

Promoting the implementation of collaborative TB/HIV activities through public–private mix and partnerships

Report of a WHO consultation
27–28 February 2008
WHO headquarters, Geneva, Switzerland

Report of a WHO meeting, not guidelines endorsed by WHO



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Abbreviations

ART	antiretroviral treatment
CPT	co-trimoxazole preventive therapy
DOTS	The internationally recommended strategy for TB control until 2005, and the foundation of the new Stop TB Strategy introduced in 2006
IPT	isoniazid preventive therapy
NGO	nongovernmental organization
NAC	national AIDS control programme
NTP	national TB control programme
PLHIV	people living with HIV
PPM	public–private mix
TB	tuberculosis
WHO	World Health Organization

1 Background

Tuberculosis (TB) is a leading cause of death among people living with HIV (PLHIV). Of the estimated 9.2 million new TB cases and 1.7 million deaths from TB in 2006, 709 000 cases (8%) and 200 000 deaths (12%) occurred in PLHIV. The African Region accounts for 85% of the global distribution of HIV-positive TB patients. Collaborative TB/HIV activities are essential to ensure that HIV-positive TB patients are identified and treated appropriately; and to prevent, diagnose and treat TB in PLHIV. In recent years, there has been considerable progress, particularly in the African Region, with the provision of TB/HIV interventions. In 2006, 12% of all notified TB patients were tested for HIV, compared with 0.5% in 2002. Of the TB patients who tested positive for HIV, 78% were treated with co-trimoxazole preventive therapy (CPT) and 41% started treatment with antiretroviral drugs. The expansion of access to life-saving antiretroviral drugs in HIV-prevalent and resource-constrained settings has also been instrumental in implementing collaborative TB/HIV activities. By the end of 2007, nearly 3 million PLHIV were receiving antiretroviral treatment, or ART.¹ However, scale-up of collaborative TB/HIV activities, in particular the essential interventions that are needed to reduce the burden of TB among PLHIV (intensified case finding, infection control and isoniazid preventive therapy – known as the Three I's) falls short of the targets of the Global Plan to Stop TB, 2006–2015.²

Patients with symptoms of TB and HIV seek and receive care from a wide variety of health-care providers outside the national TB and HIV/AIDS control programmes, depending upon availability, acceptability, costs and many other factors. These include informal village doctors, private general practitioners, public hospitals, specialized physicians, nongovernmental organizations (NGOs), medical colleges and corporate health services (Box 1).

Box 1. Broad categories of health-care providers engaged in implementing collaborative TB/HIV activities

Public health-care providers

- General hospitals
- Specialist hospitals and academic institutions
- Health institutions under state insurance schemes
- Health facilities under governmental corporations and ministries
- Prison health services
- Army health services

Private health-care providers

- Private hospitals and clinics
- Corporate health-care services
- Nongovernmental hospitals and clinics
- Individual private physicians, nurses, midwives, clinical officers
- Pharmacies and drug shops
- Traditional medical practitioners
- Informal, non-qualified practitioners

Engaging the private sector in the provision of ART has become increasingly important. In Malawi, for example, no private facilities were involved in the provision of ART in December 2004, but the number providing ART at subsidized rates through collaboration with the Ministry of Health of Malawi had increased to 23 by December 2005 and to 45 by December 2007. By 2008, 5407 patients who had started ART in Malawi had very good treatment outcomes, accounting for 5% of all PLHIV ever started on ART. The cumulative treatment outcomes of PLHIV started on ART in private facilities were: 72% alive and on ART at the site of registration, 7% dead, 6% lost to follow-up, 14% transferred out to another facility (and presumably alive) and <1% had interrupted treatment.³ Similarly, in Kenya, by August 2007 it was estimated that the private-for-profit sector cared for nearly 5000 PLHIV. The National AIDS and STDs Control Programme (NASCOP) established partnerships with 10 private hospitals for the provision of ART.

More than 40 projects on public–private mix (PPM) for DOTS have been implemented in 14 countries, of which over 25 have been evaluated for process and/or outcomes. These include diverse projects linking national TB control programmes (NTPs) to various care providers such as non-qualified village doctors (Bangladesh), informal and formal private practitioners (India), private general practitioners (Myanmar), specialist chest physicians (Kenya), public and private hospitals (China and Indonesia), NGOs (Bangladesh and Nepal) and a mix of providers (India and the Philippines). Treatment outcomes have been evaluated for over 20 000 TB patients in 15 PPM DOTS projects. Rates of treatment success in the projects that provided drugs free of charge to patients ranged between 75% and 90%.

