

# **Public-Private Mix for DOTS**

## **Towards Scaling Up**

Report of the Third Meeting of the  
PPM Subgroup for DOTS Expansion

Manila, Philippines  
4-6 April 2005



World Health  
Organization

**Stop TB Partnership**

WHO/HTM/TB/2005.356

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The logo for the Stop TB Partnership, featuring the text "Stop TB Partnership" in a bold, sans-serif font. The word "TB" is enclosed in a red circle, and the background behind the text is a stylized map of the world in shades of grey.

Stop TB Partnership

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## Abbreviations and acronyms

ATS	American Thoracic Society
DEWG	DOTS Expansion Working Group
DOT	directly observed treatment
DOTS	the internationally recommended strategy for TB control
FIDELIS	Fund for Innovative DOTS Expansion through Local Initiatives to Stop TB
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GLRA	German Leprosy and TB Relief Association
GP	general practitioner
HFI	Health Franchise Initiative
ILO	International Labour Organisation
ISAC	identified support and action countries
KNCV	The Royal Netherlands TB Association
MDG	Millennium Development Goals
MDR-TB	multidrug-resistant tuberculosis
MoH	Ministry of Health
NGO	nongovernmental organization
NTP	national TB programme
PPM	public-private mix
PPM DOTS	public-private mix for DOTS
STB-CB	Stop TB Partnership Coordinating Board
TB	tuberculosis
WEF	World Economic Forum
WHO	World Health Organization

## 1. Background

The global Stop TB Partnership is leading tuberculosis (TB) control efforts worldwide through its various working groups coordinated by the Stop TB Partnership Coordinating Board (STB-CB). DOTS is the internationally recommended strategy for global tuberculosis control. The DOTS Expansion Working Group (DEWG) represents the national TB programmes of 22 high TB-burden countries that bear 80% of the global TB disease burden, international technical partners and donor agencies engaged in global TB control. The DEWG is hosted by the World Health Organization (WHO).

Current efforts to control the disease are aimed at first achieving the global targets of detecting 70% of the estimated TB cases and curing 85% of the detected cases by 2005. In 2003, 45% of the estimated cases were detected globally and 82% were treated successfully within the national DOTS programmes. In many countries the DOTS programme is implemented exclusively through public sector health services. This has been identified as one of the major reasons for low case detection. A large proportion of patients are detected outside the DOTS programme by diverse health care providers; as a result, many of these cases are neither notified nor are their treatment outcomes known.

It has been recognized that meeting the targets for case detection and treatment success will be one important step towards achieving the TB-related impact targets of the Millennium Development Goals (MDGs) – halving the global prevalence of and mortality due to TB by 2015. Enhancing access to TB care for the poor, many of whom seek care from outside DOTS programmes, will also help to contribute towards achieving the MDGs of eradicating extreme poverty and hunger. Clearly, engaging all care providers in DOTS implementation ought to be an integral component of any strategy to achieve global TB targets.

Recognizing the necessity of involving all health care providers in TB control, the World Health Organization (WHO) has been instrumental in facilitating the initiation and scaling up of collaboration among diverse health care providers in many countries. To build on the work undertaken in this area and to address the issue urgently and effectively, the DOTS Expansion Working Group (DEWG) established a global subgroup on public-private mix for DOTS expansion (The PPM DOTS Subgroup). PPM DOTS is intended to promote the involvement of all relevant health care providers in TB control. It encompasses diverse context-specific strategies and approaches that effectively link all the entities within the public and private sectors to national TB programmes for DOTS expansion.

The first meeting of the Subgroup, held in Geneva in November 2002, urged countries to embark on and expand PPM DOTS. Since then, efforts to help achieve the TB control targets have been strengthened globally. The burden of TB and diversity of care providers is greater in Asia as compared to other WHO regions. It was thus appropriate for the WHO South-East Asia Regional Office to host the second meeting of the Subgroup in New Delhi in February 2004. By then, several pilot initiatives had been

implemented and most of them were showing promising results in terms of increasing TB case detection while maintaining high treatment success rates.

Encouraged by the positive outcome of several pilot initiatives, WHO Member countries with large private sector and sound DOTS programme have begun scaling up PPM DOTS initiatives. Some of these countries are: India, Indonesia, Kenya, Myanmar and the Philippines. In order to share the experiences gained during the scaling up of the PPM DOTS programme and providing an opportunity to observe first hand the programme in action in the Philippines, the third meeting of the PPM Subgroup was held at the WHO Regional Office for the Western Pacific in Manila from 4 to 6 April 2005. This report summarizes the proceedings of this meeting. Section 2 contains the objectives of the meeting and the expected outcomes. The presentations made at the meeting and the discussions that took place are summarized in Section 3. Section 4 lists major conclusions and recommendations and the next steps suggested for the PPM DOTS Subgroup. The agenda and the list of participants are given at Annexes 1 and 2.

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

### **2.1 Objectives**

- (i) To review the global progress on PPM DOTS;
- (ii) To identify barriers and enablers for scaling up and sustaining PPM DOTS;
- (iii) To review and finalize draft PPM DOTS guidelines;
- (iii) To make recommendations on future plans and actions.

### **2.2 Expected outcomes**

- (i) A review of the global progress on PPM DOTS;
- (ii) Endorsed final draft of PPM DOTS guidelines;
- (iii) Guidance on advocacy for PPM DOTS;
- (iv) Recommendations for future work to the DOTS Expansion Working Group, national TB programmes and the PPM Subgroup.

## **3. Summary of presentations and discussions**

The presentations at the meeting provided an overview of the progress of PPM DOTS across WHO regions and Member States. The focus was on early experiences of

scaling up of PPM DOTS. During field visits to six sites in Metro Manila, the participants had an opportunity to see and discuss working examples of scaling up PPM DOTS in the Philippines. The following section presents the activities of the Subgroup Secretariat and summarizes global progress on PPM DOTS over the last year. Specific activities in four of the six WHO regions where PPM DOTS deserves priority attention are then described in brief.

During the presentations, countries scaling up PPM DOTS were encouraged to identify barriers and enablers in their efforts. The main points that emerged from these presentations and plenary discussions are summarized in section 3.3. Participants divided themselves into four working groups that discussed key aspects of enabling scale up of PPM DOTS. Priority work areas for the PPM DOTS Subgroup that came out of these discussions are summarized in section 3.4. Box 1 lists key points that emerged from this meeting.

### **3.1 Global progress on PPM DOTS**

#### *3.1.1 The activities of the Subgroup Secretariat*

During the period under review, the Secretariat continued to provide technical assistance to countries. PPM missions were undertaken to Bangladesh, China, India, Indonesia, Kenya, Myanmar and the Philippines. Assistance was provided for the development of operational guidelines in Bangladesh and the Philippines and for the development of scale-up strategies in India, Indonesia, Kenya and Myanmar.

The Secretariat also continued to develop evidence-based policies and tools for PPM DOTS. Significant work done in this area included preparation of draft PPM DOTS guidelines, contribution to the development of the International Standards of TB Care and advice and support for the Health Franchise Initiative (HFI). Operational research and project evaluations were undertaken in Bangladesh, India, Myanmar and the Philippines. Several articles were also published.

