

Public-private Mix: A Practical Approach to Lung Health in TB Control

*Report of a Regional Workshop
Kathmandu, Nepal, 19 to 23 September 2011*



**World Health
Organization**
Regional Office for South-East Asia

SEA-TB-336
Distribution: General

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Printed in India

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Abbreviations

CRD	chronic respiratory disease
DOTS	internationally recommended strategy for tuberculosis control
DR-TB	drug-resistant tuberculosis
DST	drug susceptibility testing
EQA	External quality assurance
GFATM	Global Fund to fight against AIDS, TB and Malaria
HIV	human immunodeficiency virus
HSS	health system strengthening
ISTC	International Standards of TB Care
MDR-TB	multidrug-resistant tuberculosis
MMA	Myanmar Medical Association
MoU	Memorandum of Understanding
NGO	nongovernmental organization
NTP	National Tuberculosis Control Programme
NWG	National Working Group
PAL	practical approach to lung health
PHC	primary health care
PP	private practitioner
PPM	public/private mix
QA	quality assurance
RNTCP	Revised National TB Control Programme
WHO	World Health Organization

1. Introduction

Countries in the WHO South-East Asia (SEA) Region have continued to make steady progress with TB control. The number of notified TB cases has been increasing steadily with more than two million TB patients initiated on treatment in the Region during 2009. Based on data from national TB programmes in Member States in 2009, the overall treatment success rate achieved in the Region as a whole was 88%, close to the current target of 90%.

All Member States have adopted the WHO Stop TB Strategy since its introduction in 2006. They are implementing six components of the Stop TB Strategy according to their respective country context. The third and fourth components of the Global Plan to Stop TB, 2011-2015 are to “Strengthen health systems based on primary health care” and “Engage all care providers,” an approach to ensure universal access to high quality TB services through the involvement of all public, voluntary, corporate and private providers and the adoption of the “*International Standards for Tuberculosis Care (ISTC)*”. Such engagement requires a systematic approach to identifying the providers and facilities that have potential to provide services for TB, ensuring that the services are of high quality, and developing and maintaining linkages between these services and the appropriate public health authorities.

Despite the progress made over the past several years, there still remain many challenges to scale-up of interventions to achieve the goal of systematic engagement of all providers in TB control and to have the desired impact. The current situation with, on the one hand, the accomplishments and availability of a range of tools (culminating in the publication of “Public-Private Mix for TB Care and Control: A Toolkit”) and, on the other hand, the enormous task of scaling-up at country level, calls for a re-conceptualization of the role, of the Public-Private Mix and a thorough re-examination of its objectives, strategies and activities.

Further to this, the Stop TB strategy emphasizes the need to strengthen the health system through an innovative approach such as the

Practical Approach to Lung Health (PAL), which is based on improving the quality of care of all respiratory patients above five years of age, and focuses on the primary health care level. It is estimated that respiratory symptoms account for up to one third of patients attending primary health care facilities for any reason. Pneumonia is the leading reported cause of death in our Region among respiratory ailments; over 40% of male adults smoke, resulting in chronic obstructive pulmonary disease. Pneumonia is also frequent in females due to indoor pollution. A substantial number of cases remain undetected. There is lack of governance and information system within the six building blocks of health system strengthening. It is expected that PAL will contribute in strengthening the overall health care system, raising the level of political commitment, developing standardized policy guidance and improving the health information system, as well as improving diagnosis and management of respiratory diseases, including TB, and particularly smear-negative pulmonary TB. It is also expected that the widespread prescription of fluoroquinolones to respiratory patients, which jeopardizes development of resistance to quinolones in TB patients, will be reduced following implementation of the PAL strategy.

2. Inaugural Session

The workshop was inaugurated by Dr Lin Aung, WHO Representative to Nepal who delivered the keynote address on behalf of Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia. The Regional Director stated that though there had been a 25% decline in the prevalence of TB in the Region due to good case-finding and cure, TB continued to be a major public health problem in the Region, which bore one third of the global burden. One of the components of the new Stop TB strategy is to provide universal access to TB care by strengthening the health system and engaging all health-care providers (public, private and corporate providers). The international Standard of TB Care provides an opportunity to ensure high quality care for all TB patients. The challenges being faced in scaling up the public-private mix (PPM) need to be addressed.

The Practical Approach to Lung Health (PAL) provides an opportunity to improve quality of respiratory health care for all ages >5 years. The Regional Director emphasized the lack of good governance and the need to improve health notification system. He concluded by stating that PPM/PAL will help strengthen the health system and thereby provide universal access to health care.

This was followed by the introduction of participants. Dr Md Khurshid Alam Hyder, Regional Adviser-TB, WHO-SEARO briefed participants from Member States, regional experts and staff from WHO headquarters, the Regional Office and country offices on the objectives of the workshop as outlined below:

- Review the status, challenges and experiences in public-private mix partnership and PAL development in countries of the Region;
- Provide updates on the revised technical and programmatic guidelines for public-private partnership and PAL under national programmes, and
- Review existing national plans in order to include any additional measures required to effectively scale-up PPM and PAL in countries.

“Globally and in the Region we are fighting a disease more than centuries old and we need to fight this from primary to tertiary health care level”, said Dr Praveen Mishra, Secretary, Ministry of Health and Population, Nepal, who chaired the opening session of the workshop. He emphasized the need to have a public health approach to minimize misdiagnosis of TB. He concluded by saying that the workshop should come out with concrete recommendations and innovative approaches and tools for low-income countries which can be implemented with support from partners and proper management of funds.

3. Technical Session

3.1 Progress and plans on PPM/PAL in TB Control in SEAR

Private providers continue to be the first/alternate points of care for more than 60% of TB patients in Bangladesh, India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand. It has been recognized that there is much to be gained by partnerships in terms of wider reach and access to resources. Most countries where the private sector exists have initiated PPM and this partnership has resulted in increased case finding. However these countries need to further enhance the engagement of the private sector to ensure

optimum involvement of all potential care providers engaged in TB diagnosis, treatment and care. The main constraints faced are; human resource constraints (staff time, capacity, motivation) to rapidly expand PPM, limited networking and coordination between various players, especially in urban settings, lack of systematic involvement in QA mechanisms; inducting and monitoring of private laboratories, sustaining quality while expanding PPM and reluctance to accept supervision by NTP staff. Lack of regulatory approaches, absence of mandatory notification, non-existent accreditation and certification mechanisms and weak or usually absent drug regulation are some of the other key challenges faced by most Member States.

PAL implementation has been initiated in Nepal and Indonesia with a plan for expansion. Nepal has been the pioneer in implementing PAL in the Region. Sri Lanka and Kerala State in India have drafted a plan for piloting PAL while few of the remaining countries in the Region have not yet initiated plans for PAL implementation.

