JOINT WHO/GLOBAL FUND WORKSHOP

Reaching the "missing million" through enhancing private provider engagement as part of scaling up public-private mix for TB care and control in "high-impact" Asia

New Delhi, India
25-27 June 2014

The Global Fund
To Fight AIDS, Tuberculosis and Malaria

World Health Organization

Joint WHO/ Global Fund Workshop

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Meeting Report

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Acknowledgement

This report was prepared by Hannah Monica Dias, Mukund Uplekar and Diana Weil, with inputs from the rapporteurs of the meeting, Vijayashree HY.

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WHO/HTM/TB/2014.25

Contents

Abbreviations

ACSM	Advocacy, Communication and Social Mobilization
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBC	high TB-burden country
HDL	hospital DOTS linkage
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
ISTC	International Standards for Tuberculosis Care
MDG	Millennium Development Goal
MDR-TB	multidrug-resistant tuberculosis
NGO	nongovernmental organization
NTP	national tuberculosis control programme
PP	private provider
PPM	public–private mix
PPM Subgroup	Subgroup on Public–Private Mix for TB care and control
TB	tuberculosis
USAID	United States Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization
XDR-TB	extensively drug-resistant tuberculosis

1. Background

Delays in diagnosis leading to increased disease transmission, stagnating TB case notifications, and spread of MDR-TB are among the major challenges facing global TB control today. Care providers not linked to national TB programmes and especially private medical care providers in Asia are both a part of the problem and solution to all these challenges. Asia also has the largest burden of "missed" cases. The 2013 WHO Global TB report has identified 12 countries that account for 75% of the "missed 3 million cases" globally. High-burden countries in Asia account for over a million of these missed cases. A large proportion of these cases are likely managed outside the network of public sector services and not notified to the national TB programmes. The fact that the proportion of TB drugs sold in the private sector in Asia equal those used in public sector TB programmes, indicates that a large number of people with TB receive care in the private sector. Irrational use of diagnostics by private laboratories is also common in some countries. Furthermore, in most countries, public sector facilities such as large hospitals also contribute significantly to the burden of un-notified cases.

All Asian countries have been implementing the "engaging all care providers" component of the Stop TB Strategy. The progress however has been uneven. Countries have experienced greatest difficulties in scaling up engagement of largely unorganized private practitioners who are often the first care provider of people with TB. The attention, investments, and input on the part of public sector TB programmes to scaling up public-private mix (PPM) initiatives have been inadequate given the size and the complexity of the problem. Further, while regulations regarding mandatory case notification and rational use of TB drugs exist on paper in many countries, their enforcement is weak if not absent in most high TB-burden countries.

The global push to intensify TB case detection has also led to development of a few innovative models of engaging private providers. Social franchising models have been scaled up successfully in some settings. A newer market-sensitive, social enterprise model that incorporates use of mobile communication technology has produced impressive results in pilot projects. Another model has been successful in rational introduction of new TB diagnostics in the private sector through private laboratories. Evidence also shows that inputs into optimizing TB services in large hospitals almost always yield impressive gains in terms of increasing case notifications. The potential of the corporate sector via workplace programmes still remains largely untapped.

The knowledge and evidence-base on PPM including new working models on private sector engagement; strong attention from the Global Fund on high-impact Asia; as well as the felt-need of countries to develop ambitious, context-specific plans for countrywide expansion of PPM into national strategic plans and Global Fund "concept notes" (for Global Fund financing under the new funding model) — all provide an exceptional opportunity to

promote and expand a dual-track approach of scaling up innovative models of collaboration with all care providers, while introducing effective regulation as part of strengthening health systems. To streamline this, the Global TB Programme of the World Health Organization along with the high-impact Asia department of the Global Fund organized a joint workshop on scaling up the engagement of all care providers. The workshop focused on six high-impact Asia countries: Bangladesh, India, Indonesia, Myanmar, Pakistan and the Philippines.

This report summarizes the proceedings of the workshop. The objectives are presented in Section 2. Section 3 briefly outlines the presentations and discussions at the meeting, while the fourth section lists the major conclusions and next steps. The agenda and list of participants are presented in the appendices. The meeting presentations are available online at: http://www.who.int/tb/careproviders/ppm/meetings/en/.

