

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

(PPM TB-HIV activities)

Evidence from two pilot projects
India and Namibia



**International Union Against Tuberculosis
and Lung Disease (The Union)**

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(TBCAP)

TBCTA
The Tuberculosis Coalition
for Technical Assistance



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ACRONYMS and ABBREVIATIONS

ANC	Antenatal care
APA	Annual Plan for Action
ART	Anti-retroviral therapy
CORO	Community of Resource Organization, an NGO
CPT	Cotrimoxazole preventive therapy
CSW	Commercial sex workers
DHS	Demographic health survey
DIC	Drop-in-center
DMC	Designated microscopy centre
DOT	Directly observed treatment
DOTS	Directly observed treatment, short-course
DWS	Dai Welfare Society, an NGO
FHI	Family Health International
GP	General Practitioner
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
ICTC	Integrated Counselling and Testing Centres
IEC	Information Education Communication
KNCV	KNCV Tuberculosis Foundation
LSS	Lok Seva Sangam
M/E	Mumbai East ward
MDACS	Mumbai District AIDS Control Society
MDR-TB	Multidrug resistant TB
MDTCS	Mumbai District TB Control Society
NABCOA	Namibia Business Coalition on HIV/AIDS
NACO	National AIDS Control Organization
NAP	National AIDS Programme
NGO	Non-governmental organization
NHF	Niramaya Health Foundation
NSP	Nagri Seva Prabodhini
NSP*	New sputum positive
NTCP	National Tuberculosis Control Programme
NTP	National Tuberculosis Programme
PATH	People's association for training and health, an NGO
PLHIV	People living with HIV
PLWHA	People living with HIV/AIDS
PP	Private Practitioner
PPM	Public-private mix
PPTCT	Prevention Of Parent to Child Transmission
PSI	Population Services International
RNTCP	Revised National Tuberculosis Control Programme
SAI	Social Activities Integration, an NGO
SCC	Sputum collection centers
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBCAP	Tuberculosis Control Assistance Programme
TB-HIV	Tuberculosis/Human immunodeficiency virus
The Union	International Union Against Tuberculosis and Lung Disease
UNAIDS	United Nations Programme on HIV/AIDS
VCTC	Voluntary Counselling and Testing Centres
WHO	World Health Organization

Introduction

Engaging a wider spectrum of public and private health care providers for the delivery of collaborative Tuberculosis/Human Immune Deficiency Virus (TB-HIV) activities offers an untapped opportunity for scaling up of interventions in HIV prevalent settings. This engagement entails documenting existing experiences and practices, defining the essential package and modality of delivery of collaborative TB-HIV activities, encouraging implementation and strengthening the critical evidence base for eventual issue of policy recommendations for national TB and HIV/AIDS control programmes.

In order to maximize access to TB-HIV care through the Stop TB Strategy, it is necessary to harness the contribution of a wide range of health service providers as part of NTP and NAP activities. A protocol for promoting implementation of collaborative TB-HIV activities through public-private mix and partnerships was finalized in June 2008 by the World Health Organisation (WHO) following a consultative workshop held in Geneva in early 2008.

Process

As part of the Tuberculosis Control Assistance Program (TBCAP) activities, the International Union Against Tuberculosis and Lung Disease (The Union) guided implementation of two pilot projects with partners - InterAide in India and KNCV in Namibia. Collaborating with implementing partners in Namibia and India, the objective of The Union-led interventions was aimed at “field testing” the implementation protocol developed by WHO and to ensure any lessons learned from the pilots contribute towards final policy guidelines to be developed and disseminated by WHO.

As a first step of this part II activity under TBCAP-TB-HIV PPM APA3, The Union organized a workshop on engaging all health providers in collaborative TB-HIV activities in New Delhi, India during 22-23 July 2008. During the workshop, partners from both pilots – India and Namibia examined and discussed the protocol applicability, and identified core actions. Implementing partners presented structured baseline information on existing public/private and public/public activities for TB-HIV; and developed draft plans for implementing PPM TB-HIV by the end of the workshop. Pilot implementation was carried over a period of nine months during October 2008 until June 2009.

A post-pilot workshop was organised on 15-16 July 2009 in Paris, France at The Union headquarters. The objective of this workshop was to allow each implementing partner to present structured information, analyse findings of pilot activities related to collaborative TB-HIV activities involving public-private mix and partnerships. The evidence generation and experience garnered from implementation of these pilots are aimed at contributing towards finalizing implementation protocol for collaborative TB-HIV PPM activities by all health providers outside the public sector.

Chronology of events under Part II TBCAP TB-HIV PPM APA 3

- The Union initiated Part II activity with a pilot proposal development workshop on 22-23 July 2008 (discussions based on unedited final version from WHO received end June 2008).
- Development of detailed proposals by pilot implementation partners - Aug 2008
- Finalization of proposals and contracts - Sep/Oct 2008
- Pilot implementation begins Oct/Nov 2008
- Technical monitoring of pilot implementation by TBCAP partners WHO, FHI and The Union completed per schedule by end Q 1 implementation
- Implementation continues – end May/mid-June 2009
- Analysis, documentation by pilot projects – June 2009
- Post pilot workshop– 15-16 July 2009
- Final report of projects by Union- Sep 2009

STUDY 1: Promoting implementation of collaborative TB-HIV activities through public-private mix and partnerships in Mumbai, India

Study objective

The objectives of the TB HIV PPM Pilot Project are:

- 1) To increase access to HIV testing and treatment services to general population and TB patients undergoing treatment at DOTS Centres operated by NGOs.
- 2) To increase access to DOTS for HIV/AIDS vulnerable groups by decentralizing DOTS services (sputum collection, diagnosis/categorization, DOTS provision) to the level of HIV/AIDS high risk groups through the NGOs catering to these groups.

