Promoting the Implementation of Collaborative TB/HIV Activities Through Public-Private Mix and Partnerships

(PPM TB/HIV activities)

Report of a consultation meeting including an implementation protocol

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1. **Background**

Tuberculosis (TB) is a leading killer 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 to 0.5% in 2002. Of the TB patients tested positive for HIV, 78% were treated with co-trimoxazole preventive therapy and 41% started treatment with antiretroviral drugs. However, scale-up of activities falls short of the targets of the Global Plan to Stop TB, 2006-2015[1] . The expansion of life saving antiretroviral drugs in HIV prevalent and resource constrained settings have also been instrumental for the expansion of collaborative TB/HIV activities. By the end of 2007, 3 million PLHIV were put on antiretroviral treatment[2].

It is also well-known that patients with symptoms of TB and HIV seek and receive care from a wide variety of health care providers outside of 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, non-governmental organizations (NGOs), medical colleges, corporate health services etc. (Box 1).

Box 1. Some categories of health care providers that can be engaged in the implementation of collaborative TB/HIV activities.

Public health care providers

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

Private health care providers

- Private hospitals and clinics
- Corporate health services
- NGO hospitals and clinics
- Individual private physicians, nurses, midwives, clinical officers, etc
- Pharmacies and drug shops
- Practitioners of traditional medical systems
- Informal, non-qualified practitioners

The engagement of the private sector in the provision of ART has become increasingly important. For example in Malawi no private facilities were involved in the provision of ART in December 2004. The number of private facilities providing ART with subsidised

rate through collaboration with the Ministry of Health of Malawi has increased into 23 and 45 by December 2005 and December 2007 respectively. By the end of 2007, 5407 people were ever started on ART in Malawi with very good treatment outcomes, which account for 5% of all PLHIV ever started on antiretroviral treatment. The cumulative treatment outcome 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 were presumably alive) and <1% had stopped treatment[3].Similarly in Kenya although the correct number is not known, by August 2007 it was estimated that the private for profit sector cared for nearly 5000 people living with HIV. The National AIDS and STDs Control Programme (NASCOP) established partnership with 10 private hospitals for the provision of antiretroviral treatment[4].

Over 40 PPM DOTS projects have been implemented in 14 countries, of which over 25 have been evaluated with regard to process and/or outcomes. These include diverse projects linking NTPs to various care providers like non-qualified village doctors (Bangladesh), informal and formal private practitioners (India), private general practitioners (Myanmar), specialist chest physicians (Kenya), public and private hospitals (Indonesia and China), non-governmental organizations (Bangladesh and Nepal) and a mix of providers (Philippines and India). Treatment outcomes have been evaluated for over 20,000 TB patients in 15 PPM DOTS projects. Treatment success rates in the projects that provided drugs free of charge to patients were 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 per cent. 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 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 quality TB care. Data from Myanmar, Bangladesh, India and Philippines indicate that PPM DOTS helps to reach the poor when providers used by the poor 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 the poor[5]. This has led to WHO to promote Public-Private Mix (PPM) programmes for the engagement off all health care providers in TB control as critical component of the Stop TB Strategy[6].In 2007, 14 of the 22 high TB burden countries that account for 80% of the TB cases globally, were scaling up PPM approaches to involve the full range of care providers for TB control (1)

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 the scale-up of these activities. This was first discussed in the Joint Working Groups Meeting of the Stop TB Partnership, which was held in October 2005 in Versailles, France[7] after which WHO has undertaken a number of efforts to define the best evidence-based mechanisms to enhance the involvement of all care providers particularly non-public sectors in the scale-up of collaborative TB/HIV activities. These include a systematic review of published and unpublished engagement of private and public mix in the implementation of collaborative TB/HIV activities, documentation of practices and experiences and an expert consultation.

The systematic review[8] showed that there is emerging evidence that suggested the potential role of non-public sector involvement for the scale-up of collaborative TB/HIV activities. Most articles identified were descriptive, providing no quantitative data on the private sector involvement in TB/HIV. However, the existing qualitative evidence shows that non-public health care providers can be effectively involved in service delivery for TB/HIV. In most settings, the national programmes provided training and supervision of providers while the 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. It also highlighted 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 draw further lessons for wider implementation.

The informal expert consultation that was organised by WHO in Geneva, Switzerland on May 24-25, 2007 reviewed, discussed and analysed existing practices in the engagement of public private mix in TB/HIV implementation and scale-up. The informal consultation emphasized the importance of systematic documentation and nurturing of existing practices and defined the basic guiding principles for a successful public private mix engagement in the implementation and scale-up of collaborative TB/HIV activities, which were later developed further in the subsequent consultation (Box 2).

