Public-Private Mix for TB Care and Control

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

Istanbul, Turkey
16-18 February 2010
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Acknowledgements

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Sally Ann Ohene and Kefas Samson were the rapporteurs for the meeting. This report was prepared by Jacob Creswell, Mukund Uplekar, Knut Lonnroth and Hannah Monica Yesudian. Caroline Sorel and Jeanette Dadzie provided secretarial assistance. The report was copy-edited by Isabelle Burnier.

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Abbreviations

ACSM  Advocacy, Communication and Social Mobilization
DEWG  DOTS Expansion Working Group
DOTS  The internationally recommended strategy for TB control
FHI   Family Health International
GDF   Global Drug Facility
GLI   Global Laboratory Initiative
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
HRD   Human Resource Development
ISTC  International Standards for Tuberculosis Care
JATA  Japan Anti-Tuberculosis Association
KNCV  Royal Netherlands TB Association
MDG   Millennium Development Goal
MDR-TB multidrug-resistant tuberculosis
MSH   Management Sciences for Health
NGO   nongovernmental organization
NTP   national tuberculosis control programme
PEPFAR The US President's Emergency Plan for AIDS Relief
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
The Union  International Union against Tuberculosis and Lung Disease
USAID United States Agency for International Development
WHA   World Health Assembly
WHO   World Health Organization
XDR-TB extensively drug-resistant tuberculosis
1. Conclusions and recommendations

Engaging all care providers in TB care and control through public–private mix (PPM) approaches and promoting the International Standards for Tuberculosis Care (ISTC) are among the core components of the Stop TB Strategy. Strengthening health systems through the involvement 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 diverse public and private health-care providers.

The sixth meeting of the PPM Subgroup, supported by the Tuberculosis Control Assistance Program (TBCAP) of the United States Agency for International Development (USAID), was organized in collaboration with the National Tuberculosis Programme of Turkey and the Turkish Thoracic Society. The meeting was held in Istanbul, Turkey, from 16 to 18 February 2010.

After wide-ranging plenary presentations, discussions and deliberations in break-out groups, stimulated by informative input from NTP managers and staff, Stop TB partners, WHO country and regional offices, academics and researchers as well as the Subgroup secretariat, the Subgroup made the following conclusions and recommendations:

1.1 Conclusions

- Since the establishment of the Stop TB Partnership's Subgroup on Public-Private Mix for TB care and control in 2002, there has been considerable progress in this area. Engaging all care providers through PPM approaches and using International Standards for Tuberculosis Care (ISTC) is an essential component of the Stop TB Strategy. PPM is now regarded and promoted as engagement of not only private but all relevant providers that offer care to people with or suspected of having TB. Furthermore, the approaches and linkages developed for PPM implementation apply
not just to DOTS expansion but also to all the components of the Stop TB Strategy including health systems strengthening, TB/HIV collaborative activities and management of MDR-TB.

• The Sixth meeting of the PPM Subgroup held in Istanbul, Turkey, from 16-18 February 2010 was supported by the Tuberculosis Control Assistance Programme (TB CAP) of the United States Agency for International Development (USAID) and was organized in collaboration with the Turkish Thoracic Society. This was the first time a national professional association of the host country collaborated in organizing the meeting. The objectives of the meeting were to review the global and regional progress on PPM, discuss and finalize a toolkit meant to help scale up PPM programmes, understand regulatory approaches that may be used to expand PPM implementation, and discuss new directions to enhance PPM subgroup’s future work.

• The regional and country presentations provided a snapshot of the progress as well as constraints in scaling up PPM. The electronic recording and reporting system pioneered by countries in the Eastern Mediterranean countries now allows precise quantification of contribution of PPM and setting goals and targets for PPM scale up. Efforts of countries in the Western Pacific Region have also made it possible to determine PPM contributions in the Philippines, China, and Cambodia. Countries in the South-East Asia Region have been able to successfully involve hundreds of public, private, voluntary and corporate institutions and thousands of individual providers in TB care and control. In the African region, Ghana, Kenya and Tanzania, among many other countries, have progressed in making PPM an important component of TB care and control. Social security organizations are major collaborating providers of TB care in the Region of the Americas. In the European Region, prison health services play an important role in TB care delivery and also, PPM is seen as a key instrument to improve treatment success by ensuring patient-centered care. Almost all countries have been using ISTC as a tool to engage medical colleges and other non-programme care providers, often working through health professionals associations as in India and Indonesia. In general, where PPM
is being implemented, case detection has increased by up to 25% and high treatment success rates have been maintained.

- However, much work still remains to be done. If the goal of universal access to TB care is to be achieved, countries have to aim for detecting not just 70% but all TB cases and, to minimize disease transmission, the cases have to be spotted as early in the course of the disease as possible. In order to screen all TB cases, all providers of services to TB suspects and patients need to be systematically mapped building on information available with relevant departments and agencies and a strategic plan for their involvement developed. Apparently, in many countries, only a small proportion of non-programme care providers have been currently engaged in TB control. For example, experiences with involving traditional healers and informal providers are scanty and engaging hospitals, public and private, still remains a challenge. Recording and reporting systems that will enable measurement of contribution of different types of care providers to TB control are not in place in many countries and irrational use of anti-TB drugs outside the TB programmes continues unabated.

- Collaboration between the PPM Subgroup and other Working Groups and Subgroups of the Stop TB Partnership has so far been limited. Achievements, obstacles and opportunities for PPM for TB/HIV collaborative activities have been documented in Kenya, India and Namibia and PPM for MDR-TB is being successfully implemented in the Philippines, Bangladesh and Nepal. A great deal needs to be done to engage people with TB, their communities and their representatives to help create demand for quality-assured TB care through providers of their choice. Countries should consider non-programme care providers in developing and implementing their strategic plans for human resource development for TB care and control.

- Experiences of several countries show that combining collaboration with regulatory approaches may help in more effective and faster scale up of PPM interventions. These complementary methods may include restricting access to anti-TB drugs as done in Ghana, Tanzania and Brazil; introducing certification and accreditation of
care providers linked to an insurance-based TB benefits package as implemented in the Philippines and mandatory notification of TB cases as practised in China and several low-prevalence countries.

- Meeting participants reviewed and provided feedback on a set of 12 practical tools that formed the "PPM toolkit" designed to present a synthesis of key steps required in implementing PPM with the purpose of engaging all relevant care providers in TB care and control. It has a set of core tools such as the one used for national situation assessment and ISTC, and a set of specific tools summarizing ways to engage, for example, private practitioners, general hospitals, social security organizations and help implement PPM for MDR-TB management and TB/HIV collaborative activities. Prepared on the basis of available documented evidence and country experiences, the PPM toolkit is meant to be a useful aid to the managers and partners at the national and sub-national levels in promoting, planning and implementing PPM for TB care and control.

1.2 Recommendations

To the DOTS Expansion Working Group and the Stop TB Coordinating Board:

- Advocate and monitor scaling up PPM for the engagement of all care providers in TB control as a priority intervention to detect all TB cases, preferably early in progressing towards universal access to TB care;

- position engagement of all care providers through PPM as an essential part of health systems strengthening. To this effect, facilitate collaboration between the PPM Subgroup and other Working Groups and Subgroups including MDR-TB and TB/HIV Working Groups as well as ACSM and HRD subgroups through mechanisms such as cross-representations, joint development of work-plans and periodic reporting to the Board;

- facilitate country-specific introduction and documentation of regulatory approaches for accelerating PPM scale up including mandatory TB case notification, restricting
access to anti-TB drugs to prevent irrational use, certification and accreditation of care providers and effective use of the Internet and other electronic media to engage relevant providers;

- Advocate to countries and partners as a requirement, measuring, reporting and monitoring contribution of collaborating care providers by adapting WHO recommended revisions to the recording and reporting system.