Description of project setting

TB continues to be a public health challenge in India with an estimated 1.8 million cases annually. HIV infection rate is 0.36% with an estimated 2.31 million people living with HIV/AIDS in the country. HIV has escalated the burden of TB in India as active TB is the most common opportunistic infection that occurs in people living with HIV (PLHIV).

TB-HIV collaborative activities were initiated in a phased manner in India. Six high prevalent states including Maharashtra started with TB-HIV activities in 2001. Subsequently, the activities were expanded to eight additional states. NACO has developed a national framework for TB-HIV in February 2008 with a view to expand activities to the entire country.

There were 30,606 registered TB cases in Mumbai district during 2008 (Source: TB India 2009 – RNTCP Status Report). Mumbai has the following infrastructure under RNTCP II: 25 Treatment Units, 111 Designated Microscopy Centres, 580 DOTS Centres, 26 NGOs and 4623 PPs implementing the programme. It is estimated that in Mumbai, HIV prevalence among pregnant women is about 1.4% (Source: HIV Sentinel Surveillance 2007) which is higher than the national average of 0.25-0.31%. There are 74 Integrated Counselling and Testing Centres (ICTCs) in Mumbai.

To tackle the problem of TB-HIV co-infection, RNTCP has developed new treatment cards that records TB patients at DOTS centres who are known to be infected with HIV. Those who are found to be positive will be referred to ART centres and whether they received any CPT and ART from these centres is recorded. This has been introduced in June 08; the new reporting system was established in the public health structures during the pilot project period.

A district coordination committee set up includes representatives from the Mumbai District TB Control Society (MDTCS) and Mumbai District AIDS Control Society (MDACS), meets on a quarterly basis for reviewing the performance of TB-HIV activities. MDACS has also started a project for cross referrals at ICTCs and DOTS centres in the Public Health System in Mumbai involving two nodal NGOs. TB-HIV collaborative activities have achieved the following:

- Development of training material
- Training of RNTCP and ICTC staff
- Identification and collaboration with NGO working in STI/HIV prevention
- Training of NGO staff working in the field of STI and HIV (FHI and PSI network of NGOs trained by MDTCS and supported by Inter Aide)
- Cross referrals at ICTCs and DMC's and Health Posts(falling under public health system)

Pilot project activities

1. Intensified TB case finding in high risk groups and PLWHA in M/E and E ward
2. Providing TB services for high risk group and PLWHA
3. Sensitization of TB patients and their families about HIV/AIDS
4. Referral for HIV testing and counseling of TB patients
5. Referral for care and support
6. Development of new tools- communication material

Timeframe for implementation: 8 months

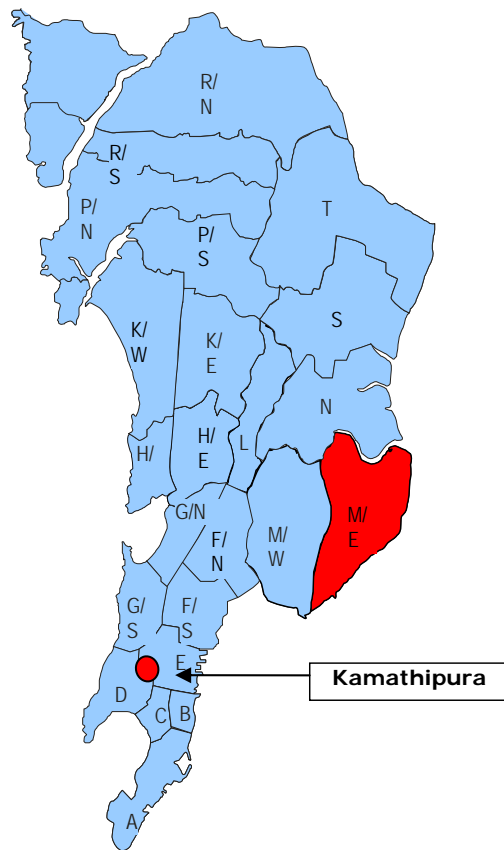
Target groups and providers considered

The target groups as illustrated in Table 1 included M/E ward for general population with high HIV prevalence (to improve access to HIV services with special focus on TB patients) and Part of D and E ward (for High risk groups- CSW's to improve access to TB services).

Table 1: Target groups	
Mumbai – M/East ward (General population)	
Population	743288
Slum population	78%
Area	32.5 sq.km
HIV prevalence (in ANC for Mumbai)	1.4%
Health services	
Public:1 municipal hospital, 2 maternity homes, 4 municipal dispensaries, 9 municipal health posts	
Private: Private practitioners = 703 (10% allopathic, 26% homeopathic, 24% Ayurvedic, 24% Unani, 15% others)	
TB NGOs: 3 (Apnalaya, LSS, PATH),	
HIV NGOs: 6 (Niramaya, CORO, Niramay Niketan, Nagri Seva Prabodhini,	

Sankalp and Dai welfare society)
Mumbai- E ward – Kamathipura; D ward- Falkland road (CSW's)
Estimated population = 10,000
Health services in the vicinity of project area = 1 public Health post, 1 public dispensary and 1 medical college hospital close by, about 100 private practitioners
NGOs: 5