The Secretariat and the core group of the Subgroup contributed to integrating PPM DOTS into evolving global TB control strategies and policies. Substantive input was also provided to the development of the draft Stop TB Strategy 2006–2015 and related draft of the 2<sup>nd</sup> Global Plan to Stop TB.

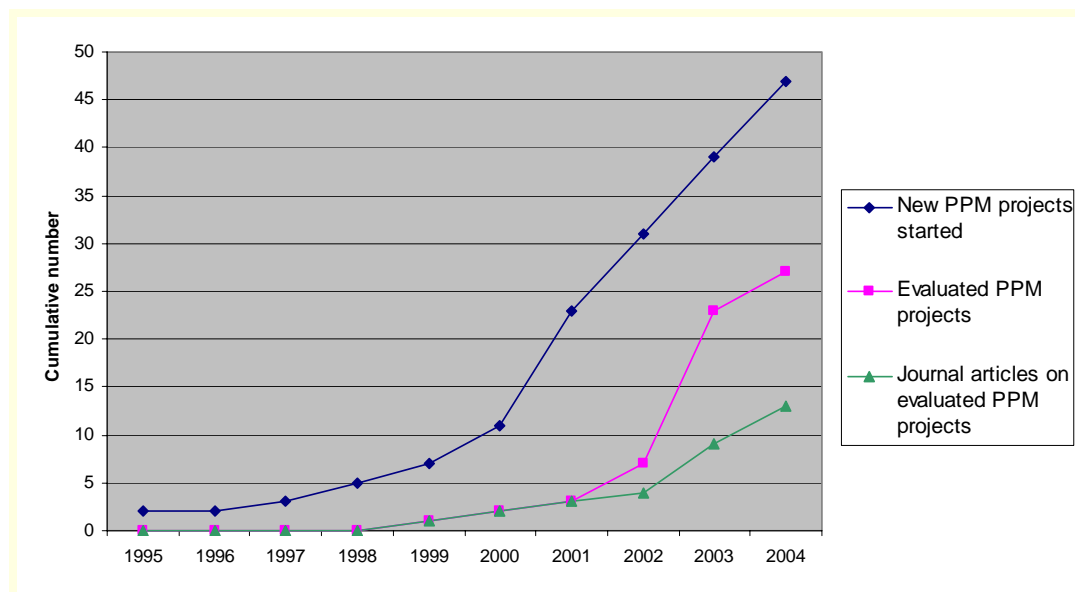
In order to raise awareness and facilitate resource mobilization, a logical framework for incorporating PPM DOTS into applications for the Round 5 of the proposals to the GFTAM was prepared and presented in a workshop for consultants identified to support countries to develop proposals. The Secretariat also participated in a series of missions sponsored by the World Bank in preparation for continuing International Development Assistance for TB control in India during 2006–2010 and assisted in developing detailed project implementation plans related to PPM DOTS scale up in the country.

### 3.1.2 Global progress

There was substantial progress made in PPM DOTS implementation and scale up in Member countries, which was noted by the Subgroup. According to the information available to the Secretariat, over 40 PPM DOTS initiatives had been launched in over 20 countries. Evaluations of these initiatives had resulted in numerous project reports and publications (Figure 1).

Figure 1.

*Cumulative PPM DOTS projects, evaluations and journal papers on PPM DOTS known to the Subgroup Secretariat, March 2005*

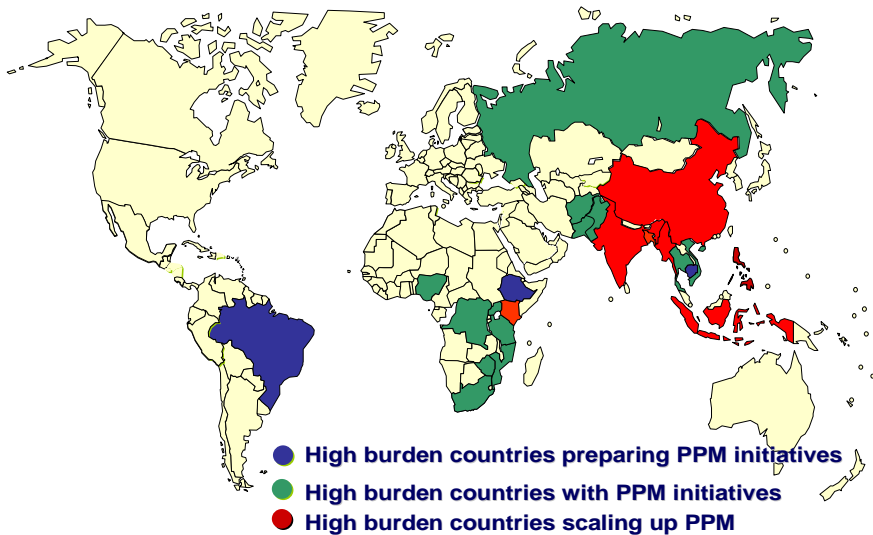


All the 22 high TB-burden countries had expressed the need to develop PPM DOTS initiatives. Of them, 12 had launched small-to-medium-size pilot projects, seven had started to scale up PPM DOTS, whereas three countries were planning to launch initiatives during 2005 (Figure 2).

Different countries were targeting different providers. For example, Philippines had focused first on the for-profit private sector. China and Indonesia had targeted primarily the hospital sector, both public and private (in Indonesia). Afghanistan and Bangladesh were involving nongovernmental organizations (NGOs) heavily in DOTS implementation. Kenya was mainly focusing on private hospitals and chest physicians. Myanmar was predominantly involving private general practitioners (GPs). South Africa was targeting health services of large private corporations. India had adopted a comprehensive approach involving a wide range of public and private providers previously unlinked to the TB control programme.

Figure 2  
Status of PPM DOTS implementation in the 22 high TB-burden countries

### PPM DOTS initiatives in High Burden Countries, March 2005



Evidence continued to accumulate from PPM DOTS project evaluations, which showed improvements in TB case detection and high treatment success rates in nearly every instance. The extent of effectiveness varied across settings and contexts, but it had been uniformly positive. New data from Bangladesh, Myanmar and the Philippines showed that PPM DOTS could help reach quality TB treatment to the poorest. For example, in a PPM DOTS franchise initiative in Myanmar targeting private GPs, it was shown that 85% of the patients belonged to the poorest segments of the population, compared to 40% of the general population. Long-standing PPM DOTS projects had demonstrated that PPM DOTS was sustainable and replicable.

Though several countries had plans for nationwide scale up and full integration of PPM DOTS into TB control strategic planning, the rate of scale up had been modest in most countries. The meeting identified barriers and enablers for further progress of the global PPM DOTS, which are outlined in sections 3.3 and 3.4 below.

Box 1

**Key points emerging from the 3<sup>rd</sup> PPM DOTS Subgroup meeting**

***The progress***

- There has been rapid progress in many countries in Asia and Africa.
- Speedier scaling up is needed for PPM DOTS to contribute significantly to reaching the global TB control targets and the Millennium Development Goals.