**To National TB Programmes / Ministries of Health**

- Undertake phased scale up of PPM based on a national situation assessment as a means of progressing towards universal access to TB care;

- adapt and use PPM guidance documents and tools to facilitate scale up of PPM as a way to contribute to health systems strengthening;

- mobilize resources for PPM scale up by utilizing opportunities available through national and international financing mechanisms; ensure sustainability and adequate domestic funding of PPM programmes;

- involve representatives of all relevant non-programme provider groups as stakeholders in developing the national strategic plans for TB care and control;

- measure and report on contribution of PPM interventions to TB control by making necessary changes to the recording itself and the system;

- introduce and document complementary approaches to help PPM scale up such as certification and accreditation of care providers, minimizing irrational use of anti-TB drugs, and setting a system for mandatory TB case notification;

- make the engagement of all care providers an integral part of scaling up management of MDR-TB and implementation of TB/HIV collaborative activities.
To the PPM Subgroup Secretariat

- Finalize and disseminate the PPM toolkit based on the feedback received from and beyond the participants of the meeting;

- assist countries in making use of the PPM toolkit for scaling up PPM in a systematic way and in measuring and reporting contribution of PPM to TB care and control;

- document and disseminate ways to introduce complementary approaches to scale up PPM such as mandatory TB case notification, certification and accreditation of care providers and restricting availability of anti-TB drugs to authorized care providers;

- assist countries in mobilizing financial resources for PPM scale up through domestic and international funding mechanisms;

- set up collaboration with MDR-TB and TB/HIV Working Groups and the Subgroup on HRD through cross-representation, joint development of work plans and joint country missions and joint technical assistance;

- work with the ACSM subgroup to help create demand from the community for quality-assured TB care through all care providers

Sixth PPM Subgroup meeting participants
2. Background

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, national TB programmes, policy makers, field experts, international technical partners and donor agencies.

At the first meeting of the Subgroup in November 2002, generic regional and national strategies for PPM were developed and endorsed. The second Subgroup meeting reviewed the growing PPM evidence base emerging from numerous PPM initiatives. The second meeting also broadened the scope of PPM to include the involvement of public sector providers not yet linked to NTPs. The third Subgroup meeting identified barriers and enablers for scaling up and sustaining PPM for TB care and control and endorsed the global guidance document on implementing PPM DOTS. 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 Subgroup reviewed the global and regional progress on PPM and identified mechanisms for engaging institutional providers such as national professional associations, hospitals and corporate sector health services.

The sixth meeting focused on ways to expand scale-up of PPM programmes and help address deceleration of TB case detection globally. Successes of and constraints to PPM scale-up across WHO regions and countries were discussed. The meeting participants contributed to finalizing a toolkit to facilitate PPM scale-up in countries. The meeting also discussed ways to improve working across the Stop TB Partnership's Working Groups and Subgroups and new directions for the PPM Subgroup's future work were held.

This report summarizes the proceedings of the sixth meeting. The objectives and expected outcomes are outlined in Section 2. Section 3 summarizes the presentations, discussions and group work, while Section 4 lists the major conclusions and recommendations.
3. Objectives and expected outcomes

3.1 Objectives

1. To review the global and regional progress on PPM for TB care and control.
2. To review and discuss a promotional toolkit meant to help scale up PPM programmes.
3. To discuss regulatory approaches to engage diverse care providers.
4. To discuss new directions for the Subgroup's future work including joint work with the various Working Groups and Subgroups of the Stop TB Partnership.

3.2 Expected outcomes

1. A review of global and regional progress on PPM.
2. A promotional toolkit outlining practical tools and evidence-based approaches for engaging diverse care providers in PPM for TB care and control.
3. Recommendations for future work on PPM for TB care and control.

Presentations at the Sixth PPM Subgroup Meeting
4. Summary of presentations and discussions

4.1 The inaugural session

The Chair of the PPM Subgroup inaugurated the event by highlighting that the Subgroup meetings provide the only global platform for periodic sharing of experiences related to engaging all care providers in TB care and control. He said that one of the group’s expectations was the development of a roadmap for accelerating PPM scale up at the country level. The participants were warmly welcomed by the NTP manager of Turkey and the Turkish Thoracic Society (TTS) representative. The WHO Representative to Turkey elaborated on the background of TB control in Turkey. She emphasized the importance of Turkey in the fight against TB in the European Region and the appropriateness of holding the meeting in close collaboration with the NTP and TTS. The Director of the Stop TB Department gave a brief overview of global TB control and elaborated on the expectations from the PPM Subgroup. Specifically, he discussed the following points:

- the need to scale up PPM projects to nationwide programmes, to engage large numbers of providers and strengthen the capacity of all providers.

- the way to address major challenges including, measuring the private sector contribution to TB control, increasing the involvement of other working groups in implementing PPM, controlling the misuse of anti-TB drugs and exploring the possibility of regulatory approaches.

- the means to explore a systematic approach to TB control to enhance equity in access to care.
He posed a number of questions for the Subgroup to consider:

- Are PPM initiatives still projects or programmes?
- Is there a large proportion of care providers still to be engaged?
- Is there a need for capacity strengthening within the non-State sector?
- What can be done against the unabated misuse of anti-TB medicines?
- How can the weak contribution of providers that has been measured be improved?
- How effective are regulatory approaches and can they be adopted?
- Limited uptake/input by MDR-TB, TB/HIV, GLI, ACSM- how can this be improved?
- How can the Subgroup promote a systems approach?

### 4.2 Scaling up PPM – Regional progress and constraints

This session included presentations on two sub-themes: the progress made and lessons learnt in the three WHO Regions that have a relatively large non-State sector -- Eastern Mediterranean, South-East Asia and Western Pacific and constraints to scaling up PPM and ways to address them in the remaining WHO regions -- Americas, Africa and Europe.

**Eastern Mediterranean Region**

The WHO Regional Office for the Eastern Mediterranean (EMRO) reported that Afghanistan, Egypt, Pakistan, Somalia, Sudan, Syria and Yemen, have conducted national situation assessments and that they all have developed PPM guidelines as well. Jordan and Pakistan have PPM collaboration activities for MDR-TB programmes and most countries have PPM focal points, national committees and initiatives ranging from collaboration with prisons to NGOs. Support from the Global Fund has allowed many countries to carry out more standard and sustained PPM approaches. Twelve of the region's 22 countries made improvements to their recording and reporting systems including registering the source of reference in TB district, laboratory, and suspect registers. Other PPM initiatives included the electronic registry where cases are notified by source of reference - Public, Private, Community, Self, and others. Raw data were routinely received and analysed from Egypt, Iran, Iraq, Jordan, and Syria (please refer to Figure 1). In addition, an electronic national reporting system has been implemented in...
Egypt, Jordan and Syria while pilots are being done in Iraq, Oman, Somalia and Yemen. EMRO reported that a number of different factors supported the success the region enjoyed in implementing PPM activities. This included the availability of much-needed funds from major donors such as the Global Fund, supporting capacity building, good documentation of successes, operational research, promoting supportive legislation including banning the sale of anti-TB drugs in the private market and the wide utilization, translation and endorsement of the ISTC.