The impact on case detection has also been evaluated in several PPM projects. All these projects have shown an increase in case detection ranging from 10% to 61%. A cost and cost-effectiveness analysis undertaken for two well established projects in India showed that PPM DOTS is at least as cost-effective as DOTS delivered exclusively by the public sector and that the approach is much more cost effective compared with anti-TB treatment in the conventional non-DOTS private health sector. Moreover, PPM DOTS significantly reduces the financial burden for TB patients and facilitates access to high-quality TB care. Data from Bangladesh, India, Myanmar and the Philippines indicate that PPM DOTS helps to reach poor people when providers used by them are also involved.

In conclusion, evidence emerging from the field shows that PPM DOTS is a feasible, productive and cost-effective approach to improve case detection and treatment outcomes as well as foster equity in access and financial protection for poor people.⁴ A WHO guidance document on PPM implementation is also available.⁵ This has stimulated WHO to promote PPM programmes for the engagement of all health-care providers in TB control as a critical component of the Stop TB Strategy.⁶ In 2007, 14 of the 22 high TB burden countries that account for 80% of TB cases globally were scaling up PPM approaches to involve the full range of care providers for TB control.

There is a consensus on the wider engagement of all health providers in the implementation of collaborative TB/HIV activities, as it provides an untapped opportunity for scaling-up these activities. This was first discussed in the Stop TB Partnership Meeting of Joint Working Groups held in October 2005 in Versailles, France.⁷ Furthermore, during the HIV Implementer's Meeting held in June 2008 in Kampala, the need to scale-up essential activities to reduce the

burden of TB in PLHIV (the Three I's) was underlined. In response to the October 2005 meeting, and in parallel with the June 2008 meeting, WHO undertook a number of efforts to define the best evidence-based mechanisms to enhance the involvement of all care providers, particularly non-public sectors, in scaling up collaborative TB/HIV activities. These included a systematic review of published and unpublished engagement of PPM in the implementation of collaborative TB/HIV activities, documentation of practices and experiences, and an expert consultation.

The systematic review highlighted emerging evidence to suggest the potential involvement of the non-public sector in scaling-up collaborative TB/HIV activities. Most articles identified were descriptive and provided no quantitative data on private sector involvement. However, the existing qualitative evidence shows that non-public health-care providers can play an effective role in delivery of TB/HIV services. In most settings, national programmes provided training and supervision of providers, while non-public health-care providers were mostly engaged in activities such as referral, supervision of treatment, voluntary counselling and testing, home-based care and provision of patient information. Most of the relevant articles were from the Asian and the African continents. The review also highlighted the many initiatives on collaborative TB/HIV activities in various settings undertaken by the non-public-health care sector that need further nurturing and evaluation to identify the best models and extract lessons for wider implementation.

WHO organized an informal expert consultation on 24–25 May 2007 in Geneva, Switzerland to review, discuss and analyse existing practices in the engagement of PPM providers in implementing and scaling-up collaborative TB/HIV activities. The meeting emphasized the importance of systematic documentation and nurturing of existing practices, and formulated basic principles for successful PPM engagement. These guiding principles were developed further at a subsequent consultation (Box 2).

A situation analysis carried out in Nairobi, Kenya highlighted not only the existing opportunities for scale up of collaborative TB/HIV activities through the engagement of the non-public sector but also the associated challenges, which largely concern funding insufficiencies, lacking technical staff for supervision and lack of guidelines and policies at the national level. These analyses and findings suggest the importance of systematic approaches in defining the best evidence-based strategies to enhance non-public sector involvement in scaling up collaborative TB/HIV activities.

2 Informal expert consultation meeting, February 2008

WHO conducted a second informal expert consultation to promote PPM involvement in implementing collaborative TB/HIV activities through a review of existing evidence and experiences and define core aspects and actions needed for the implementation of such activities by a wider spectrum of providers from the public and private sectors. The meeting also sought to inform the development of steps for implementation of collaborative TB/HIV activities by public and private providers and the generation of critical evidence and experience, including pilot testing in different countries.

More than 40 people participated in the meeting, including representatives from eight countries where TB/HIV PPM activities are ongoing or planned, international NGOs, medical associations, donors and United Nations agencies (*Annex I* and *Annex II*).