Fig 1: Mumbai district map



Main findings and Results from pilot study

1. **Pilot project initiated situational analysis and intervention planning in both M/E ward and portion of D and E ward sites.** Pilot completed baseline mapping approaches assessing existing health facilities, both public and private involved in TB-HIV activities.
 - Baseline information captures private sector contribution to TB and HIV control activities. Two NGOs (LSS and PATH) were involved in providing TB services to the general population in M/E ward.
 - Baseline identifies that 6 HIV NGO's (NHF, DWS, Niramay Niketan, NSP, CORO, and Sankalp) are involved in providing HIV services to high risk groups and general population in M/E ward.
 - NGO (SAI) involved in providing HIV services to high risk population in Kamathipura.
 - 131 PPs expressed intention to be involved in TB or HIV related services.
2. **Project implemented wide range of activities in both the project sites:** M/E ward and Kamathipura. The project activities relating to: intensified TB case finding in high risk groups and PLWHA; sensitization of TB patients and their families about HIV/AIDS; improving referrals of TB patients for HIV counseling and testing were implemented according to the proposed pilot action plan.
3. **Improving access for TB patients: Referral from NGO DOT Centres for HIV testing, CPT and ART**
 - NGOs involved in TB services initiated referrals of TB patients for HIV testing and counselling starting October 08. Data for those patients reporting back to the NGOs with ICTC reports were recorded in TB treatment card and registers. Total number of patients accessing services at ICTC centres was also recorded.
 - Starting Oct 08, TB NGO (LSS) started screening and referral activities in 9 DOTS Centres of M/E ward. The other TB NGO (PATH) initiated TB patients for HIV testing from two of its DOTS centres starting Nov 08. While newly registered patients were offered referrals during last quarter 2008, all patients enrolled on treatment were offered referral for HIV testing from quarter 1 2009. Newly registered patients in DOT centres under TB-NGOs were counselled during the treatment period (6-8months) and motivated for referrals to ICTC.
 - **There is an observable increase in referrals for HIV testing among TB patients during Q 1 (15 fold) and Q 2 (8 fold) of 2009 compared with baseline (Table 2).** Correspondingly, a higher number of co-infected patients were placed on CPT (23 patients) and ART (6 patients) during the pilot project implementation during Q 1 and Q 2 2009.

- During project period, there were 524 referrals from the on-going 1442 patients, out of which 37 have reported back to be HIV-positive. 305 patients who were referred reported back to be HIV negative and status of 182 is unknown (meaning that all the patients who were referred are not reporting back on the status of testing). Since HIV testing is voluntary, all the DOT providers were discouraged from asking reports of HIV testing and their roles were limited to referral and providing information on HIV. Out of 37 who were found HIV positive, 23 had been started on CPT and 6 were on ART. **NGO referrals to ICTC during the implementation period have increased from 7% to 36%. This increase in referrals for HIV testing may be attributable among many factors to pilot activities involving NGO's to actively counsel and refer TB patients for HIV testing. There is also a corresponding increase in patients who underwent HIV testing (19 during baseline to 115 during Q 2 2009) and increase in co-infection among those reporting back to NGOs (6 during baseline to 16 during Q 2 2009).**
- Availability of CPT at health posts was initiated during the project implementation period by MDACS and MDTCS.

Table 2: Referrals from DOT centers operated by TB NGOs in M/E ward					
	Baseline for 3 months	Q4 08	Q1 09	Q2 09	Total
Total on-going patients	281	213	559	670	1442
Referrals to ICTC	19 (7%)	82(38%)	293(52%)	149 (22%)	524 (36%)
Tested for HIV	19 (100%)	41(49%)	190(65%)	115 (77%)	346 (66%)
Reported back as HIV Positive	6 (32%)	7 (18%)	12 (6%)	16 (14%)	37 (10%)
Reported back as HIV Negative	13	31	176	97	305
HIV Status not known	0	43	103	36	182
NSP HIV Pos	3	1	3	4	8
Patients started on CPT	0	0	4	19	23
Patients started on ART	1	0	4	2	6

4. Improving access for HIV testing among TB patients: Referral from NGO DMC for HIV testing

LSS operates a designated microscopy centre (DMC) in M/E ward. TB suspects who are reported as sputum positive at the DMC were routinely referred for HIV testing to nearby ICTCs. This was started as an activity for the implementation of the pilot project. During the project period, 135 sputum positive patients were referred to ICTC. However only 52 patients reported back as HIV negative and status of the remaining 83 is not known (Table 3).

Table3: Referral from NGO DMC (LSS) to ICTC in M/E ward				
	Q4 08	Q1 09	Q2 09	Total
NGO – LSS DMC (referral of sputum positive patients)				
Sputum positive TB patients diagnosed	65	26	46	137
Referred for HIV testing	63	26	46	135
Reported back as HIV Pos	0	0	0	0
Reported back as HIV Neg	19	10	23	52
Status not known	44	16	23	83

5. Improving access to TB services among PLWHA and high risk groups in M/E ward through involvement of NGOs

NGOs involvement ranged from improving awareness related to TB among their target population to ensuring referrals for TB diagnosis.

- NHF referred TB suspects to sputum collection centers (SCC), and DMC operated by LSS.
- Dai Welfare Society referred TB suspects to the nearest health post for further screening and diagnosis.
- Niramay Niketan already had a DOTS Centre for its out-patients. Also, patients admitted in the wards are put on DOTS if diagnosed with TB.
- DAI, CORO, Sankalp and NSP referred TB suspects to the nearest health facility and conducting IEC activities in collaboration with LSS.
- All HIV NGO's involved in the pilot referred TB suspects to RNTCP directly or through LSS.
- Please note that NHF has no referrals from March – May 09, Sankalp had no referrals in the month of March 09 (this month being the year ending and the NGOs were busy with year end reporting) and NSP had no referrals for TB in April – June 09.
- Out of the 108 referrals for TB diagnosis, 95% suspects completed the diagnosis procedure and 34% of them were found to be TB patients. 94% of these were put on DOTS.
- Data from Sankalp is not available for the month of June 09 as the NGO has stopped operations in M/E ward.