A situation analysis done in Nairobi, Kenya showed not only the opportunities that exist for scaling up collaborative TB/HIV through the engagement of the non-public sector but also the challenges for scale up of activities, which largely revolve around lack of funding, inadequate technical staff for supervision and lack of guidelines and policies at the national level (4). These analysis and findings suggest the importance of systematic approach to define the best evidence base strategies to enhance the involvement of non-public sector in the scale up of collaborative TB/HIV activities.

2. Informal expert consultation meeting, February 2008

In follow-up to the aforementioned efforts, WHO has conducted a second informal expert consultation meeting to promote the involvement of public and private mix in the implementation of collaborative TB/HIV activities through the review of the existing evidence and experiences and define the core aspects and actions that are needed for the implementation of collaborative TB/HIV activities by a wider spectrum of public and private providers. It was also intended to inform the development of an implementation protocol to promote the scale-up of collaborative TB/HIV activities by public and private providers and the generation of critical evidence and experience, including piloting in different countries.

More than 40 people participated in the meeting representing eight countries where TB/HIV PPM activities are ongoing or planned, international NGOs, medical associations, donors and UN agencies.

The following were the critical issues that were discussed during the meeting:

2.1. Experiences and practices

During the meeting experiences and practices from countries (El Salvador, Ethiopia, India and Kenya) and international NGOs (World Economic Forum and Population Service International) in the implementation of collaborative TB/HIV activities were presented and discussed. Existing opportunities to commence PPM for collaborative TB/HIV activities in Namibia were also discussed.

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

Ethiopia: PPM activities in TB control were initiated in 2006. Today, there are 21 private facilities which provide TB services in collaboration with the National TB Programme. The National programme has a very ambitious plan of extending the PPM TB activities and collaborative TB/HIV activities into 100 private facilities through 2007-2008. There is also increasing engagement of the private sector in the provision of HIV prevention and treatment services. This offers a very good opportunity to harness the engagement of private and public sector in the implementation and scale-up of collaborative TB/HIV activities.

India: Inter Aide NGO in **India** is coordinating the activities of different NGOs which deliver TB services. From October 2006, they have been implementing a project aimed at TB/HIV collaboration, targeting high risk groups for HIV infection, with an objective to increase access to TB/HIV services through NGOs catering to these groups. Achievements include involving 99 private practitioners in red-light areas, training 300 community volunteers, 112 field supervisors/outreach workers, 22 counselors and 31 doctors.

Kenya: a separate agency has been in charge of liaising with private providers. In Nairobi, 88 private providers have been involved so far, and activities are increasing in other large urban centres. Both private for profit, faith-based and NGO providers are now involved in TB/HIV. More than half of TB patients tested in the private sector are HIV positive, while almost 40% of those receive ART. Commodity supply is the key challenge, while other challenges include reaching the most vulnerable, and building capacity of the NTP to carry this work forward.

World Economic Forum: The focus of WEF is on the role of different health- and non-health-related businesses in TB/HIV. Different examples of their involvement include: developing models of social support and care; encouraging TB patients to test for HIV, and if positive enrolling them in the company programme which includes treatment for

both diseases; workplace and community care; managing voluntary counselling and testing centres; running training and school health programmes and integrated HIV, TB and malaria services. The potential for the involvement of the businesses in implementing collaborative TB/HIV activities has been recognised and consultation within the different stakeholders is ongoing.

Population Services International: adopted two approaches for involving all health providers in TB/HIV: NGO-public sector collaboration in Lesotho, Namibia, Swaziland, South Africa, Zambia, Zimbabwe; and social franchising in Myanmar. These initiatives are yielding positive results. For example in South Africa, around 8500 persons were identified as HIV positive through different efforts and put on 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 meeting discussed and further improved the basic guiding principles that were developed during the previous consultation based on country experiences and the discussions. These principles are believed to facilitate the commencement and successful implementation and scaling up of collaborative TB/HIV activities (Box 2). PPM TB/HIV activities require coordination and collaboration among the National AIDS and TB Control programme and the 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 the National TB and AIDS Control Programmes and implementation of basic DOTS strategy and basic HIV prevention and treatment services
- A national conducive policy environment and capacity to support PPM TB/HIV activities. .
- Coordination between the national AIDS and TB programmes at all levels (states, regions, provinces or districts) and all private and public stakeholders involved in the initiatives
- Strong and continued advocacy to involve all providers and to ensure buy-in of all relevant TB and HIV stakeholders for PPM TB/HIV activities.
- Drugs and consumables supplied free of charge to the providers should be provided free of charge to the patients
- Diagnostic tests should be widely accessible and affordable
- Capacity building (including training and supervision) should be in line with the national policies and standards
- Build on existing collaboration and/or opportunities between private and public sector and national TB and AIDS control programmes as it ensures sustainability and avoids the creation parallel structures
- Ensure the provision of technical assistance - internal and/or external
- Ensure continuity of services to end users in cases when providers dropped out.

