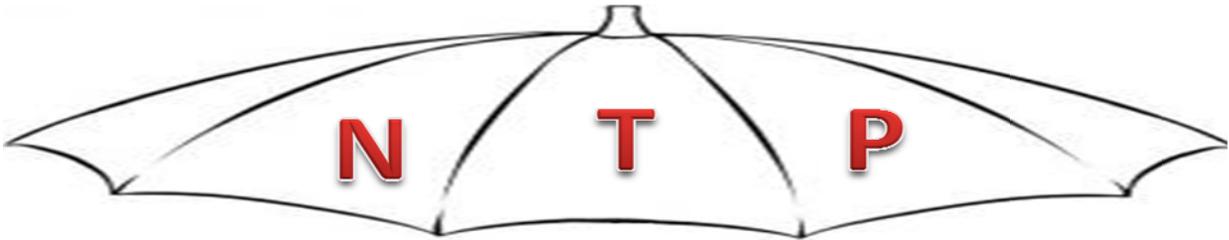




SAARC Guidelines for Private–Public Mix Approach for National TB Control Programmes



SAARC TB and HIV/AIDS Centre
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CONTENTS

Preface

Abbreviations

1. Introduction	1
2. WHO End TB Strategy	3
3. Engage Community and Civil-society	5
4. Benefits of PPM Approach in NTP	6
5. PPM Contribution to Public Health	7
6. Implementing PPM for TB Control	7
6.1. A National Situation Assessment	8
6.2. Creating National Resources for PPM	9
6.3. Developing Operational Guidelines	10
6.3.1. Objective of PPM	11
6.3.2. Task mix for different providers	11
6.3.3. Development of practical tools	12
6.3.4. Training	13
6.3.5. Official recognition	14
6.3.6. Incentives and enablers	15
6.3.7. Surveillance and monitoring	16
6.4. Local Implementation	17
6.4.1. Preparation	18
6.4.2. Mapping and first contact with providers	18
6.4.3. Selection of providers	19
6.4.4. Implementation proper	20
6.4.5. Advocacy and Communications	20
6.5.6. Supervision & monitoring for scaling up	21
7. SAARC Member States, PPM scaling up in NTP	24
7.1. Afghanistan	24
7.2. Bangladesh	25
7.3. Bhutan	30
7.4. India	31
7.5. Maldives	32
7.6. Nepal	33
6.7. Pakistan	36
6.8. Sri Lanka	39
References	40

PREFACE

This document is produced to comply the decision of the Twenty-Sixth Meeting of the Governing Board of SAARC TB and HIV/AIDS Centre held in Kathmandu from 11th to 12th January 2017. The title of the task was approved as Development of Frame-work and Guidelines for Public Private Mix. Accordingly, the documents has been prepared and sent to the SAARC Member States for their perusal.

This document guides the people who work in National TB Control Programmes on how to engage all relevant health care providers under the common umbrella of Public Private Mix Approach of TB care and control and helps to create an evidence-based for achieving an effective PPM for TB control. This document aims to guide NTPs people to initiate and expand the programmes to involve all relevant health care providers in TB control as well as it helps to promote access to quality TB care in the country. PPM will help not only in increasing TB case notification but also in reducing the financial burden to TB patients as well as National TB control programmes as a whole. Proper implementation of PPM could get a further boost through the International Standard for TB Care (ISTC). The ISTC could be used to secure a broad base of endorsements NTPs, professional medical and nursing societies, academic institutions, I/NGOs etc.

We have taken WHO publications on PPM in TB control as references to produce this document. We wish to extend our thankful acknowledgement for the people who developed the PPM guidelines for WHO. We thankfully acknowledge to our National TB Control Programme Managers of Member States for their support and guidance to complete this document.

Dr. R. P. Bichha
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ABBREVIATIONS Used

ACSM	Advocacy, Communications and Social Mobilization
AIDS	Acquired Immunodeficiency Syndrome
BEPZA	Bangladesh Export Processing Zone Authority
BGMEA	Bangladesh Garments Manufacturing Exports Association
BHUs	Basic Health Units
DEPZ	Dhaka Export Processing Zone
DOT	Directly Observed Treatment
DOTS	Directly Observed Treatment Short-course
EPZ	Export Processing Zone
GFATM	Global Fund for AIDS, TB and Malaria
GPs	General Practitioners
HIV	Human Immunodeficiency Virus
I/NGOs	International Non-governmental Organizations
ICT	Information and Communications Technology
ISTC	International Standard for TB Care
KAP	Knowledge, Attitude and Practice
LoA	Letter of Agreement
MDGs	Millennium Development Goals
MDR	Multi Drug Resistant
MoU	Memorandum of Understanding
NGOs	Non-governmental Organization
NPR	Nepalese Rupee
NTPs	National Tuberculosis Control Programmes
PMPs	Private Medical Practitioners
PP	Private Practitioner or (Health care provider of any type)
PPIA	Private Provider Interface Agency
PPM	Public Private Mix
PPP	Public Private Partnership
PSKP	Progoti Samaj Kallyan Protisthan
RNTCP	Revised National TB Control Programme
SAARC	South Asian Association for Regional Cooperation
STAC	SAARC Tuberculosis and HIV/AIDS Centre
STDs	Sexually Transmitted Diseases
TB	Tuberculosis
UATBC	Universal Access for TB Care
WHO	World Health Organization

SAARC Guidelines for Public-Private Mix Approaches to Control Tuberculosis in Member States

1. Introduction

The burden of Tuberculosis in SAARC Member States is enormous. Among the 30 TB High Burden Countries of WHO, we have 3 countries, namely India, Pakistan and Bangladesh with more number of patients with symptoms suggestive of tuberculosis (TB) seek care from private health-care providers. These care providers, often not linked to public sector-based on National Tuberculosis Control Programmes (NTPs), may serve a large proportion of TB suspects. The size, types and roles of these care providers vary greatly within and across the countries. In some settings there is a large private commercial sector and numerous non-governmental organizations (NGOs) while in others there are public sector providers such as general hospitals that operate outside the scope of NTPs. Evidence suggests that failure to involve all care providers used by TB suspects and patients hampers case detection, delays diagnosis, leads to inappropriate and incomplete treatment, contributes to increasing drug resistance and places an unnecessary financial burden on patients as well as on country.

Engaging all relevant health care providers in TB care through public-private mix approaches is an essential component of the WHO End TB Strategy. **Public-Private Mix** (PPM) for TB prevention and care represents a comprehensive approach for systematic involvement of all relevant health care providers in TB care to promote the use of International Standards for TB Care (ISTC) and achieve National goal of TB control targets. PPM encompass diverse collaborative strategies such as public-private (between NTP and the private sectors), public-

public (between NTP and other public sector care providers such as general hospitals, prison or military/police health services etc.), and private-private (between an NGO or a private hospitals/poly-clinics and the neighborhood private providers) collaboration. PPM also implies engaging relevant care providers in prevention and management of Drug Resistant Tuberculosis (DR-TB) and in the implementation of collaborative activities for the management of TB/HIV co-infections.