Table 4: Report from HIV NGOs in M/E ward					
Indicators	Total				
	Baseline (3 months before date of implementati on)	Q4 08	Q1 09	Q2 09	Total (Oct 08 to June 09)
Referrals for HIV testing	383	101	303	273	677
HIV infected	11	6	18	12	36
Referral for TB diagnoses	35	31	42	35	108
Sputum test done	35	30	38	35	103
Diagnosed with TB	13	15	10	10	35
Sputum Pos	13	15	9	8	32
NSP	11	7	9	Not known	16
Put on DOTS	13	14	10	9*	33*
Cat I	11	7	9	1	17
Cat II	2	7	1	0	8
Cat III	0	0	0	0	0

* Data on categorization not available with the NGO (DAI)

** Data from Niramay Niketan is not included as it is a hospice, hence acting as a referral for HIV positive patients

For Q4 08, the first quarter of implementation, please note that the data collected for NHF, DWS and Niramay Niketan is for 3 months, whereas for CORO, NSP and Sankalp data is only for 1 month (activity initiated during Dec 2008).

- Comparing with baseline data, the suspect referrals are similar during the implementation period Q4 08, Q 1 and Q 2 09.

There were 24 TB-HIV coinfection cases started on DOTS in the HIV NGOs during the project period out of which 2 died while on treatment. Outcome of the rest of the patients will be declared at the end of one year (Table 4).

6. Improving access to TB services among PLWHA and high risk groups in Kamathipura through involvement of NGOs

- NGO involved in implementing pilot activities in Kamathipura was SAI. Activity implementation was delayed owing to human resource at the NGO and NGO citing inadequate finances from the pilot.
- **SAI treatment regimens for TB patients were not in alignment with RNTCP. All the patients found to be smear positive for TB during Q4 08 were started on private treatment (the drugs are received through a separate funding agency). To solve the issue a meeting was conducted in the month of Jan 09 and the activities were started in the last week of January.** The action plan included involvement of a VCTC and a DIC run by SAI for the CSW's. However, the Medical officer in charge of DIC resigned, so no data form DIC was available for the project period
- During the project period the number of referrals from SAI to the RNTCP sputum testing centres increased from 6 in the 3 months preceding the pilot project to 32 during the 5 months of project implementation.
- Efforts were made to put all the diagnosed TB patients on DOTS and in spite of the difficult situation, 7 were put on DOTS under the RNTCP.

Table 5: Report from HIV NGO in E ward				
	Baseline (Aug 08 – Oct 08)		Project period (Jan-May 09)	
	ICTC	DIC	I.CTC	DIC
Referrals for HIV testing	199	60	88	0
HIV infected	27	6	21	0
Screened for TB	6	6	41	0
Referral for sputum test	3	3	32	0
Sputum test done	-	0	17	0
Diagnosed with TB	-	0	10	0
Sputum Pos	-	-	9	0
NSP	-	-	3	0
Sputum Neg	-	-	0	0
Pts on DOTS	-	-	7*	0
Cat I	-	-	3	0
Cat II	-	-	3	0
Cat III	-	-	0	0

* Categorization of 1 patient was not available

7. Role of Private Practitioners (PPs)

- Baseline information revealed the involvement of 131 PPs actively referring TB suspects to DMC in M/E ward. These PPs were sensitized on referring HIV suspects to ICTCs.
- Pilot activity included a sensitization programme organized by LSS in Feb 09 attended by 35 GPs. The importance and achievements of the involvement of PPs in the RNTCP were discussed and the new TB-HIV collaborative activities were introduced with encouragement to refer their HIV suspects to the ICTCs.
- During the pilot implementation, 13 patients were referred to ICTC by 10 PPs, out of which 4 tested positive, 6 negative and status is not known for 3 suspects.

8. Community mobilization activities

Various community mobilization activities such as group talk, patient meetings, street play and community meetings were conducted in M/E ward during the pilot implementation. The objective of these IEC activities was aimed at improving the awareness levels of community on TB and HIV within the community. The activities in M/E ward started from Dec 08 while it started in Feb 09 in E ward. LSS conducted all TB-HIV IEC activities in M/E ward in collaboration with HIV NGOs. The following tables 6 and 7 illustrate IEC activities during pilot implementation.

Table 6: Community mobilization activities in M/E ward								
Type of IEC	Q4 08		Q1 09		Q2 09		Total	
	No. of prog	Attendees	No. of prog	Attendees	No. of prog	Attendees	No. of prog	Attendees
Group Talk	3	93	14	254	28	393	45	740
Patient meetings	-	-	7	232	-	-	7	232
Street Play	1	200	2	110	-	-	3	310
Poster Exhibition	-	-	7	240	-	-	7	240
Community Meetings	1	300	-	-	-	-	1	300
Total	5	593	30	836	28	393	63	1822

- In addition to community awareness, LSS staff on their visits to TB Patients conducted awareness meeting with the family. 120 such families were contacted and there were 520 attendees for the same.

Table 7: Community mobilization activities in E ward						
Type of IEC	Q1 09		Q2 09		Total	
	No. of prog.	Attendees	No. of prog.	Attendees	No. of prog.	Attendees
Group Talk	14	254	8	205	22	459
Street Play	2	110	4	220	6	330
Poster Exhibition	7	240	6	390	13	630
Total	23	604	18	815	41	1419

- Table 7 illustrates community mobilization activities in E ward with a high concentration of CSW's. These activities targeted CSW's attending the general and STI clinics of SAI, their partners and passers-by in the area.