2.3. Defining task mix for collaborative TB/HIV activities

The situation analysis in Kenya (4) and the experiences of other countries showed on the importance of defining the task mix for collaborative TB/HIV activities depending on local policies and context. Mapping health providers and investigate their current role in TB diagnosis and treatment, their capacity to perform different DOTS tasks as well as their willingness to participate in PPM DOTS 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		
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. Protocol to promote the implementation of PPM TB/HIV activities

The meeting discussed and developed a protocol to promote the implementation of PPM TB/HIV activities that aims at providing practical and generic steps to National AIDS and TB control programmes of HIV prevalent settings 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 ≥1% or HIV prevalence among tuberculosis patients is ≥5%. In those countries where national HIV prevalence is below 1%, national tuberculosis 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 tuberculosis. The protocol is 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. It also offers mechanism for piloting so that the upcoming PPM TB/HIV pilot projects can generate evidence which 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.

The implementation of the protocol requires understanding the country context of its response for 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 and ripe to commence and scale. Due to the available incomplete evidence on the implementation of collaborative TB/HIV, scale-up of PPM TB/HIV requires locally tailored measures including the piloting and evaluation of the activities for nationwide coverage. The implementation of the protocol does not necessarily need the presence of a national policy specific for PPM TB/HIV activities or a national authority to supervise these activities. Interested groups such as NGOs, professional associations or private practitioners can commence the implementation with collaboration of the representative of the National AIDS and TB control programmes appropriate to the level of their function (state, province or district). The protocol is organised in four stages and provide the necessary action steps that need to be undertaken: planning; preparation; local implementation and monitoring and evaluation.

2.4.1. Planning stage

The planning stage include action steps that are of strategic importance with implications at national, regional and local levels, and which are needed to commence the implementation of collaborative TB/HIV activities by all service providers. The action steps will serve to leverage effective local implementation, and monitoring and evaluation of the activities to be implemented by interested parties, and facilitate their eventual evaluation for the nationwide scale up of activities. Planning for commencement and scale-up of collaborative TB/HIV activities can be done by interested parties (NGOs, professional associations or interest groups of private professionals) at all levels once the presence of conducive policy environment promoting

Stop TB Strategy that promote both PPM TB and collaborative TB/HIV activities is confirmed. In short the planning stage will address whether the commencement PPM TB/HIV activities are feasible and identify the package of collaborative TB/HIV activities to be implemented, define types of providers and select implementation sites.

The following are the action steps for the planning stage of PPM TB/HIV activities:

- Identify national (or local) level focal persons from TB and HIV programmes and, preferably, set up a national (or local) multi-stakeholder (public sector, private for profit and non for profit, medical associations etc.) advisory group or link with existing TB/HIV coordinating (or similar) body at national or local level.
- Add PPM TB/HIV activities to the terms of reference of the national or local TB/HIV coordinating bodies.
- Assess preparedness of the national TB and HIV programmes to engage in TB/HIV PPM activities at all levels. This includes identifying the existence of a conducive national policy environment and programme guidance at national or local level.
- Define issues, needs and goals of the PPM TB/HIV activities and conduct a situational analysis at national or local level. This step include definition of the type of providers and activities, and opportunities that will promote the commencement and scale-up of PPM TB/HIV activities including any ongoing PPM TB and collaborative TB/HIV activities in the areas intended to implement PPM TB/HIV activities.
- Analyse the national or local epidemiological situation of TB and HIV and the HIV related TB problem. Review any existing health seeking and knowledge, attitudes and practices surveys on TB, HIV and HIV related TB.
- Assess current and potential future role of the national health insurance scheme, if applicable and define their implication for PPM TB/HIV activities.
- Address incentives and enablers for the full engagement of the providers, in accordance to national and local context and existing norms.
- Define drug regimens in accordance to the national policy and ensure an effective supply management system in the local context.
- Define a proposed model of implementation that give due emphasis to the national and local context and identify the package of collaborative TB/HIV activities that needs to be implemented and the category of providers. The model should include proposed target provider group(s), the support to be provided by TB and HIV programmes at the national and local implementation level, and clarity in the monitoring and evaluation aspects by defining possible indicators. The model should have flexibility if a need arises to introduce change during the implementation.
- Determine process and outcome indicators to be monitored in accordance to the monitoring and evaluation guidance (see below)
- Identify and justify selection of initial implementation and expansion sites and categories of providers based on the implementation model.
- Involve relevant agencies in advocating for political and financial commitment including from the national government.
- Identify and define support structures and functions which include financing schemes, local responsible persons from TB and HIV programmes and a steering group that include representatives of target providers and patient support groups. The technical and administrative support needed and mechanisms for periodic monitoring and documentation of experiences and evidence for scale-up need to be defined.