2. Objectives

The objectives of the workshop were to:

- Examine innovative approaches to engage private practitioners in diverse country-settings and ways to sustain, replicate and scale up these approaches
- Examine regulatory approaches to help scale up public-private mix for TB care and control
- Review and enhance specifics of public-private mix interventions in the national strategic plans and concept notes of high-impact Asia countries for the Global Fund's new funding model

3. Summary of presentations and discussions

The workshop was opened by Urban Weber, Department Head for High Impact Asia at The Global Fund, Khurshid Alam Hyder, the TB Regional Adviser for the WHO Office for South-East Asia and Mukund Uplekar from the Global TB Programme in Geneva. Meeting presentations can be accessed here.

Session 1:

The first session provided an overview of the meeting objectives and agenda. This was followed by a presentation from the Global Fund to Fight AIDS, TB and Malaria (the Global Fund) on its new funding model and its relevance for PPM. A WHO presentation then highlighted the case of the missed 3 million and called for strategic action. The last presentation in this session reviewed the key outcomes of an USAID/World Bank meeting held in Washington DC in May 2014, on sustainable financing of private sector engagement for TB care.

The new funding model and its relevance to PPM

During the past decade, the Global Fund has become the largest external funder of TB programmes, providing over US$ 3.5 billion in funding for TB since 2002. The Global Fund has a new funding model to facilitate effective investments and to reach as many people affected by the diseases as possible. The new funding model aims to ensure predictable funding for those countries with a high disease burden and low ability to pay, and aims to incentivize better performing interventions.

To apply for financing through the new funding model, countries or partners need to develop a strong concept note through dialogue with key stakeholders in the country. The private sector is a key actor in this dialogue and representatives must be engaged in prioritization of country needs and concept note development.

The new funding model offers various opportunities throughout the application and implementation process for the engagement of all care providers in TB prevention, care and control. PPM is included as a common intervention for streamlining across all core modules.

Scaling up PPM to reach the "missing million" in high-impact Asia: a strategic approach

An overview of the new post-2015 Global TB Strategy was presented. PPM is a key component in the new strategy, and is critical for the world to achieve the ambitious post-2015 targets of ending the global TB epidemic. Two major barriers block progress in TB care and control: reaching the 3 million missed cases and bringing down TB incidence.

About 3 million people are "missed" each year by health systems and many therefore do not get the TB care that they need and deserve. Nearly half of these missed TB cases are in Asia. The majority of these people with TB first go to the private sector, often seeking care from multiple providers in their journey to access TB treatment, such as drug sellers, private practitioners, hospitals etc. Unfortunately the TB management practices of these providers are rarely aligned with national or international standards, and they don't notify people under their care to national health systems for lack of information, incentives or tools. Furthermore out of pocket expenses to access care in the private sector places a heavy financial burden on TB patients. Engaging all care providers is therefore critical to ensuring these missed patients are reached with quality care.

In addition, regulation in countries regarding mandatory case notification and rational use of TB drugs is largely not enforced or absent.

All this points to the need for a strategic approach to PPM scale up especially in the Asian context. A proposed strategy mix is highlighted below – based on successful country experiences and innovative pilot models:

1. Strengthen NTP / MOH capacity and optimize investments to help scale up PPM
2. Optimize and expand engagement of large hospitals and institutions such as NGOs and medical colleges
3. Consider entrusting private practitioner engagement to "intermediaries organizations" through: Social franchising / Social enterprise / Similar indigenous approaches / professional associations
4. Mobilize and support business sector for workplace TB programmes
5. Enact and/or enforce regulatory approaches
   - Mandatory case notification
   - Rational drug sale and use
   - Certification / Accreditation / Designation systems
6. Engage communities and CSOs to enable their demand for and support quality TB care

Sustainable financing of private sector engagement for TB care: Report from the Washington meeting

In May 2014, a three-day working meeting was co-convened by the United States Agency for International Development (USAID) and the World Bank, in collaboration with the Stop TB Partnership's subgroup on PPM.