9 Information from ICTCs and DMC's

- Information was collected from 5 ICTCs where the HIV testing is done for the project. Four of them are in M/E ward while 1 is in M/W ward but caters to population from the border areas of M/E ward also.
- The ICTC reports are submitted to the Mumbai District AIDS Control Society (MDACS) on a monthly basis by the ICTC counsellor, validated and made available to NGOs only about 1-2 months later. Data from 4 ICTCs available until June 09 and 1 ICTC until April 09. Table 8 illustrates the performance during period of project implementation:

Table 8: Data from Public health facility-ICTC							
		Baseline	Q4 2008	Q1 2009	Q2 2009	Total Project period	
ICTC ATTENDANCE							
Total No. of Clients who attended ICTCs (VCTC+PPTCT)		3221	2768	4305	3917	10990	
Out of these Referred from NGO (From ICTC records)		145	80	132	154	366	
Out of these Referred from PP (From ICTC records)		6	0	9	5	14	
Total No. tested HIV positive		109	84	148	115	347	
HIV Positive from NGO referrals (From ICTC records)		2	1	2	7	10	
HIV Positive from PP referrals (From ICTC records)		0	0	0	0	0	
REFERRAL OF SUSPECTED TUBERCULOSIS CASES FROM ICTC TO RNTCP							
Suspects Referred to RNTCP diagnostic Services	HIV+ve		68	28	66	76	170
	HIV-ve		130	82	230	167	479
Diagnosed as TB	Sputum Positive TB	HIV+ve	0	1	1	2	2
		HIV-ve	24	7	0	21	21
	Sputum Negative TB	HIV+ve	0	0	1	1	1
		HIV-ve	1	0	0	9	9
	Extra-Pulmonary TB	HIV+ve	5	0	0	2	2
		HIV-ve	3	9	0	16	16
Out of above diagnosed TB Patients, number receiving DOTS	Cat I		0	0	0	1	2
	Cat II		0	0	0	0	1
	Cat III		0	0	0	1	4
REFERRAL OF SUSPECTED HIV CASES FROM RNTCP TO ICTC							
No. of TB Patients Tested for HIV at ICTC		213	302	1051	555	1908	
No. detected to be HIV Positive		19	12	42	27	81	

- Performance of ICTCs and HIV NGOs can be compared on quarterly basis. As seen in the data provided by HIV NGOs, baseline referrals are higher than the following periods. Also referrals during Q4 08 and Q2 09 are markedly much lower than the baseline. Overall performance in Q1 09 is better.
- During the project period, the ICTCs were requested to record referrals from NGOs and PPs. There is a discrepancy in the recorded referrals: HIV NGOs data shows 524 referrals whereas ICTCs records reveal NGO referrals at 366. This could be due to:
 - Poor record maintenance at the ICTCs (increased workload as multiple sources of referrals take up time for accurate recording).
 - Suspects referred from NGOs may get dual referral slips, one from the NGO and another from the ICTC and so the patient maybe recorded as ICTC referral.
 - Suspects with referral slips can access any ICTC (not necessarily from the same area).
- Similarly, there is a difference between the number of patients reported as referrals from PPs by the ICTC and those reported by the project. This is due to the fact that the project involved only 131 PPs (out of 703) who had been regularly referring TB suspects to the RNTCP. The difference in referrals is due to the number of patients referred to the ICTCs by the other PPs not involved in the project.
- Also, it may be noted that there are no records from ICTC as to how many patients who diagnosed with TB were actually put on DOTS. 51 (including 5 HIV +ve) were found to be having TB but no data on categorization was available.
- 81 of the 1908 TB patients tested from RNTCP were found to be positive (4.2%). Patients referred from TB NGOs (PATH and LSS) have higher HIV positivity rates (10%) among those who reported back.

10. Roles of various stakeholders in the pilot project

Figure 2 illustrates the interrelation between various stakeholders, existing relationships and newer linkages developed such as referrals by PPs for HIV testing. Few linkages that existed informally were streamlined and strengthened during pilot implementation e.g. cross-referrals among TB and HIV NGOs, referrals from TB NGOs to ICTCs etc.

Some new links were added to existing linkages e.g. PPs were referring TB suspects to the DMC's and providing information to the TB NGOs to facilitate follow-up. A similar component for HIV referrals was added.