All SAARC Member States are implementing PPM activities attached with the activities of NTP.

A great deal of progress has been made in global tuberculosis control in recent years through the large-scale implementation of DOTS. It has been acknowledged though that TB control efforts worldwide, although impressive, are not sufficient. The global TB targets, detecting 70% of TB cases and successfully treating 85% of them and halving the prevalence and mortality of the disease by 2015 as part of the Millennium Development Goals (MDGs) which has already being achieved by the systematic involvement of all relevant health care providers in delivering effective TB services to all segments of the population in the country.

In most Member States of SAARC with a significant burden of TB, DOTS implementation was limited largely to public sector services under National Tuberculosis Control Programmes (NTPs). In reality, however, many patients with symptoms of TB, including the very poor, do seek and receive care from a wide variety of health care providers outside the network of NTP services. The magnitude and the role of these non-NTP providers, both private and public, vary greatly from country to country. Some countries have a large private medical sector that provides services to all segments of population, both rich and poor. Private providers also include practitioners who may not be formally qualified,

such as traditional healers in rural areas and informally-trained practitioners in urban slums. Civic groups working with disadvantaged communities and nongovernmental organizations (NGOs) provide TB care in many places in the country. Urban areas in most countries have a mix of public sector providers, which include medical college hospitals, speciality centres such as chest clinics and general public hospitals. In spite of being a part of the public sector, these providers do not always coordinate with NTP or apply DOTS.

2. WHO End TB Strategy

The vision for the post - 2015 global tuberculosis strategy is “a world free of tuberculosis”, also expressed as “zero deaths, disease and suffering due to tuberculosis”. The goal is to end the global tuberculosis epidemic.

The Millennium Development Goal target “to halt and begin to reverse the incidence of tuberculosis by 2015” has already been achieved. The related Stop TB Partnership targets of reducing tuberculosis prevalence and death rates by 50% relative to 1990. Under End TB strategy, new, ambitious yet feasible global targets are proposed for 2035. These include achieving a 95% decline in deaths due to tuberculosis compared with 2015, and reaching an equivalent.

The 90% reduction in tuberculosis incidence rate from a projected 110/100000 in 2015 to 10/100000 or less by 2035 are the targets to equivalent to the current levels in some low-incidence countries of North America, western Europe and the Western Pacific. An additional the target proposed to ascertain progress of universal health coverage and social protection is that by 2020, no tuberculosis-affected person or family should face catastrophic costs due to tuberculosis care and support by engaging all relevant health care providers in TB care and control through Public Private Mix (PPM) approaches is an essential component of the

WHO's End TB Strategy. One of the components of End TB Strategy is engagement of communities, civil society organizations and public and private health care providers.

The End TB Strategy at a glance (2016–2035)

VISION	A WORLD FREE OF TB - zero deaths, disease and suffering due to TB			
GOAL	END THE GLOBAL TB EPIDEMIC			
INDICATORS	MILESTONES		TARGETS	
	2020	2025	SDG 2030 ^a	End TB 2035
Reduction in number of TB deaths compared with 2015 (%)	35%	75%	90%	95%
Reduction in TB incidence rate compared with 2015 (%)	20% (<85/100 000)	50% (<55/100 000)	80% (<20/100 000)	90% (<10/100 000)
TB-affected families facing catastrophic costs due to TB (%)	0	0	0	0
PRINCIPLES				
<ol style="list-style-type: none"> 1. Government stewardship and accountability, with monitoring and evaluation 2. Strong coalition with civil society organizations and communities 3. Protection and promotion of human rights, ethics and equity 4. Adaptation of the strategy and targets at country level, with global collaboration 				
PILLARS AND COMPONENTS				
1. INTEGRATED, PATIENT-CENTRED CARE AND PREVENTION				
<ol style="list-style-type: none"> A. Early diagnosis of TB including universal drug-susceptibility testing, and systematic screening of contacts and high-risk groups B. Treatment of all people with TB including drug-resistant TB, and patient support C. Collaborative TB/HIV activities, and management of co-morbidities D. Preventive treatment of persons at high risk, and vaccination against TB 				
2. BOLD POLICIES AND SUPPORTIVE SYSTEMS				
<ol style="list-style-type: none"> A. Political commitment with adequate resources for TB care and prevention B. Engagement of communities, civil society organizations and public and private care providers C. Universal health coverage policy, and regulatory frameworks for case notification, vital registration, quality and rational use of medicines, and infection control D. Social protection, poverty alleviation and actions on other determinants of TB 				
3. INTENSIFIED RESEARCH AND INNOVATION				
<ol style="list-style-type: none"> A. Discovery, development and rapid uptake of new tools, interventions and strategies B. Research to optimize implementation and impact, and promote innovations 				

^a Targets linked to the Sustainable Development Goals (SDGs)

3. Engage Communities and Civil-society

A robust response to end the tuberculosis epidemic will require the establishment of lasting partnerships across the health and social sectors between the health sector and communities. Informed community members can identify people with suspected tuberculosis, refer them for diagnosis, provide support during treatment and help to alleviate stigmatization and discrimination. Civil society organizations have specific capacities and NTPs can be benefited from harnessing them. Their competencies include reaching out to vulnerable groups, mobilizing communities, channeling information, helping to create demand for care, framing effective delivery models and addressing determinants of the tuberculosis epidemic. NTPs should reach out to civil society organizations not currently engaged in tuberculosis care, encourage them to integrate community-based tuberculosis care into their work, and widen the network of facilities engaged in tuberculosis care and prevention. Civil society should also be engaged in policy development and planning as well as periodic monitoring of programme implementation important activity in WHO End TB strategy is to Scale up Public Private Mix (PPM) approaches and promote International Standards for Tuberculosis Care.

In many countries, tuberculosis care is delivered by diverse private health care providers. These providers include pharmacists, formal and informal practitioners and non-governmental and faith-based organizations, as well as corporate health facilities. Several public sector providers outside the purview of national tuberculosis programmes also provide tuberculosis care. These include, inter alia, large public hospitals, social security organizations, prison health services and military health services. Leaving a large proportion of care providers out of an organized response to tuberculosis control has contributed to stagnating case

notification, inappropriate tuberculosis management, and irrational use of tuberculosis medicines leading to the spread of drug-resistant tuberculosis.

NTPs will have to scale up country - specific Public Private Mix (PPM) approaches already working well in many countries. To this effect, close collaboration with health professional's associations will be essential.