4. Workshop on PAL

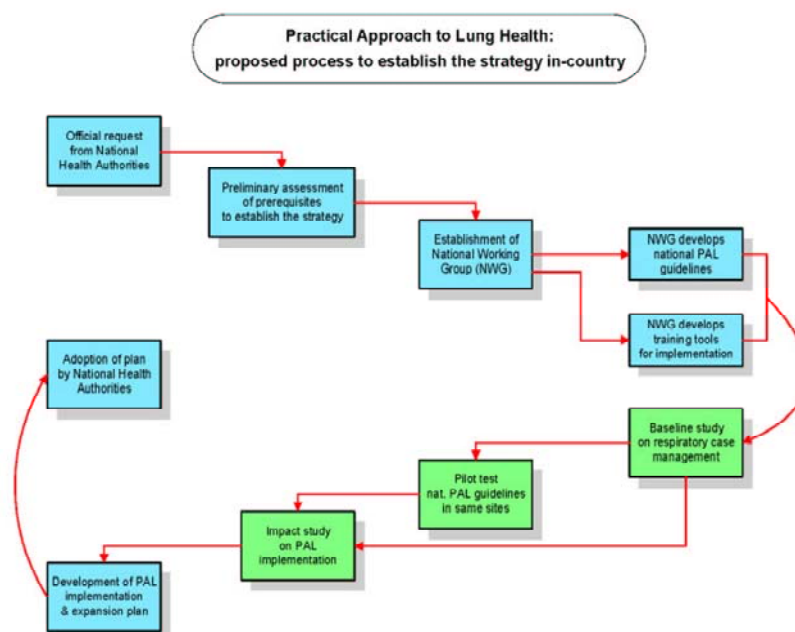
4.1 Concept of PAL strategy and overview of PAL development in the world

The third component of the Stop TB Strategy namely, “contribute to health system Strengthening” includes PAL as one of the main approaches. The rationale behind PAL initiative is the fact that respiratory conditions are very common and contribute from 20-35% of the outpatients at the primary health centre level. A systematic sound approach to manage these patients can be achieved by PAL that advocates for a syndromic management of patients who attend health services for respiratory symptoms with an objective to improve the quality of care. Experiences from different countries implementing PAL were shared. In general, drug prescription decreased both in terms of antibiotics and adjuvant drugs. Use of inhaled β agonists increased. The constraints identified in PAL development identified were lack of human resources, inadequate technical capacities and experts, funding issues and lack of documentation from countries implementing PAL.

4.2 Process to adapt, develop and implement PAL in countries

The practical approach to lung health needs to be adapted to country's health systems environment, and the necessary tools need to be developed and implemented within the context of respective health systems. The PAL adaptation, development and implementation should follow a step-wise process as outlined below:

- (1) Political commitment and official approval
- (2) Preliminary assessment and discussion in country to adapt PAL
- (3) Establishment of a National Working Group (NWG) on PAL
- (4) Preparation of PAL Guidelines
- (5) Training material development for PAL
- (6) PAL site-piloting
- (7) PAL implementation and expansion plan development
- (8) Mobilization of funding resources
- (9) PAL implementation
- (10) PAL in educational institutions



4.3 Key elements and process to develop PAL guidelines and training materials

Guidelines need to be targeted to suit the user with standardized diagnostic procedures and patient management and detail the referral procedures. Guidelines should contain details about the syndromic approach for diagnosis, alert signs to rule out emergencies, guidelines for clinical management and when and where to refer patients. The guidelines need to be tested in real situations and modified if necessary and endorsed by the ministry of health.

Training is mandatory to implement the guidelines and health workers own the guidelines. The contents should be adapted to the skills and knowledge of the health workers in the country. Three modules are essential for training: The participants' module, trainers' module and the course facilitator's module. Clinical case scenario and practical demonstrations should be included in the training. Both pre- and post-test evaluation material should be prepared.

4.4 PAL site-piloting

Piloting of PAL is required to test and validate the implementation of PAL guidelines and training material developed by the NWG, document that PAL improves the quality of care provided by health personnel who are dealing on daily basis with patients with respiratory symptoms in a PHC setting and provide sound data on the potential impact of PAL to national health authorities in order to get their support for PAL implementation and the potential donors. Indicators used for assessment will be: the proportion of respiratory conditions in a PHC setting; decrease of referral of respiratory patients from PHC setting to upper health level (better integration in PHC); improvement of the process of diagnosis of TB among respiratory patients and, if possible, of TB detection; reduction in drug prescription in general; and of antibiotics and adjuvant drugs in particular; improvement of drug prescription in CRD patients; and reduction in the cost of drug prescription. The three steps needed to carry out a feasibility study are:

- (1) Baseline study: assessment of the quality of care provided to respiratory patients by PHC workers without any intervention;
- (2) Intervention: training on PAL of the same PHC workers; and

- (3) Impact study: re-assessment of the quality of care provided to respiratory patients by PHC workers after training on PAL.

4.5 Country presentations on the experience of PAL implementation

Three SEAR countries (Nepal, Indonesia and India) who have initiated PAL implementation presented their experiences and shared the implementation progress:

Nepal

Nepal is one of the first countries where PAL surveys were carried out (1998 – Nawalparasi district). The PAL guidelines and training material were adapted and developed in Nepal in 2001. PAL was tested in a field cost-effectiveness study (Nawalparasi). It is included in the current NTP long-term strategic plan (2010-2015). Nepal has good political commitment to implement PAL through TB care and control services and PAL programme is implemented with integrated health services through TB programme. Presently PAL is implemented in 9 districts and 163 health facilities and 416 health workers have been trained on PAL. Funding from Global Fund Round 7 / National Strategic Application (NSA) is available to expand PAL (US \$ 2.6 million) and a strategic plan to expand PAL nationwide by 2015 has been drawn up. The country plans to implement PAL in five districts annually till 2015.

Indonesia

The PAL working group developed draft guidelines and training materials starting from October 2008 and finalized in March 2009. PAL implementation commenced in 2009 after the Faculty of Public Health, University of Indonesia became the principal recipient (PR) of Global Fund Round 8. Based on adapted guideline and training materials, PAL is still at the piloting stage in three provinces (Jakarta special area, West Java and Lampung). The country is planning to expand to districts and health centres within the pilot provinces until 2014. Efforts are on to ensure PAL sustainability:

- Incorporating inhaled drugs in the current list of essential drugs at health centre.
- Incorporating chronic respiratory diseases, diagnostic and treatment equipment in the standard list of equipment of health centre.
- Expansion to other provinces will take place after 2014 with a step-wise adaptation of training materials and guideline.

India

Political and administrative sanction was accorded to pilot the project in Kerala by the State Government with due understanding of objectives, stakes, commitments and milestones. A Technical Working Group was formed to develop Technical and Operational Guidelines (TOG) in 2009 through workshops and consultative processes involving national and international experts. Training modules on PAL for medical officers, staff nurses and health workers are prepared and recording and reporting forms are prepared. The pilot project is to be implemented in two districts of Kerala and based on the experience gained, the plan for future action will be drawn up.

The participants were divided into two groups, one group consisting of countries that have not yet initiated PAL activities and the other group with countries with some experience with PAL. The two groups worked on their future plans of action and presented them.

The country plans have been shown as annex 1.

5. Workshop on PPM

5.1 Experiences on field visits

Participants were divided into four groups. They visited the PPM sites in Nepal and presented their observations.

Group 1 visited the Health Research and Social Development Forum (HERD), an NGO centre. This NGO is linked to the Leeds University, U.K.,

and is funded by GFATM. It acts as an interlink between the NTP, community and the private sector. Its major focus is on urban slums and it looks after comprehensive health care. The NGO has a very good recording system, helps NTP from need identification to proposal development. The clinic is far away from the slum and the DOT centre is situated on the third floor.