South-East Asia Region
The WHO Regional Office for South-East Asia (SEARO) highlighted some notable examples of progress, including increasing case notification by 25% and treatment success rates by over 90% in projects in India and Myanmar, reduction in default rates by at least 10% in Sri Lanka. Additionally, Nepal has 50% of its MDR-TB patients managed in the private sector using PPM approaches. Overall, the region reported the involvement of 360 medical colleges, 22 000 private practitioners, 1500 large private and public hospitals, 150 corporate institutions, 2500 NGOs and 550 prisons in PPM activities. SEARO noted the importance of national policies and plans for PPM and the appointment of PPM focal points at central level of NTPs, for success. Other important
steps have been the development of clear guidelines for PPM activities, the launching of coalitions of professional associations, partner support and outside funding including the Global Fund. Steps to improve PPM uptake include evaluating the use/cost-benefit of incentives and enablers, and more documentation and dissemination of results for greater support and resources for PPM.

**Western Pacific Region**

The WHO Regional Office for the Western Pacific (WPRO) highlighted PPM initiatives in four countries that have made significant contributions to TB Control. In China, the 2004 Infectious Disease Law mandated notification of TB suspects and cases through an Internet-based reporting system. This initiative with monetary incentives for reporting and tracing contributed to 30% of reported TB cases. In Cambodia engaging private pharmacies and doctors for referral produced 12,577 referred TB suspects and 1,418 TB cases in the first phase of a project which is now being scaled up. In the Philippines a national and 16 regional coordinating committees have been established along with 221 PPM DOTS units across the country. PPM contributed 6,914 TB cases (representing 6% of national case detection rate) in 2008. Viet Nam has begun a pilot project that is currently operational in 15 provinces, engaging 612 private practitioners. Although the coverage is still limited, the project has demonstrated high yields. During the first two quarters of 2009 the private practitioners identified 2,354 TB suspects and 588 TB cases with a yield of 25%. WPRO reported that good use of the findings of the national situation assessments and various prevalence surveys as well as active engagement of professional societies has greatly helped efforts for PPM progress. The need to move beyond the project phase is especially important and has been consolidated in the Philippines. To further support the scale-up efforts, enhanced legislative support including integrated infectious disease notification with electronic reporting systems and regulated availability of anti-TB medicines has been beneficial. Improved financing of health insurance schemes will be vital as will the inclusion of MDR-TB activities in PPM projects.

**African Region**

The WHO Regional Office for Africa (AFRO) reported PPM activities in nine high TB-burden countries (HBCs) that involved NGOs, pharmacists, private health providers, and
traditional healers. The Democratic Republic of the Congo reported the involvement of 551 private providers (PPs) while Nigeria and Kenya were involving 410 and 382 PPs respectively. Regionally, the proportion of TB cases notified by the private sector is hard to determine due to the lack of data collection in the reporting forms. This underscores the need for stronger monitoring and evaluation systems in the Region. Inadequate human and financial resources to set up demonstration/learning projects has been a major obstacle for PPM scale-up as is the fact that the private sector is not a regular health provider and needs tools for engagement which are not always available at country level. More documentation of working models is also needed to spur increased uptake. One of the main areas of focus for the Region in the future will be the scale up of workplace engagement in TB and TB/HIV collaborative activities. Overall, more support to countries will be needed to improve PPM scale-up including new tool development, documentation of successful projects and partner involvement in demonstration projects.

**European Region**

The WHO Regional Office for Europe (EURO) reported that seven of 18 high-priority countries were reporting data on PPM and that providers involved include prisons, NGO clinics, pharmacies and drug dispensaries, general hospitals, primary health clinics, and military health services. In Kazakhstan, there are 1024 PPs reporting data to the NTP and in 2008 they reported 1515 TB cases. The main impediments to PPM activities included the lack of situation analyses or mapping, legislation in countries limiting NTP collaboration with others, and health systems under reform. These obstacles will be the target of future PPM initiatives in the Region.

**4.3 Ground speak - Approaches and needs**

The objective of this session was to discuss the processes and outcomes of some successful initiatives from selected countries. The presentations included: involvement of medical colleges in India, outlining experiences from India, the diverse PPM models in Pakistan and experiences of engaging professional associations in Turkey.
Involving medical colleges, India

Presently there are 271 medical colleges linked to RNTCP. Setting up of national and regional task forces for involvement of medical colleges and financial support to participating medical colleges have reaped rich dividends. In 2008, medical colleges accounted for 28% of TB suspects referred, 23% of new cases detected and 8% of TB patients provided with DOTS (Figure 2).

![Figure 2: India-Contribution by provider, especially medical colleges in 14 cities with an intensified PPM project](image)

PPM models in Pakistan

The different models used in Pakistan's effort to scale up PPM were presented. Pakistan has received increasingly large grants from the Global Fund for PPM activities including 20 million USD from Round 9. Two main models that have been used for case finding and treatment activities- an NGO-based model and a franchising model. These models together have contributed almost 10% of cases detected over the last two years (Figure 4). With Global Fund Round 9 funding, it is expected that the franchising model will continue to expand to include MDR and TB/HIV as well.
### Engaging Professional Associations, Turkey

At the close of the session, a representative from TTS gave an overview of TB control in Turkey and discussed their work in the country. Turkey has been experiencing a slow decline in incidence and has been able to meet both WHO goals of case detection (81%) and treatment success (91%). TTS has over 2750 members and is active in many areas including advocacy, training, research, international relationships and scholarships. A lot of work is being done among high risk populations where 19 000 people were screened for TB including prisoners.

#### 4.4 Partners speak – Doing it more and better

There were six short presentations by partners who described ongoing PPM activities in various regions and countries.

<table>
<thead>
<tr>
<th>Districts led model</th>
<th>Implemented in how many districts</th>
<th>Total cases registered in 2008</th>
<th>Treatment success in 2008</th>
<th>Total cases registered in 2009</th>
<th>Contribution (%) in National Data in 2008</th>
</tr>
</thead>
<tbody>
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<td>93%</td>
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<tr>
<td>NGO led model</td>
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<td>80%</td>
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<td>Gulak Devi</td>
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<td>14414</td>
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<tr>
<td>Total Contribution in National Data</td>
<td>120</td>
<td>63164</td>
<td>54%</td>
<td>49132</td>
<td>19%</td>
</tr>
</tbody>
</table>

*Figure 3: Contribution by various private sector models in Pakistan*
**KNCV**

KNCV is active in more than 40 countries and one of its five strategic directions for 2011-2015 includes engaging all health care providers to ensure equitable and universal access to quality TB care. The data from the Hospitals-DOTS Linkage project in Indonesia were presented and discussed.

**TBREACH**

An overview of the new TBREACH initiative elaborating how it could be a tool used by countries to increase case detection was presented. TBREACH will fund pilot projects of one and possibly two years in length, with funding between one half and one million USD. All proposals have to be approved by the NTP in country. The deadline for proposal submission was 5 March 2010. Announcements of successful applicants would be made by April and implementation would begin in June. There was extensive discussion on the eligibility criteria for countries and strict cost per additional case detected. It was emphasized that while the standards are set for this round, subsequent rounds might have different criteria to let more countries apply.