Source of information: **End TB Strategy Global strategy and targets for tuberculosis prevention, care and control after 2015**

4. Benefits of PPM Approach in NTP:

- ✓ Evidence suggests that failure to involve all care providers used by TB suspects and patients hampers case detection, delays diagnosis, leads to inappropriate and incomplete treatment, contributes to increasing drug resistance and places an unnecessary financial burden on patients.
- ✓ PPM encompasses diverse collaborative strategies such as public-private, public-public and private-private collaboration. PPM also implies engaging relevant care providers in prevention and management of MDR-TB and in the implementation of TB/HIV collaborative activities.
- ✓ Several project evaluations have shown that PPM could help increase case detection (between 10% and 60%), improve treatment outcomes (over 85%), reach the poor and save costs.
- ✓ The WHO policy on engaging all care providers in TB care and control provides guidance on practical steps that countries should undertake to involve various health care providers in National TB control efforts.

5. PPM Contribution to Public Health

- ✓ PPM can reduce malpractice by fostering evidence-based TB diagnosis and treatment. This improves cure rates and reduces risks of drug resistance. It also limits misdiagnosis of TB and, unnecessary and often costly treatment.
- ✓ PPM can help increase TB case detection and reduce diagnostic delays by involving all health care providers in timely referral and diagnosis of TB. This also helps cut the chain of transmission at an early stage.
- ✓ PPM can improve access to treatment and help overcome barriers such as stigma, by involving health care providers from whom the poor, marginalized and most vulnerable seek care.
- ✓ PPM reduces costs to patients by ensuring that treatment for TB is free of charge and all other costs are kept to a minimum. PPM can also reduce indirect costs for patients by providing services closer to their homes or workplace.
- ✓ PPM contributes towards completeness of epidemiological surveillance on TB when all care providers who diagnose and treat TB follow proper TB recording and reporting routines linked to national information systems.
- ✓ PPM improves management capacity of both the public and the private sector, and can contribute to health systems strengthening in general.

6. Implementing PPM for TB Control

In PPM, the NTPs are mandated to shoulder the stewardship role, to ensure that technical standards are met, drugs are provided free of charge to patients, and that

all aspects of coordination, training, contracting, supervision and surveillance are carried out as per NTP guidelines.

As WHO recommendations, the generic PPM approach involves the following main steps for the implementing PPM for TB control.

1. A National situation assessment

2. Creating National resources for PPM

3. Developing National operational guidelines on PPM

4. Local implementation

5. Supervision and monitoring for scaling up

6. 1. A National Situation Assessment

There are several steps involve in situation assessment which we can consider as follows:

i. Map Providers

- ✓ Collect list of all health care providers from public sector, volunteers' organizations (I/NGOs), academia, private for profit/non-profit sector etc.
- ✓ Sort them out and determine their association with NTP, if they are presently linked with NTP, on what capacity they are playing their role and assess what potential contribution the providers can make
- ✓ Identify input required to optimize their contribution
- ✓ Collection of detailed information sketch a mapping of their service areas and determining their TB management practices, the number and proportion of TB

cases they detect and treatment outcomes among their patients. This could be very useful in designing PPM interventions.

ii. Assess NTP capacity for PPM

NTPs should not only have demonstrated how DOTS can be successfully implemented but should also have additional capacity to set up and support a sustainable partnership.

It can be started in areas where DOTS is effectively operational. Evidence shows that PPM can be successfully undertaken if functioning microscopy units and treatment and supervisory services are available locally within the public sector.

Even in the absence of these services, NTPs could begin involving the non-NTP providers early in the planning stages of setting up and developing DOTS programmes.

Early involvement is particularly relevant in areas where public sector services are sparse or do not exist at all.

iii. Assess regulatory environment

Existing regulation concerning anti-TB drug prescription and TB notification should be reviewed as part of the situation assessment. Ways to enforce existing regulations which are beneficial for DOTS should be explored along with free supply of anti-TB drugs may be linked to a system of certification to ensure their proper use. Functioning policy for notification of all TB cases diagnosed or treated outside NTP facilities should be enforced.

6. 2. Creating National Resources for PPM

Creating National resources for Public – Private Mix, there should be a systematic and sustainable development of PPM, it is very essential to have a PPM focal nodal person at NTP. This focal person should be advised and guided by a steering group

such as a National PPM task force with representatives from major provider groups and stakeholders. The PPM stakeholders should be at National, Provincial as well as in Local levels, such as:

- Ministry of Health as well as in other Ministries, such as Indigenous, Labour, Transport, Finance etc.
- Department of Health Services as well as in other Departments
- Health Insurance Organizations as well as in Academic Institutions
- Social welfare programmes or I/NGOs working in TB services delivery
- Professional Organizations as well as in Hospitals, Poly-clinics or Pharmacy Associations etc.
- Pharmaceuticals as well as drug manufacturing Industries
- Consumer organizations as well as social service organizations

All relevant Local, National and International funding sources should be tapped for PPM piloting and scale up.

6. 3. Developing Operational Guidelines

Operational guidelines are very important to define the role and responsibility of NTP and non-NTP people. To develop the operational guidelines, WHO has proposed seven essential elements, such as:

- 1) Objectives for PPM
- 2) Task mix for different providers, NTP and Non-NTP people
- 3) Development of practical tools to help implementation
- 4) Required training

5) Official recognition

6) Incentives and enablers and

7) Monitoring & Evaluation (M&E)

6.3.1) Objectives for PPM

The objectives should be formulated in relation to the objective of National TB Control Programme (NTP) and targets as well as to the End TB Strategy.

6.3.2) Task mix for different providers

Task mix for different providers should be defined in a central part of planning a PPM initiative locally is to map health providers and investigate their current role in TB diagnosis and treatment, their capacity to perform different DOTS tasks as well as their willingness to participate in PPM.

DOTS implementation, divided into "**clinical**" and "**public health**" tasks

Clinical Tasks
<ul style="list-style-type: none">▪ Identify TB Symptomatic▪ Collect sputum samples▪ Refer TB suspects▪ Notify/Record cases▪ Supervise treatment▪ Do smear microscopy▪ Diagnose TB▪ Prescribe treatment▪ Inform patient about TB

Public Health Tasks
<ul style="list-style-type: none">▪ Identify and supervise treatment supporters▪ Follow-up on defaulters▪ Training care providers▪ Supervision▪ Quality assurance for laboratories▪ Monitoring and Evaluation▪ Drugs and supplies management▪ Provide stewardship/financing

Source: WHO Technical Guidelines

- ✓ To illustrate, an NTP should be in a position to carry out all the tasks; a medical college or a public, voluntary or private institution may also be able to undertake most clinical and public health tasks.
- ✓ The NTP would be expected to fill the gaps and weaknesses by supporting or taking on the tasks that other providers are unwilling or unable to carry out.
- ✓ Responsibility and key functions of NTP include provision of funds, supply of drugs and other materials and quality assurance. The NTP should constitute a local task force, coalition or coordination committee. It should have representatives of relevant responsibility and accountability. This body can act as an interface between NTP and other providers. It may also advise NTP in carrying out various tasks such as advocacy, sensitization, training, supervision, quality control, monitoring and evaluation.