Group 2 visited an NGO called JANTRA that works in collaboration with the Japan Anti TB Association. Funding is through GFATM and primarily provides microscopy and referral services to engage private and public sectors.

Group 3 visited a local NGO, the Helping Hand. Staff have good technical knowledge, have a good referral system, private practitioners (PPs) refer patients, but their documentation is not good.

Group 4 visited the Nepal AntiTB Association Clinic and the Kalimati Chest Hospital run by the National AntiTB Association (NATA) and the laboratory facilities of German Nepal Tuberculosis Project (GENETUP). The NATA is basically involved in health promotion activities, preparing ACSM material for curative aspects of TB. The Kalimati Chest Hospital, the only one in the country provided management of serious side-effects for TB, DRTB and HIV-TB.

The Genetup laboratory is funded by GFATM and though private, acts as the National Reference Laboratory. It caters to private sector for culture/DST and registers patients diagnosed with MDR-TB.

In conclusion, there is a good PPM initiative in Nepal, but the documentation is not up to the mark.

5.2 Public-private mix for TB care and control: Global progress and lessons

The public-private mix (PPM) is a systems approach to TB care delivery. There is a need for public-public mix to involve the public sector institutions that are involved in health-care delivery other than those that traditionally come under the health ministry. There is a wide range of private health-care providers to be involved in TB care to achieve universal

access to TB care. Specific roles have to be provided by different levels, for example, the government/NTO should be looking after clinical and public health tasks, whereas a private practitioner can be expected to look after the clinical functions. Over the years evidence has accumulated to show that it is feasible to effectively scale up PPM and that it will reduce the delay in case finding and is cost-effective. There has been an average increase of around 20% in case notifications by involving non-NTP care providers.

The PPM tool kit was presented and its use in scaling up PPM after adaptation was discussed. Countries then presented the usefulness of the kit and their intentions to use specific components of the toolkit. In general, it was felt that the tool is useful after adaptation to suit the country needs.

5.3 Country presentations on implementation of PPM experience in scaling up of private practitioners

Myanmar

There is a strong political commitment to involve all health-care providers in TB control activities. Involvement of PPs in Myanmar NTO is through combined efforts of PSI and MMA. Myanmar has three schemes for private providers: Scheme 1 - Health education and proper referral of suspects; Scheme 2 - Health education, referral and to act as a DOT provider; and Scheme 3 - Referral, diagnosis and treatment provision and to act as an affiliated DOT clinic. The PSI is implementing Scheme 3 while MMA is implementing all three schemes. Contribution to case notification in the year 2010 was 12% by PSI and 1.6% by MMA. PSI has an incentive scheme for providers; incentives are given at regular intervals in terms of transportation, nutrition, money to patients while MMA provides “incentive in kind” to PPs, and other incentives to patients. Myanmar plans to involve pharmacies and informal health-care providers in future. The major barriers to expansion are collaboration with local health authorities; change of attitude for both public and private doctors (only ~ 10% of the doctors are under PPM); sustainability of current achievement and financial resources and involvement of medical universities.

India

There is a multiplicity of health-care providers, and the first point of contact is often nongovernmental providers for more than half the patients. A huge volume of anti-TB drugs are sold outside by the private sector. The RNTCP provides leadership and support to facilitate systematic involvement of health-care providers outside the programme for control of TB with revised schemes based on sputum collection, microscopy centre, culture and DST and treatment adherence. A systematic approach is followed, consisting of sensitization, orientation and signing of an MoU for RNTCP schemes. The RNTCP provides periodical monitoring and supervision of activities and commodity assistance/ grant-in-aid.

The RNTCP and other schemes have been endorsed by the Indian Medical Association and the Indian Medical Professional Associations' Coalition against Tuberculosis has been formed. An intensified PPM project has been implemented in 14 urban areas where the programme has provided additional human resources to assist district programme managers. It has included private laboratories in diagnostic network.

The IMA coordinated PPM projects in several states with financial assistance through GFATM R6. The future plans include constituting a National Technical Working Group on PPM; exploring the scope of interface agency for contracting PPM; involving private laboratories; making tuberculosis a notifiable disease; regulating the sale and distribution of antiTB drugs; and devising flexible financing pools at the state level.

Timor-Leste

There are only nine private practitioners in the country, but the government doctors practise in private clinics. The NTP conducts regular meetings with PPs. For future there is a plan to involve traditional healers in the programme.

Scaling up the NGOs' engagement

Bangladesh

Bangladesh is a good example of involvement of NGOs in TB control activities. Currently 44 NGOs are involved in the programme. They contribute to joint resource mobilization, implementation, capacity building and health system strengthening. The rural programme is managed by two NGOs with logistic support from the NTP. They engage different health-care providers to enhance the TB control activities. In future, the country proposes to actively engage professional bodies and specialists using the international standards of TB care (ISTC).

Nepal

Several NGOs are involved in TB control activities in Nepal. Almost all I/NGOs concerned with TB and TB/HIV are engaged at different levels such as policy, planning, advocacy and public awareness raising, facilitating in implementation of activities, and delivering the TB services (diagnosis and treatment management). The National Reference Laboratory for culture/DST is run by an NGO. It serves both government and private sectors. The only TB hospital is run by an NGO. The Nepal Drug Resistant TB Programme is an excellent example of public-private partnership; at present, about 50% sites offering treatment services are in public and private sectors outside of the NTP. These partners implement the DR TB services under the leadership of the national programme. However, there is a need for more intensive effort to strengthen the supervision and monitoring system of the TB Control Programme through private sector and improving its documentation. The country is planning to expand PPM in five cities each year and cover the whole country by 2015.

Bhutan

There are no NGOs working in Bhutan. Hence the scope for involving NGOs is very limited. The country plans are to involve monks, pharmacies and traditional healers in TB control activities.

Scaling up the engagement of hospitals and academic institutions

Indonesia

The PPM was initiated first in hospitals (Yogyakarta) and lung clinics/hospitals because of the greater role played by the hospital in providing better outputs (institutional approach) in 2000. Besides those facilities other private hospitals/clinics, NGOs: Perdhaki, Pelkesi, LKC, PPTI; community: PAMALI; FBO: Aisyah (30 million members) and NU (60 million members) are also supporting TB DOTS services implementation and advocacy to local government. In 2009 the country brought out Managerial Guidelines for Hospital Standards in TB care developed jointly by 3 Directorates General (CDC, Medical Services and Community Health). The managerial guidelines for Hospital Standards in TB care have been disseminated and distributed in 639 Hospitals (DOTS) from out of a total of 1627 hospitals since November 2009 by Directorate of Medical Services. Hospital accreditation will be done in collaboration with DMS and funded by GFATM R10. In all 40% hospitals are engaged in TB care. For scaling up it is proposed that an ISTC be established and accreditation to further involve all health-care facilities/ hospitals, and to have 90% of 1627 hospitals accredited in coordination with the Directorate of Medical Services by 2014. The quality of TB services should be one of the indicators for hospital accreditation in order to provide quality management through: periodic supervision; money; and training/retraining using standardized modules and curricula.