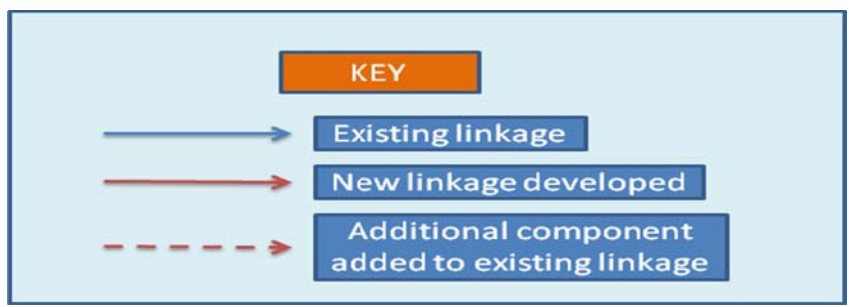
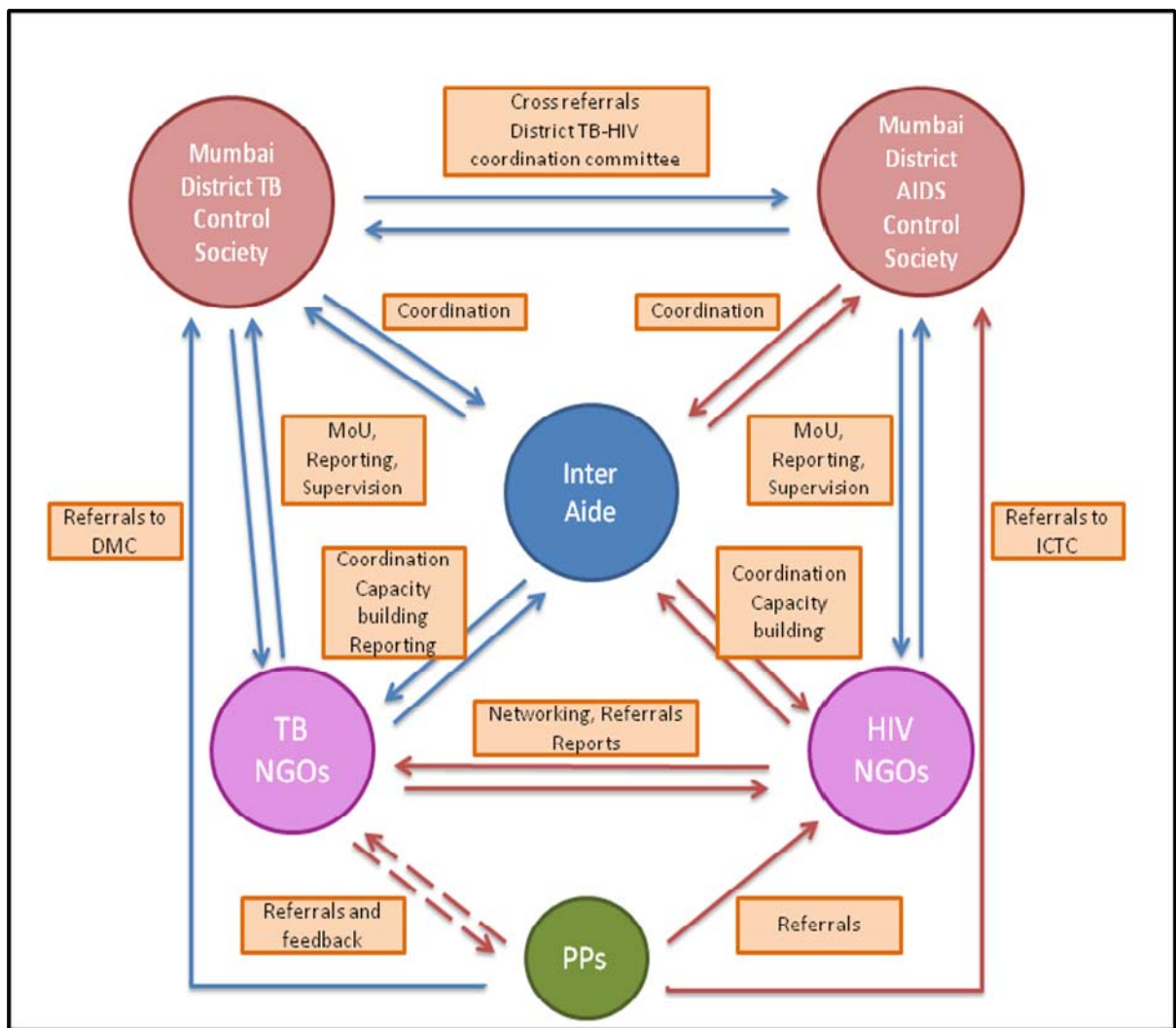


Figure 2: Role of stakeholders in Mumbai Pilot project

STUDY 2: Promoting implementation of collaborative TB-HIV activities through public-private mix and partnerships in Namibia

Study objective

- To apply TB-HIV PPM protocol to promote implementation of collaborative TB-HIV activities in two sites, Windhoek and Oshana in Namibia.

Description of project setting

Namibia is a low-middle income country in South-West Africa. It has a well structured public health service, which is the major health care provider to the population of over two million inhabiting the vast territory of the country. While precise statistics are unavailable, the majority of the population, about 90%, depends mainly on the public health services for their health care needs. This includes health facilities of faith-based organizations which are also supported by the government. The country is divided into 13 regions; each of which is made up of one to four administrative districts. The network of public health services across the 13 regions and 34 districts of the country offer health care at a nominal fee through 30 public district hospitals, 44 health centers and 265 clinics. Three intermediate hospitals and one national referral hospital provide support to the district hospitals. (DHS: 2006/7 page 3). There are 34 laboratories in the public sector, managed by the Namibia Institute of Pathology. The country is sparsely populated, with the population spread across a vast territory thereby making physical access to health care a major challenge. Only 25% of the population lives within a 10 km radius from a government health care facility. Human resources for health care are also a major constraint that impedes activities of many public health programmes. Independent public institutions established by the state also offer health services to their members and are very closely linked to the state health care system. These entities include the National Defense Health Care System, the Prisons Health Service and the University of Namibia.

Namibia is among countries that carry the greatest burden of the TB and HIV as well as TB-HIV dual infection. The 2008 antenatal seroprevalence survey revealed an HIV prevalence of 17.8% among pregnant women. According to the "UNAIDS 2008 Report on the Global AIDS Epidemic" the number of people living with HIV/AIDS in the country was estimated to be 180,000 by the end of 2007. Namibia reported 13,737 cases of all TB forms in 2008 which translates to a case notification rate of 655 cases per 100,000 population. Of these cases 9,188 (66.9%) had a recorded HIV status. The proportion of HIV among the TB patients with a known HIV status was 59%. The treatment success rate in 2007 is reported at 83% for new smear positive (SM+) cases. The default rate in this category of patients was 4.7%, while death and transfer out rates were 5.4% and 3.6%, respectively. Treatment failure rate for new smear positive cases was 3.3%. The treatment success rate for patients on re-treatment remained low at 67%. The number of MDR-TB patients started on treatment in 2008 was 201.