***The scope***

- PPM DOTS implies inclusion of all public, voluntary, corporate and private health care providers not yet involved in DOTS implementation. PPM DOTS thus concerns all combinations of public-public, public-private and private-private collaboration for improved access to DOTS.
- PPM DOTS is not meant simply to increase TB case detection but a strategy to improve quality of TB care by implementing a standardized approach to TB care across all health care providers. PPM DOTS is expected to improve access, save costs to patients and reduce development of drug resistance.

***The evidence base***

- There is enough evidence collected from over 40 PPM DOTS projects and over 20 000 patients evaluated worldwide that PPM DOTS can help to increase case detection and improve treatment success rate in a cost-effective way.
- PPM DOTS projects are scaleable and sustainable.
- By targeting providers used by the poorest segments of populations and ensuring provision of free or heavily subsidized treatment, PPM DOTS projects have managed to improve access to and reduce financial burden of TB care for the poor.
- More operational research is needed in areas like the effect of PPM DOTS on access to care for the poor, effect on diagnostic delay, cost-effectiveness of PPM DOTS scale up, opportunities for incorporating PPM DOTS into TB/HIV and DOTS+ strategies, and appropriate motivators for different provider categories.

***The actions required***

- Finalization and dissemination of the PPM DOTS global guidelines.
- Using the forthcoming 'International Standards of TB Care' document for advocacy and training.
- Intensified technical assistance for PPM DOTS to countries by Subgroup partners.
- Development of a strategy for training of global and regional experts on PPM DOTS.
- Development of an advocacy strategy for PPM DOTS to boost PPM DOTS uptake.
- Work to place PPM DOTS among core activities of the 2<sup>nd</sup> Global Plan to Stop TB.
- Coordination with other working groups and subgroups of the Stop TB Partnership.
- Mobilization of additional financial and human resources for realizing above actions.

## **3.2 Progress in WHO regions**

Regional progress reports were presented by representatives of the Stop TB units of the WHO Regional Offices for Africa, Eastern Mediterranean, South-East Asia and the Western Pacific. They are summarized below. Figures 3, 4 and 5 highlight important country examples with useful lessons of global relevance.

### *3.2.1 African Region (AFR)*

The Regional Office had a focal person for PPM DOTS. The progress made during the last year included adapting the global framework on PPM DOTS for the African Region and getting it reviewed and ready for publication. Pilot initiatives were in place in some of the anglophone countries with part or full funding support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) (in Ghana), FIDELIS (in Nigeria), WHO (in Kenya, Nigeria, South Africa, Tanzania, Uganda and Zimbabwe) and bilateral donors (GLRA in Nigeria). Ghana and Kenya were set to scale up their activities. The Democratic Republic of Congo was reported to have a working PPM initiative in the Capital, Kinshasa. A presentation was made on an early pilot project in place in Nigeria, supported by GLRA. This small pilot project involving selected private hospitals had been initiated in Onitsa. The contribution to case detection was limited, but the initiative had managed to establish trust between the previously estranged public and private health sectors with the help of an intermediary organization.

PPM DOTS was yet to take roots in many francophone and lusophone countries. This was attributed largely to the countries' preoccupation with first strengthening their national TB programmes, the lack of human resources, funding constraints and the lack of technical capacity. Identified barriers also included insufficient political commitment for PPM DOTS in some countries.

### *3.2.2 Eastern Mediterranean Region (EMR)*

DOTS expansion had generally progressed well in the Region. Several of the middle-income countries, such as Jordan, Lebanon, Oman and Qatar, had established effective referral routines from private and public providers for treatment under DOTS in the NTP units. Egypt was scaling up PPM DOTS activities that included medical colleges, NGOs and private practitioners. Iran, Pakistan, Sudan and Yemen had started pilot initiatives as well.

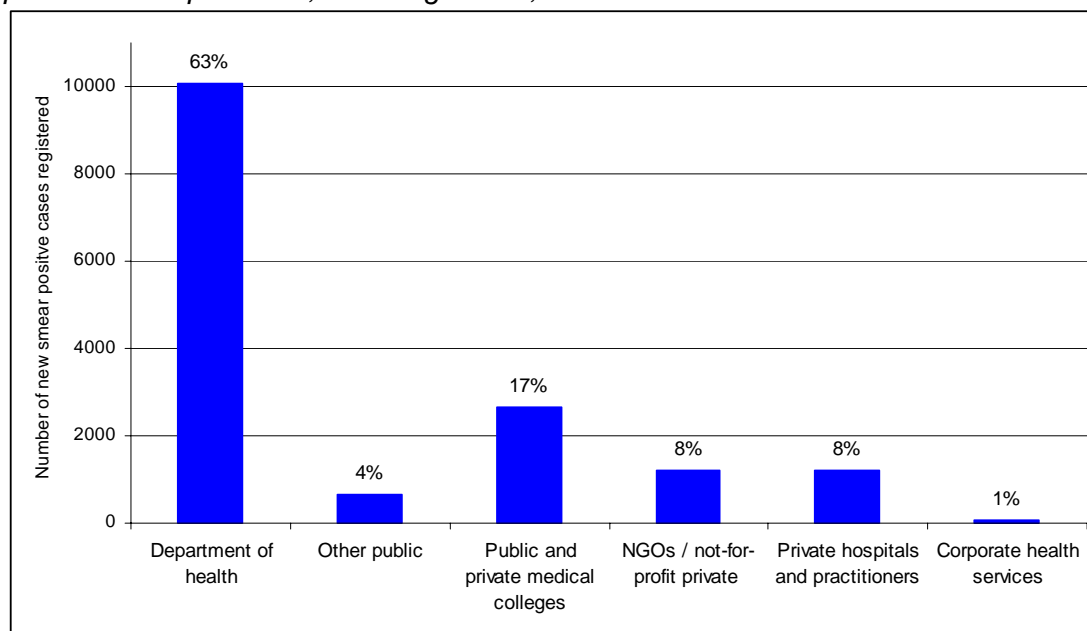
Major challenges for PPM DOTS did remain in the Eastern Mediterranean Region. While DOTS coverage was currently 87% and the treatment success 84%, the regional case detection was only 28%. The countries with the highest TB burden in the Region, Afghanistan and Pakistan, were still at the level of assessment and pilot testing of PPM DOTS. Strengthened PPM DOTS will be a key component of the 2006-2011 regional strategic plan for TB control. The next phase of engagement, where more work was expected in replicating successful PPM examples and bringing them to scale, will be critical to increase case detection rates.

### 3.2.3 South-East Asia (SEAR)

Most countries in the Region had made considerable progress in implementing PPM DOTS. India was leading the way. The country's Revised National TB Control Programme (RNTCP) had implemented a comprehensive strategy for the formal involvement of all relevant health care providers in DOTS expansion. Tools and guidelines had been developed to facilitate inclusion of a variety of providers including public and private medical colleges, public hospitals, NGOs and private practitioners. Figure 3 presents early results of the contribution of different providers to TB control. India had a focal person for PPM DOTS in the WHO country office and 14 PPM DOTS consultants who assisted PPM DOTS scale up in 14 large cities. PPM DOTS was now an integral part of the national TB control strategy and PPM activities had been initiated in all states.