**The Global Fund**

An overview of PPM activities supported by the Global Fund was presented and discussed. The overall funding and number of countries receiving money for PPM activities have both increased from 2003 through 2008 across regions, with 62% of countries with active grants currently receiving money for PPM (Figure 4). Around 4.4% of TB funding of the Global Fund is allocated to PPM and the three largest recipients of PPM funding are China, Ghana and Indonesia. The discussions revolved around the reasons why a third of the countries do not include PPM activities in their applications, as well as how to strengthen the current PPM projects which mainly focus on ACSM activities, and training.
The Union
The Union presented the TB/HIV PPM pilots implemented in India and Namibia during 2008-09. Future technical assistance plans involve Global Fund Round 9 activities in India, conducting regional training courses and technical support to countries for PPM planning and implementation in line with the Global Plan and Regional Plans to Stop TB.

JATA
The presentation focused on the work of the Japan Anti-Tuberculosis Association (JATA) and touched on how PPM fits into its activities. JATA has a basic management training course for NTPs which includes a PPM component. They also involve NGOs, professional societies and private practitioners in various TB control activities, which include operational research, training and field projects.

FHI
A brief overview of FHI activities in Bangladesh was presented. Activities include promoting ISTC, engaging major hospitals to comply with ISTC and assisting the NTP in incorporating the Stop TB Strategy and ISTC in medical curricula.

MSH
The last presentation of the session was by Management Sciences for Health (MSH). MSH is currently working in 32 countries worldwide. The importance of having legal
frameworks in place for PPM activities and improving indicators to assess the contribution of providers in PPM was discussed.

4.5 A toolkit to help scale up PPM – Introduction to the Group Work

An outline of the PPM toolkit under development was presented as an introduction to the group work session. It is a 12-page user-friendly compilation of available knowledge and experiences on different components of PPM activities and includes a CD with important reference materials (Figure 5). It targets public and private practitioners, various care providers, TB programme management, and NGOs. A draft of the kit was circulated to each participant and the expectations of the group work were explained. A quick review of the work anticipated during the second day was then provided, including critically reviewing the tools and the plan to present findings during the meeting as well as a timeline for finalizing the tool by May.

![Figure 5: PPM Toolkit](image)

Day one concluded after this presentation.
4.5.1 Group Work

On the second day, six break-out groups, each tasked with two tools, were organized to discuss the 12 components of the PPM toolkit. They were then provided with all of the tools and key discussion points, as well as the outcomes expected from this exercise. A two-hour plenary session followed to discuss the outputs of each group and how to best finalize the product. The output of the session is presented in Appendix 1.

Field Trip
Following the group work session, a field visit trip was organized to help the participants understand the functioning of a TB services clinic operated by the Turkish Thoracic Society.
4.6 PPM beyond DOTS - How can we work together?

A series of working groups and subgroup presentations detailing collaboration with PPM were presented covering three broad areas:
- Relevance of PPM to the work of other subgroups and working groups.
- Activities implemented or planned by the group related to engaging all care providers.
- Ways to include PPM into the work of the group.

Subgroup on Human Resource Development

The Subgroup on Human Resource Development (HRD TB Subgroup) is the newest subgroup of the DOTS Expansion Working Group (DEWG). Human resource issues are cross-cutting and relevant to PPM because health workers are found in all sectors. The HRD TB Subgroup is concerned with the different functions involved in planning, managing and supporting the professional development of the health workforce.

The HRD TB Subgroup is still in the process of mapping its relevant partners and developing a workplan. Input was requested from participants to suggest possible joint activities with the Subgroup.

Joint work between the HRD TB and PPM Subgroups could be facilitated by
- advocacy of the existence of new sub-groups in networks,
- recognition of common goals,
- improved dialogue at different levels of the health care system,
- broadened scope of the understanding of engaging all care providers through PPM approaches as a strategy to reach the goal and vision of human resource development.

TB/HIV Working Group

The TB/HIV response to PPM was presented in two parts. There was a general presentation and then a country-specific example from Kenya. One of the TB/HIV Working Group’s advocacy strategies is to target NGOs not working on TB, particularly in Africa. The primary advocacy message is that any AIDS NGO which does not work on TB is providing substandard care. Meetings held with partners have resulted in TB...
screening being a mandatory part of HIV proposals to PEPFAR. There is still much work to be done however, as a joint WHO-ILO survey showed, although 95% of governments indicated that they would like TB to be included in HIV workplace programmes, only 43% of workplaces address TB through their HIV programs. WHO has reacted to calls for guidance on how to engage all partners in the TB/HIV response and a protocol promoting the implementation of collaborative TB/HIV activities through public–private mix and partnerships was developed in 2008. Next steps include generating evidence by utilizing the protocol and documenting the lessons learned.

In Kenya, 40% of private sector physicians treat TB and 11% report cases which amounts to 2% of all notified cases. PPM in Kenya is done in collaboration with the Kenya Association for Pulmonary TB and Lung Disease. A range of providers were engaged, recruited and trained according to national guidelines and standardized tools, of which TB/HIV management was an important element. The major barriers have been lack of human resources, skills of staff, financing for PPM implementation and standardization of treatment protocols.

**MDR-TB Working Group**

For PPM in MDR-TB control, only 5% of the estimated 500,000 incident cases each year are diagnosed and treated under GLC-approved projects. With the 95% gap and the call for universal access to MDR-TB management by 2015, it is impossible to achieve targets without engaging all care providers. The major issue for MDR-TB management is its complexity, the lack of political commitment and funding. Very little has been done in relation to engaging all care providers but the decision by the MDR-TB core group to take the lead and develop a strategy on the matter following the Ministerial Meeting in Beijing in 2009 was a start. Solutions to MDR-TB lie in improved health systems and implying all parties in efforts.

**ACSM Subgroup**

Collaboration with the public and private sector is critical for the work of the ACSM Subgroup. NGOs and community-based organizations (CBOs) can liaise with public or private partners to ensure community members have access to care. There is however, a need to build and strengthen the capacity of these organizations to understand TB
and the roles they can play in engaging the community in TB control efforts. Furthermore, for good advocacy and communication, it is important to have a community representative in both the ACSM and PPM subgroups.

4.7 Regulatory approaches to help PPM scale up

Restricting access to anti-TB medicines - The Ghana Experience

From the 1970s to the late 1990s, anti-TB drugs were sold in the private pharmacies in Ghana. The decision to regulate anti-TB drugs was taken in 1996-97. Since legal restriction through an Act of Parliament would have been difficult, a programmatic approach was taken. All stakeholders were engaged to have a common vision to prevent anti-TB drug resistance. The Ghanaian Food and Drugs Board was lobbied to stop anti-TB drug importation and the sale of anti-TB drugs was made unprofitable. The NTP was able to reach a consensus that every TB suspect should be managed under the same national guidelines through individual consultation and stakeholder meetings. The NTP ensured anti-TB drugs were available at no charge to prevent imports by the private sector. They also worked to create awareness among the public that anti-TB drugs are free and they were warned of the dangers of fake anti-TB drugs. The result of these efforts are that, adverse treatment outcomes decreasing and treatment success is improving. The default rate was 2.4% in 2008 and most importantly no anti-TB drugs are available outside of the NTP.

Certification and accreditation - The Philippines experience

The Philippines started PPM in the late-1990s and expanded it in early 2000. In its efforts to engage all health care providers in the Philippines, the NTP faced two major challenges – first, expanding and sustaining public-private partnership in TB control and second, ensuring quality services are being provided by both the public and private health providers. The introduction of the DOTS facility certification and accreditation in 2003 was an attempt to address these issues.