6.3.3) Development of practical tools

The practical tools for implementation PPM are can be taken as the laboratory request form, referral-for-treatment form, feedback or back-referral form, transfer form, laboratory register, TB register and the TB treatment cards etc. Most of the tools could be adaptations of those used routinely by NTP. A few new tools may have to be developed. As in the case of operational guidelines, the development of PPM tools should be undertaken in close consultation and dialogue with stakeholder provider groups.

In summary, three types of useful practical tools have been found:

- 1) Templates of contract to formalize collaboration such as a Memorandum of Understanding (MoU) for institutions and a Letter of Agreement (LoA) for individual providers.

- 2) Tools of referral to facilitate referral routines and flow of information such as laboratory request form, back-referral or feedback form, case notification form, etc; and
- 3) Tools of supervision to enable monitoring which include the usual NTP tools with minor adaptations such as treatment cards, laboratory and treatment registers, supervision check lists, quarterly reports, etc.

Locally appropriate mechanisms and resources may be required to monitor referrals and to ensure that patients diagnosed with TB do not drop out after referral for treatment. For example, a log of referred TB cases can be kept while copies of referral forms are sent to staff dedicated to follow-up referrals.

In some settings, implementation and evaluation of PPM projects have been possible with the introduction of just two additional new formats – referral forms for the use of non-NTP providers and acknowledgement or feedback forms for NTP – along with proper recording of the identity of referring and treating provider in laboratory and treatment registers.

6.3. 4) Training

The success of PPM initiatives depends on how friendly staff of NTP is and how well other provider groups are sensitized and trained. Therefore, PPM operational guidelines should include a training strategy, which is linked to or integrated with other NTP training activities.

The training strategy should include the following steps:

Formulate training materials and training programmes, using or adapting available TB training modules

- a) Declare the task mix
- b) Content of the training for different providers, including NTP staff, based on an analysis of training needs in relation to assigned tasks
- c) Adjust the training methodology as per local context and the different characteristics of providers and working conditions
- d) Work out a structure for follow up after training, which is linked to ongoing programme supervision activities
- e) Regular revision of training programmes and plans based on evaluations

NTP and international training materials and methods which is already acceptable by the health information system should be used as a basis for the training. SAARC TB and HIV/AIDS Centre (STAC) can facilitate in this task. However, training materials and methods need to be suitably adapted to special needs and working conditions of different types of providers. For example, it is unreasonable to expect a busy private practitioner to attend a training course for several days. Identification and participation of suitable trainers is also very important. A common observation has been that the involvement of senior officials within NTP and well-known National and International experts in the private sector as trainers helps considerably to improve the credibility and acceptance of the training.

6.3. 5) Official Recognition

Official recognition is a process by which an NTP officially acknowledges that a provider, laboratory or an institution has met the appropriate criteria to provide the services being recognized. For

example, in case of institutions, the recognition would require compliance with a uniform set of standards and procedures essential for proper delivery of standardized, quality TB care. While the criteria for certification and de-certification should be related to the specific task allocated to respective providers, these criteria should be similar for the public and private sectors. The certification may be informal initially and may gradually evolve into a formal, standardized procedure. Periodic evaluations of the system of certification as well as that of the criteria used for it should be undertaken. Re-certification should be done at regular intervals.

6.3.6) Incentives and enablers

The factors affect the motivation of providers of all types to engage in the DOTS approach.

Incentives and enablers, if well designed, can overcome some of the motivational barriers. They are useful not only to attract care providers and ensure their continued involvement but also to enhance their performance.

Financial compensation may be necessary for providers who manage a large number of TB suspects and cases. However, evidence shows that individual private practitioners who have few TB patients at any time, may find, non-monetary incentives sufficient to enter into collaboration with NTP.

Some examples of effective non-monetary incentives include:

- a) Access to free TB drugs,
- b) Access to free training and continuing education,

- c) Access to free microscopy services,
- d) Access to deliver high quality services,
- e) Recognition due to formal association with a government programme

The types of incentives may vary from setting to setting. Financial incentives may have to be considered when bringing PPM DOTS to scale or when negotiating collaborative arrangements with professional associations.

6.3.7) Surveillance and monitoring

It is important to monitor the process of PPM in relation to defined objectives. Core indicators for monitoring the process and measuring the contribution of providers to overall TB control targets are summarized below:

Process indicators

1. Proportion of reporting units that have implemented a PPM strategy

Measurement = Number reporting units that have implemented PPM strategy/total number of units in the selected areas

2. Proportion of non-NTP health units (such as clinics, hospitals, institutions, etc) participating in referral/diagnosis/treatment reporting of TB cases

Measurement = Number of non-NTP providers in an area (unit) who are participating in DOTS implementation/all non-NTGP providers in the selected areas

Out-come indicators

3. Proportion of new smear positive cases detected through referral by non-NTP providers

Measurement = Number of new smear positive cases registered from among those referred by non-NTP providers/all new smear positive cases registered

4. Proportion of new smear positive cases detected through **diagnosis** by non NTP providers

Measurement = Number of new smear positive cases diagnosed by non-NTP providers/all new smear positive cases registered

5. Proportion of new smear positive TB patients receiving DOT from non-NTP providers

Measurement = Number of new smear positive cases who received DOT from non-NTP providers/all new smear positive cases registered

6. Treatment outcomes of new smear positive cases treated by different non-NTP providers

Measurement = Cohort analysis disaggregated by type of health care provider delivering DOT

6. 4. Local Implementation

NTPs repeatedly invite other care providers for training and receiving discouraging responses are not uncommon. In view of the inexperience of local NTP staff in interacting with diverse, independent care providers, clear guidance on how to proceed with local implementation should be given.

The logical five steps in local implementation of PPM for TB control would be:

- 1) Preparation
- 2) Mapping and first contact with providers
- 3) Selection of providers
- 4) Implementation proper and
- 5) Advocacy and communications

6.4.1) Preparation

Before local implementation begins, following activities must be completed.

- ✓ The first prerequisite of preparation is a written message from NTP management on the importance and priority of PPM
- ✓ Operational guidelines, including guidance on local implementation, should preferably be made available
- ✓ Draft sensitization and training materials should be ready for use.
- ✓ NTP staff must be oriented about PPM their tasks and responsibilities should be defined and a plan of implementation should be available according to locally defined objectives for PPM
- ✓ A local task force, equivalent to national task force, may be established to engage all relevant partners in planning and implementation at local level. Such a local task force might also be given operational responsibilities towards sensitization, training, supervision and quality control

6.4.2) Mapping and first contact with providers

A map of its area is needed to enable NTP unit to mark of all public and private health care providers on it. In large urban areas, such maps may have to be prepared with a door-to-door census of all types of health care providers. Other public health programmes and NGOs working in the area may be able to assist in this task. While mapping will provide a general idea of the nature of individual and institutional providers, a first contact with the providers will be required to understand their current and potential contribution to TB control. During these visits, relevant NTP staff should also provide general information about the local DOTS programme and convey the desire to begin collaboration. Information

obtained on different providers during the first contacts should be included in the mapping exercise.

