude et  
de Recherche en santé publique et en  
Bioéthique (CERB)

**Brazil**
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Programme Manager, TB and Leprosy Control Programme

Ms Cristina Boaretto  
PPM Focal point in NTP

Dr Antonio Carlos Moreira Lemos  
President, Pneumology and Tisiology Society Brazil

Dr Mahfuza Rifat  
Programme Specialist TB, BRAC

Mr Dzutué Alain Patric Ledoux  
(Mr Fogué Foguito)  
Community Representative
**China**  
Dr Daniel Chin  
Senior Program Officer, Tuberculosis  
Bill & Melinda Gates Foundation  

Dr Xiao Donglou  
Director-General, Department of Disease Control, Ministry of Health

Dr Li Liang  
Secretary, TB Department, Chinese Medical Association Beijing Chest Disease Hospital

Dr Wang Lixia  
Director, Chinese Centre for TB Control and Prevention, Centre for Disease Control & Prevention, Ministry of Health

Dr Wang Wenjie  
Director, Division of TB Prevention, Department of Disease Prevention and Control, Ministry of Health

**Ethiopia**  
Dr Abate Bane  
Vice-President, Ethiopian Medical Association & Chair of Internal Medicine

Mr Bekele Chaka  
National TB Programme Manager, Ministry of Health

Mrs Genet Derese  
PPM focal point in NTP

Dr Zelalem Gizaw  
Representative, Bethzatha Health Service PLC

**Democratic Republic of Congo**  
Dr Mbutuku Mbambili Lepili Antoine  
Président, Conseil National de l’Ordre des Médecins (CNOM)

Dr André Okumu Ndongosieme  
National TB Programme Manager, Ministry of Health

**France**  
Mr Case Gordon  
World Care Council

Dr Ira David Rusen  
Director, Department of TB Control & Prevention, International Union Against TB and Lung Diseases (IUATLD)

**India**  
Dr R.V. Asokan  
Indian Medical Association  
RNTCP National Coordinator

Dr Lakhbir Singh Chauhan  
National TB Programme Manager, Deputy Director-General of Health Services, Ministry of Health

Dr Surinder Kumar Jindal

Dr Jean Pierre Malembe  
PPM focal point in NTP
DOTS Expansion Working Group Meeting

Professor & Head, Department of Pulmonary Medicine & Director, WHO Collaborating Centre for Tuberculosis and Lung Diseases, Fondazione Salvatore Maugeri, IRCCS

Ms Blessina Kumar
Community Representative

Professor Giovanni Sotgiu
Assistant Professor of Hygiene and Public Health, Biostatistics and Clinical Epidemiology

Dr Rajendra Prasad
Professor and Head, Department of Pulmonary Medicine

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Director, India Resource Centre International Union Against TB and Lung Disease

Dr Tatsuo Sugiyama
Vice Head, Department of International Cooperation Research Institute for TB (RIT) Japan Anti-Tuberculosis Association (JATA)

Mr R.S. Shukla
Joint Secretary Ministry of Health and Family Welfare

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Dr Erlina Burhan
Vice Secretary of Indonesian Respirology Association

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Dr Mukhtar Ikhsan
Directorate General CDC & EH Ministry of Health

Dr Tatsuo Sugiyama
Vice Head, Department of International Cooperation Research Institute for TB (RIT) Japan Anti-Tuberculosis Association (JATA)

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Dr Prisca Oyuga Akello
TB-patient activist World Care Council

Dr Jeremiah Chakaya
Chair, DEWG Technical Expert, National Leprosy and TB Control Programme

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Dr Giovanni Battista Migliori
Focal person ERS for TB

Dr Chris Mureithi
Chair, Kenya Association for the Prevention of Tuberculosis and Lung Disease (KAPTLD)

Dr Giovanni Battista Migliori
Focal person ERS for TB

Dr Dave Paul Muthama Paulo
PPM focal point in NTP

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NTP Manager, National Leprosy and TB Control  

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Kenya Medical Association  

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PPM focal point in NTP  

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Pneumologist, Associação Medica de Moçambique  

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National TB Programme Manager  
Ministry of Health  

**Mexico**  
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Director, National TB Program  
National Center of Epidemiological Surveillance and Disease Control  

Dr Miguel Ángel Salazar Lezama  
National Pneumologists Association  

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Professor Tin Aye  

Chair, Myanmar Medical Association  

Dr Win Maung  
National TB Control Programme Manager, Ministry of Health  

Professor U Nyunt Thein  
Head of Medicine, Myanmar Medical Association  

**Netherlands**  
Dr Maarten van Cleeff  
Project Director, TB CAP  

Dr Jaap Broekmans  
Consultant, KNCV Tuberculosis Foundation  

Dr Peter Gondrie  
Head, International Programme Support Unit, KNCV Tuberculosis Foundation  

Dr Rene L’Herminez  
Senior TB Consultant  
KNCV Tuberculosis Foundation  

**Nigeria**  
Dr Odume Bethrand  
PPM focal point in NTP  

Dr Lovett Lawson
Executive Director, Zankii Medical Centre

**Norway**

Dr Mette Margrethe Klouman
Norwegian Heart and Lung Patient Organisation (LHL)

**Philippines**

Dr Jamie Lagahid
Director III, National Center for Disease Prevention and Control
Department of Health

Ms Amelia Sarmiento
Executive Director of the Philippine Coalition Against Tuberculosis (PhilCAT)