In partnership with the Philippine Coalition Against TB (PhilCAT) and technical assistance from USAID-funded project, PhilTIPS, the NTP developed and issued the policies and guidelines for DOTS facility certification in conjunction with a Quality
Assurance programme. In 2003, the Philippine Health Insurance Corporation (PhilHealth) launched the accreditation of providers of the DOTS outpatient benefit package. Various tools such as the certification/accreditation standards, training courses, guidelines and a monitoring guide were developed. A cadre of certifiers/accreditation staff and technical assistance providers were trained. Certification processes included: self-assessment by health facility, provision of support to the health facility by technical assistance providers, assessment through site visits by regional certifiers, review of the team’s recommendation and approval by the Regional Coordinating Committee and issuance of certificate by the National Coordinating Committee. Certified facilities apply for accreditation at the local office of PhilHealth, documents are assessed and applications endorsed to the Accreditation Committee who decides on the application. An accredited DOTS facility can receive payments for treatment which amount to USD $90 for every new case of TB. As of 2009, 2900 private practitioners were certified, representing 20% of the total estimated practitioners.

Challenges still remain to be addressed, such as a low number of certified and accredited DOTS facilities and low utilization rate. However, the NTP plans to move forward by improving implementation, providing financial incentives to encourage health staff participation including the private practitioners, extending coverage to re-treatment cases and by developing a package for MDR-TB.
Mandatory case notification- The China experience

Recognizing that weak collaboration between hospitals and dispensaries was resulting in low referral, follow-up and case detection, with less than 10% of cases registered, China initiated a “public-public mix” partnership approach to strengthen collaboration between public hospitals and TB dispensaries. An Internet-based Communicable Disease reporting system (IBCDRS) was used. The reporting of all TB suspects/cases through IBCDRS within 24 hours, referral of TB suspects/patients in hospital, and follow-up of referred TB patients who do not arrive in TB dispensary, was made mandatory. The results have been impressive. The proportion of total cases contributed by hospitals from 2004-2007 has doubled while follow-up rates for referral and suspect tracing has increased as well.

![Figure 6: A series of graphs showing the contribution of Phil Health to PPM scale-up in the Philippines](image)

![Figure 7: Chinese hospitals contribution to TB case detection](image)

<table>
<thead>
<tr>
<th>Total number of active TB cases registered</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of active TB cases among those referred by hospitals</td>
<td>18,649</td>
<td>24,628</td>
<td>32,522</td>
<td>37,799</td>
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<tr>
<td>Contribution of hospitals to total active TB cases (%)</td>
<td>18.5</td>
<td>25.7</td>
<td>33.5</td>
<td>37.5</td>
</tr>
<tr>
<td>Number of smear (+) cases registered</td>
<td>457,116</td>
<td>595,471</td>
<td>548,626</td>
<td>556,837</td>
</tr>
<tr>
<td>No. of 88+ cases referred by hospitals</td>
<td>91,038</td>
<td>122,438</td>
<td>160,186</td>
<td>178,601</td>
</tr>
<tr>
<td>Contribution of hospitals to SS+ (%)</td>
<td>10.3</td>
<td>22.0</td>
<td>29.3</td>
<td>32.9</td>
</tr>
</tbody>
</table>
Appendix 1

Group Work Summary

Six working groups were set up to discuss each of the 12 tools in the toolkit to help scale up PPM. Each group discussed two tools. The group discussions focused on:

1. broad recommendations on content and presentation
2. detailed suggestions submitted in writing to the meeting rapporteur before the end of the meeting.

The groups were instructed to:

- assign one rapporteur per tool (two rapporteurs per group).
- prepare two PowerPoint slides per tool for a plenary discussion on, general observations and suggested changes (broad suggestions, no details).
- keep presentation to a maximum of five minutes per tool.

Below is a summary of the group work and recommendations from the groups for each tool.
Group 1

Basic concepts and national situation assessment (Tools 1 and 2)

Facilitators: Frank Bonsu and Jeremiah Muhwa Chakaya

Recommendations:

PPM - Basic Concepts

The group recommended that the tool capture the broader public health aspect of PPM more clearly; for example early case detection through the private sector can cut the chain of transmission. More specificity in the types of groups to target was requested, including vulnerable group (migrants, labors, slums dwellers, indigenous and prisoners) and other groups (military and the corporate sector). The group also recommended that more country examples be included.

National Situation Assessment (NSA)

More emphasis should be placed on having the NSA done through a consultative process with input from all stakeholders. Information should be provided on, origin of data collection, e.g. NTP and MoH. The text should also describe the task of the NTP to demonstrate willingness for partnership and play the key leadership and stewardship role. The group also made some observations regarding the headings and numbering systems that seemed to be out of order.
Group 2
Operational guidelines and ACSM (Tools 3 and 4)

Facilitators: Andrea Godfrey and SS Lal

Recommendations:
Operational Guidelines for PPM
The group felt that the tool had a clear and logical flow, that was flexible for use in different ways. Further information was needed about the PPM task mix and the practical tools. The group recommended more case studies and more references with links in the electronic version. Also, they felt that the tool should discuss topics such as financing and sustainability.

Advocacy, Communication and Social Mobilization (ACSM)
The tool should define the rationale and scope of ACSM in PPM more clearly and high level advocacy should be added in the tool as a key component. The monitoring and evaluation (M&E) section should include linkages with the M&E tool in the toolkit. The group recommended the tool have more case studies. Including captions for the photographs and electronic links to the references was also recommended.
Group 3
Private practitioners and Hospitals (Tools 5 and 6)

**Facilitators:** Md Abdul Hamid and Jan Voskens

**Recommendations:**

**General Comments**
Some of the participants felt that the term *toolkit* was not appropriate and that a reference tool or PPM factsheets would be a better title. More information and evidence would improve all tools, which should be prioritized with *core* tools and one *targeted* to specific groups. Each tool should follow a similar structure and layout.

**Engaging Private Practitioners in TB Care & Control**
A background section including evidence and available data should be added. The tool should have cross-references to other tools as well as more and updated references, for example engagement of traditional/alternative providers and templates for Memoranda of Understanding (MoUs) and other documents for use by NTPs. The section on incentives could be more detailed so it would provide guidance on how to establish compensation/incentive systems for the private sector as many managers are not well versed on how to cost services (cost-recovery schemes).

**Engaging Hospitals in TB Control and Care**
A background section including evidence and available data should be added. Information should be inserted on intensive case-finding among risk groups through multiple hospital units (diabetes, smokers, TB/HIV) and adding Practical Approach to Lung Health (PAL) should be considered. The section on involving and developing partnerships could be improved with more details on how partner organizations can assist hospitals and TB programmes, including advocacy, referral schemes, defaulter tracing, community DOT, education and counseling.
Group 4

Workplaces and Social Security Organizations (Tools 7 and 8)

Facilitators: Akihiro Ohkado and Pedro Suarez

Recommendations:

Engaging Workplaces in TB Care and Control
The background section should be improved with stronger advocacy and a rights-based approach. The tool should have cross-references to other tools as well as more and updated references and the examples given in the text could represent a broader geographical balance. The suggestion was also made that the text was too theoretical and should focus more on concrete examples. The group recommended that the tool mandate HIV and TB to be included as part of occupational safety and health and encompass corporate social responsibility.