6.4.3) Selection of providers

For active collaboration, prioritization of providers and their trainings are very important steps for local implementation. Selection of DOTS Providers should be done very carefully considering many factors. Some common principles should be given for consideration:

- a) Institutional providers are likely to give a higher yield of cases but will also require greater time and attention on the part of senior NTP staff. These may include medical colleges, general public hospitals, corporate health care institutions, institutions under health insurance organizations, etc.
- b) Since private practitioners may be the first port of call for most people, involving them will have additional benefits like reducing diagnostic delay and cost of care for patients.
- c) The poor are likely to first approach NGOs operating in poor areas, non-physicians like pharmacists, non-qualified providers and traditional healers. Approaching these types of providers might help in providing the poor with better access.
- d) In some communities, female patients may prefer female care providers. Involving female care providers may help to address gender differentials in case detection

After initial mapping, first contact and sensitization, it should be possible to identify tough-to-tackle providers. It is worthwhile making a beginning with willing providers before spending energies on those reluctant to collaborate.

6.4.4) Implementation proper

The method of launching PPM locally will vary from setting to setting. In the beginning, PPM should be seen by both public and private counterparts as a "learning- by-doing" exercise. Before expecting great outcomes of PPM, a key requirement, for NTP staff, would be to give a sufficient time and input patiently. The referral routines should be adhered to and proper records must be maintained.

Any irregularity on the part of collaborating providers with regard to adherence to guidelines, providing quality care and maintaining proper records, if found, must be brought to their notice immediately, and corrective measures should be taken to avoid recurrence.

Continuous dialogue between involved partners is necessary to address identified problems. Process and outcome indicators will help to monitor the progress and evaluate the outcome of PPM.

6.4.5) Advocacy and Communications

DOTS programme is self-advocating in NTP both for patients and for other care providers. It has been observed that as the services improve, more and more patients get attracted to them. This also helps in improving the image of the programme among other care providers. A successful and strong NTP is in a better position to elicit collaboration from other care providers. To generate and sustain interest in PPM DOTS, advocacy should be directed both at NTP managers and staff and their counterparts among other private and public provider groups.

Improvements in communications are required at two levels – inter-provider communication and patient-provider communication. NTP staff may need input to learn to communicate effectively with diverse provider groups and all care providers would benefit from lessons in improving their communication and interaction with TB suspects and cases. Providing information to patients on the availability of TB services in the public and private sectors and the charges they may or may not need to pay for different services offered would help make the collaboration open and transparent and may also help minimize the possibilities of misuse and malpractice. NGOs with expertise in communication and social mobilization may provide useful assistance in communicating with both providers and patients. Locally-appropriate advocacy and communication methods and materials should be used giving due consideration to the social stigma attached to the disease and to those suffering from it.

6.5. 6) Supervision & Monitoring for Scaling up

After conducting a proper situation assessment, creating adequate National resources, developing operational guidelines and giving guidance on local implementation should greatly facilitate setting up PPM initiatives in multiple and diverse settings. It is advisable to initiate implementation at sites where DOTS is being implemented satisfactorily and some additional capacity is available to take on PPM. Experience shows that implementation at all sites may not be equally smooth. Some unforeseen issues may surface during early implementation. Development of mutual trust will also require some time. Early initiatives will help to demonstrate the capacity and willingness of both the public and private sector counterparts to actually undertake the tasks agreed upon. A careful process and outcome documentation of early initiatives will provide important lessons. Based on these, the operational guidelines should be modified or finalized. The

International Standards for TB care (ISTC) could be a powerful tool for advocacy and education as well as implementation of PPM. Scaling up of PPM should be in phases and should be based on a National plan. It should be an iterative process informed by experience gained from local implementation.

Some early experiences of scaling up show that making PPM an integral part of National TB control efforts requires sustained input and attention from NTP as well as involvement and support from major non-governmental players such as inter-sectoral coalitions to fight TB and professional associations. The initial enthusiasm on both public and non-public sides may wane for a variety of reasons. The staff may view PPM-related work as additional burden. Supervision may suffer if any additional staff inducted are withdrawn. Routine transfers of public sector staff, in or out of the PPM areas, necessitate their orientation and introduction to PPM activities which, if not done, may set back the process of ongoing implementation. It is, therefore, necessary to ensure sufficient long-term financial and human resources for PPM, and make PPM training a part of human resource development plans in NTP.

It is also important to integrate PPM into routine surveillance and monitoring system. If the results of collaboration in terms of increasing participation of other providers, increased case notification, improved programme performance, enhanced image of the programme in the eyes of other care providers and the community and, above all, increased patient satisfaction become apparent to involved partners, they are likely to remain enthused and to continue their productive collaboration.

Generally Accepted Public-Private Mix (PPM) model

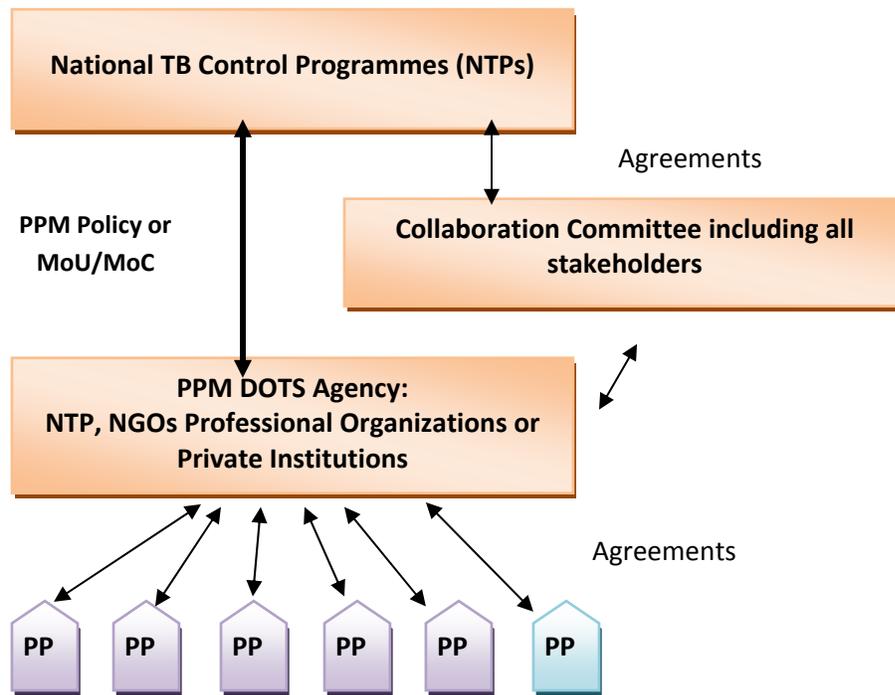


Diagram concept source: WHO technical guidelines

This model emphasizes the need for government stewardship. All PPs can potentially be involved; their specific contributions to PPM projects need to be tailored to their level of competence, to people's health-care preferences and to the local health-care context.