Thailand

In Thailand, all public hospitals are involved in the TB control programme at all levels such as screening, case-finding, diagnosis and treatment and imparting training/health education. Though all medical college hospitals participate, there is an underreporting of cases. Nearly 50% of private hospitals are also involved. The NTP provides training and logistics, support for holding regular meetings and for supervising, monitoring and evaluating the activities. Budget is provided by the country and GFATM. The challenges faced are fragmentation of TB services in large hospitals, low case notification/under registration and reporting , low quality of DOTS in large hospitals and the private sector and low commitment to participate in

TB control. The country proposes to enhance the engagement of private hospitals by setting up a PPM committee, and developing human resources, providing regular training, supervision and monitoring to improve recording and reporting system, and by systematically implementing TB/HIV collaborative activities.

Sri Lanka

Public-private partnership: It is planning to establish three DOT centres around private hospitals to implement proper DOT and reporting system. The constraints faced are: consultants are managing TB patients in the public as well as private sectors without notifying and registering them; medical personnel are not adhering to national guidelines, thereby resulting in under- and over-diagnosis; and inadequate treatment due to interrupted drug supply. The county's future plans for scaling up include: clear national policy mandating notification and registration of TB patients detected in government and private sector hospitals; following national guidelines of international standards based on TB care; training of the private sector laboratory staff establishing EQA for the private sector laboratories engaged in TB microscopy and culture; and establishing a good recording and reporting system.

Engagement of prison inmates

Maldives

Currently the national TB control programme is being implemented directly under the Centre for Community Health and Disease Control delivering TB preventive and curative activities through all government hospitals, health centres (HC's), Maldives National Defence Force (MNDF), Police and the Department of Penitentiary. Services are being provided to prison inmates through dissemination of leaflets by law enforcement officers through the Department of Penitentiary. The Department also conducts awareness workshops for prison officers and provides active screening services to prison inmates. As part of the active screening process, a tuberculin survey was conducted among prison inmates.

Discussion during the session concentrated on the need for a situation analysis to improve the recording and reporting system.

6. Engaging pharmacies: collaboration and the way forward

The launch of the WHO/International Pharmaceutical Federation (FIP) joint statement on the role of pharmacists in TB care and control at the FIP's 71st World Congress, inaugurated in the presence of Her Excellency the President of India, was the culmination of joint efforts and collaboration of more than a year and a half among WHO's Stop TB Department, Essential Medicines and Pharmaceutical Policy unit of WHO's Health Systems Strengthening (HSS) cluster and FIP. The Joint Statement, was signed by the ADG/HTM on behalf of WHO and the President of FIP. The ADG/HTM delivered the keynote address with a video incorporated at the inauguration ceremony of the World Congress. A press conference was also organized by the FIP on the occasion. The event and the statement were widely publicized in the Indian and international press.

7. Regulatory approaches

In September 2011 a joint statement was signed by WHO and the International Pharmaceutical Association on the need for regulating the sale of antiTB drugs. The need to involve pharmacies has been recognized since the poor and vulnerable population with chest symptoms approach a plethora of providers including the pharmacies. They can be involved in referral and providing DOT. In addition, pharmacies can decide to procure and dispense only quality products. Since sale of ATT drugs is only a small proportion the total sale, it is possible to consider accredited pharmacies for sale of ATT drugs. Among the SEAR countries, ATT drugs are available across the counter in many. The essentials for a regulatory approach are: strong political support for regulating access with a clear, explicit policy; a well-functioning TB programme that guarantees continuous supply of free drugs; and a pro-active partnership with key private providers; and public awareness about free TB treatment through Information, education, communication and civil society engagement. All stakeholders such as policy-makers and drug authorities, programme managers, pharmaceutical companies, professionals and their associations, pharmacists and their associations and the civil society, consumer associations and activists need to be involved in the process.

8. Group work on preparing the operational framework for scaling up engagement of NGOs, private practitioners and hospitals

A group work was organized and countries presented their future plans for expansion and scaling up of PPM. The country presentations are given in Annex 2.

9. Conclusions and recommendations

Practical approach to Lung Health (PAL)

Conclusion

The PAL goes beyond DOTS and TB control programme and is to be considered as an approach to reach the “universal access” target and a mechanism for health systems strengthening. It should be included in the national health plan as part of HSS and there is a need to involve several health sectors. Whether the PAL initiative will be part of NTP or others needs to be decided according to country policy. Resource mobilization needs to be done by including PAL as part of TB or HSS proposal to the GFATM. Currently, in the Region only Nepal has begun to implement PAL activities. Indonesia has formed a national working group for PAL implementation and is in the preparatory phase. India is planning to pilot test in two districts in one state (Kerala) with commitment from the local government.

Recommendations

(1) Ministry of Health and Family Welfare

- Establish a National Advisory Working Group to oversee the policy, strategy and guideline development and to provide overall coordination and monitoring oversights.
- To appoint/nominate a focal point for PAL.

- Prepare plans and budgets for PAL and follow the “10 steps” approach for introduction and expansion.
- Stimulate discussions within the ministries of health to adopting PAL initiative under an appropriate section/division of the Ministry.
- Engage other concerned sectors within the health system for optimum PAL implementation. Depending on country context this may include noncommunicable diseases, Logistic Management Division, HMIS, drug regulatory authorities, HRD and others.

(2) World Health Organization

- SEAR to designate a focal person for PAL.
- Establish a list of PAL consultants for the Region and disseminate it.
- WHO to provide technical assistance to Member States.
- Organize a five-day workshop for PAL training in the Region.
- Include PAL in the agenda of the Regional Technical Working Group and National TB Programme Managers’ meetings.

Public-private mix (PPM)

Conclusions

Though all the Member States are involved in implementing PPM, the following bottlenecks still exist:

- Insufficient commitment and priority to PPM.
- Only a small proportion of private practitioners are involved.
- Involvement of nonqualified health-care providers is minimal.
- Many health NGOs are not engaged in TB care.
- Suboptimal involvement of large hospitals (public/private/corporate/academic)
- Weak documentation and reporting of PPM contributions.

- Regulatory approaches for rational practices and drug use are nonexistent in most member states.
- Implementation of national plans for PPM is inadequate.

Recommendations

Ministry of Health and Family Welfare

- Programme managers to raise the priority for PPM and mobilize human and financial resources.
- Utilize intermediary organizations and innovative approaches to enhance the involvement of PPs.
- Promote ISTC/patient charter.
- Develop specific mechanisms to target non-qualified providers/pharmacies.
- Map NGOs working for health and encourage those not involved to work for TB.
- Develop country-specific schemes for involving large hospitals in consultation with higher authorities responsible for hospitals, specifically addressing internal coordination and external networking.
- Insist on proper documentation of the contribution of PPM and reporting the same at national and global levels.
- Understand and initiate country-specific needs and mechanisms to implement regulatory approaches including mandatory case notification, accreditation and rational drug use.
- Ensure proper implementation and monitoring of national PPM scale-up plans.

World Health Organization

- Create a Regional Advisory Group to expedite and monitor PPM scale-up.
- Designate a regional focal point for PPM.
- Prioritize PPM in the agenda of the TWG and Programme Managers' meetings.
- Promote ISTC/patient charter in the Member States.