Engaging Social Security Organizations (SSOs)
There were concerns that the size of the tool in relation to others was small and that less text be used. The tool should highlight sustainability issues on TB control by engaging SSOs, propose ways the NTPs can involve SSOs and motivate private sector participation and increased access. A section on scaling up was recommended. Here the group had similar thoughts about the background, references and examples as for the Workplace tool, suggesting that the introductory section be improved with stronger advocacy and a rights-based approach. The tool should have cross-references to others as well as more and updated references. The examples given in the text could also represent a broader geographical balance.
**Group 5**

**PPM for TB/HIV and MDR-TB management (Tools 9 and 10)**

**Facilitators:** Vishnu Kamineni and Rosalind Vianzon

**Recommendations:**

**General Comments**

The tools should be prioritized with thematic or core tools and one targeted to specific groups. The new design might follow the Stop TB Strategy with main components and TB/HIV and MDR-TB under the same heading. A design recommendation was to separate the left and right side of the folder for these two groups. The target audience should be NTPs or NGOs and the private sector, but each tool should follow a similar structure and layout and have well-defined case studies.

**TB/HIV and MDR-TB management**

The TB/HIV tool should be folded into the MDR-TB one following the Stop TB strategy format, have cross-references to other tools and include less text and explanations. It should follow a simple planning, preparation and implementation format. It should have case studies that include approaches, outcomes and lessons. It would also be good to insert examples on community-based MDR-TB care, psycho-social support and case studies for EURO.
Group 6

International Standards of TB Care and Monitoring & Evaluation (M&E) (Tools 11 and 12)

Facilitators: Samiha Baghdadi and Phil Hopewell

Recommendations:

General
The purpose and target audience of the whole toolkit needs to be better defined. There was concern that it would not be possible for one document to be both an advocacy tool and technical brief. The group asked for all documents in the tool-kit to have a standardized layout and said that the most important product for countries was to have practical step-by-step guides on implementation. Therefore it would also be important and useful to highlight country experiences.

ISTC
The intended audience should be better specified and include NTPs, professional associations and non-NTP providers. The content could focus more on clearly defined steps for utilization with country experiences included with each step. The box with ISTC standards should also be taken out and the CD with reference material should include the Handbook for using the ISTC, a link to the ISTC.org website and the Patient’s Charter for TB Care.

Monitoring and Evaluation
The tool should include information on reporting mechanisms, supervision and periodic evaluation instead of focusing on indicators. Terminology should be consistent and terms such as engaged and active participation should be clearly defined. Cross-reference and harmonization with Hospital and Private Practitioners components could help reduce volume of this tool.
## Appendix 2

### Meeting Agenda

<table>
<thead>
<tr>
<th>16 February 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 - 9:00</td>
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</table>

**Session I: Introduction**  
Chair: Phil Hopewell

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>9:00-9:05</td>
<td>Opening remarks by Subgroup Chair</td>
</tr>
<tr>
<td>9:05-9:20</td>
<td>Welcome addresses</td>
</tr>
<tr>
<td>9:20 - 9:30</td>
<td>Global TB Control today: expectations from the PPM Subgroup</td>
</tr>
<tr>
<td>9:30 - 9:40</td>
<td>Objectives and agenda</td>
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<tr>
<td>9:40 - 10:00</td>
<td>Discussion</td>
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</tbody>
</table>

**Coffee 10:00 – 10:30**

**Session II: Panel: Scaling up PPM – Lessons from Regions**  
Chair: JM Chakaya

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>10:30 - 10:40</td>
<td>What has EMR achieved and how?</td>
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<tr>
<td>10:40 - 10:50</td>
<td>What has SEAR achieved and how?</td>
</tr>
<tr>
<td>10:50 - 1:00</td>
<td>What has WPR achieved and how?</td>
</tr>
<tr>
<td>11:00 - 1:30</td>
<td>Discussion</td>
</tr>
</tbody>
</table>

**Panel: Scaling up PPM – Strategies for Regions**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>11:30 - 11:40</td>
<td>Constraints in AFR and how do we address them?</td>
</tr>
<tr>
<td>11:40 - 11:50</td>
<td>Constraints in AMR and how do we address them?</td>
</tr>
<tr>
<td>11:50 - 12:00</td>
<td>Constraints in EUR and how do we address them?</td>
</tr>
<tr>
<td>12:00-12:30</td>
<td>Discussion</td>
</tr>
</tbody>
</table>

**Lunch 12:30 – 14:00**

**Session III: Groundspeak - Approaches and Needs**  
Chair: Prof Arzu Yorgancioglu

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>14:00-14:15</td>
<td>India (Medical Colleges)</td>
</tr>
<tr>
<td>14:15-14:30</td>
<td>Pakistan (General practitioners)</td>
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<tr>
<td>Time</td>
<td>Activity</td>
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<tr>
<td>14:30-14:45</td>
<td>Turkey (Professional Societies)</td>
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<tr>
<td>14:45–15:00</td>
<td>Discussion</td>
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<tr>
<td><strong>Coffee 15:00 – 15:30</strong></td>
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<tr>
<td><strong>Session IV: Panel: Partnerspeak – Doing it more and better</strong></td>
<td>Chair: L Blanc</td>
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<tr>
<td>15:30-15:40</td>
<td>KNCV</td>
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<tr>
<td>15:40-15:50</td>
<td>TB REACH</td>
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<tr>
<td>15:50-16:00</td>
<td>USAID</td>
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<tr>
<td>16:10-16:20</td>
<td>The Global Fund</td>
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<tr>
<td>16:20-16:30</td>
<td>The Union</td>
</tr>
<tr>
<td>16:30–17:00</td>
<td>Discussion</td>
</tr>
<tr>
<td><strong>Session V: A toolkit to help scale up PPM – Introduction to the Group Work</strong></td>
<td></td>
</tr>
<tr>
<td>17:00 - 17:15</td>
<td>Putting together a PPM toolkit</td>
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<tr>
<td>17:15 - 17:30</td>
<td>Guidance on proposed group work</td>
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<tr>
<td><strong>17 February 2010</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Session V: Group Work</strong></td>
<td></td>
</tr>
<tr>
<td>9:00 - 12:30</td>
<td>Group Work on the toolkit in Six groups</td>
</tr>
<tr>
<td><strong>Lunch 12:30 – 14:00</strong></td>
<td></td>
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<tr>
<td><strong>Session VI: Plenary</strong></td>
<td>Chair: Cheri Vincent</td>
</tr>
<tr>
<td>14:00 - 15:30</td>
<td>15 min presentation/discussion by each group</td>
</tr>
<tr>
<td><strong>Coffee 15:30 – 16:00</strong></td>
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<tr>
<td>16:00 - 16:30</td>
<td>Discussion: PPM advocacy and effective use of the toolkit</td>
</tr>
<tr>
<td><strong>Session VII: Panel: PPM beyond DOTS: How can we work together</strong></td>
<td>Chair: Nani Nair</td>
</tr>
<tr>
<td>16:30 - 16:45</td>
<td>Subgroup on Human Resources</td>
</tr>
<tr>
<td>16:45 - 17:00</td>
<td>MDR-TB Working Group</td>
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<tr>
<td>17:00 - 17:15</td>
<td>TB/HIV Working Group</td>
</tr>
<tr>
<td>17:15 - 17:30</td>
<td>Patients and community (ACSM Subgroup)</td>
</tr>
<tr>
<td>17:30 - 17:45</td>
<td>Reflections from the PPM Subgroup</td>
</tr>
<tr>
<td><strong>18 February 2010</strong></td>
<td></td>
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<tr>
<td><strong>Session VIII: Panel: Regulatory approaches to help PPM scale up</strong></td>
<td>Chair: S Egwaga</td>
</tr>
<tr>
<td>09:00– 09:15</td>
<td>Restricting access to anti-TB medicines (Ghana)</td>
</tr>
<tr>
<td>09:15– 09:30</td>
<td>Certification and accreditation (Philippines)</td>
</tr>
<tr>
<td>09:30– 09:45</td>
<td>Mandatory case notification (China)</td>
</tr>
<tr>
<td>Time</td>
<td>Event</td>
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<td>-------------------------------------------------</td>
</tr>
<tr>
<td>09:45– 10:00</td>
<td>Discussion</td>
</tr>
<tr>
<td><strong>Coffee</strong></td>
<td>10:00 – 10:30</td>
</tr>
<tr>
<td><strong>Session IX:</strong> Conclusions and recommendations</td>
<td>Chair: A. Seita</td>
</tr>
<tr>
<td>10:30 - 11:00</td>
<td>Conclusions and recommendations</td>
</tr>
<tr>
<td></td>
<td>Phil Hopewell</td>
</tr>
<tr>
<td>11:00– 12:00</td>
<td>Discussion</td>
</tr>
<tr>
<td>12:00– 12:30</td>
<td>Thanks and next steps</td>
</tr>
<tr>
<td></td>
<td>Knut Lonnroth</td>
</tr>
<tr>
<td>Lunch</td>
<td>12:30 – 14:00</td>
</tr>
<tr>
<td>14:00 – 16:00</td>
<td><strong>Meeting of the Core Group of the PPM Subgroup</strong></td>
</tr>
<tr>
<td>16.00 - 17.00</td>
<td><strong>PPM Core group meets with executives of the Turkish Thoracic Society</strong></td>
</tr>
</tbody>
</table>
Appendix 3