The meeting brought together TB, health financing and public-private partnership experts to identify the essential elements for the sustainability, growth and future relevance of PPM efforts. The goal was to improve the sustainability of private sector engagement in TB control by bringing together innovations in service delivery models and financing.

USAID made a presentation on the outcomes of the meeting and it's relevance to discussions in the workshop. Some highlights are presented below:

- A range of strategies are needed to finance various context-specific PPM models in TB, and new mechanisms represent a significant opportunity. Sustainability of such financing relies in part on the incorporation of TB and PPM into domestic health financing streams. Currently, the predominant source of financing for PPM is input-based domestic and donor financing, but countries are increasingly exploring output or results-based financing (RBF) and financing via health insurance agencies. Social protection programs can also supplement with patient enablers. A range of tools and schemes are needed that can be adapted to produce the optimal PPM for each country's context. Whatever mix of financing is used, pooling of the financial resources is a critical step to reduce complexity and standardize service packages.

  A variety of entities and mechanisms can organize providers and enforce quality control.
- Existing PPM achievements have used the dual concepts of the NTP as steward of health standards and quality, and an intermediary as an organizing force for individual private providers. These concepts of standards and an organizing entity remain intact, but there are an increasing number of ways to implement them. Standards and quality can be strengthened by linking to accreditation and reimbursement schemes (e.g., when TB is covered by a national health insurance scheme), or by demanding certain outputs under RBF. The organizing of providers (and further quality control) can be mediated by social businesses, social franchises, and organizations that change business incentives by altering market dynamics.
- Within PPM schemes, there is an increasing need to integrate health services, both for efficiency and cost savings. Linking TB programs with high volume and/or high-income generating health services can help to improve access to care, expand TB control efforts and cross-subsidize TB care.
- The use of incentives and enablers should be considered to encourage participation in PPM. For this strategy to be effective, the field will need more information about provider microeconomics and motivations to design verifiable and reliable incentive systems.

Effective engagement of the private sector requires TB control programs to look outwards – not only to other healthcare providers, but also to experts in healthcare financing, market dynamics, business planning, and other areas that are essential for a new generation of PPM work. Countries were invited to review and the outcomes of the Washington meeting and consider innovative mechanisms to scale up PPM.

Session 2: Approaches to engage private practitioners

Q and A: Approaches and challenges to scaling up

The second session began with a "question and answer" panel where country representatives shared experiences on the progress made in scaling up PPM and the related challenges of implementing some PPM components.

- In Bangladesh there has been extensive training and capacity building of private sector providers, and enforcement of notification has met with some success. Challenges include lack of capacity to cover the vast and unregulated private sector, suboptimal

engagement of the Bangladesh Medical Association and inadequate support and supervision of private practitioners engaged in PPM.

- In India, individual private practitioners are being involved for diagnosis and treatment via PPM schemes and through collaboration with the Indian Medical Association. Private Provider Interface Agency (PPIA) model is being implemented in Mumbai to strengthen private practitioner engagement. Efforts are also ongoing to involve informal practitioners. They are encouraged to refer TB suspects to the NTP.
- Engaging all care providers in Indonesia is underpinned by a strong PPM strategy. Collaboration with the Indonesian Society of Respirology (PDPI) in engaging private practitioners has met with major success. Implementation of mandatory notification is in the pipeline.
- In Myanmar, engagement of private practitioners is done via 3 PPM schemes. Incentives are provided to practitioners for referring TB cases to the NTP. However challenges remain, the supervision and monitoring of practitioner activities is inadequate, in addition practitioners refuse to undertake recording and reporting.
- In Pakistan, the most successful model is NGO engagement to reach private practitioners. Efforts were also made to engage solo general practitioners in TB through social franchising. However this model was not replicate as it was human resource intensive. There is a lack of regulation for private practitioners, and need for simplified PPM reporting tools.
- In the Philippines, private practitioners refer TB cases to the NTP and receive financial incentives. Free drugs are provided by the programme.