*Figure 3.*

*New S+ cases notified, by source of referral, in the last three quarters of 2004 in 12 cities scaling up PPM DOTS in India. Numbers above bars represent percentage of the total number of cases registered. About a third of the medical colleges are private. Thus, the total contribution from private sector providers, including NGOs, was about 20%*



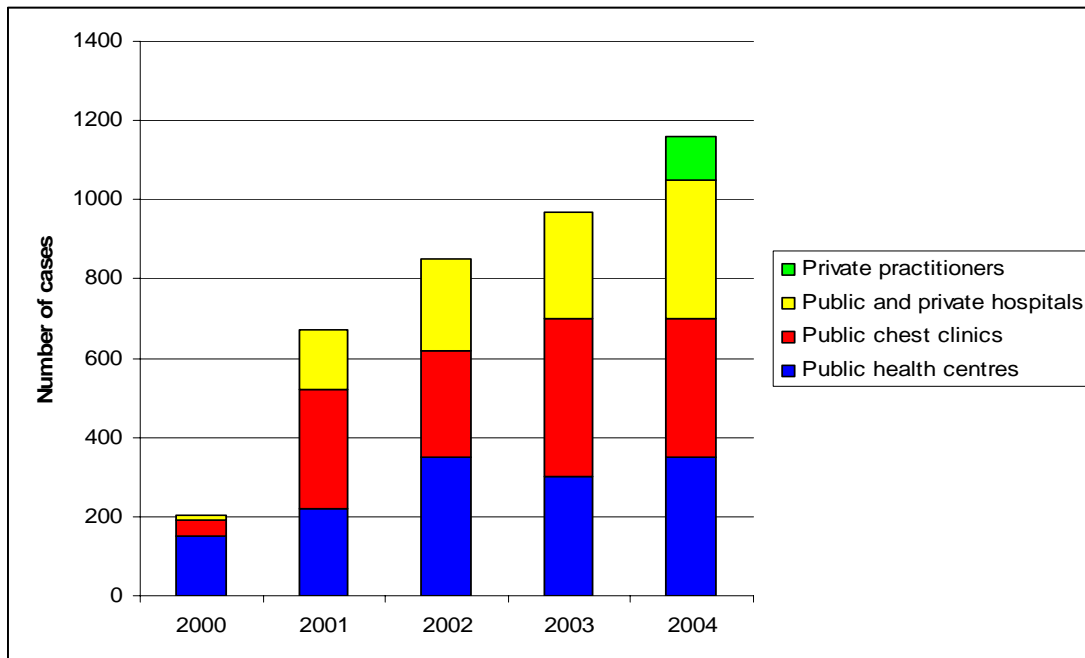
Source: Dr L.S. Chauhan, RNTCP, India

Indonesia had also begun scaling up the involvement of public and private general hospitals and chest clinics. As an example, Figure 4 shows the effect of linking health centres, lung clinics, hospitals and lately, private practitioners, in DOTS implementation in Yogyakarta. Early positive results were also reported from a subsidized health franchise scheme in Myanmar. This and other initiatives to involve private GPs were being scaled up in the country. Large NGOs were major providers of TB care under DOTS in Bangladesh. These NGOs were increasingly acting as intermediaries for the involvement of private providers in both urban and rural areas. In a large project covering 26 million people, the Damien Foundation had successfully involved private

village doctors in DOTS implementation. Figure 5 depicts the contribution of village doctors to DOT in this first, well documented, rural PPM DOTS project in Bangladesh. Nepal, Sri Lanka and Timor Leste had pilot projects involving private practitioners, NGOs and community-based organizations. Thailand also had initiatives involving private hospitals in DOTS implementation.

*Figure 4.*

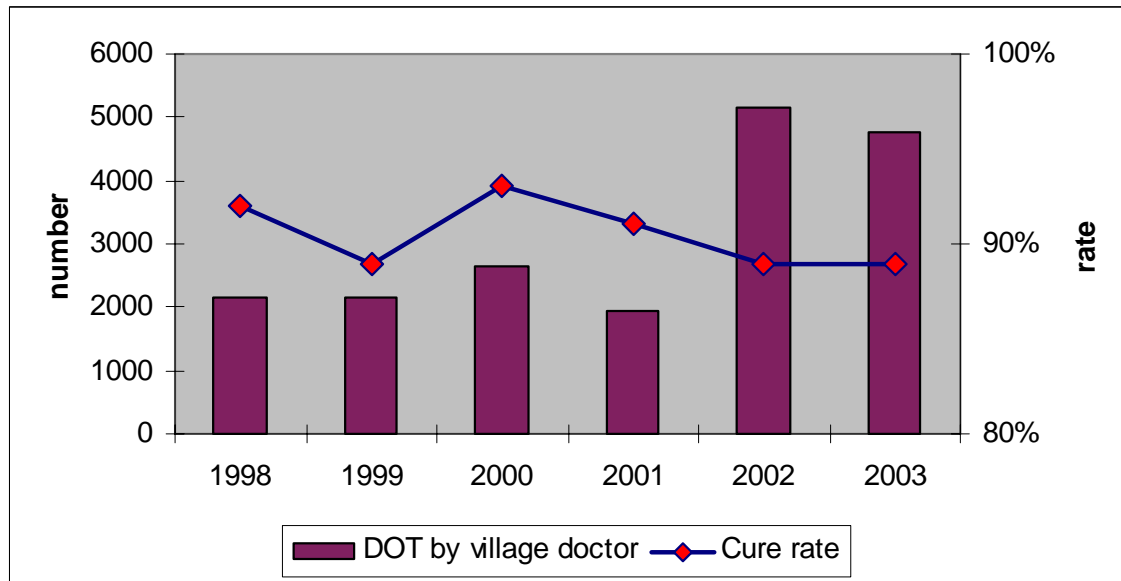
*Case detection of new smear positive TB in Yogyakarta, Indonesia, following active involvement of public sector lung clinics and public and private hospitals from 2001 and private practitioners in 2004.*



Source: Voskens J. Progress Report on Hospital DOTS Linkage Project, DI Yogyakarta, Indonesia, Period: 2004. MoH Indonesia, KNCV, GORGAS, 2005.

Figure 5.

Number of patients receiving DOT from village doctors and cure rates among them in a project population of 26 million in rural Bangladesh. The total number of patients receiving treatment by village doctors between 1998 and 2003 was 18 792.