List of Participants

COUNTRY REPRESENTATIVES

AFRICAN REGION

DEMOCRATIC REPUBLIC OF CONGO
Dr Jean-Paul Okiaia
National TB Programme Manager
Ministry of Health
4310 Boulevard du 30 juin
B.P. 3088 Kin 1
Kinshasa Gombé

GHANA
Dr Frank Bonsu
National TB Programme Manager
Disease Control Unit
P.O. Box KB 493
Korle Bu
Accra

KENYA
Dr Jeremiah Muhwa Chakaya
Chief Research Officer
Centre for Respiratory Diseases Research
Kenya Medical Research Institute
P.O. Box 47855
Nairobi, 00100

Dr Joseph Kimagut Sitienei
National TB Programme Manager
Ministry of Health
P.O. Box 20781
Nairobi, 00202

IGERIA
Dr Mansur Kabir*
Federal Ministry of Health
Department of Public Health
N°2 Justice Sowemimo ST. Asokoro
Abuja

Dr Rupert Eneogu*
Federal Ministry of Health
Department of Public Health
No. 2 Justice Sowemimi ST Asokoro
Abuja

SWAZILAND
Dr Themba Dlamini
National TB Programme Manager
P.O. Box 54
Manzini

DEMOCRATIC REPUBLIC OF TANZANIA
Dr Allan Tarimo
Ministry of Health and Social Welfare
P.O. Box 9082
Dar es Salaam

* Unable to attend
EASTERN MEDITERRANEAN REGION

AFGHANISTAN
Dr Lutfullah Manzoor
Darulaman
Sanatorium Road
National TB Control Programme
Ministry of Health
Kabul

PAKISTAN
Dr Noor Ahmad Baloch
National TB Control Programme
Manager
Ministry of Health
Islamabad

D Habibullah Sakhidad Habid
Darulaman
Sanatorium Road
National TB Control Programme
Ministry of Health
Kabul

EUROPEAN REGION

AZERBAIJAN
Professor Eljan Mammadbayov
Director
Research Institute of Pulmonary And Lung Diseases
E. Suleymanov Str. 2514
Aze 118
Baku

TURKEY
Dr Filil Duyar Agca
General Practitioner
5th TB Dispensary
Ankara

Professor Erkan Bozkanat
Gülhane Military Medical School
Haydarpasa Training Hospital
Istanbul

Dr Hamza Bozkurt
Head of TB Control Department
Ministry of Health
Ilkiz Sokak No. 4, Eust D Blok
Kat 5 Sihhiye
Ankara

Professor Haluk Celasir
Turkish Thoracic Society
Süreyyapasa Chest Diseases and Surgery
Training Hospital
Maltepe
Istanbul

Professor Faruk Ciftci
Gülhane Military Medical School
Haydarpasa Training Hospital
Istanbul
Dr Onur Fevzi Erer
Chest Diseases and Surgery
Training Hospital
Yenisehir
Izmir

Dr Zeki Kilicaslan
Istanbul University Cerrahpasla
Tip Falültesi
Göğus Hastalıkları Anabilim Dali
Istanbul

Professor Serir Özkan
Chest Diseases and Surgery Training
Hospital
Yenisehir
Izmir

Dr Süha Özkan
TB Coordinator of Ankara Province
Ministry of Health
Sihhiye
Ankara

SOUTH-EAST ASIA REGION

INDIA

Dr Suresh Gutta*
National Coordinator, TB
Indian Medical Association
Indraprastha Marg
New Delhi 110002

Dr Kuldeep Singh Sachdeva
Ministry of Health and Family Welfare
Central TB Division
Nirman Bhawan
New Delhi - 110011

Professor Seref Özkan
Ataturk Chest Disease and Surgery
Training Hospital, Kecioren
Ankara

Dr Suat Seren
Training Hospital for Thoracic Medicine and Surgery
Yenisehir
Izmir

Dr Mustafa Hamidullah Türkâni
Deputy Head, Department of TB Control
Sihhiye
Ankara

Professor Arzu Yorgancioğlu
Turkish Thoracic Society
Turan Güneş Bulvarı
Koyunlu Sitesi No: 175/19 Oran
Ankara

INDONESIA

Dr Erling Burhan
Indonesian Society of Respirology
Persahabatan Hospital
Jarkata

Dr Sophia Hermawan
Head of Specialized Hospital
Directorate of Specialized for Medical Care Ministry of Health
Ministry of Health
Jakarta

Dr John Sugiharto
National Technical Officer
KNCV
Jakarta

* Unable to attend
**MYANMAR**

**Dr Thandar Lwin**  
National TB Programme Manager  
National TB Control Programme  
Department of Health  
Ministry of Health  
Nay Pyi Taw

**Dr Moe Zaw**  
Assistant Director (TB)  
National TB Control Programme  
Department of Health  
Ministry of Health  
Nay Pyi Taw

**WESTERN PACIFIC REGION**

**CAMBODIA**

**Dr Mao Tan Eang**  
Director  
278/95 Sangkat Boeung Keng Kang II  
Khan Chamcar Mon  
Phnom Penh

**CHINA**

**Dr Haibo Xie**  
National Centre for TB Prevention and Control  
27 nan Wei Road  
Beijing 100050

**Ms Du Ying**  
National Centre for TB Prevention and Control  
27 nan Wei Road  
Beijing 100050

**THAILAND**

**Dr Yuthichai Kasetjaroen**  
Director, Bureau of Tuberculosis  
Bureau of Tuberculosis  
116 Sudprasert Road  
Bangklo, Bangkholeam  
Bangkok 10120

**PHILIPPINES**

**Dr Rosalind Vianzon**  
TB Unit, Infectious Diseases Office  
National Centre for Disease Prevention and Control  
Department of Health  
Bldg 13, San Lazaro Compound  
Rizal Avenue, Sta Cruz  
Manila

**VIETNAM**

**Dr Truong Thi Thanh**  
National Hospital of TB and And Respiratory Diseases  
463 Hoang Hoa Tham St  
Ba Dinh District  
Hanoi
Dr Nguyen Dinh Tuan
PPM Focal Point
National Hospital of TB and Respiratory Diseases
463 Hoang Hoa Tham Street
Ba Donh District
Hanoi