The following critical issues were discussed.

2.1 Country experiences and practices

Country representatives (from El Salvador, Ethiopia, India and Kenya) and NGOs (the World Economic Forum and Population Services International) shared experiences and practices in implementing collaborative TB/HIV activities. Existing opportunities to commence PPM for such activities in Namibia were also discussed.

El Salvador. PPM engagement in El Salvador has included the establishment by the private sector of schools for health professionals and the involvement of a network of private laboratories and faith-based primary care clinics; setting up TB/HIV support groups; and involving prisons, the military and police. Next steps planned to strengthen the response to TB/HIV include introducing the newly developed TB/HIV clinical manual for use by health professionals including in the private and public sectors, streamlining the referral system to accelerate the diagnosis of TB and treatment of patients among PLHIV by implementing innovative strategies, and improving the monitoring and evaluation of activities.

Ethiopia. Initiated in 2006, PPM activities now include 21 private facilities that provide services for TB control in collaboration with the NTP. The national programme has an ambitious plan to extend these joint activities to 100 private facilities in 2007–2008. The private sector is also increasingly engaged in delivering HIV prevention and treatment services. This offers an important opportunity to harness the engagement of the private and public sectors in implementing and scaling up collaborative TB/HIV activities. Planned activities include strengthening laboratory quality assurance, intensifying trainings for TB/HIV management, involving more private providers in TB/HIV activities, and conducting awareness-raising activities in the community to increase demand for services.

India. Inter Aide, a French NGO operating in India, coordinates the activities of various NGOs responsible for delivering TB services. Since October 2006, it has been implementing a project on TB/HIV collaboration targeting high-risk groups for HIV infection, with the objective of increasing access to TB/HIV services through NGOs catering to these groups. Achievements include involving 99 private practitioners in areas where sex workers operate, training 300 community volunteers, 112 field supervisors and outreach workers, 22 counsellors and 31 doctors.

Kenya. An agency separate from the NTP is responsible for liaising with private providers; 88 providers are currently involved (in Nairobi). Activities are extending to other large urban centres and now involve private-for-profit, faith-based and NGO providers. More than half of TB patients tested in the private sector are HIV-positive, almost 60% of whom received CPT, and 40% ART. Supply of commodities is the main challenge; other challenges include reaching the most vulnerable and building NTP capacity to progress this work.

World Economic Forum. The World Economic Forum focuses on the role of different health- and non-health-related businesses in delivering TB/HIV collaborative activities. Examples include: developing models of social support and care; encouraging TB patients to test for HIV and, if HIV-positive, enrolling them in the company programme that includes treatment for both diseases; delivering workplace and community care; managing voluntary counselling and testing centres; running training and school health programmes as well as integrated HIV, TB and malaria programmes. The potential for business involvement in implementing collaborative TB/HIV activities has been recognized and consultation with the prospective different stakeholders is ongoing.

Population Services International. A nonprofit organization that works with the private sector to address the health problems of low-income and vulnerable populations in more than 60 developing countries, Population Services International adopted two approaches for involving health providers in collaborative TB/HIV activities: NGO public sector collaboration (in Lesotho, Namibia, South Africa, Swaziland, Zambia and Zimbabwe) and social franchising (in Myanmar). These initiatives are yielding positive results. In South Africa, for example, around 8500 people were tested as HIV-positive through different efforts and offered appropriate care and support services; in Myanmar, 417 providers are taking part in the initiative. Strengthening the collaborative TB/HIV activities in these existing services is planned.

2.2 Guiding principles for PPM TB/HIV activities

The basic guiding principles developed at the previous consultation were discussed and modified based on country experiences and discussions. These principles are intended to facilitate initiation as well as successful implementation and scaling up of collaborative TB/HIV activities (Box 2). PPM TB/HIV activities require coordination and collaboration among national AIDS and TB control programmes as well as public and private service providers. This collaboration can be either at national, state, regional, provincial or district level, depending on the local context.