NTP formulates a PPM policy in consultation with all stakeholders and takes all responsibility and accountability. A coordination mechanism helps to bring the public and private sectors together, agree on implementation. The basic management unit – public, private, corporate or voluntary bodies implement DOTS through a network of willing health care providers in area. PP stands for health care providers of any type.

7. SAARC Member States, PPM scaling up in NTP –

7.1. Afghanistan

Public-Private Mix DOTS

Private health providers are the largest part of the health care providers in Afghanistan. This sector is often the first point of contact for a significant number of TB suspects and patients. Because of their flexibility and easy accessibility, these service providers have gained credibility and are popular among patients.

Experiences from pilot projects in other countries show that partnerships between public and private health care sectors can increase TB case detection rates and improve patient adherence. Such partnerships reduce diagnostic delays and cost to the patients who get quality NTP services from the provider of their choice. The strengths of these sectors can be utilized to supplement the government's efforts to control TB.

Public-Private Mix DOTS Strategy

The National approach to PPM DOTS in Afghanistan is based on the optimum contribution of health care providers out of NTP/MoPH and NTP strategy regarding PPM activities. This is aimed to increase case detection and improve quality of care for those TB patients who are seeking private and public (out of NTP/MoPH) health services. The PPM-Mix DOTs policy, strategy, and operational guidelines to be used for the scaling up the engagement of public and private sector in TB control activities have been developed.

Aim of PPM-DOTS

To increase case detection by enhancing the ability of private health providers to identify and diagnose pulmonary TB cases.

To increase treatment success rate by improving the quality of TB care received by patients attending private facilities.

Objectives of PPM-DOTS

1. To build the capacity of non NTP health care providers in TB case management
2. To improve accessibility of the population to the TB quality
3. Services with involving of non-NTP health care providers in TB case managements.
4. To decrease diagnostic delays of TB suspect patients seeking health care in non-NTP health care providers.
5. To improve TB suspect cases recording and reporting system in non NTP health care providers.
6. To reduce TB patients' direct and indirect costs.

Source: http://pdf.usaid.gov/pdf_docs/Pnadu425.pdf

7.2. Bangladesh

Involving all health care providers: PPM

Public-Private Mix (PPM)

- Global TB control cannot be achieved by public health services alone
- A range of partners need to be involved: policy makers, technical and development partners, both public and private

- Wider partnership will also help address the resource requirements for delivering effective services: human resources, financing and service infrastructure in the longer term

Public with Private

- NTP collaborating with NGOs, Private Medical College Hospitals, Corporate Sectors & Professional Associations

Public with Public

- NTP collaborating with other Public Health Institutions, Military Hospitals, Police Hospitals, Public Workplace health facilities

Private with Private health care providers

- NGOs working with Private GP, Health facilities of corporate sectors

National Committee and Working Group for PPM

- PPM DOTS National Steering Committee: formed and functional
- PPM DOTS Central Working Group (One): formed and functional
- PPM DOTS Divisional Working Group (Six): formed and functional
- The current and potential providers for PPM in Bangladesh are institutional and individual
- The practical tools to formalize the partnership may be through contracting tools (e.g. MoU, or LoA) to establish effective linkages with individual and institutional providers.

Public & Private Health Institutions

- Academic Medical Institutions, e.g. medical colleges, specialized institutions and universities (36 Public & Private), NGO Hospital and Clinics.
- Other Government Hospitals e.g. : All Sadar hospitals, All upazila health complexes and All chest hospitals etc.
- Corporate Sectors/Work Places e.g: Bangladesh Garments Manufacturing Exporters association (BGMEA), Export Processing Zone (EPZ), Port, Railway, Garments, Knitting and other Companies, etc.

Corporate Sectors / Work Places involvement through engaging Bangladesh Garments Manufacturers and Exporters Association (BGMEA)

- NTP has Established partnership with the largest Association – BGMEA
- Members of BGMEA possess more than 4 thousand factories
- Employs 2.4 millions workers
- BGMEA has 10 health centers throughout the country
- BGMEA is SR of PR-2 in R-8 Grant of GFATM

Activities with BGMEA

- Advocacy and orientation meeting with Leaders of BGMEA, owners and workers of the garment factories, TB Management Training for the Medical Officers and Clinic Managers of BGMEA health centers- Ongoing
- Formal MOU completed and establishment of DOTS centers in BGMEA Health centers in progress

Workplace TB control and Care is operated in following three largest workplaces through statutory body of the Bangladesh Export Processing Zone Authority (BEPZA):

- Chittagong Export Processing Zone (CEPZ) Health Center (Supported by BRAC NGO)

DOTS centre established in 2004

- Youngone Group Medical Centers in CEPZ -DOTS centre established in 2001

DOTS centre established in 2001

- Dhaka Export Processing Zone (DEPZ) Health Center (Supported by Damien Foundation NGO)

DOTS centre established in 2004

Partnering with Corporate Sectors

1. Shared Corporate Health Centre:

Dhaka and Chittagoang EPZ hospital

2. Company DOTS Centres

The *Youngone Group DOTS Centre* and *48 workplaces* through the Public Private Partnership Project - PPP (supported by Leeds University) and partner NGOs (BRAC, Damien Foundation and PSKP).

Achievements

- Engagement (MOU) of largest Association of Corporate Sector (BGMEA)
- Strong collaboration and harmonization between BGMEA and other Company Health Centers
- Established workplace TB care and control with collaboration with

- different NGOs and Public Private Partnership Project supported by Leeds University
- DOTS Corner is functional at 3 corporate sector health facilities: DEPZ, CEPZ, Young one Group
- Functional PPM Committee and working groups
- Disseminated PPM guidelines
- Effective PPM-ACSM

Constraints

- Supervision and coordination by NTP of partnership initiatives
- Engagement with other Corporate sector's Associations
- Limited Collaboration and coordination with different ministries
- Limited collaboration with Individual Industries /Companies
- Lack of policies and practical guidelines to address specific traits and need
- Little documented evidence on potential modes of involvement
- Limited capacity for public health functions: poor patient retrieval, limited referral links

<http://www.who.int/tb/careproviders/ppm/BangladeshPPMWorkplaceYoungone.pdf>

7.3. Bhutan

Public-private collaboration

The private health sector in Bhutan is in a rudimentary stage. There are no private practitioners. There is one private laboratory (in Phuentsholing) performing AFB microscopy. The workload is very low, although one smear-positive case was identified and subsequently referred to Phuentsholing Hospital for treatment. The laboratory technician is trained for sputum microscopy and sends all positive slides to the hospital for reconfirmation. The majority of patients attending this laboratory come from across the border.