Namibia has an active and well organized thriving private medical sector which comprises individual nurse practices, solo medical practitioners, group medical practices, private hospitals and health services offered by big and medium businesses. The better off population, about 30% of the organized work force in the private sector and about 70% employees of the public sector, seek health care from the private medical sector. The precise number of private facilities or the health workforce engaged in the private sector is not easy to ascertain. Private medical care is expensive and costs of private care are met largely through medical insurance schemes commonly referred to as Medical Aid.

Fig 3: Two pilot sites in Namibia: Oshana and Windhoek in Khomas region



Current contribution of private providers to TB control

The NTCP does not yet have any system in place yet to measure or disaggregate contribution of private providers to TB diagnosis and treatment. In the absence of any documentation, it is believed that up to 5% of TB patients and 10-15% HIV patients may be getting their treatment in the private sector, with a significant variation among regions. If the information elicited by the mission that came to evaluate PPM from pharmacies is any indication, it does seem that the burden of TB cases managed in the private sector may not be large. On the other hand, the mission learnt that there are requests from a medical aid institution to examine the appropriateness of prescriptions for TB they receive for reimbursement from their clients. Although, in large part, private providers seem to refer their TB suspects and patients to the public sector clinics before or after diagnosis or after partial treatment, it is important to determine the precise burden of TB being managed in the private sector.

Pilot project activities

1. Setting up TB-HIV PPM subgroup,
2. Mapping out private providers in the 2 selected sites,
3. Adapting International Training and Education Center for HIV (ITECH) training materials for training private sector,
4. Developing referral mechanisms,
5. Incorporation of TB into existing NABCOA HIV workplace programmes,
6. Engaging medical aid groups for standardizing TB and HIV care and treatment
7. Engaging private practitioner and pharmacist associations
8. Engaging private companies through breakfast meetings on TB-HIV

Timeframe for implementation: 8 months

Target groups and providers considered

The pilot implementing agencies: KNCV and NABCOA identified 2 pilot sites in Namibia to test the TB-HIV PPM protocol.

1. Windhoek district of the Khomas region; population: 292,771
2. Oshana region population 183,452

Main findings and Results from pilot study

Pilot implementation began in Nov 2008. The pilot implementation was carried out concomitantly as KNCV had planned PPM activity implementation (under TBCAP in Country Operating Plans 2008 (COP08) and APA4 plans).

- Pilot implementation contributed towards strengthening TB-HIV working group through formation of a TB-HIV PPM subgroup as well as facilitating regular meetings of the working group (6 meetings in 7 months). Terms of Reference for the group were drafted and finalised during pilot implementation.
- NTCP and ITECH adapted NTCP and ART training materials for use by private practitioners.
- Pilot implementation included contributing towards developing referral mechanisms
 - Referral mechanisms in the public sector for TB and HIV care existed to a variable extent. These are different from hospital to hospital as in some hospitals both TB and HIV care clinics are manned by the same doctors while in some situations it is managed by different doctors. In some places the two clinics are adjacent, with a few metres while some are few kilometres apart. In some TB clinics HIV counselling and testing is done within the clinic, while in some clinics they refer the patient for HIV counselling and testing. TB treatment is sometimes initiated in some ART clinics while some refer TB patients to the TB clinic.
 - Formal referral mechanism between the public sector and the private sector is not developed for HIV care, but exist in various forms for TB.
 - Although this is not documented; TB patients receive work place DOT in different regions. The NTCP guidelines describe work place DOT as one form of DOT encouraged by the country; this is taught to doctors, nurses and pharmacists. After the courses, some health workers go on to practice what they learnt. The NTCP does not collect information about the patients on various forms of DOT; but support and supervision visits have shown that a number of TB patients receive DOT in the work place.
- Pilot activity included capacity building initiatives
 - Four trainings on TB-HIV were conducted for doctors, nurses and pharmacists in the private sector (one in Oshakati; three in Windhoek) as a collaborative activity between the NTCP, KNCV Tuberculosis foundation, I-TECH, Management Sciences for Health and Medscheme.
- **Engagement of NABCOA:** by KNCV to include TB activities in their HIV workplace programs:
 - a. A **memorandum of understanding (MOU)** was signed between KNCV and NABCOA. The following activities were carried out by NABCOA.
 - NABCOA TB support officer conducted TB sessions and facilitated

- During this pilot implementation period, following 10 Companies were identified in Windhoek and Walvis Bay to participate in the pilot: Telecom Namibia, Air Namibia, Shoprite, Meatco, Traubross, Salt Refiners, Cadilu fishing, Etale fishing, Hanganana fishing and Mondipak.
- Two workplace programme trainings and two peer education trainings were conducted.
- NABCOA distributed TB awareness material in 60 Private Sector companies as part of the World TB day commemoration.
- A4 and A3 TB posters were developed and distributed at NABCOA training events and meetings.
- Pilot implementation included NABCOA facilitating creation of DOT points in Windhoek based companies.