Box 2. Guiding principles for commencing and scaling-up the involvement of public and private providers in collaborative TB/HIV activities

- Existence of national TB and AIDS control programmes and implementation of basic DOTS strategy and basic services for HIV prevention and treatment
- An environment conducive to national policy, and capacity to support PPM TB/HIV activities
- Coordination between the national AIDS and TB control programmes at all levels (state, regional, provincial, district) and among all private and public stakeholders involved in the initiatives
- Strategic and regular advocacy to involve all providers and ensure buy-in of all relevant TB and HIV stakeholders in PPM TB/HIV activities
- Medicines and consumables supplied free of charge to providers extended free of charge to patients
- Diagnostic tests widely accessible and affordable
- Capacity building (including training and supervision) in accordance with national policies and standards
- Strengthen existing collaborative mechanisms and/or emerging opportunities between private and public sector and national TB and AIDS control programmes optimized to ensure sustainability and avoid duplication of structures
- Provision of technical assistance (internal and/or external) ensured
- Ensured continuity of services to end users in cases of provider decisions to opt out of PPM scheme.

2.3 Defining task mix for collaborative TB/HIV activities

The situation analysis conducted in Kenya and the experiences of other countries demonstrate the importance of defining the task mix for collaborative TB/HIV activities according to local policies and context. Mapping health providers and investigating their current role in diagnosing and treating TB, their capacity to perform different DOTS tasks as well as their willingness to participate in PPM DOTS has been a central part of planning. To guide this process, it is useful to define which provider type can take on which collaborative TB/HIV task. *Table 1* lists some of the main tasks based on the 12 collaborative TB/HIV activities to provide indicative guidance for the local implementation of collaborative TB/HIV activities. Depending on local contexts, these tasks should also be considered for relevant provider categories.

Table 1 Indicative TB/HIV collaborative activities task mix for different provider categories		
Collaborative TB/HIV activities	Rationale	Distribution of task or involved stakeholders
A. Establish the mechanisms for collaboration		
A.1 Set up a coordinating body for TB/HIV activities effective at all levels	Coordinating body is needed (at all levels) to ensure more effective collaboration between the two programme efforts and the private and public service providers.	National, TB and AIDS Control Programmes and their system at regional, state, provincial or district levels. Professional Associations, Service provider interest groups, other line ministries such as Ministry of Justice
A.2 Conduct surveillance of HIV prevalence among tuberculosis patients	Surveillance is essential to inform programme planning and implementation. The method chosen will depend on the national TB and HIV situation, and the availability of resources and expertise.	National TB and HIV/AIDS Control Programmes
A.3 Carry out joint TB/HIV planning	Roles and responsibilities of two programmes have to be clearly defined, and should focus on all collaborative TB/HIV activities, capacity building, training, resource mobilization and advocacy, communication and social mobilization.	National TB and HIV/AIDS Control Programmes and their system at regional, state, provincial or district levels. Professional Associations, service provider interest groups, line ministries
A.4 Conduct monitoring and evaluation	M&E helps ensure continuous improvement of programmes' performances. It involves collaboration and referral linkages between different services and organizations.	National TB and HIV/AIDS Control Programmes and their system at regional, state, provincial or district levels.
B. Decrease the burden of tuberculosis in people living with HIV/AIDS (the Three I's)		
B.1 Establish intensified TB case-finding	Screening for early signs and symptoms of TB among PLHIV increases the chance of survival, improves quality of life, and reduces the transmission of tuberculosis in the community. Involves suspect identification, referral or patient or family education	All HIV treatment and care providers involved in the PPM initiative. Informal providers for patient referral.
B.2 Introduce isoniazid preventive therapy (IPT)	Six to nine months of IPT prevents the progress of latent TB infection into TB disease in PLHIV.	All HIV care providers to be involved in the PPM initiative. Pharmacists and informal providers to assist adherence for IPT
B.3 Ensure TB infection control in health care and congregate settings	Health care workers and their patients are at risk of being infected by TB (especially in congregate settings) if infection control is not properly maintained.	All TB and HIV treatment and care providers involved in the PPM initiative.
C. Decrease the burden of HIV in tuberculosis patients		
C.1 Provide HIV testing and counselling	Testing should be offered to all TB suspects and patients as it offers an entry point of prevention, care, support and treatment of HIV/AIDS and TB.	All TB diagnosis and treatment service providers involved in the PPM initiative.
C.2 Introduce HIV prevention methods	Providing or referring for HIV prevention services. Choice of method will depend on the type of transmission: sexual, parental, and/or vertical.	All TB diagnosis and treatment service providers involved in the PPM initiative. Informal providers included.
C.3 Introduce co-trimoxazole preventive therapy (CPT).	CPT is useful to prevent several secondary bacterial and parasitic infections in adults and children with HIV/AIDS and improves mortality and morbidity in HIV positive TB patients.	All TB and HIV treatment and care providers involved in the PPM initiative.
C.4 Ensure HIV/AIDS care and support	Providing or referring for comprehensive AIDS care and support services (clinical management, nursing care, palliative care, home care, counselling and social support).	All TB diagnosis and treatment service providers involved in the PPM initiative.
C.5 Introduce antiretroviral therapy (ART)	ART improves the quality of life and greatly improves survival for PLHIV. It transforms HIV infection into a chronic condition with improved life expectancy. ART also reduces the incidence of TB in HIV positives.	All TB and HIV treatment and care providers involved in the PPM initiative.