Discussions following country remarks highlighted the need to ensure financial sustainability of PPM especially for those which were predominantly funded externally. Particular mention was made to the social franchising model of Myanmar. It was discussed, even after successful implementation of this model for more than ten years, there were challenges with funding, which called for attention of sustainability.

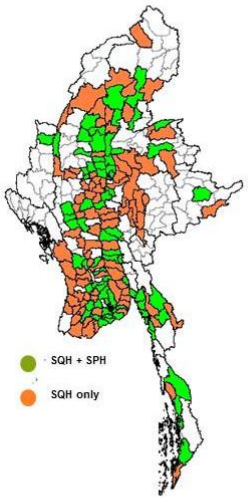
Concern was raised that civil society's involvement is not seen as a priority in PPM strengthening in countries. It was emphasized that civil society is an important partner in engaging all care providers and should be involved in country PPM activities.

Panel discussion:
Productive ways of engaging private practitioners and finding the missing million

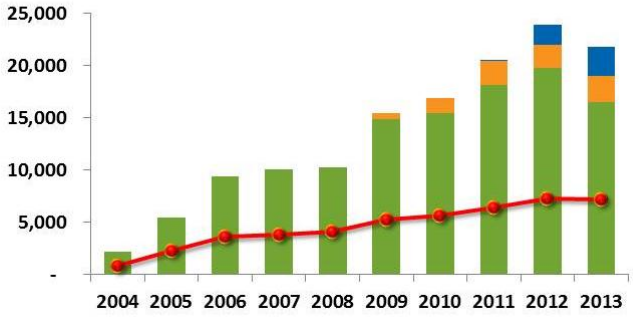
A panel discussion with international and country partners was held on productive ways of engaging private practitioners in reaching the missed million people with TB.

- PSI presented its social franchising model in Myanmar and the success they have had in engaging private providers and pharmacies. Both financial and non financial incentives and enablers were vital to support the engagement of providers. The challenges in provider engagement were also highlighted – including increased workload, inadequate diagnostic facilities, remote location of private clinics hindering collaboration, complexities of private clinics run by public providers and vertical programs created by different donors.

Network coverage for TB Program in Myanmar (April 2014)



Resources	# of Townships	# of Providers
SUN Quality Health	198	923
SUN Primary Health	75	1817
Interpersonal Communicators	38	60
Pharmacies	38	526



- Social business models for engaging the private sector were presented next. The outcomes of implementing the social business model in Karachi, Dhaka and Jakarta with support from the TBXpert project and TBREACH was shared. While the pilot initiatives show good progress in case detection, challenges remain in taking these models to scale. The challenges include, high capital investment costs, conflict between public health and business priorities, reaching regional consensus on branding and further investments to integrate multiple diseases into the model to generate sustainable revenues for social business.

- PATH then made a presentation on the Private Provider Interface Agency (PPIA) model in Mumbai. PPIA is designed to strengthen the capacity of networks of private health care providers in the Municipal Corporation of Greater Mumbai (MCGM) to ensure early and accurate diagnosis of tuberculosis (TB) cases through effective TB case management. The aim of the agency is to improve TB diagnosis and treatment to ultimately improve case notification and treatment success for TB patients who seek health care from private-sector providers that are not linked to the Revised National Tuberculosis Control Programme (RNTCP) run by the public health system.

  The agency is underpinned by an innovative model with six main features: a network approach; maintenance of PP's patient management autonomy; an incentive scheme; presence at the zone and ward levels; adoption of new information and communication technology (ICT); and use of fast, accurate diagnostic tools. Central to this approach is changing private providers' behaviors by mobilizing, incentivizing, and developing capacity of PPs to provide early and accurate diagnosis of TB cases and effective TB case management.

- A presentation was made by the Indonesian Society of Respirology (PDPI) on using the International Standards for TB Care as a tool for engaging the private sector in Indonesia. PDPI is implementing a PPM project to engage private pulmonologists in the national TB

control programme, using the ISTC. The objectives of the project are to ensure all TB patients are managed according to the ISTC and to ensure all TB cases found through PDPI are reported to the National TB Programme. Between 2010 and 2013 over 10 000 TB cases were detected in 3 provinces and managed by pulmonologists through the PDPI project. The project will be expanded to 4 new provinces in the coming year.