2. 4. 2. Preparation stage

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

The following are the action steps for the planning stage of PPM TB/HIV activities:

- Define roles and responsibilities of the local HIV and TB counterparts and the defined service providers including task mix in close consultation with all the stakeholders involved in the initiative.
- Identify national and local resources to create or build capacity to manage and supervise PPM TB/HIV activities.
- Prepare generic local implementation tools for each of the activities defined in the package of the implementation model depending on national and local contexts.
- Develop training materials for target provider group(s) based on existing guidelines in accordance to national policy and programme guidance.
- Orient or train relevant staff from TB and HIV programmes at national or local level on PPM TB/HIV activities with particular emphasis of highlighting the added responsibilities
- Establish effective referral mechanisms between different HIV and TB service delivery sites and means of ensuring that the referrals are practiced
- Develop incentives and motivators in accordance to national policy and local norms to ensure effective engagement of all the stakeholders identified for PPM TB/HIV activities.
- Develop national and local communication strategy to generate demand for PPM TB/HIV activities by both providers and patients. The communication strategy should also focus on health seeking behaviours that impair the utilisation of these services.
- Develop generic memorandum of understanding (MOU) between National AIDS and TB Control Programmes or the relevant body (such the TB/HIV coordinating bodies) and the institutions interested in the implementation of PPM TB/HIV activities to formalise the collaboration. Generic letter of Agreement can be developed for individual service providers.
- Develop accreditation and certification mechanisms for providers engaged in PPM TB/HIV activities as a means of incentive or quality ensuring mechanism.
- Ensure key services needed for PPM TB/HIV activities are in place or a referral mechanism exist to access them. This 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)

2. 4. 3. Local implementation stage

These action steps in the local implementation stage include 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. The local implementation depends on the implementation tools and systems that are established in the preparation stage and is the critical step for the monitoring and evaluation of the initiative so that it can be scaled up depending on the evidence. The local implementation can be done by interested parties such as NGOs, professional associations or interest groups of private professionals or individual providers defined by the preparation stage with collaboration of the counterparts of the National AIDS and TB Control Programmes at the local level.

The following are the action steps for the local implementation stage of PPM TB/HIV activities:

- Establish and maintain a coordination mechanism of the local implementation with higher-level structures such as national or local TB/HIV or PPM TB/HIV coordinating bodies.
- Undertake physical mapping and sensitization of providers (with use of communication tools), and if applicable donors, partners and patient groups to mobilise them for PPM TB/HIV activities.
- Define role and responsibilities of target providers depending on local context. This will include, if applicable, the localisation of the task mix that is developed during the preparation stage.
- Enhance networking and sharing of experiences among the engaged service providers and ensure their knowledge is up the level and up to date.
- Conduct orientation and task-based training covering all essential aspects for target service providers. This will include provision of clear instruction on expected tasks, the use of the implementation tools developed in the preparation stage, monitoring and evaluation and defining the utility of the referral systems.
- Define innovative and friendly ways of training particularly for private providers in such a way that their routine work is not disrupted and their motivation and interest is kept. For example ‘on the job’ training is often optimal for private for profit providers.
- Provide accreditation and certificates for involved providers.
- Ensure contractual agreement either through memorandum of understanding with institutions or letter of agreement with individual providers.
- Promote the work of the involved providers through local advocacy and communication means.
- Provide supervision on regular basis. This involves the introduction of supervisory staff and explaining supervision routines for the involved providers. It is also important to clarify the expectations of the involved providers from the supervision.
- The supervision should focus on the following critical areas amongst others: registers, information, education and communication, the use and access of diagnostic facilities, availability of drugs and other consumables.
- Ensure sustainable system of commodities supply and management at the local level.