2.4 Steps for promoting the implementation of PPM TB/HIV activities

The meeting formulated steps for promoting the implementation of PPM TB/HIV activities that aim to provide national AIDS and TB control programmes in HIV-prevalent settings with a list of activities to initiate, expand and systematically document the engagement of private and public service providers for collaborative TB/HIV activities. HIV-prevalent settings are defined as countries, subnational administration units (e.g. states, districts, counties) or selected facilities (e.g. referral hospitals, prisons, drug rehabilitation centres) where the adult HIV prevalence rate among pregnant women is $\geq 1\%$ or where HIV prevalence among TB patients is $\geq 5\%$. In those countries where national HIV prevalence is $< 1\%$, national TB and HIV control authorities should identify and define HIV-prevalent settings (subnational administrative units or facilities) based on the epidemiology of the HIV epidemic and the magnitude of HIV-associated TB. These steps are also aimed at encouraging organizations and associations of private and public service providers working on TB and HIV to include collaborative TB/HIV activities in their activities, through collaboration with national, regional and local authorities. They also offer a mechanism for pilot testing to enable prospective PPM TB/HIV pilot projects to generate evidence that will eventually inform global and national policies on the engagement of private and public providers in the implementation and scale-up of collaborative TB/HIV activities.

Implementation of steps requires understanding of the country context in its response to TB/HIV, identifying a need to engage all health-care providers in collaborative TB/HIV activities and assessing that the guiding principles to commence activities are present. Given the available incomplete evidence on the implementation of collaborative TB/HIV activities, scale-up of PPM TB/HIV requires locally tailored measures including the piloting and evaluation of the activities for nationwide coverage. Implementation of steps does not require the presence of a national policy specific to PPM TB/HIV activities or of a national authority to supervise these activities. Interested groups such as NGOs, professional associations or private practitioners can commence implementation with collaboration from representative of the national AIDS and TB control programmes appropriate to the level of their function (state, provincial or district). The steps are organized in four phases and provide the necessary action steps to be taken: planning, preparation, local implementation, and monitoring and evaluation.

2.4.1. Planning

The planning stage includes action steps of strategic importance that have implications at national, regional and local levels. These steps, which are needed to commence the implementation of collaborative TB/HIV activities by all service providers, serve to leverage effective local implementation as well as facilitate monitoring and evaluation of activities and their eventual evaluation for nationwide scale up. Planning for commencement and scale-up can be done by interested parties (NGOs, professional associations or interested groups of private professionals) at all levels once a conducive policy environment that promotes the Stop TB Strategy and PPM TB as well as collaborative TB/HIV activities is in place. In short, the planning stage will address whether the commencement of PPM TB/HIV activities is feasible and identify the package of collaborative TB/HIV activities to be implemented, define types of providers and select implementation sites.

The following action steps are involved in the planning stage:

- identifying national (or local) level focal points from TB and HIV control programmes and, preferably, setting up a national (or local) multi-stakeholder (public sector, private-for-profit and non-for-profit, medical associations, etc.) advisory group or linking with an existing TB/HIV coordinating (or similar) body at national or local level;
- adding PPM TB/HIV activities to the terms of reference of the national or local TB/HIV coordinating bodies;
- assessing preparedness of the national TB and HIV control programmes to engage in TB/HIV PPM activities at all levels, including identifying the existence of a conducive national policy environment and programme guidance at national or local level;
- defining issues, needs and goals of PPM TB/HIV activities and conducting a situational analysis at national or local level. This step includes defining the type of providers and activities and identifying opportunities to promote the commencement and scale-up of PPM TB/HIV activities including any ongoing PPM TB and collaborative TB/HIV activities in the intended implementation areas;
- analysing the national or local epidemiological situation of TB and HIV and the HIV-related TB problem, and reviewing any existing surveys on health-seeking behaviours and knowledge, attitudes and practice on TB, HIV and HIV-related TB;