A few private pharmacies were visited in Phuentsholing and Thimphu. One private pharmacy was selling ethambutol and pyrazinamide. There appears to be no regulation on the sale of these drugs.

Source: http://apps.searo.who.int/PDS_DOCS/B0392.pdf

7.4. India

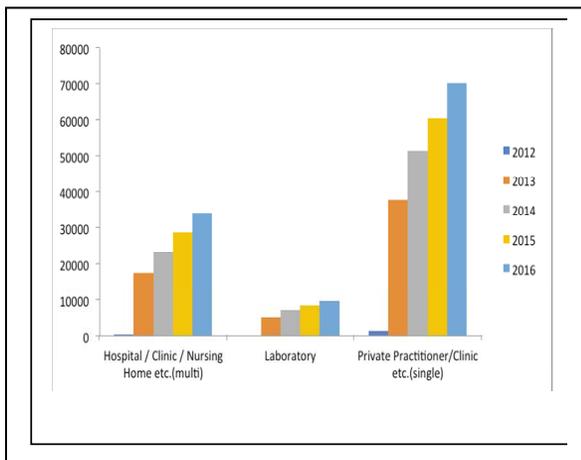
Public Private Partnership

Effective engagement of all health care providers (private practitioners, chemists, laboratories, NGOs, AYUSH) at a scale commensurate to their presence is crucial to achieve Universal Access to TB Care. Majority of times, these providers are first contact for care of patients. Since the inception of RNTCP, multiple prior interventions through various strategies have been deployed to engage NGOs and Private Providers for TB control efforts.

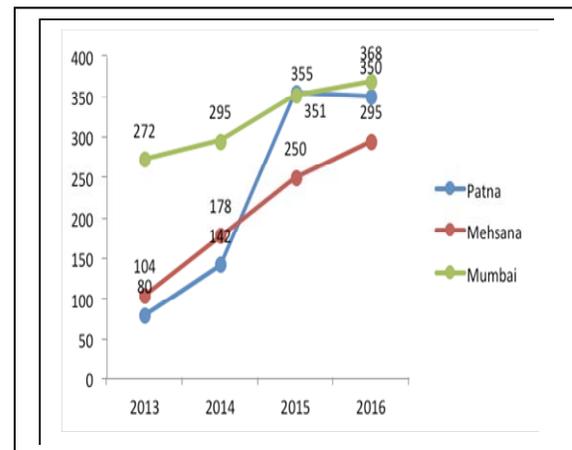
Engagement of Private Practitioners

Since TB has been made a notifiable disease, more than 1,13,961 private health establishments are registered under NIKSHAY till December 2016. Among them, 70,146 are private practitioners/clinics (single), 34,105 hospitals/clinics/nursing homes (multi) are and 9,710 are laboratories. Following chart shows how private health establishment registration grew over period of time. Maximum private health establishments got registered in 2013. Since then, more than 15,000 facilities are getting registered, every year. In 2016, 16,282 facilities registered and 3,30,186 TB patients were notified from private health establishments.

Private Health Establishment Register in NIKSHAY – Cumulative Over Years



Intervention to engage private providers



Universal Access to TB Care (intervention to engage private providers)

To engage private sector providers, a package of interventions have been implemented in the project Universal Access to TB care (UATBC). The intervention are aimed at improving TB notifications by offering information and communication technology (ICT) support that is convenient to providers, free TB drugs for notified TB patients, (free/subsidized diagnostic services in Patna and Mumbai) and extending public health services including adherence support to treatment outcome for patients diagnosed and treated in the private sector. The interventions are implemented in the districts of Patna in Bihar, Mehsana in Gujarat and Mumbai and Nagpur in Maharashtra. In Patna and Mumbai, a private provider interface agency (PPIA) is used to enroll and extend public health services for a large number of private providers to ensure efficient service delivery. In Mehsana and Nagpur, the RNTCP staffs are encouraged to manage the service delivery intervention. The interventions began in 2014 except Nagpur which started in September 2015. At the intervention sites, total TB case notification rates were increased 1.5-4 folds.

7.5. Maldives

COLLABORATION WITH OTHER PROGRAMS

The Ministry of Health coordinates with the ministries of Home Affairs and Education in implementing various components of NTP. Collaboration with the HIV/AIDS program has been initiated. Health providers in the private sector and NGOs involved in conducting health programs and refer all suspected or diagnosed cases to the NTP.

Source: <http://www.searo.who.int/maldives/mediacentre/tb-nsp-2015-2020.pdf?ua=1>

7.6. Nepal

PPM - ISTC

Endorsement of New Stop Strategy as a national policy of NTP by Government of Nepal in 2006, NTP has proposed serial of activities toward engaging private & public health providers to ensure wider provision of standardized diagnosis, treatment and follow-up in line with national protocol.

DOTS orientation/training to public/private practitioners, paramedics, nursing, industrial workers, slum dwellers, prisoners, pharmacists, laboratory staffs etc is one of the key activities of NTP. Urban TB control program through mobilization of private health sectors, health personnel and volunteers is a part of PPP activities and country wide 43 municipalities are engaged till now.

Objectives of PPP

To engage public and private health care providers to ensure provision of quality TB services in line with NTP policy, International Standard of TB Care (ISTC) and Patient Charter.

Urban TB control programme

The burden of TB in urban is high because the urban migration rate is in increasing trend. At the same time rapid expansion of private health care facilities in urban is in place to fulfill the diverse interest of urban people. NTP has initiated to engage private health providers of urban by developing linkage (recording, referral & feedback) mechanism between private health providers and NTP.

NTP has planned to extend its PPM activities in all 58 Municipalities of Nepal by 15 July 2015. The NTC carried out review of PPM programme in 2012 and made following recommendations for further development;

Regulation for managing Anti-TB drugs at market: Anti TB drugs are commonly available at the local markets at the price of NPR 36/per dose/day. There is not placed any mechanism to ensure the complete treatment of patients from the private sector. Hence, the NTC should take initiation to regulate for managing availability of Anti TB drugs at local market.

Expansion of DOTS in urban health clinic: The Municipality Offices have already established urban health clinics to provide public health services to the urban community. The NTP should developed aggressive plan for establishing DOT centres at urban health clinics to improve the accessibility of TB services and DOTS centres opening hours also should be flexible considering patient needs.