Session 3: Regulatory approaches to help scale up PPM

Pursuing regulatory approaches – country example

The third session opened with a presentation on regulatory approaches and their enforcement in the Indian context. The success of India in curbing the sale of serological tests through a government ban and in collaboration with IPAQT was highlighted. IPAQT – the Initiative for Promoting Affordable Quality TB tests is a consortium of private diagnostic laboratories supported by not-for-profit stakeholders such as the Clinton Health Access Initiative and the McGill International TB Centre in India to ensure that, high quality TB tests are used for TB diagnosis, diagnostics are affordable to patients and that diagnosis is linked to treatment via the RNTCP. IPAQT helped inform laboratories of the serological test ban and also ensured that serological tests were not used by their network of laboratories.

India has also made notification of TB cases mandatory in the country. To facilitate reporting India has created a web-based recording and reporting system - Nikshay. The system is still in its early stages but TB cases are increasingly being notified through it. Regulation on sale of anti-TB drugs over the counter also exist, but enforcement of the law needs to be strengthened. Lastly consumer protection laws exist to protect patients from malpractice. These laws have not yet been applied to TB in India as is the case in Indonesia.

Session 4: Plenary on enforcing regulatory approaches

Group Work and plenary

Participants then broke out into 6 groups to review various TB regulatory approaches such as: mandatory case notification, curbing irrational drug use, certification and accreditation of providers. Groups listed current situation in countries, actors and actions required beyond NTPs, human resource requirements within and beyond NTPs and financial resources required. The groups then presented an overview of their discussions at the plenary session.

Session 5: Some essentials of PPM expansion

The second day opened with presentations on PPM scale up, measurement, corporate sector engagement and PPM for MDR'TB management.

Translating PPM concepts into activities and budgets

The first presentation overviewed experiences of the TBREACH initiative of the Stop TB Partnership. The initiative promotes early and increased TB case detection using innovative approaches especially in poor, underserved and vulnerable groups. The costs and impact in terms of people with TB reached were presented. Reaching the missed million should be a key part of Global Fund interventions in countries.

Measuring contribution of PPM to TB care and control

The importance of measuring the impact of PPM in countries was highlighted. Country experiences from India, Indonesia and Pakistan was highlighted. It was emphasized that in addition to cases detected, indicators should include reduction of delay in access to care, decreasing out-of-pocket expenses for patients and cost effectiveness.

Strategies to engage the business sector

The potential of engaging workplaces in TB prevention, treatment and care efforts still remains largely untapped, with only small initiatives in some countries such as Bangladesh, Cambodia, China, Kenya, India, Philippines, and South Africa. On the other hand, there are many examples of workplace HIV programmes, however only a few of them include activities to reduce the burden of TB. A survey conducted jointly by the International Labour Organization (ILO) and the World Health Organization (WHO) revealed that 57% of 21 000 workplaces did not address TB within their HIV workplace programmes. The presentation overviewed the need to scale up engagement of the corporate sector in countries with a high burden of TB (especially in Asia) and outlined guiding principles to help initiate and scale up involvement of the business sector in TB prevention, treatment and care.

A frame work on PPM for programmatic management of drug-resistant TB

Although encouraging progress has been made in engaging non-NTP providers in basic TB care and control activities, there has been to date limited progress in engaging non-NTP health care providers in DR-TB management. Globally in 2012, an estimated 3.6% of new tuberculosis (TB) cases and 20% of previously treated cases have multi-drug resistant TB (MDR-TB)[1]. An estimated 450, 000 MDR-TB cases emerged worldwide in 2012. Despite slow progress, management of DR-TB is still a big challenge, with globally in 2012, only 5% of new bacteriologically-confirmed TB cases and 9% of those previously treated for TB tested for DR-TB, and only 28% of the 300,000 estimated MDR-TB patients detected amongst the notified pulmonary TB cases. Among the detected MDR-TB cases, 92% were started on treatment. The gap between diagnosis and treatment is however growing rapidly in many countries as a result of the recent rapid expansion in diagnostic capacity, with a growing number of diagnosed MDR-TB and rifampicin resistant TB (RR−TB) patients being placed on "waiting lists for treatment". Greater efforts are needed to achieve universal access to care for MDR-TB, as targeted by 2015 in the Global Plan to Stop TB and the 2009 World Health Assembly resolution. Engaging all relevant health care providers in the management of DR-TB cases is one of the important interventions to achieve that goal. The presentation outlined the structure of a framework document under development by WHO on PPM for programmatic management of drug-resistant TB.