Annex 1 Country plans for PAL implementation

Country	Political commitment	Preliminary assessment	Establishment of National Working Group (NWG)	Development of PAL guidelines	Development of training material	PAL testing in pilot sites	PAL implementation and expansion plan	Resource mobilization	Start Expansion	PAL in health education curricula
Bangladesh	- Issue a letter to Directorate-General of Health Services, Ministry of Health for approval of formation of NWG with TORs (LD, NTP) - Appointment of PAL focal point within the NTP (LD, NTP) - Fund will be available through CPJ/MR-10 Country Office - January 2012	- Done in April 2008	- Finalisation of TORs - Establishment of NWG - December 2011	- NWG will take leadership technical assistance - Draft available June 2012	- Tech. Assistance from WHO and partners - Development for all category of staff - September 2012	- Selection of pilot site - Capacity building of staff - Implementations - Review of sites - Supervision and Monitoring - September 2012	- With Lessons learned from pilot sites, - Expansion plan - Work plan with budget - June 2013	- Identify sources (eg. GFA/M, TB fund) - June 2013	- Based on availability of - Capacity - Development - Procurement - Supply - Establish-ment of M&S - Supervision and Monitoring - September 2013	- Through assistance from NTP - In Medical and Nursing Curriculum - 2015
Bhutan	- Debriefing with the DCHS - Presentation about PAL and international experience. - Conduct meeting with MoHF, October - November 2011	- Formation of a technical team from NTP / MoHF – to formulate a preliminary assessment. - Conduct assessment. Discuss the findings with MoHF and get final approval - November 2011 – January 2012	- Formation of NWG, Chair – DCHS, Co-chair – NTP and Other stakeholders - HIV/AIDS, ICMH (physician/ paediatrician) MoHF officials responsible for health service - PHC / Police / MoHF / NSD / Police / NSCO - January 2012	- Seek international assistance through WHO. - Review National Health Policy and international best practice guidelines – - Gather and review the pre- assessment data. - Develop a national PAL guideline draft - Conduct feasibility test at PHC level - Final correction and approval of PAL guidelines - January - April 2012	- Seek international assistance through WHO - Review pre- assessment findings and collect model training modules - Develop draft training module - Finalise the draft module through a training workshop - Final correction and final approval - Conduct training of trainers - June 2012	- Review the pre- assessment data - Explore funds, technical and human resource - July- September 2012	- Review and evaluate the findings from pilot meeting - Review the PAL guideline by holding stakeholder's meeting - Develop plan for PAL implementation throughout the country - (Finance/equipment/ human resource) October – November 2012 - Final correction and approval - October – November 2012	- Request for external resources for second phase (eg. Global fund, etc.) - Ensure government funding through political commitment - October – November 2012	- Expanded PAL according to the expansion plan	- Incorporate PAL in the existing health services trainings
Maldives	- Debriefing with the DCHS - Presentation about PAL and international experience. - Conduct meeting with MoHF (October 2011)	- Formation of a technical team from NTP / MoHF – to formulate a protocol for preliminary assessment, which will be used as the baseline. - Conduct assessment. Discuss the findings with MoHF officials to get final approval - (November 2011 - January 2012)	- Secure funds for extra staff - Staff recruitment specific to PAL - Formation of NWG - Chair – NTP - Other stakeholders: HIV/AIDS (physician/paediatrician) MoHF officials responsible for health service (PHC) / DPRS (Prison) / NSD / Police / NSCO - January 2011	- Seek international assistance through WHO - Review National Health Policy and international best practice guidelines – - Collect model training pre- assessment data - Develop a national PAL guideline draft - Conduct feasibility test in PHC level - Final correction and approval of PAL Guideline - January - April 2012	- Seek international assistance through WHO - Review pre- assessment findings and collect model training modules - Develop draft training module - Field test the draft module through a training workshop - Final correction and final approval - Conduct training of trainers - April-June 2012	- Review the pre- assessment data - Explore funds, technical and human resource - Choose a single atoll for piloting and duration - July – September 2012	- Review and evaluate the findings from pilot meeting - Review the PAL guideline by holding a stakeholder's meeting - Develop plan for PAL implementation throughout the country - (Finance/equipment/ human resource) October – November 2012	- Request for external resources for second phase (eg. Global fund, etc.) - government funding through political commitment - October – November 2012	- Expanded PAL according to the expansion plan	- Incorporate PAL in the existing health services trainings - November 2012

Country	Political commitment	Preliminary assessment	Establishment of National Working Group (NWG)	Development of PAL guidelines	Development of training material	PAL testing in pilot sites	PAL implementation and expansion plan	Resource mobilization	Start Expansion	PAL in health education curricula
Myanmar	-NTP, MoH/DoH, Assignment of a person from MoH/DoH to coordinate TB Society -MMA -Q4 2011	-Composition -DOH -NTP -Dept. of Planning (CAVI/HSS project) -Dept. of Disease Control and Medical Care – Essential Drug Programme -Dept. of Public Health -Dept. of Medical Care -Dept. of Medical Sciences -Department of Medical Universities -MMA, PSI -WHO -Q1 2012	-Technical consultant -Financial resources -Information System -Q2 2012	-Composition: -DOH, NTP -Dept. of Planning (CAVI/HSS project) -Dept. of Disease Control and Medical Care – Essential Drug Programme -Dept. of Public Health -Dept. of Medical Care -Dept. of Medical Sciences -Department of Medical Universities -MMA, PSI -WHO -Q1 2012	-Technical consultant -Financial resources -Information System -Q2 2012	-Set up a sub-group under National Working Group -Technical consultant -Input from TB Technical and Strategic Group -Q3-4 2012.	-Technical consultant -Financial resources -Q4 2012	-Decision by National Working Group -Guidelines piloted in 11 divisional TB centre, 1 district and 1 township including private sector, MMA and PSI -Q1 2014	-Technical consultant -Financial resources -Starting with pilot project and followed by stepwise scale-up -Q2 2013	
Thailand	-Introduce PAL to NTP/policy makers from the National Tuberculosis (NTP) coordination Oct 2011 -Meeting with stakeholders to introduce PAL and find out key person (November 2011) -Meeting with key person (November 2011) -Identify key national health issues available within the health system (NWG) (NTP, November 2011) -Meeting for develop Thailand preliminary assessment (NTP) (December 2011)	-Level of demographic and epidemiologic transitions as well as the burden of respiratory illnesses within the national health system (December 2011). -Identify national health issues available within the health system (NWG) (NTP, November 2011). -Meeting for develop Thailand preliminary assessment (NTP) (December 2011).	-Along with Step 1	-Workshop with NWG and technical assistant to develop draft of PAL guidelines for each level by following the national procedures (February 2012) -Technical assistance to review and finalize the first draft (WHO expert) (March 2012) -Meeting to review the first draft guidelines after the meeting to users (March 2012) -Approve the PAL guidelines by NWG. (March 2012)	-Meeting with NWG and technical assistant to develop draft of training material for each level by following the national procedures (April 2012) -Meeting for review the first draft of training material (WHO expert) (May 2012) -Approve the training material by NWG. (June 2012)	-Meeting to select pilot sites (NTP) (July 2012) -Training all users at all levels (Public Health Office, community hospitals, health centres, etc) (July 2012) -Field evaluation result analysed regarding PAL guidelines and training material (July 2012) -Finalization of the guidelines and training material (August 2012) -Field evaluation (August 2012)	-Development of multi-year strategic plan to expand PAL services in collaboration with NWG (Sept 2012)	-Develop the protocol to expand PAL targeting national strategic division of MoPH (NWG) (August 2012) -Include PAL in the Global Fund proposal (NTP and NCOs) (September 2012) -Explore the possibility of funding the implementation of the plan through bilateral and multilateral cooperation. (August 2012)	-NTP to take the leadership (Oct 2012)	-NTP and NWG to take the leadership (January 2013)
Timor Leste	-PAL focal point within NTP (2011) -Assign a person from country national health authorities regarding PAL possibilities. -Conduct workshop with relevant sector (January 2012) -Mobilize some seed money from CFC for programming or through WHO (by NTP)	-Burdens of respiratory diseases within health system (HMS, MoH) (July 2012)	-Established NWG on PAL with NTP, HMS, Pharmacy, Department, MCH and other professionals (February 2012)	-Technical assistance through WHO to develop the guidelines (May 2012) -Workshop with the users on the first guidelines draft (NWG) (September 2012) -Finalization of PAL guideline for field testing (November 2012)	-Technical assistance through WHO to develop training material (NTP) (November – December 2012) -Finalization of training Material (NWG) (December 2012)	-Field testing of PAL guidelines and training material (May 2013) -Finalization of PAL guidelines and training material based on the results of the field testing (June 2013)	-Development of the multi-year strategic plan to expand PAL services in collaboration with NWG (August-September 2013)	-Explore the possible sources of funding, including international (NCO, USAM, CFC, Bilateral and multilateral cooperation) (Oct 2013) -Organize a national meeting with relevant sector to present the strategic plan to expand PAL (Oct 2013)	-NTP take the leadership (January 2014)	-NWG take the leadership (July 2013)