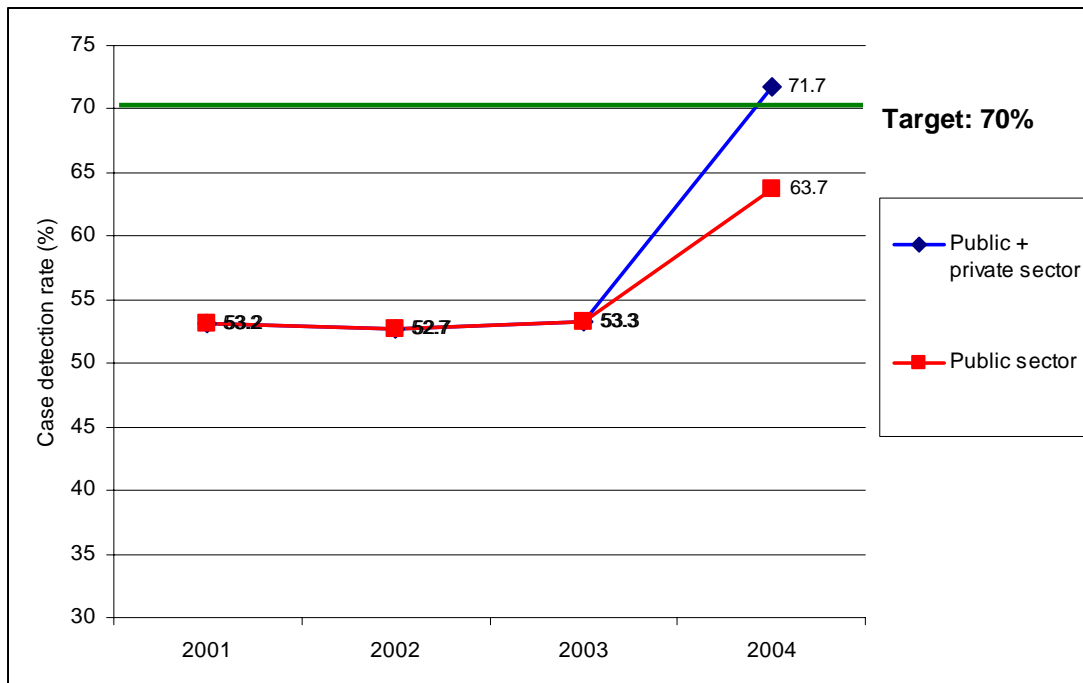
Source: Dr Salim, Damian Foundation, Bangladesh

### 3.2.4 Western Pacific Region (WPR)

The Philippines and China had made significant progress in scaling up PPM DOTS during the past year. The NTP in the Philippines had developed operational PPM DOTS guidelines and was scaling up the involvement mainly of private hospitals, clinics and individual physicians. PPM DOTS was now an integral part of TB control policy and planning. The evolving social health insurance scheme -- Philhealth -- included adequate reimbursement for TB case management to public and private units that had been accredited to offer TB care under DOTS. Regional coordination committees for PPM DOTS had also been established in all the country's regions. These committees supervised PPM DOTS implementation in certified public and private PPMD units spread across the country. The contribution of the PPMD scale up to the increase in case detection in the project areas is shown in Figure 6.

Figure 6.

Case detection trends at five sites (total population about 3 million) in the Philippines with seven PPM DOTS units supported by the GFATM.



Source: Evaluation report of the GFATM-supported PPM DOTS initiatives in the Philippines. NTP, Tropical Disease Foundation, PhilCAT, WHO/WPRO and WHO/Philippines, 2005.

In China, the PPM DOTS activities are centred on establishing linkages between health centres and public hospitals. Case detection in the country increased dramatically from 30% in 2002 to 60% in 2004. This was attributed partly to the intensified involvement of hospitals in DOTS. A core activity had been to improve referral routines between hospitals and TB dispensaries. The new Internet-based infectious disease notification system had greatly facilitated this process. Village doctors had been involved in DOT provision from the start of the DOTS programme in China. Future interventions will focus on improving the quality of diagnosis in hospitals and better tracing of reported cases. Evaluations of pilot projects funded by the GFATM and FIDELIS will help define scaleable actions. Viet Nam has had a pilot project but had not scaled up activities. Cambodia was preparing a PPM DOTS pilot project for launch in 2005.

For several years the Republic of Korea and Japan, the intermediate-burden countries, had employed comprehensive approaches to involve all health care providers in TB control through advanced disease control legislation and health insurance schemes for TB care. The Republic of Korea made TB reporting mandatory for all private providers in 2001, and implemented an Internet-based reporting system in 2003. As a result, TB case detection doubled in 2001 compared to 2000, with the increase due entirely to the private sector providers.

### 3.3 Barriers and enablers for scaling up PPM DOTS

The discussions within break-out groups and at the plenary session that followed highlighted the need to define scale up and develop standardized indicators to monitor progress and assess the contribution of PPM DOTS to TB control. Scaling up at country level would imply utilizing maximally the potential of all relevant health care providers in DOTS implementation and minimizing inappropriate TB management practices. Scale up might be measured in terms of the proportion of providers involved or the proportion of the population living in areas where there are working PPM DOTS initiatives. Scaling up at regional and global levels would mean initiating and expanding PPM DOTS in key countries, including the 22 high-burden countries and other priority countries identified by the regions. These definitions need to be further operationalized and measurable indicators need also to be developed.

The Subgroup acknowledged various identified barriers to scale up PPM DOTS. These included: limited networking and coordination between various authorities and providers; poorly organized private sector; weak referral and information exchange mechanisms; distrust among partners; adverse financial incentive systems; weak quality assurance mechanisms; and time constraints of private providers to participate in sensitization and training programmes. To facilitate the scaling up, five key factors were identified as enablers:

*i. **Commitment of NTP and Ministry of Health:*** Mobilizing human and financial resources essential to scale up PPM DOTS required commitment on the part of the NTP and support from the Ministry of Health. Hesitation to embark on scaling up PPM DOTS initiatives persisted among stakeholders. This might partly be due to a perceived lack of evidence concerning benefits and risks.

*ii. **National support structure:*** Experience showed that a coalition, a national task force or a national partnership could help to effectively coordinate contributions from a range of stakeholders at national and local levels. A national focal point for PPM DOTS and sub-national PPM DOTS resource persons could further improve technical capacity for PPM DOTS.

*iii. **Additional human resources:*** Countries that were scaling up PPM DOTS initiatives experienced limitations due to insufficient human resources for planning, sensitization, training, supervision, monitoring and evaluation. Rapid scale up without securing adequate resources for these functions risked compromising quality. Human resource development plans for TB needed to incorporate provision of human resources for PPM DOTS.

*iv. **Appropriate tools*** were required to facilitate country-specific scale up. Such tools might include: a national policy, operational guidelines, adapted training materials, advocacy tools, an improved referral, reporting and notification system and tools to establish appropriate contractual relationships and financial arrangements where required.

v. **Technical support** was crucial for assisting countries in developing and implementing PPM DOTS strategies. The Subgroup had been helpful in several ways like providing a generic framework and tools, helping document and share experiences, mentoring and providing technical assistance. However, there was a further need to strengthen work in a number of areas outlined in the following section.

### **3.4 Areas for priority action to support scale up**

#### *3.4.1 PPM DOTS Global Guidelines and International Standards of TB Care*

The draft PPM DOTS global guidelines prepared by the Secretariat were reviewed and endorsed by the meeting, which advised that the guidelines should be finalized and disseminated soon. The guidelines would be useful for NTPs to develop their own national policies and operational guidelines. The document will also help develop strategies for local implementation. The participants acknowledged that detailed advice on how to involve specific provider types will have to be country-specific. There might be a need to develop supporting documents and resources including advocacy and training materials on PPM DOTS.

The draft document 'International Standards of TB Care' was discussed at the meeting. The Subgroup endorsed the concept of international standards of TB care and agreed with the process of producing the document. The need for a short, simple version of the guidelines in lay language was also stressed, both for advocacy purposes and for dissemination to all types of providers. The idea of an accompanying patient charter was welcomed. When available, the document could well be used for PPM DOTS training and advocacy. Box 2 summarizes the concept of international standards of TB care.