Session 6 & 7: Enhancing PPM component of national strategic plans

Group Work and plenary

The participants were divided in country groups to discuss how PPM components in national strategic plans (NSPs) and Global Fund Concept notes could be enhanced to ensure accelerated scale up of PPM. Countries filled in a template of current and planned PPM interventions in National Strategic Plans/Concept Notes along with estimated financial and human resource requirements. Building on this countries listed targets up to 2017 for PPM on contribution to case notification private and non-NTP care providers. Countries then

[1] *Multidrug-resistant TB (MDR-TB): resistant to at least rifampicin and isoniazid.*

developed a strategic matrix on how current/planned PPM interventions could be strengthened to reach the targets set. The strategic matrix and targets will be used by countries to strengthen their existing NSPs and concept notes, or those to be developed (Indonesia). The table below presents the PPM targets developed by the six countries:

Bangladesh				
Current and potential contribution to case notification by private (for profit and non-profit) care providers				
2013	**2014**	**2015**	**2016**	**2017**
120,280	120,500	120,900	124,000	130,200
Current and potential contribution to case notification by non-NTP public sector care providers				
34,920	35,000	35,100	36,000	37,800
India				
Current and potential contribution to case notification by private (for profit and non-profit) care providers				
2013	**2014**	**2015**	**2016**	**2017**
25,000	65,000	500,000	1 million	1.5 million
Current and potential contribution to case notification by non-NTP public sector care providers				
Disaggregated data not collected for non-NTP public sector care providers				
Indonesia				
Current and potential contribution to case notification by private (for profit and non-profit) care providers				
2013	**2014**	**2015**	**2016**	**2017**
85,000	94,000	111,000	131,000	145,000
Current and potential contribution to case notification by non-NTP public sector care providers				
255,000	270,000	275,000	280,000	285,000
Myanmar				
Current and potential contribution to case notification by private (for profit and non-profit) care providers				
2013	**2014**	**2015**	**2016**	**2017**
24,816	27,680	30,100	32,470	34,890
Current and potential contribution to case notification by non-NTP public sector care providers				
4691	6399	8318	10,311	12,379
Pakistan				
Current and potential contribution to case notification by private (for profit and non-profit) care providers				
2013	**2014**	**2015**	**2016**	**2017**
58,288	84,500	109,096	136,183	164,490
Current and potential contribution to case notification by non-NTP public sector care providers				
1800	5000	7000	8500	10,000
Philippines				
Current and potential contribution to case notification by private (for profit and non-profit) care providers				
2013	**2014**	**2015**	**2016**	**2017**
8%	15%	15%	15%	15%
Current and potential contribution to case notification by non-NTP public sector care providers				
4%	10%	10%	10%	10%

4. Conclusion and next steps

The workshop was perceived as being of great value by all the participating countries and partners. A major outcome of the workshop was the template developed by each country group to enhance the PPM components of country national TB strategic plans and / or Concept Notes for the Global Fund applications. The template outlined concrete actions and deliverables with human and financial resource implications. Countries also set case notification targets expected to be achieved through PPM expansion.

Planned PPM activities in each country included those to expand collaboration as well as enforce regulation for mandatory case notification, rational use of TB drugs and certification/accreditation systems for collaborating providers.

The workshop products will be used by each country as the basis of preparation of the PPM component of the Global Fund concept notes and/or accelerating PPM scale up in each of the six countries. WHO, the Global Fund and partners committed their support in helping countries achieve this.

Appendix 1.