Country	Political commitment	Preliminary assessment	Establishment of National Working Group (NWC)	Development of PAL guidelines	Development of training material	PAL testing in pilot sites	PAL implementation and expansion plan	Resource mobilization	Start Expansion	PAL in health education curricula
Countries with Plan for PAL implementation										
India (only state of Kerala)	Steps 1-5 already completed. Training materials to be printed and training of trainers at selected sites to be conducted after identification of trainers. This is proposed to be done in November 2011. Provision of Operational Guidelines and SOPs to the selected health facilities and Procurement of Drugs during Nov 2012. Funding for the project will be by the RNTCP of Kerala. Based on the results of the pilot, decision regarding districts will be taken regarding further expansion.									
Indonesia	Steps 1-4 already completed. PAL guidelines will be drafted during Q1 2012. Plan is to expand to two districts each year between 2012-2014. This will depend on the availability of funding. Resource mobilization from WHO, USMD, and local budgets. Stepwise expansion to other provinces will take place after 2014 after adaptation of training materials and guidelines.									
Sri Lanka	Workshop with Director, NPTCCD, consultant chest physicians, consultant community physicians, DTCOs, medical officers and health education officers to prepare training modules (finalize and print the modules between October - December 2011. The next step will be to identify trainers and conduct the training with technical assistance from WHO. (Between January-March 2012). Training of PHC workers in institutions where PAL is piloted will be done between April-May 2012. Essential drugs for PHCs in the piloting area will be supplied. (The drugs for piloting will be provided by the Ministry of Health). The PAL equipment for PHCs and supply of the identified list of equipment to the selected HGI in the piloting area will be according to needs assessment. (Equipment was procured through the GFATM R6 funds) This activity will be carried out during June-July 2012. Collection of data from the given data collection formats and processing and analysing data by the NPTCCD and comparison with the similar data will be done between July-December 2012. Expansion to other districts will be carried out after ensuring political commitment and formation of NWC during the next five years.									
Nepal	Nepal is the only country in the SEA Region to have implemented PAL. The PAL guidelines and training material were adapted and developed in Nepal in 2007, and were tested in a field cost-effectiveness study (Nawalparasi). The PAL is included in NTP's long term strategic plan. A joint team from WHO-HQ, WHO-SEARO, WHO-Nepal visited Nepal and PAL piloting was carried out following the decision of the Ministry of Health and Population and other key partners along with NTC, in two districts (Bhaktapur and Nawalparasi). A WHO staff was recruited from mid-July 2007 for five-and-a-half months to assist PAL implementation. Major activities for implementation included training for basic health services staff (hospitals, PHC, HP and SHP), training and refresher for MCHVs/VHVs (HP and SHP), orientation workshop for FCHVs and regular supervision and monitoring in PAL implementing sites (trimesterly evaluation and planning workshop in districts). The proposed expansion plan has been charted out and it is proposed to introduce PAL in five districts each year starting from 2010 and the whole country to be covered by 2015.									

Annex 2

Country presentations on PPM

Experiences in scaling up of private practitioners

<p>Myanmar</p>	<p>Private practitioners are involved either through PSI or MMA. There are three schemes for involvement; Scheme 1 - Health education and proper referral of suspects; Scheme 2 - Health education, referral and to act as a DOT provider; Scheme 3 - Referral, diagnosis and treatment provision and to act as an affiliated DOT clinic. In all, 1022 practitioners are involved, 912 with Scheme1, 2 with Scheme 2 and 118 with Scheme 3. Contribution by PSI has been 12.6% of all forms of TB reported in 2010. The current approach for PPM is through advocacy and training on TB control, drugs and laboratory supplies, distribution from NTP, and endorsement and dissemination of International Standards for Tuberculosis Care (ISTC) to medical universities, tertiary hospitals, Myanmar national health professional associations. The PSI and MMA offer incentives to patients and MM also provides incentives in kind to PPs. Supervision and monitoring are performed by the NTP.</p> <p>The major barriers to scaling up are: change of attitude for both public and private doctors (Only ~ 10% of the doctors are under PPM), operational barriers at all levels – transportation, health-seeking behaviour of patients and patient support, etc; sustainability of current achievement and financial resources and involvement of medical universities. The planned actions for strengthening the engagement of PPs are:</p> <p>NTP: To involve informal health-care providers and drug sellers in TB control</p> <ul style="list-style-type: none"> - To coordinate with DMS to include ISTC in revised medical curriculum. <p>PSI : To expand 100 SQH clinics, 500 SPH workers, 20-25 townships annually to achieve 15% national case detection by 2015</p> <ul style="list-style-type: none"> - To involve informal health-care providers and drug sellers (TB Reach) - To initiate TB/HIV prevention and control activities - To mobilize financial/ logistic support to MDR cases in close collaboration with NTP
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	<p>MMA-TB</p> <ul style="list-style-type: none"> - To expand to 150 townships and to involve 1 500 PPs by 2015 - To scale up Scheme III
<p>India</p>	<p>RNTCP provides leadership and support to facilitate systematic involvement of health-care providers outside the programme for control of TB.</p> <ul style="list-style-type: none"> - Schemes for involving PPs have been in vogue since 2000 and they were revised in 2008. The RNTCP PPM IMA Project (to involve qualified practitioners) was launched in six states; IMPACT (Indian Medical Professional Association Coalition against TB) was launched in 2010 with the Project Axshya (partnership with Civil Society – to involve unqualified private practitioners/ AYUSH). A systematic process has been used to involve PPs: Sensitization of administrators and opinion leaders, Orientation of RNTCP staff on PPM DOTS, Mapping of PPM health-care providers, Prioritization of providers most likely to contribute, Sensitization and training of PPM providers, Signing of RNTCP schemes (Memorandum of Understanding-MoU) and Start of service delivery. Currently around 10.063 PPs are involved in RNTCP. An intensified PPM project was launched in 14 urban areas in 2003. In Quarter 1 2010, 20% of the symptomatics were referred by PPS and contributed to 5% additional new sputum positive cases. The challenges faced in engaging PPs are: <p>NTP:</p> <ul style="list-style-type: none"> - Inadequate experience in dealing with other sectors - Lack of faith in the capacity of the private sector - Lack of clarity among District officials regarding operationalization of fundflow mechanism. - Lack of strong intermediary groups that can facilitate links and payments between government and private sectors <p>Private-practitioner related</p> <ul style="list-style-type: none"> - Large and unorganized private sector - Lack of faith in public sector health programmes - Low priority for carrying out public health programmes - Perception of RNTCP being rigid regarding diagnosis, regimens, DOT