#### *3.4.2 Capacity for technical assistance*

The Subgroup emphasized that the number of experts who could provide technical assistance to countries needed to be increased considerably. A first step would be to create a resource of experts from within the Subgroup. Incorporating PPM DOTS into global, regional and national training programmes of TB consultants would be the logical second step. For this purpose linkages should be established with the existing global TB Training Task Force. One of the meeting groups discussed capacity strengthening for technical assistance and deliberated specifically on ways to incorporate PPM DOTS into existing training courses. The group identified limited manpower for technical assistance at the global level as a major barrier. On training approaches, the group emphasized that exposure to actual PPM DOTS implementation in the field should be an important element of training. The group also felt that the development of training centres linked to PPM DOTS sites (like centres of excellence or WHO collaborating centres) could facilitate regional training on PPM DOTS. The group made the following specific recommendations:

- i. Expand and strengthen the WHO-based PPM Subgroup Secretariat. In particular, both resources and capacity for provision of global technical assistance should be increased.
- ii. Promote deployment of a dedicated focal person for PPM activities at the WHO regional and, where appropriate, country offices. This would be accomplished ideally by designating a full-time staff member with the appropriate title, responsibilities and budget to promote regional PPM activities.
- iii. Initiate a specific project to develop a generic PPM curriculum for implementation in training programmes at global, regional and national levels.
- iv. Designate WHO collaborating centres for PPM DOTS activities and use them as partners and resource centres for PPM training and evaluation in countries within respective regions.

## Box 2

### International Standards of TB Care

*An important current effort to address the issue of quality of care for tuberculosis is the development of a set of international standards. This effort is being led by a consortium of organizations concerned with global tuberculosis care and control (American Thoracic Society, Centers for Disease Control and Prevention [USA], Dutch Tuberculosis Foundation [KNVCV], International Union Against Tuberculosis and Lung Disease, and World Health Organization). A fundamental premise that underlies these standards (still in draft form) is that all providers who undertake treatment of patients with tuberculosis must recognize that not only are they treating an individual, they are assuming an important public health function that entails responsibility to the community as well as to the individual patient under their care. In spite of many differences among countries in terms of their economic conditions, health care systems and epidemiological circumstances and among health care providers, the basic principles of care for persons with or suspected of having tuberculosis are the same worldwide. Consequently, the fundamental approaches to tuberculosis care can be described in a set of essential standards that are applicable in all areas and by all health care sectors -- national tuberculosis programmes, other public sector providers and private providers. Engagement of all care providers, public and private, in delivering a high standard of tuberculosis care for all patients, including patients with sputum smear-positive, sputum smear-negative and extra-pulmonary tuberculosis, tuberculosis caused by drug-resistant organisms and tuberculosis in patients with HIV infection, is essential both to protect the health of communities and to restore the health of individuals with the disease, while preventing tuberculosis in their families and others with whom they come into contact.*

*In accordance with the DOTS strategy the standards will address the basic elements of diagnosis and treatment of tuberculosis with a series of straightforward statements that are backed by evidence. The intent is to secure a broad base of endorsements – national tuberculosis programmes, professional medical and nursing societies, academic institutions, nongovernmental organizations that provide medical care, HIV-focused organizations – and be able to use the standards to create peer pressure for providers to conform to the principles as well as to serve as the basis for pre-service and in-service training.*

*The areas to be addressed by the standards include: identification of persons who should be evaluated for tuberculosis; the requirement to seek bacteriological confirmation of the diagnosis in all persons suspected of having tuberculosis; the use of drug regimens of proven effectiveness; the need for treatment support and supervision; the recommendation that under defined epidemiological circumstances HIV counseling and testing should be performed; the need to consider antiretroviral treatment for patients with HIV infection who have tuberculosis; the need to evaluate all patients for the possibility of drug resistance; and the requirement that providers report cases to the public health authority. It is recognized that a set of standards is only a tool and having a tool does not guarantee that the job will be done correctly. However, with proper use and broad-based support, the standards should be a useful means of improving the quality of care for tuberculosis. The PPM DOTS Subgroup has endorsed the concept and the process of developing International Standards of TB Care*

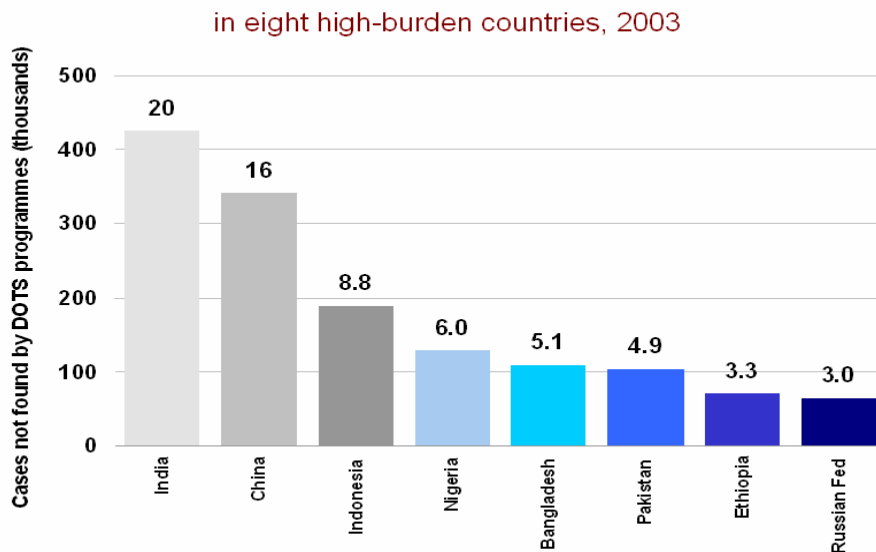
*Source: Philip Hopewell, Co-chair, Steering Committee on International Standards of TB Care*

### 3.4.3 PPM DOTS in the Second Global Plan to Stop TB

The 2<sup>nd</sup> Global Plan to Stop TB, currently under development, will outline a strategic plan for TB control during 2006–2015. The plan will consider means to help meet the TB-related targets of the MDGs. Incorporation of the global PPM DOTS scale up into the 2<sup>nd</sup> Global Plan and in other global TB control strategy documents was essential. It was highlighted that over 60% of the global undetected cases were concentrated in six high TB-burden countries: Bangladesh, China, India, Indonesia, Nigeria and Pakistan (Figure 7). The Subgroup underscored the importance of intensifying PPM DOTS efforts in these countries.

Figure 7.  
Undetected Smear-positive TB cases under DOTS in eight high-burden countries, 2003.

#### Smear-positive TB cases undetected by DOTS programmes



Figures indicate the proportion of all missed cases which are missed by each country

### 3.4.4 Advocating PPM DOTS

The meeting stressed the need to disseminate country experiences of PPM DOTS more widely to a range of partners and stakeholders. One of the groups discussed strategies for advocacy to promote scaling up of PPM DOTS. The group felt that advocacy and resource mobilization, although pursued, had not yet pushed PPM DOTS into the generalized consciousness of policy-makers, health systems managers, NTPs, patients, providers, technical agencies and donors. In most countries, PPM DOTS had not reached the tipping point where it would be considered an essential component of DOTS expansion. The group highlighted the importance of developing PPM advocacy

and communications strategies and tactics in order to boost progress of PPM initiatives from pilot projects to scaled-up programmes.