- assessing the current and potential future role of national health insurance schemes, if applicable, and defining their implications for PPM TB/HIV activities;
- addressing incentives and enablers for the full engagement of providers in accordance with the national and local context as well as existing norms;
- formulating drug regimens in accordance with national policy and ensuring a local drug supply management system;
- defining a proposed model of implementation that gives due emphasis to the national and local contexts and identifying the package of collaborative TB/HIV activities for implementation as well as the category of providers. The model should detail the proposed target provider group(s), the support to be provided by TB and HIV programmes at national and local implementation levels, and clarify monitoring and evaluation aspects by defining possible indicators. The model should be flexible enough to accommodate changes made during implementation;
- determining process and outcome indicators to be monitored in accordance with the monitoring and evaluation guidance (see below);
- identifying and justifying selection of initial implementation and expansion sites and categories of providers based on the implementation model;
- involving relevant agencies in advocating for political and financial commitment, including from national governments;
- identifying existing support structures and functions, including financing schemes, locally responsible officers from TB and HIV control programmes and a steering group that includes representatives of target providers and patient support groups, and defining the technical and administrative support needed and mechanisms for periodic monitoring and documentation of experiences and evidence for scale-up.

2.4.2 Preparation

The action steps and activities required in the preparation stage concern the tools, supplies and essential systems that are necessary to facilitate local implementation, and monitoring and evaluation of PPM TB/HIV activities. Many of these activities can be done by interested parties (NGOs, professional associations or interested groups of private professionals) at an appropriate level (national, state or district) in collaboration with national AIDS or TB control programmes. This stage is intended to provide programme guidance (tools and systems) for local implementation based on the implementation model(s) defined in the planning stage.

The following action steps are involved in the planning stage:

- defining the roles and responsibilities of local HIV and TB counterparts and defined service providers, including task mix, in close consultation with all relevant stakeholders;
- identifying national and local resources to create or build capacity for managing and supervising PPM TB/HIV activities;
- preparing generic local implementation tools for each of the activities defined in the package of the implementation model, depending on national and local contexts;
- developing training materials for target provider group(s) based on existing guidelines in accordance with national policy and programme guidance;
- orienting or training relevant staff from TB and HIV control programmes at national or local level on PPM TB/HIV activities, emphasizing their additional responsibilities;
- establishing effective referral mechanisms between different HIV and TB service delivery sites and ensuring that referrals are initiated;
- developing incentives and motivators in accordance with national policy and local norms to ensure the effective engagement of all relevant stakeholders;
- developing a national and local communication strategy to generate demand for PPM TB/HIV activities by both providers and patients. This strategy should also focus on health-seeking behaviours that impair use of these services;

- developing a generic memorandum of understanding between national AIDS and TB control programmes or the relevant bodies (e.g. TB/HIV coordinating bodies) and interested institutions to formalize the collaboration. A generic letter of agreement can be developed for individual service providers;
- developing accreditation and certification mechanisms for providers engaged in PPM TB/HIV activities as incentives or a quality-ensuring mechanism;
- ensuring the existence of, or a referral mechanism to access, key services for PPM TB/HIV activities. These include diagnostic services (quality-assured smear-microscopy, X-ray facilities, HIV testing), prevention services (IPT, TB infection control) and treatment services (TB treatment, CPT, ART and treatment for opportunistic infections).
- enhancing networking and sharing of experiences among service providers and ensuring that their knowledge meets agreed standards and is current;
- conducting orientation and task-based training for target service providers covering all essential aspects, including the provision of clear instruction on expected tasks, use of the implementation tools developed in the preparation stage, monitoring and evaluation and defining the utility of the referral systems;
- defining innovative and accessible training methods, such as “on-the-job” training for private providers, that accommodate work schedules and maintain levels of motivation and interest;
- ensuring contractual agreements either through memoranda of understanding (with institutions) or letters of agreement (with individual providers);
- promoting the work of involved providers through local advocacy and communication;

2.4.3 Local implementation

The action steps in the local implementation stage involve activities that are needed to implement PPM TB/HIV activities in the identified implementation sites based on the implementation model developed in the preparation stage. Local implementation is contingent upon the presence and use of tools and systems that have been established in the preparation stage, and is the critical step for monitoring and evaluation of the initiative for scale up. Local implementation can be done by interested parties such as NGOs, professional associations or interested groups of private professionals or individual providers defined in the preparation stage, with collaboration from national AIDS and TB control programme counterparts at the local level.