	<ul style="list-style-type: none"> - Issue of financial incentives offered by existing PPM schemes - Need for administrative requirements and MoU <p>Patient-related</p> <ul style="list-style-type: none"> - Contradicting information from health sector/systems - Lack of trust in the quality of care provided by public sector - Issues of stigma and confidentiality <p>Regulatory environment</p> <ul style="list-style-type: none"> - AntiTB drugs: easily purchased from the market. - TB notification: not mandatory - Almost no regulations on establishment of private practice <p>The RNTCP is in the process of preparing for the next phase by stressing the importance of universal access; PPM is a major issue. During the next five-years (2012-2017), it is proposed to:</p> <ul style="list-style-type: none"> - Constitute a National Technical Working Group on PP - Explore the scope of the interface agency to act as an interface for contracting PPM - Involve private laboratories - Making tuberculosis a notifiable disease - Regulating the sale and distribution of antiTB drugs - Devising flexible financing pools at state level
Timor-Leste	<p>Country has nine full-time PPS, but all government doctors practise outside office. The NTP conducts regular meetings with PPS and provides training. The challenges faced are: inadequate supervision by NTP. and no target for PPs to achieve. The future plans are to have regular supervision from NTP to private practitioners, continue to provide support, expand DOT to private practitioners, give target to private practitioners to measure capacity for achievement and to continue to provide training to private practitioners.</p>

Experiences in scaling up NGOs and business sector

Bangladesh	<p>Bangladesh is a good example of NGO involvement. Currently 44 NGOs are involved as partners of NTP e.g: BRAC, Damien Foundation, The Leprosy Mission, Bangladesh, Lepra Bangladesh, RDRS, HEED Bangladesh, SSFP, PPPP (Operation research) and BGMEA / BKMEA etc. NGOs are contributing in joint resource mobilization, implementation, capacity building and health system strengthening. From October 2009 to September 2010, 32 063 patients have been referred and 463 patients have been managed by the corporate sector health facilities. The main barriers to scaling up engagement are: Maintaining and Improving quality services; Sustaining and Scaling up PPM; Lack of adequate information on the size of TB caseload managed in the private sector. In addition, TB management practices in the private sector are not standardized and need close monitoring and supervision. There is no regulation for anti-TB drug sale. Actions proposed to scale up engagement are: to do a situation analysis and guideline update; to actively engage professional (e.g. BMA, BPMPA, BKMEA) specialists using the International Standards for TB Care; enhance coordination and collaboration between different ministries; expand collaboration with industry, corporate sector and pharmacy holders through respective associations; development and distribution of advocacy materials to private providers; and to engage private hospitals, clinics and diagnostic centres.</p>
Nepal	<p>Nepal has formed an international cooperation network (TBCN) consisting of BNMT, GENETUP, INF, NLR, LHL, Nuffield/Leeds, HERD, SAARC TB and HIV/AIDS Centre (STC), and WHO. Almost all I/NGOs concerned with TB and TB-HIV are engaged at different levels such as policy, planning, advocacy and public awareness-raising, facilitating in implementation of activities and delivery the TB services (diagnosis and treatment management) through their own clinics. Major activities include regular meeting of national PPM working groups, sensitization meetings with local organizations, formation of PPM working groups at national and district levels, workshop to develop district specific PPM/ISTC action-plans in 16 cities, establish and strengthen TB services delivery centre/sub centres with PPM/ISTC mobilizing local resources, and establishing service linkage, referral and feedback mechanisms. The main challenges faced are: Addressing management issues raised by private practitioners:</p> <p>Logistic management for private service centre especially in a big city; expansion of TB diagnosis services in private health institution (might be lacking in planning or facing problem in activity distribution; follow-up</p>

	<p>activities are very limited; establish feedback (case-finding) mechanism for service linkage; provide support to poor TB patients who are in need and provide orientation to pharmacists. The future plans include Expansion of PPM in 5 cities annually, PPM/ISTC orientation in medical colleges and academic institutions, Provide training to medical practitioners, Provide training to general health workers, PPM/ISTC orientation to private hospital and PPM DOTS advocacy campaign in slum areas and others vulnerable groups etc.</p> <p>There is a need more intensive effort to strengthen the supervision and monitoring system through private sector in TB Control Programme</p>
Bhutan	<p>The current approaches in the country include referral/monks/traditional healers. There are no antiTB drugs available in pharmacies. The country does not find much role for NGOs. It proposes to involve monks, traditional healers, multisectoral task force members (MSTF), Community Action Group(CAG) and BCCI/Corporations. Actions to be undertaken are: advocacy/sensitization, training, seek technical assistance and additional financial support, strengthen coordination and collaboration, and strengthen linkages with TB and HIV programme. And scale up MDR-TB management. The main barriers are: geographical terrains, superstitions, low literacy rate in some pockets, mobile population, hard-to-reach populations, large number of migrant workers and Porous border towns.</p>