2. 4. 4. Monitoring and evaluation stage

The monitoring and evaluation stage is a critical step that informs the performance of PPM TB/HIV activities for further scale-up and expansion. It involves defining indicators based on the WHO guidelines on monitoring and evaluation of TB/HIV activities[9] and the implementation of the revised recording and reporting formats[10] . The indicators that need to be monitored should be defined and agreed on locally based on the local implementation model, and recording and reporting formats in line with international and national recommendations should be developed. Involved service providers should be provided with the forms accompanied with training. Data quality control mechanisms should be introduced at the local level to ensure best data that inform the performance of PPM TB/HIV activities.

Table 2. Examples of indicators that may be considered during 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
	Number of health care providers trained, by type of staff	
Preparation	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 health facilities/providers participating in TB/HIV activities	Number of participating non-NTP health facilities as a percentage of all non-NTP heath care facilities in the selected area (use inventory of non-NTP providers in the area)
	Proportion of new TB cases detected through referral by non-NTP providers	Number of new TB cases detected through referral by non-NTP providers as a percentage of all new TB cases
	Proportion of new TB cases diagnosed by non-NTP providers	Number of new TB cases diagnosed by non-NTP providers as a percentage of all new TB cases
	Proportion of new TB cases receiving DOT by non-NTP providers	Number of new TB cases receiving DOT by non-NTP providers as a percentage of all new TB cases receiving DOT
	Proportion of PLWHA (attending for HIV testing or HIV treatment) screened for TB at non-NTP health units	Number of PLWHA attending for HIV testing or treatment at non-NTP health units screened for TB as a percentage of all PLWHA attending for HIV testing or treatment at non-NTP health units
	Proportion of newly diagnosed HIV-positive people who are given IPT at non-NTP health units	Number of newly diagnosed HIV-positive people who are given IPT at non-NTP health units as a percentage of all newly diagnosed HIV-positive people at non-NTP health units
	Proportion of TB patients tested for HIV at non-NTP health units	Number of TB patients tested for HIV at non-NTP health units as a percentage of all registered TB cases at non-NTP health units
	Proportion of HIV-positive TB patients receiving CPT during their TB treatment, at non-NTP health units	Proportion of HIV-positive TB patients receiving CPT during their TB treatment at non-NTP health units as a percentage of all HIV-positive TB patients and non-NTP health units
	Proportion of HIV-positive registered TB patients who receive ART during/at the end of TB treatment at non-NTP health units	Proportion of HIV-positive registered TB patients who receive ART during or at the end of TB treatment at non-NTP health units as a percentage of all HIV-positive registered TB patients at non-NTP health units

3. Conclusion and next steps

The engagement of all care providers PPM TB/HIV activities in settings with high HIV prevalence carries a huge untapped potential for the scale-up of collaborative TB/HIV activities and should be encouraged. Furthermore, effective linkages with different health care providers to provide integrated services play a key role to strengthen health systems. The experiences and evidence of implementation should be systematically documented and inform the development of a policy on how the engagement of all providers in collaborative TB/HIV activities. The implementation of the protocol included in this document will serve the purpose of facilitating the implementation and documentation of collaborative TB/HIV activities by all providers under routine programmatic conditions. Therefore, WHO and partners should encourage the use of the implementation protocol to set up demonstration projects for implementing TB/HIV PPM activities.

Countries with national and local TB/HIV coordinating bodies needs to promote the engagement of representatives from the public private mix in the bodies in order to promote their interest. Given that the activities in this area should be implemented only in settings with existing TB and HIV programmes, policies and activities, PPM TB/HIV is aimed at consolidating, rather than fragmenting both programmes and related activities and policies. Ongoing PPM TB/HIV activities need to be systematically documented and shared. The progress in promoting TB/HIV PPM should be presented and discussed at forthcoming meetings of the Stop TB Partnership's subgroup on PPM for DOTS expansion who should play a leadership role in collaboration with the TB/HIV Working Group of the Stop TB Partnership to promote for PPM TB/HIV activities.

This document and the protocol will be made available on relevant TB and HIV websites to promote its implementation and encourage piloting of projects in as many countries as possible through collaboration with national AIDS and TB Control programmes. Existing funding mechanisms should be explored to ensure the availability of resources for the piloting and scaling up of these initiatives. The documentation and review of the experiences and evidence from such pilot projects should inform nationwide scale up of activities in the respective countries and will also inform the development of global policy and programme guidance.

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