Establish strong coordination with likeminded stakeholders in the district: Every district has already formed PPM working committee but very few people have knowledge about that committee and its roles and responsibilities in the TB control activities. The district (public) health offices and partners needs to be developed very strong mechanism to make coordination among stakeholders effective.

Inventory of private health care providers: It is true that NTP has a lack of information about total private laboratories, clinics, nursing homes and other health care providers at the district. The NTC should prepare inventory of all private health service providers and prepare a plan of action to enhance the performance of PPM programme.

Involvement of private medical practitioners in TB control: It is evident that people are seeking tuberculosis care from private sectors, which requires involvement of private health care providers in the TB control programme. Depending upon the institutional capacity and resources, they can be involved in various areas such as TB screening, diagnosis, and treatment and referral. Particularly, private pharmacies might have a prominent role in suspect identification and referral; private lab for quality diagnosis and private practitioners in TB case management.

Training/Orientation to Private Medical Practitioners: private health care providers needs to be properly oriented and trained on TB and its services, and National protocol of TB case management: screening, diagnosis, treatment, monitoring, follow up and referral. It is recommended that NTP guidelines should be distributed to all the Private Medical Practitioners (PMP).

Quality assessment in private sector: TB patients have the right to get the quality care (diagnosis, treatment and follow-up) and ensuring that their rights are met is the prime responsibility of national TB control programme. Thus, it is crucial to assess the quality of microscopy in the private sectors.

Regular monitoring and mentoring to PMPs: While formalizing the programme agreement with private sector, a clear monitoring framework should be developed. Local TB supervisors should technically be able to provide onsite mentoring to PMPs. Local public health authorities should take the lead role to harmonize the public private mix in urban settings and ensure that the national standards are utilized, free diagnosis is provided, free drugs are given, and records are kept well and follow-up done as required.

Support from NTP and other stakeholders: Since private sectors are delivering TB services in the study areas, a strong support from the national TB control programme as well as from other stakeholders is needed in order to strengthen the existing services and ensure effective implementation and sustain of PPM activities.

Public awareness on TB and its services: Aggressive and innovative awareness activities on TB and its services among the people are needed so that they themselves seek quality care.

Source: <http://www.nepalntp.gov.np/index.php?view=page&id=70>

6.7. Pakistan

PRIVATE PUBLIC PARTNERSHIPS

Many studies have shown that, in low-income countries, the majority of the patients initially attend a private provider before TB is suspected^b; Pakistan is no exception. There are some 42,700 private, registered facilities involved in the provision of healthcare to the population; the largest number of these is clinics and chemist shops (69 percent) and medical stores (27 percent), there are also 550 private hospitals. There are doctors who work in the public and private sectors simultaneously (Planning Commission GoP, Pakistan 2005). It is generally believed that about 70 percent of the population visits the private sector practitioners.

PPP development is recognised as an essential strategy by the Government of Pakistan, which has included it as a priority activity in the 10th Five Year Development Plan (health chapter) and in the allocation of public sector funds for

the NTP (NTP, PC-1 2005-2009). Indeed some PPPs are already operational within the health sector. The Government of Punjab, for example, has contracted out the management of all 104 Basic Health Units (BHUs) in one district (Rahim Yar Khan) to an NGO: the Punjab Rural Support Programme. Nearly two years after the transfer of management, a household survey was conducted to evaluate the outcome of partnership. The results showed that utilisation of a BHU, among respondents reporting an illness in the last month, was 54 percent higher in NGO managed district as compared with an adjacent government managed district (World Bank 2006).

In Pakistan, many of the private facilities mentioned above, including private hospitals/clinics, solo private practitioners, NGOs and pharmacies as well as informal non-qualified practitioners are involved in the management of TB. A high proportion of patients use private-for-profit providers because of their acceptability; greater ease of access; shorter waiting periods; longer or more flexible opening hours; better availability of staff and drugs; more sensitive health workers; and greater confidentiality in dealing with diseases such as TB and sexually transmitted diseases (STDs) which carry social stigma (Aljunid 1995; Swan and Zwi 1997 quoted by Brugha and Zwi 1998). However, the TB cases managed by private providers are neither recorded nor reported and so are not consolidated into national data.

Currently, it is almost exclusively the public sector which follows the NTP guidelines/ WHO Strategies. A KAP study conducted by the NTP in two cities of Pakistan revealed that only one of 245 physicians was aware that cough for longer than three weeks is the main symptom suggesting pulmonary TB and less than 1 percent of doctors relied on sputum smear microscopy for diagnosing pulmonary Tuberculosis (Shah et al 2003). Thus TB patients attending General Practitioners

are deprived of standardised management under DOTS. This not only effects their proper management but also poses risks to the patient and society through continued infectivity and drug resistance because of inappropriate prescription of anti-TB drugs and interruptions in the treatment.

International studies corroborate this:

“Without engaging private providers, poor quality and sometimes harmful care will continue; they show that private providers can help expand access in rural as well as urban areas; and they point to the need for careful institutional design. Other analyses have found — and this is a critical point — some evidence that well-managed networks of private providers can offer a service that has a positive impact on the quality of the public sector” (Travis & Cassels).

International evidence concerning TB services has demonstrated this last point; that is, PPP can result in high treatment success rates and can contribute to case detection. An evaluation of 25 PPM projects in 14 countries, based on treatment outcomes for over 20,000 TB patients, revealed that treatment success rates in the projects that provided drugs free of charge to patients were between 75 percent and 90 percent. Several projects also showed an increase of case detection ranging between 10 percent to 60 percent (WHO 2006).

Many of the initiatives are area-specific and are narrowly focused, targeting a particular aspect of TB control. They can, however, serve as pilots for learning lessons regarding implementation, for replication in scaling up such activities, or for the development of collaborative approaches. They have shown, for example that PPP activities need to be carried out at the operational levels (that is, districts in Pakistan) and that networks with the district, provincial and national levels of TB control are essential.

One intervention study on the development of a viable model of PPP conducted in a city in Pakistan, Rawalpindi, had very encouraging results. After the intervention, there was a significant positive change in the practices of General Practitioners for the management of pulmonary Tuberculosis. However they had a number of concerns, firstly, the reporting requirements because of their weak administrative capacity, and secondly losing patients when they are sent to public facilities for sputum smear examination. Patients also showed concerns which included long queues to avail themselves of diagnostic services and the attitude of staff in the public facility (Sadiq et al 2004).

In NTP Pakistan more than 2000 GPs involved in 66 districts contributing towards 20% of TB case notification. MOU's involving private and other health sectors signed with Pakistan Chest Society, National Rural Support Program and Military Hospitals.

http://ntp.gov.pk/uploads/ntp_1369819747_Finalreport_ppp_NTP08_09_06.pdf

7.8. 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.

Source: http://apps.searo.who.int/pds_docs/B4796.pdf

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