Workshop Agenda

25 June 2014 Reaching the "missing million" through scaling up public-private mix in TB care and control in "high-impact Asia"		
Session I: Opening Session		***Chair: Phil Hopewell***
9:00 - 9:20	Welcome and introductions	*Rajesh Bhatia, WHO SEARO* *Urban Weber, The Global Fund*
9:20 – 9:30	Meeting objectives and agenda	*Mukund Uplekar*
9.30 - 9.45	The new funding model and its relevance to this meeting	*Mohammed Yassin*
9:45 - 10:00	Scaling up PPM to reach the "missing million" in high-impact Asia: a strategic approach	*Mukund Uplekar*
10:00 - 10:30	Report from the Washington meeting (May 2014): sustainable financing of private sector engagement for TB care	*William Wells*
COFFEE 10:30 – 11:00		
Session II: Approaches to engage private practitioners		***Chair: Urban Weber***
11:00 – 12:00	**Q and A:** Approaches and challenges to scaling up	*Abdul Hamid* *RS Gupta* *Dyah Mustikawati* *Si Thu Aung* *Ejaz Qadeer* *Lyn Vianzon*
12:00 – 13:00	**Panel discussion:** Productive ways of engaging private practitioners and finding the missing million – 10 minutes presentation on approaches to large scale engagement of private practitioners.	*P P Swe* *S Sahu* *SS Lal* *Erlina Burhan*
LUNCH 13:00 – 14:00		
Session III: Regulatory approaches to help scale up PPM		***Chair: M K A Hyder***
14:00 – 14:20	Pursuing regulatory approaches – country example – country context	*KS Sachdeva* *Sunil Nandraj*
14:20 – 14:30	Guidance on the group work	*Mukund Uplekar*
14:30 -15:30	Group work I on regulatory approaches	*Country teams and facilitators**
COFFEE 15:30 – 16:00		
Session IV: Plenary on enforcing regulatory approaches		
16:00 – 17:00	Plenary on regulatory approaches – short presentations and feedback from participants	*Country Reps*

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Session V: Some essentials of PPM expansion		***Chair: Dyah Mustikawati***
9:00 – 9:15	Translating PPM concepts into activities and budgets	*Jacob Creswell*
9:15 – 9:30	Measuring contribution of PPM to TB care and control	*Knut Lonnroth*
9:30 – 9:45	Strategies to engage the business sector	*Monica Dias*
9:45 – 10:00	A frame work on PPM for PMDT	*Linh Nguyen*
10:00 – 10:30	Discussion on the session presentations	
COFFEE 10:30 – 11:00		
Session VI: Group Work – Enhancing PPM component of NSPs		***Chair: Blessina Kumar***
11:00 – 11:30	Guidance on country-specific group work	*Mukund Uplekar*
11:30 – 13:00	Group Work II on enhancing PPM components within NSPs/Concept Notes incorporating collaborative and regulatory approaches	*Country Teams and facilitators**
LUNCH 13:00 – 14:00		
13:00 - 15:30	Group Work II continued	
COFFEE 15:30 – 16:00		
Session VII: Plenary – Presentation of outlines for feedback		
16:00 – 17:00	Brief country presentations giving brief outlines of enhanced PPM components, for feedback	*Country Representatives*
27 June 2014		
Session VIII: Plenary: Enhanced PPM components within NSPs		***Chair: William Wells***
09:30 - 10:30	Final country presentations of 20 minutes each on enhanced PPM components within NSPs/Concept Notes	*Country Representatives*
COFFEE 10:30 – 11:00		
11:00 – 12:30	Final country presentations – Continued	*Country Representatives*
12:30 – 13:00	Next steps and wrap up	

Appendix 2.
List of participants

SOUTH-EAST ASIA REGION

Bangladesh

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7. R.S.Gupta
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9. Niraj Kulshreshtha
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10. Sudipta Dey
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11. Puneet Dewan
The Bill & Melinda Gates Foundation
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12. Sarabjit Chadha
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13. Sai Praveen Haranath
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14. Dr Narinder Saini
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15. Suresh Gutta
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16. Shamim Mannan
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