Dr Rosalind Vianzon
National TB Control Programme Manager, Department of Health

Professor Charles Yu
President elect, Philippine College of Physicians

**Russian Federation**

Professor Vladislav Erokhin
Deputy of the Russian Association of Phthisiopulmonology

Professor Yulia Mikhailova
Director, Central Research Institute for Organization and Informatization in Public Health, MoHSD

Dr Elena Skachkova

Head, Center for TB Control Monitoring in the Russian Federation

**South Africa**

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Cluster Manager, TB Control and Management, Department of Health

Dr Yogan Pillay
PPM focal point in NTP National TB Control and Leprosy Programme, Department of Health

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TB-patient Activist
World Care Council

**Sweden**

Dr Davide Manissero
ECDC

**Switzerland**

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The Global Fund to Fight AIDS, Tuberculosis and Malaria

Dr Lasha Goguadze
Senior Health Officer, Tuberculosis Health & Care Department, International Federation of Red Cross/Red Crescent Societies (IFRC)

Mr Robert Matiru
Stop TB Partnership Secretariat
World Health Organization, Geneva
<table>
<thead>
<tr>
<th>Country</th>
<th>Name</th>
<th>Position/Role</th>
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<tr>
<td>Thailand</td>
<td>Dr Alasdair Reid</td>
<td>HIV/TB Adviser, Prevention, Care and Support Unit, Epidemic Monitoring and</td>
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<td>Policy Department, UNAIDS</td>
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<td></td>
<td>Mr Suksont Jittimanee</td>
<td>Chief of Strategy and Plan</td>
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<td>Bureau of Tuberculosis</td>
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<td></td>
<td>Dr Sripapa Nateniyom</td>
<td>Senior Expert on Preventive Medicine</td>
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<td>Department of Disease Control Ministry of Public Health</td>
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<td></td>
<td>Mr Phanchai Rattanasuwan</td>
<td>Senior Medical Officer on Preventive Medicine</td>
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<td>Regional Office of Disease Prevention and Control 11, Department of Disease</td>
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<td>Dr Daranee Wiriyakitjar</td>
<td>Representative, Anti-Tuberculosis Association of Thailand (ATAT)</td>
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<td>Uganda</td>
<td>Dr Harold Bisase</td>
<td>Focal Point for PPM DOTS and representing within the Uganda Stop TB Partnership</td>
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<td>United Kingdom</td>
<td>Dr Bertie Squire</td>
<td>Senior Lecturer, Manager, Equi-TB Knowledge Programme, Liverpool School of</td>
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<td>Tropical Medicine</td>
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<td>Ms Gini Williams</td>
<td>TB Project Manager, International Council of Nurses (ICN)</td>
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<td>Ms Amy Adelberger</td>
<td>Senior Program Officer, Tuberculosis, Bill &amp; Melinda Gates Foundation</td>
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<td>Ms Susan Bacheller</td>
<td>TB Team Leader, Global Health Bureau, Office of Health, Infectious Disease and</td>
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<td>Nutrition, US Agency for International Development</td>
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<td></td>
<td>Ms Lisa Caen</td>
<td>Division of Pulmonary &amp; Critical Care, San Francisco General Hospital</td>
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<td>Mr Riberto Colorado</td>
<td>WCC-LA, San Diego, CA</td>
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<td>Dr Russell Ernest</td>
<td>Journalist Scientific Medical Press</td>
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<td>Mr Jan Gheuens</td>
<td>Bill &amp; Melinda Gates Foundation</td>
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<td>Dr Phil Hopewell</td>
<td>Chair, PPM Subgroup</td>
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<td></td>
<td></td>
<td>Professor of Medicine</td>
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<td>Ms Maureen Johnson</td>
<td>Pacific Health Summit</td>
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<td>Center for Health &amp; Aging</td>
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<td>National Bureau of Asian Research</td>
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</table>
Ms Fran Du Melle
   Director, International Activities, American Thoracic Society

Dr Eugene McCray
   Chief, International Research and Program, Centers for Disease Control and Prevention

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   Clinical Care Institute for HIV/AIDS
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   Technical Director, TB Program PATH

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Dr Ayodele Awe, Nigeria
Dr Roberta Pastore, Mozambique
Dr Mwendaweli Maboshe, Zambia
Dr Wilfred Nkhoma, Zimbabwe

WHO/AMRO
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AMRO
Dr Rafael Lopez Olarte
Dr Yamil Silva

WHO/EMRO
Dr Akihiro Seita, Regional Adviser,
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WHO/SEARO
Dr Nani Nair, Regional Adviser,
TB, SEARO
Dr Hans Kluge, Myanmar
Dr Firdosi Mehta, Indonesia
Dr Douglas Fraser Wares, India
Dr Suvanand Sahu, India

WHO/EURO
Dr Richard Zaleskis, Regional Adviser, TB,
EURO
Dr Pierpaolo de Colombani
Dr Wieslaw Jakubowiak, Russian Federation

WHO/WPRO
Dr Pieter van Maaren, Regional Adviser, TB,
WPRO
Dr Katsunori Osuga
Dr Otamasaki
Dr Cornelia Hennig, China
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- Ms Karin Bergstrom
- Ms Annemieke Brands
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- Dr Malgosia Grzemska
- Ms Keri Lijinsky
- Dr Knut Lonnroth
- Dr Pierre-Yves Norval
- Dr Mukund Upilekar
- Ms Hannah Monica Yesudian
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