The following action steps are involved in the local implementation stage:

- establishing and maintaining a coordination mechanism for local implementation with higher-level structures such as national or local TB/HIV or PPM TB/HIV coordinating bodies;
- physically mapping and sensitizing providers (with use of communication tools) and, if applicable, donors, partners and patient groups for mobilization of PPM TB/HIV activities;
- defining the roles and responsibilities of target providers according to the local context, which may include localizing the task mix that was developed during the preparation stage;

- providing regular supervision, including introducing supervisory staff and explaining supervisory routines for involved providers as well as clarifying the expectations of the involved providers from the supervision;
- focusing supervision on critical areas such as use of registers, information, education and communication, use of and access to diagnostic facilities, and availability of drugs and other consumables;
- ensuring a sustainable system of commodities supply and management at the local level.

2.4.4 Monitoring and evaluation

Monitoring and evaluation is critical in informing further scale-up and expansion of PPM TB/HIV activities. This stage involves defining indicators based on WHO guidelines on monitoring and evaluation of TB/HIV activities⁸ and implementing the revised recording and reporting forms.⁹ The indicators for monitoring should be defined and agreed upon locally based on the local implementation model. The recording and reporting forms should be developed in line with international and national recommendations; forms are provided to involved service providers during training. Data quality control mechanisms should be introduced at the local level to ensure optimal data for assessing the performance of PPM TB/HIV activities.

Table 2 Sample indicators for monitoring and evaluation of PPM TB/HIV activities		
Broad activity	Indicators	Measurement
Planning	Appointed PPM TB/HIV focal point	Yes or No
	Situation analysis done	Yes or No
	Mapping of providers done	Yes or No
Preparation	Number of health care providers trained, by type of staff	
	Referral mechanisms between different TB and HIV delivery sites developed	Yes or No
	Certification mechanism in place: Memorandum of Understanding for involving different institutions developed	Yes or No
Local implementation	Proportion of non-NTP and non-NAP health facilities/providers participating in TB/HIV activities	Number of participating non-NTP and non-NAP health facilities as a percentage of all non-NTP and non-NAP health care facilities in the selected area (use inventory of non-NTP and non-NAP providers in the area)
	Proportion of new TB cases detected through referral by non-NTP and non-NAP providers	Number of new TB cases detected through referral by non-NTP and non-NAP providers as a percentage of all new TB cases
	Proportion of new TB cases diagnosed by non-NTP and non-NAP providers	Number of new TB cases diagnosed by non-NTP and non-NAP providers as a percentage of all new TB cases
	Proportion of new TB cases receiving DOT by non-NTP and non-NAP providers	Number of new TB cases receiving DOT by non-NTP and non-NAP providers as a percentage of all new TB cases receiving DOT
	Proportion of PLHIV (attending for HIV testing or HIV treatment) screened for TB at non-NTP and non-NAP health units	Number of PLHIV attending for HIV testing or treatment at non-NTP and non-NAP health units screened for TB as a percentage of all PLHIV attending for HIV testing or treatment at non-NTP and non-NAP health units
	Proportion of newly diagnosed HIV-positive people who are given IPT at non-NTP and non-NAP health units	Number of newly diagnosed HIV-positive people who are given IPT at non-NTP and non-NAP health units as a percentage of all newly diagnosed HIV-positive people at non-NTP and non-NAP health units
	Proportion of TB patients tested for HIV at non-NTP and non-NAP health units	Number of TB patients tested for HIV at non-NTP and non-NAP health units as a percentage of all registered TB cases at non-NTP and non-NAP health units
	Proportion of HIV-positive TB patients receiving CPT during their TB treatment, at non-NTP and non-NAP health units	Proportion of HIV-positive TB patients receiving CPT during their TB treatment at non-NTP and non-NAP health units as a percentage of all HIV-positive TB patients and non-NTP and non-NAP health units
	Proportion of HIV-positive registered TB patients who receive ART during/at the end of TB treatment at non-NTP and non-NAP health units	Proportion of HIV-positive registered TB patients who receive ART during or at the end of TB treatment at non-NTP and non-NAP health units as a percentage of all HIV-positive registered TB patients at non-NTP and non-NAP health units

3 Conclusion and next steps

Engaging all care providers of PPM TB/HIV activities in settings with high HIV prevalence involves tapping their potential to scale-up collaborative TB/HIV activities and should be encouraged. Furthermore, effective linkages with different health-care providers to provide integrated services play a key role in strengthening health systems. Country experiences and evidence on implementation should be systematically documented and used to inform the development of policy on how to engage care providers in collaborative TB/HIV activities. Steps contained in this document should facilitate implementation and documentation of collaborative TB/HIV activities by all care providers under routine programmatic conditions. WHO and partners should therefore encourage the use of these steps to set up demonstration projects for implementing TB/HIV PPM activities.