It was felt that though enough success stories did exist but 'promotional' PPM material was grossly inadequate. The group identified the following target audience for advocacy on PPM DOTS at the global level: Stop TB Partners and other Working Groups of the Partnership; donor agencies (bilateral, GFATM, FIDELIS, etc.); the International Labour Organisation (ILO) and the World Economic Forum (WEF). At national level the target group for advocacy could be: NTP; Ministry of Health and other ministries contributing to health services delivery; Ministry of Finance; parliamentarians; professional associations; non-public health sector and patient organizations. The group identified several specific PPM DOTS advocacy products that needed to be developed and tailored to the different target groups:

- i. National-level success stories of PPM DOTS scale up Economic advocacy paper for PPM DOTS
- iii. "What is PPM DOTS?" generic as well as country-specific documents
- iv. "PPM DOTS - What's in it for me?": Advocacy for involving specific provider types
- v. "TB at the Workplace" in collaboration with ILO and the World Economic Forum.

#### *3.4.5 Collaboration with other Stop TB Working Groups*

Strategies for global TB control were in transition and were progressing from DOTS expansion to expanding access to care, improving quality of care, scaling up the availability of appropriate treatment for drug-resistant TB and integrating care for TB and HIV. In this context, one of the groups discussed linkages between the PPM DOTS Subgroup and other Working Groups and Subgroups of the Stop TB Partnership. The group concluded that linking all health care providers should be a core component of national plans for the new activity areas and PPM DOTS could be a pathfinder to contribute to the expansion of DOTS Plus and TB/HIV services. To better define PPM DOTS strategies that will help improve access to TB care for the poor, the group emphasized that collaboration between the TB and Poverty Network and the PPM DOTS Subgroup was essential. Furthermore, the need to establish close linkages with the Advocacy and Communication Working Group and seek their help to develop advocacy strategies and tools for PPM DOTS was highlighted. For ongoing engagement with other groups, it was recommended that members of the Subgroup should be represented in other working groups and vice versa.

#### *3.4.6 Operational research*

Previous PPM DOTS Subgroup meetings had identified important areas for operational research. Some of them include incentives and enablers for different types of providers, effect of PPM DOTS on diagnostic delay, equity in access in scaled-up programmes, barriers and enablers to scale up and cost-effectiveness of scale up. The need to pursue the operational research agenda was stressed. Partnering with academic institutions for the dual purpose of their sensitization and undertaking quality operational research was also recommended.

### *3.4.7 Resource mobilization*

Working on an ambitious agenda will require simultaneously addressing the need for additional resources for PPM DOTS at all levels. Countries needed to identify the financial gap for PPM activities and make efforts to mobilize resources to minimize it. PPM DOTS must figure in national TB control planning, budgeting and funding applications. The Subgroup and its Secretariat should also focus on the needs of priority countries, identified on the basis of the burden of TB, relevance of PPM DOTS, need for technical assistance and likelihood of success. The Subgroup should continue to assist countries in mobilizing resources while intensifying advocacy for PPM DOTS. Besides other donor agencies, the GFATM provided an excellent opportunity for most countries to secure resources for scaling up PPM, both as a part of TB control and for strengthening of health systems.

## **4. Conclusions and recommendations**

After three days of presentations, discussions, field visits and work on key topics in several groups, two major observations emerged from the meeting. One, since many countries had now completed or were about to complete the geographical expansion of DOTS coverage, it was time they initiated and scaled up strategies to improve access to quality TB care by all segments of populations, and two, one of the most logical and effective strategies would be PPM DOTS. On taking stock of PPM DOTS-related activities and their progress globally, the Subgroup agreed on the following conclusions and made recommendations for the future course of action.

### **4.1 Conclusions**

- (a) There was growing interest about PPM DOTS generally. Many countries had embarked on it and some countries and regions had made rapid progress in scaling up PPM DOTS.
- (b) Scaling up PPM DOTS faced a number of barriers.
- (c) The current capacity at national, regional and global levels to provide technical support for scaling up PPM DOTS was weak.
- (d) There was great scope to establish and strengthen linkages between the Subgroup and other Stop TB working groups and initiatives, including DOTS Plus, TB/HIV and Advocacy and Communications working groups and the TB-Poverty Network.
- (e) Efforts to advocate and promote PPM DOTS at global, regional and national levels deserved greater attention.
- (f) The draft PPM DOTS guidelines prepared by the Subgroup should be finalized and disseminated widely.

- (g) The concept and process of developing the 'International Standards of TB Care' document initiated by WHO, American Thoracic Society (ATS) and other major Stop TB partners was fully acceptable to the Subgroup; this document could be an important tool to engage all care providers in TB control.

## 4.2 Recommendations

### ***For the STOP TB Coordinating Board and the DOTS Expansion Working Group:***

- (a) Enhance the profile of the Subgroup within the DEWG and the Stop TB Partnership and strengthen support for Subgroup activities.
- (b) Advocate PPM DOTS – linking all care providers to national TB programmes – as a prominent part of the Second Global Plan to Stop TB, especially to improve access to quality TB care for the poor.
- (c) Promote PPM DOTS during missions to countries and important events such as World TB Day.
- (d) Review progress of PPM DOTS regularly during DEWG and STB-CB meetings.
- (e) Mobilize resources to strengthen capacity for PPM at global, regional and national levels in order to assist in initiating, evaluating and scaling up PPM DOTS.

### **For Ministries of Health and national TB programmes**

- (a) Adapt the new PPM DOTS guidelines to country conditions in order to help plan, implement and scale up PPM.
- (b) Make countrywide PPM DOTS scale up a core and integral component of the national TB plan and budget.
- (c) Develop and implement a human resource development plan for national TB programme and other health care providers.
- (d) Document PPM DOTS initiatives to contribute to the evidence base of enablers and barriers to scale-up efforts.
- (e) Ensure that all available funding sources are tapped for PPM DOTS, including local funding sources, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Fund for Innovative DOTS Expansion through Local Initiatives to Stop TB (FIDELIS), etc.

### **Next steps for the PPM DOTS Subgroup**

- (a) Ensure adequate incorporation of PPM DOTS in the 2<sup>nd</sup> Global Plan to Stop TB.
- (b) Develop training strategies for PPM DOTS, including introduction of PPM DOTS in the existing national, regional and international TB training courses.
- (c) Develop an advocacy strategy for PPM DOTS, including advocacy tools for different target groups such as donors, technical partners, MoH/NTP, health care providers and users.
- (d) Finalize, launch and disseminate widely the global PPM guidelines and assist countries for their local adaptation and use.
- (e) Use 'International Standards of TB Care' to promote PPM DOTS.
- (f) Provide technical assistance for scaling up PPM DOTS in countries, with particular attention to improving access by, and reducing financial burden on, the poor.
- (g) Assist countries to incorporate PPM DOTS in the GFATM and other grant proposals.
- (h) Develop standard monitoring indicators for PPM DOTS and advocate their use.
- (i) Assist in documenting and evaluating PPM DOTS scale up in order to improve the evidence base.
- (j) Establish action-oriented linkages with the Poverty Network of the Stop TB Partnership and the DOTS Plus, TB/HIV as well as Advocacy and Communications working groups.