Scaling up engagement of hospitals and academic institutions

Thailand	<p>All public sector hospitals (1057 MoPH, 13 BKK hospitals, 5 ministry of defence/police) are involved in NTP. All nine medical universities and 152 out of 312 private hospitals participate in the programme. However, there is underreporting from medical universities. Furthermore, hospitals under the Ministry of Defence do not report. All hospitals undertake screening, case-finding, diagnosis and treatment and DOT/health education. The current approaches for involving hospitals include supporting (NTP guidelines, training, laboratory, drugs, IEC material, etc.), regular meetings (sustain commitment), supervision and monitoring and evaluation. Programmes are funded through country/GF budget. Major challenges and barriers to scaling up engagement of PPM are: fragmentation of TB services in large hospitals, low case notification/underregistration and reporting, low quality of DOTS in large hospitals and private sectors and low commitment to participate in TB control. Planned actions to scale up/strengthen engagement are: involvement of private hospitals through public hospitals (MoPH, BMA, military, university) to participate on the programme (make commitment: set up PPM committee and developing Human resources etc.), and improving treatment success rates. Urgently</p>
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	strengthen patient support and DOTS in public and private hospitals, Increase case notification (training, develop R/R system), strengthening of regular supervision, monitoring and evaluation and systematically implement TB/HIV collaborative activities in private sector.
Indonesia	<p>The PPM in Indonesia involves various health providers such as hospitals, prisons, workplace/industry, PPs, health insurance and Ministry of Defence. The PPM was initiated first in hospitals (Yogyakarta) and lung clinics/hospitals because of the greater potential role played by hospitals in providing better outputs (institutional approach) in 2000. Besides those facilities other private hospitals/clinics, NGOs : Perdhaki, Pelkesi , LKC, PPTI; community : PAMALI; FBO : Aisyah (30 million members) and NU (60 million members) are also involved in supporting TB DOTS services, implementation and advocacy with local government. The current approach to engage hospitals in TB care and control are managerial guidelines for hospital standards in TB care were developed in 2009 by 3 Directorates General (CDC, Medical Services, Community Health) include organizational plan, criteria of DOTS hospital, composition of DOTS team, training, and development of internal, external and laboratory networks. The managerial guidelines for hospital standards in TB care have been disseminated and distributed 639 Hospitals (DOTS) from out of a total 1627 Hospitals since November 2009 – by Directorate Medical Services. Seven strategies have been formulated to achieve the vision of “Toward a free TB, healthy, just and self-reliant society.” Under the National Strategic Plan 2010-2014 and PPM Plan of Action 2011-2014 and there is regular training, monitoring and supervision for hospital DOTS linkage (HDL). The country has involved Directorate, Medical Services as subrecipient for GF TB Round 10/SSF (Single Stream Funding) for Hospital accreditation. 26 Medical Faculty staff from 52 Public and private medical faculty were engaged to develop DOTS curricula. It is proposed to have an accreditation done for hospital and (DOTS and Non-DOTS) starting in Q4 – 2011 coordination with Directorate, Medical Services for scaling up HDL. Currently, 315 of 533 (59%) government hospitals, 221 of 867 (26%) private hospitals, 22 of 63 (35%) of Parastatal hospitals, 73 of 155 (57%) of army/police hospitals and all 8 of lung hospitals are implementing DOTS.</p> <p>The major barriers to scaling up engagement are:</p> <ul style="list-style-type: none"> • TB service delivery challenges <ul style="list-style-type: none"> – Equitable access for unreached population – universal access for DOTS services – Area-specific burden – geographical, epidemiologic variation

	<ul style="list-style-type: none"> - DOTS expansion at hospital, clinic, private practitioners' level - Compliance of care providers to ISTC • Health system challenges <ul style="list-style-type: none"> - Low local commitment and lack of advocacy - Coordination and harmonization of programme implementation - Low allocation of financial resources - Gaps in Human resources - Weak regulatory functions <p>Planned activities for scaling up are: Establish ISTC and accreditation to further involve all health-care professionals/ all hospitals. Up to 2014, 90% of 1627 hospitals have been accredited in coordination with Directorate, Medical Services, Quality of TB services is one of the indicators for hospital accreditation; Involving private laboratories and private pharmacists and quality management improvement through: periodic supervision and training/retraining by using standardized modules and curricula.</p>
Sri Lanka	<p>The current approaches for involving private hospitals and academia are: mobilize communities for intensive patient support and IEC activities; support to the Working Group on development and supervision of public-private-academia partnership, TB/HIV collaboration, gender equality and MCH integration into TB control; motivating medical personnel to refer TB suspects and patients to chest clinics from private health-care facilities through public-private partnership; establishing 3 DOT centres around private hospitals to implement proper DOT and reporting system. The challenges faced are: consultants are managing TB patients in the public as well as private sector without notifying and registering, medical personnel are not adhering to national guidelines causing under and overdiagnosis and inadequate treatment due to interrupted drug supply in government and private hospitals. The future plans include having a clear national policy mandating notification and registration of TB patients detected in government and private sector hospitals, and following national guidelines of international standards based on TB care, establishing 12 DOT centres around private hospitals to implement proper DOT and reporting system, training of the private sector laboratory staff (Initial and refresher) and establish EQA in private sector laboratories that are engaged in TB microscopy and culture (performed by the NTRL) and to establish a reporting system.</p>

Scaling up engagement of prisons:

Maldives	<p>Currently, the national TB control programme is being implemented directly under the Centre for Community Health and Disease Control delivering TB preventive and curative activities through all government Hospitals, HCs, MNDF, Police, Department of Penitentiary. The current approach to involve prisons includes:</p> <ul style="list-style-type: none">• Dissemination of leaflets to prison inmates and law enforcement officers through the Department of Penitentiary• The Department of Penitentiary with technical assistant conducts awareness workshops for prison officers• The NTC in collaboration with prison officers provides active screening services to prison inmates• The MNDF and police services conduct awareness workshops for officers with technical assistance from NTC• The MNDF and Police services conduct active TB screening for newly recruited officers with assistance from NTC• The youth from BG sports club conduct active screening for members with assistance from NTC <p>A focal point was selected by the Department of Penitentiary to communicate between NTC and prison inmates. A tuberculin survey was also conducted. The barriers to sustaining and scaling up are: health system reforms, large number of expatriates with TB and frequent change of prisons with poor medical documentation – particulars are lost to follow-up.</p> <p>It is proposed to hold a large-scale screening programme within the prison and among law enforcement personnel.</p>
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Annex 3

Agenda

- (1) Overview of Regional PPM/PAL progress/initiatives
- (2) Concept of PAL Strategy and overview of PAL development at global level
- (3) Process to adapt, develop and implement PAL in country: what are the steps?
- (4) Key elements and process to develop PAL guidelines
- (5) Training material development to implement
- (6) PAL site-piloting
- (7) What indicators to use to monitor and evaluate PAL services?
- (8) Experience in PAL development and implementation in Nepal
- (9) Experience in PAL development in Indonesia
- (10) Experience in PAL development in Sri Lanka
- (11) Experience in PAL development in Bangladesh
- (12) Experience in PAL development in India (Kerala State)
- (13) Organization of the work groups

Annex 4

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The third and fourth components of the Global Plan to Stop TB, 2011-2015, are to “Strengthen health systems based on primary health care” and “Engage all care providers,” an approach to ensure universal access to high quality TB services through the involvement of all public, voluntary, corporate and private providers and the adoption of the “International Standards for Tuberculosis Care (ISTC)”. The plan emphasizes the need to strengthen the health system through an innovative approach such as the Practical Approach to Lung Health (PAL), which is based on improving the quality of care of all respiratory patients above five years of age, and focuses on the primary health care level.

The specific objectives of the regional workshop on Public and Private Mix/Practical Approach to Lung Health in TB Control were to review the status, challenges and experiences in public-private mix partnership and PAL development in countries of the Region, provide updates on revised technical and programmatic guidelines for public-private partnership and PAL under national programmes and review existing national plans in order to include any additional measures required to effectively scale up PPM and PAL in countries.

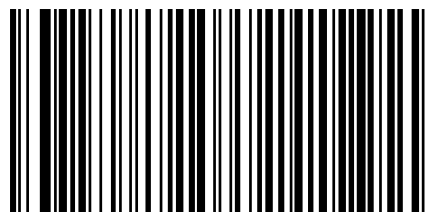
The workshop addressed several important issues including the progress and plans on PPM and PAL in TB control in the WHO South-East Asia Region followed by presentations on concepts of PAL strategy, overview of PAL implementation at the global level, and the key elements and process to adapt, develop and implement PAL at the country level. Some countries in the Region shared their experiences on PAL development and implementation. The workshop deliberated on the global progress on PPM and on the use of the tool kit for PPM expansion plan. The plans on scaling up engagement of private practitioners, NGOs and hospitals in TB care and control were drafted by the countries. This report contains discussions and deliberations made during the workshop along with conclusions and recommendations for supporting the Member States in developing and implementing appropriate management of PAL and PPM according to their country context.



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SEA-TB-336