Countries with national and local TB/HIV coordinating bodies should promote the membership of PPM representatives to maximize their buy-in. Such activities should be implemented only in settings with existing TB and HIV control programmes, policies and activities. PPM TB/HIV activities aim to consolidate, rather than fragment, both programmes and related activities and policies. Ongoing PPM TB/HIV activities should be systematically documented and shared with relevant national and international stakeholders. Progress in promoting PPM TB/HIV activities should be presented and discussed at forthcoming meetings of the Stop TB Partnership subgroup on PPM for DOTS Expansion. This subgroup should also lead collaboration with the Stop TB Partnership Working Group on TB/HIV to promote PPM TB/HIV activities.

These steps will be made available on relevant TB and HIV web sites to promote implementation, and encourage piloting of projects in countries through collaboration with national AIDS and TB control programmes. Existing funding mechanisms should be explored to ensure the availability of resources to pilot test and scale up these initiatives. The evidence derived from such pilot projects should inform both the nationwide scale up of activities in respective countries and the development of global policy and programmatic guidance.

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Annex 1 Consultative workshop on public–private mix and partnerships to promote the implementation of collaborative TB/HIV activities, 27–28 February 2008 – Agenda

27 February 2008			
09:00–09:10	Opening and welcoming remarks	L. Blanc	
09:10–09:20	Objectives and expected outcomes of the meeting	L. Velebit	
Objective 1: Review the existing evidence and experiences in the implementation of collaborative TB/HIV activities by a wider spectrum of public and private providers and draw lessons for scale up			
09:20–09:35	Non public health providers engagement in TB/HIV: review of the published and unpublished literature	M. Yesudian	Chair: S. Egwaga
09:35–09:50	Situation analysis of TB/HIV and PPM in Kenya	J. Sitienei	Chair: S. Egwaga
09:50–10:10	Discussion: what is the evidence telling us?	all	
10:10–10:30	Coffee break		
10:30–10:45	Private sector experience from Ethiopia: challenges and opportunities for all care providers in TB/HIV	B. Chaka	Chair: F. Salaniponi
10:45–11:00	Private sector experience from India: challenges and opportunities for all care providers in TB/HIV	H. Gupte	Chair: F. Salaniponi
11:00–11:15	Private sector experience from WEF: challenges and opportunities for all care providers in TB/HIV	S. Puri	Chair: F. Salaniponi
11:15–11:30	Private sector experience from PSI: challenges and opportunities for all care providers in TB/HIV	M. Elliott	Chair: F. Salaniponi
11:30–12:15	Discussion: what are the lessons that can be drawn?	all	Chair: F. Salaniponi
12:15–12:30	Civil society involvement in Global Fund applications	N. Matsha	Chair: F. Salaniponi
12:30–13:30	Lunch		
Objective 2: Discuss core aspects and actions needed for the implementation of collaborative TB/HIV activities by a wider spectrum of public and private providers and inform the implementation protocol			
13:30–13:45	Purpose and structure of the protocol, and Group Work introduction and expectations	L. Velebit	
13:45–15:00	Group work		Facilitators: J. Sitienei S. Puri G. Stallworthy V. Kaminen
15:00–15:30	Coffee break		
15:30–16:30	Group work		
16:30–17:30	Report back from groups and discussion	all	Chair: E. McEwan
28 February 2008			
09:00–09:20	What does implementation of a protocol entail: lessons from engaging all health providers TB initiatives - country experience	J. Chakaya	
09:20–10:30	Group work		
10:30–11:00	Coffee break		
11:00–12:30	Group work		
12:30–13:45	Lunch		
13:45–14:45	Report back from groups and discussion		Chair: J. Voskens
14:45–16:15	Open Discussion: key steps and needs to implement the protocol; and next steps	all	Chair: J. Chakaya
16:15	Concluding remarks	P. Nunn	
	Wrap up and tea/coffee		

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