## Agenda

### Third meeting of the Public-Private Mix Subgroup for DOTS Expansion 4-6 April 2005, Manila, Philippines

#### Day 1 – Monday, 4 April 2005

##### Session 1: Welcome

**Chair: D. Ahn**

08:30–08:40 Welcome address

S. Omi, Regional  
Director, WPR

08:40–08:50 Self introductions

All

08:50–09:00 Group photo

All

09:00–09:30 *Coffee break*

##### Session 2: Global progress

**Chair: P. Hopewell**

09:30–9:45 The meeting agenda, objectives and expected  
outcomes

M. Uplekar

09:45–10:00 PPM DOTS and the 2<sup>nd</sup> Global Plan to Stop TB

L. Blanc

10:00–10:15 Barriers and enablers to scaling up PPM

K. Lönnroth

10:15–10:45 Report from AFRO

D. Kibuga

10:45–11:15 Report from EMRO

S. Baghdadi

11:15–11:45 Report from SEARO

N. Nair

11:45–12:15 Report from WPRO

D. Ahn

12:15–13:15 *Lunch break*

##### Session 3: Country experiences of scaling up

**Chair: B. Sørensen**

13:15–13:45 The Philippines

R. Vianzon

13:45–14:15 China

Jiang Shiwen

14:15–14:45 India

L.S. Chauhan

14:45–15:15 *Coffee break*

##### Session 4: Experiences from diverse initiatives

**Chair: J. Lagahid**

15:15–15:35	Rural PPM DOTS in Bangladesh	M. A. H. Salim
15:35–15:55	Evaluation of a PPM pilot initiative in Nigeria	A. Eligan
15:55–16:15	PPM DOTS through social franchising in Myanmar	N. N. Ming / Sheela Rangan
16:15–17:00	Discussion	
17:10–17:30	Introduction to field visits and group work	K. Lonroth
17:30–18:30	<i>Cocktails, hosted by the Regional Office for the Western Pacific</i>	

## **Day 2 – Tuesday, 5 April 2005**

07:00–15:00	Field visit to PPM DOTS sites (including lunch)	
15:00–18:00	Group work: Four groups will work on key issues related to scaling up PPM DOTS	

## **Day 3 – Wednesday, 6 April 2005**

**Chair: L.S. Chauhan**

### **Session 5: Group work presentations**

09:00–09:20	Group 1: Barriers to scaling up PPM DOTS	Group representative
09:20–09:40	Group 2: Introduce PPM into global and regional training on TB	Group representative
09:40–10:00	Group 3: Advocacy to promote scaling up of PPM DOTS	Group representative
10:00–10:20	Group 4: Linkages with other Stop TB Working Groups / Initiatives	Group representative
10:20–10:50	<i>Coffee break</i>	

### **Session 6: Key issues of global relevance**

**Chair: L. Blanc**

10:50–11:10	International standards of TB care	P. Hopewell
11:10–12:00	PPM DOTS Global Guidelines	M. Uplekar / K. Lonroth
12:00–13:30	<i>Lunch break</i>	

### **Session 7: Recommendations and next steps**

**Chair: P. Hopewell**

13:30–15:30	Recommendations and next steps	
15:30–16:00	Closing remarks	S. Omi, Regional Director, WPR

17:00–18:00 **Meeting of the Core Group of the PPM DOTS Subgroup**

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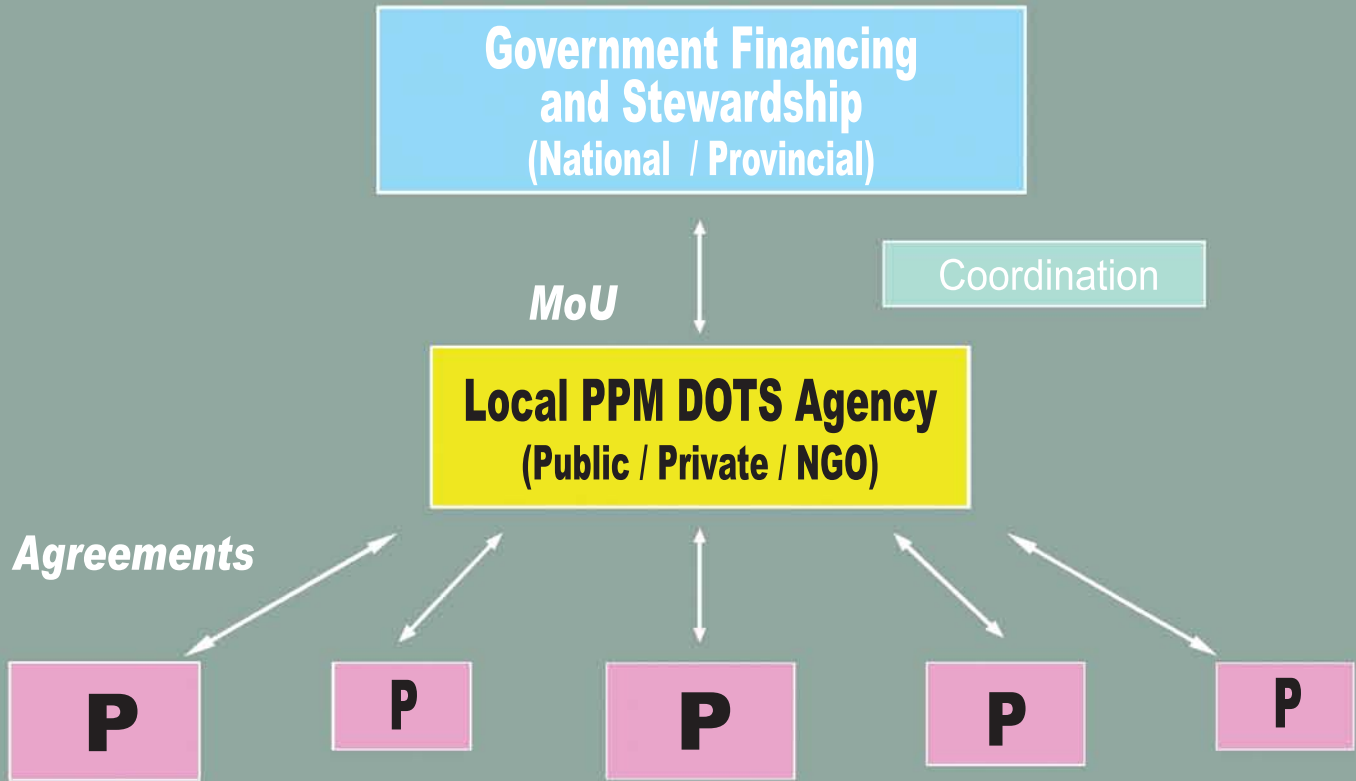
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# A generic PPM structure emerging from PPM DOTS field projects



The national government formulates a PPM policy in consultation with the stakeholders. A coordination mechanism helps to bring the public and the private sectors together, agree on implementation schemes and maintain dialogue. A local DOTS agency – public, private or voluntary – implements DOTS through a network of willing health care providers in an area. P indicates public, private or other providers.

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