PATIENTS AND COMMUNITY REPRESENTATIVE

Ms Blessina A. Kumar
Flat B - 13 Lakeview Apartments
Plot No. 876, Wart 8 Mehrauli
New Delhi 11030
India

PARTNER REPRESENTATIVES

AMERICAN THORACIC SOCIETY
Ms Fran Du Melle
Senior Director, International Activities
American Thoracic Society
1150 18th Street, Suite 300
Washington DC, 20036
USA

Dr Philip Hopewell
Professor of Medicine
Division of Pulmonary and Critical Care Medicine
San Francisco General Hospital Room 5KI
San Francisco, CA 94110
USA

DAMIEN FOUNDATION
Dr Md Abdul Salim Hamid
Country Director and Medical Adviser
Damien Foundation Bangladesh
House 24, Road 18, Banani, Block A Dhaka
Bangladesh

FAMILY HEALTH INTERNATIONAL
Dr M. Hossain
Manager, TBCAP Bangladesh
House No. 5, Road 35
Gulshan 02 - Dhaka 121
Bangladesh

FRANCIS J. CURRY NATIONAL TUBERCULOSIS CENTER
Mr Tom Stuebner
Center Director
Francis J. Curry National Tuberculosis Center
University of California, San Francisco
3180 18th Street, Suite 101
San Francisco, CA 94110
USA

THE GLOBAL FUND
Dr S.S. Lai
Senior Technical Officer
Strategy, Performance and Evaluation
The Global Fund to Fight AIDS
Tuberculosis and Malaria
8, chemin de Blandonnet
1214 Vernier
Geneva
Switzerland
INTERNATIONAL LABOUR ORGANIZATION
Dr Lee Nah Hsu
Senior Technical Specialist
ILO Programme on HIV/AIDS and the World of Work (ILO/AIDS)
4 route des Morillons
CH 1211 Geneva 22
Switzerland

JAPAN ANTI TUBERCULOSIS ASSOCIATION
Dr Akihiro Okado
Senior Researcher, Department of Epidemiology and Clinical Research
The Research Institute of TB
Japan Anti-Tuberculosis Association
Matsuyama 3-1-24
Kiyose 204-8533
Tokyo
Japan

KNCV TUBERCULOSIS FOUNDATION
Dr Jan Voskens
Senior Consultant
International Unit
KNCV Tuberculosis Foundation
Parkstraat 17, The Hague
The Netherlands

MSH
Dr Pedro Suarez
430 North Fairfax Drive
Suite 400
Arlington, Virginia 22203
USA

NUFFIELD INSTITUTE FOR HEALTH
Dr John Walley
Professor in International Public Health
Nuffield Institute for Health, LIHS
University of Leeds, Charles Thakrah Bldg
101 Clarendon Road
LS2 9PL, Leeds, Yorks
United Kingdom

PATH
Dr Mayra S. Arias
Technical Officer
HIV and TB Global Programme
PATH
1800 K. Street NW
Suite 800
Washington, D.C., 20006
USA

THE UNION
Dr Vincent Kamineni
Technical Consultant
The Union South East Asia
International Union Against Tuberculosis and Lung Disease
C-6 Qutub Institutional Area
New Delhi 110016
India
**AFRICAN REGION**

**Dr Bah-Kelta**  
Regional Adviser TB  
WHO Regional Office for Africa  
Brazzaville  
Congo

**Dr Henrietta Wembayama**  
Medical Officer, TB/HIV  
WHO Regional Office for Africa  
Brazzaville  
Congo

**Dr Nicolas Nkire Nkire Mashen**  
National Professional Officer  
The Office of the WHO Representative  
Kinshasa  
Democratic Republic of Congo

**Dr Sally Ann Ohene**  
National Professional Officer  
TB Focal Point  
The Office of the WHO Representative  
Accra  
Ghana

**Dr Philip Dash Patrobas**  
The Office of the WHO Representative  
Abuja  
Nigeria

**Mr Kefas Samson**  
Medical Officer  
The Office of the WHO Representative  
Mbabane  
Swaziland

**EASTERN MEDITERRANEAN REGION**

**Dr Akihiro Saita**  
Regional Adviser, TB  
WHO Regional Office for the Eastern Mediterranean  
Cairo  
Egypt

**Dr Samia Baghdadi**  
Medical Officer, TB  
WHO Regional Office for the Eastern Mediterranean  
Cairo  
Egypt

**Dr Syed Karam Shah**  
Medical Officer  
The Office of the WHO Representative  
Kabul  
Afghanistan

**Dr Sevil Huseynova**  
Medical Officer, STB  
The Office of the WHO Representative  
Amman  
Iraq

**EUROPEAN REGION**

**Dr Pierpaolo de Colombani**  
Medical Officer, TUB  
WHO Regional Office for Europe  
Kobenhavn  
Danemark

**Dr Cristina Profili**  
The WHO Representative and Head of Country Office to Turkey  
WHO Country Office  
Ankara  
Turkey

* Unable to attend
**SOUTH-EAST ASIA REGION**

**Dr Nani Nair**  
Regional Adviser, TB  
WHO Regional Office for South-East Asia  
New Delhi  
India

**Dr Erwin Cooreman**  
Medical Officer, TB  
The Office of the WHO Representative  
Dhaka  
Bangladesh

**Dr Mohamed Akhtar**  
Medical Officer, TB  
The Office of the WHO Representative  
Kathmandu  
Nepal

**WESTERN PACIFIC REGION**

**Dr Wojin Lew**  
Medical Officer for Stop TB and Leprosy Elimination  
WHO Regional Office for Western Pacific  
Manila  
Philippines

**Dr Nobuyuki Nishikiori**  
Medical Officer, Stop TB  
WHO Regional Office for Western Pacific  
Manila  
Philippines

**Dr Cornelia Hennig**  
Medical Officer  
The Office of the WHO Representative  
Beijing  
China

**Dr Mariquita J. Mantala**  
National Professional Officer  
The Office of the WHO Representative  
Building 3, Department of Health  
San Lazaro Compound, Sta Cruz  
Manila  
Philippines

**Dr Pham Huyen Khanh**  
National Professional Officer  
The Office of the WHO Representative  
Hanoi  
Viet Nam

**Dr Giampaolo Mezzabotta**  
Medical Officer  
The Office of the WHO Representative  
Hanoi  
Viet Nam

**WHO HEADQUARTERS**

**Dr Mario Raviglione**  
Director, Stop TB Department

**Dr Léopold Blanc**  
Coordinator, STB/TBS

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

**Mr Jacob Creswell**  
Technical Officer, STB/TBS

**Ms Jeanette Dadzie**  
Assistant, STB/TBS

**Ms Colleen Daniels**  
Technical Officer, STB/TBS

**Dr Lucia Diitu**  
Medical Officer, TB REACH
Ms Andrea Godfrey  
Technical Officer, STB/TBC

Dr Ernesto Jaramillo  
Medical Officer, STB/TBS

Dr Knut Lönnroth  
Medical Officer, STB/TBS

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

Dr Suvanand Sahu  
Medical Officer, TB REACH

Dr Mukund Uplekar  
Medical Officer, STB/TBS

* Unable to attend
Four useful tools for PPM planning, implementation and advocacy

"The International Standards for TB Care"

"The PPM Guidance Document"

"The National Situation Assessment tool"

"The PPM Advocacy Brochure"

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

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