b. Two PPM breakfast meetings were carried

- A breakfast meeting was held in **Windhoek** on the 12th May 2009 and in **Walvis Bay** on the 13th May 2009.
- Out of a total of 60 expected guests from 38 companies in Windhoek, 53 attended. In Walvis Bay 25 participants from 20 companies attended.
- Participants were from the offices of the Governor from both regions, private doctors, private sector and from different government ministries including Health, Defence, Finance and Education.
- Feedback from the participants indicated that the information shared by Dr. Margot Uys a TB workplace programme expert from ***That's it*** in South Africa was useful to them as it informed them on the impact of TB on businesses and how this impact can be minimised.
- The meetings also received political support from the governor of Khomas Region Cllr. Sophia Shaningwa and Mayor of Walvis Bay Cllr. Uilika Nambahu. Ministry of Health and Social Services directors for both regions and a representative from KNCV also participated in these meetings.

c. Company based activities

- At **Telecom Namibia**, a TB-HIV information session was held on the 27th of February with 21 of their Peer Educators who came from the regions. This session was part preparation for world TB day commemoration. The sessions also included distribution of IEC material for the Peer Educators to take to the regions and distribute as part of TB awareness.
- **Air Namibia** requested NABCOA to conduct TB-HIV information sessions from the 6th to 9th of April 2009 at all their offices in Windhoek. A total of 158 employees were reached.
- At **Shoprite** a TB-HIV awareness session was held with 20 shop floor staff on the 7th of May. Additional sessions have been scheduled in order to reach all their employees.

- At **Meatco**, two awareness sessions were conducted on the 15th of May 2009 and were attended by a total of 65 participants. More sessions have been scheduled in order to reach all staff.
- **Traubros** staff attended an HIV/AIDS /TB awareness session on the 21st of May 2009 at their premises. 36 staff members including management attended the sessions; only six employees who were not at work did not attend the session.
- **Cadilu fishing** had 66 employees who attended a TB-HIV awareness session on the 22nd of June 2009, including managers. Members of staff who were on leave were excluded from the sessions.
- At **Mondipak Walvis Bay**, a TB-HIV awareness session with 7 management staff was held. General staff members were excluded from this session because the factory employees were very busy since it was peak business time. However, the nurse on site promised to conduct sessions with them and report to NABCOA. This is one of the companies already rolling out TB treatment and ARV's on site.

- **Baseline mapping exercise** was conducted in Oshana region by the Chief Medical Officer for the NTCP who visited the region and requested information from private practitioners in their practices. There is one private hospital; patients admitted in this hospital are all referred by the private practitioners in the town. Patient cannot be admitted without being referred by one of the private practitioners in the town. The mapping exercise followed discussions that had been carried out between the faculties that taught the TB-HIV course in November with the private practitioners who attended the course. During the mapping exercise the following observations were made:
 - Most practitioners indicated that they were referring all their TB patients to the public sector.
 - TB patients are reluctant to go to public hospitals for TB treatment due to the long waiting time.
 - Practitioners who were aware of PPM activities through the training workshops that have been conducted were open to share information on their TB and HIV activities.

Table 9: DATA ON PATIENTS ON TB TREATMENT AND HIV TREATMENT IN THE PRIVATE SECTOR IN THE NORTHERN REGIONS (OSHANA), NAMIBIA

Doctor	Number of TB patients	Number of HIV patients	Number of TB-HIV Patients
1	0	100	0
2	1	250	0
3	0	250	0
4	0	12	0
5	0	300	0
6	0	1000	0
7	0	32	0
8	50	200 (+50 pre-HAART)	Data not provided
9	0	48; 2 on 2 nd line	0
10	Data not provided	Data not provided	Data not provided
11	0	250	0
12	0	13 (+5 pre-HAART)	0
13	2	42	2 TB-HIV
14	Data not provided	Data not provided	Data not provided
15	Data not provided	60	5

- There were about 8000 patients on ART in the public sector at Oshakati State Hospital, the referral hospital for the northern regions. The Oshakati ART clinic caters mainly for Oshana region. The number of patients on chronic HIV care in the public sector in Oshakati, including those on pre-ART care was about 15 000 at the time of the assessment.
- The same mapping exercise could not be done in Windhoek as it was noted that doctors become cooperative after having attended the training sessions. Three trainings were therefore carried out in Windhoek on TB, TB-HIV and MDR-TB. One primarily targeted nurses and 2 other trainings targeted doctors and pharmacists.
- **Engagement of private medical aid societies** was initiated during the pilot implementation. Medscheme has been engaged and has assisted in getting doctors to attend the two trainings in Windhoek; a third meeting is planned in Walvis bay/Swakopmund towns. The medical aid societies under Medscheme have shown willingness to classify TB as a special program; this will entail working with the NTCP to develop acceptable standards of care and ensuring that once treatment is started the patient will be seen right through to the end. Setting up the program is involving and will take some time to be functional. The

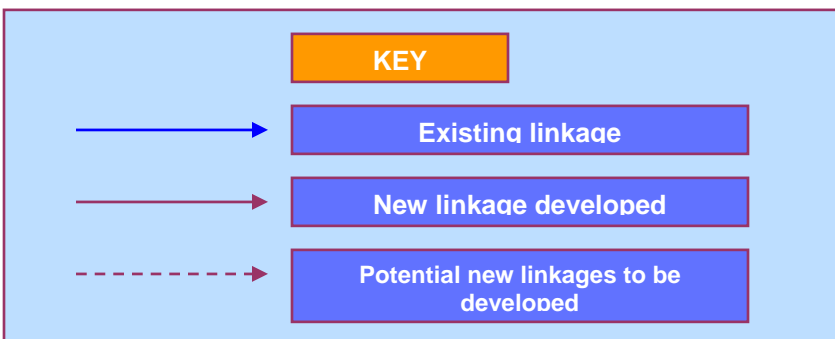
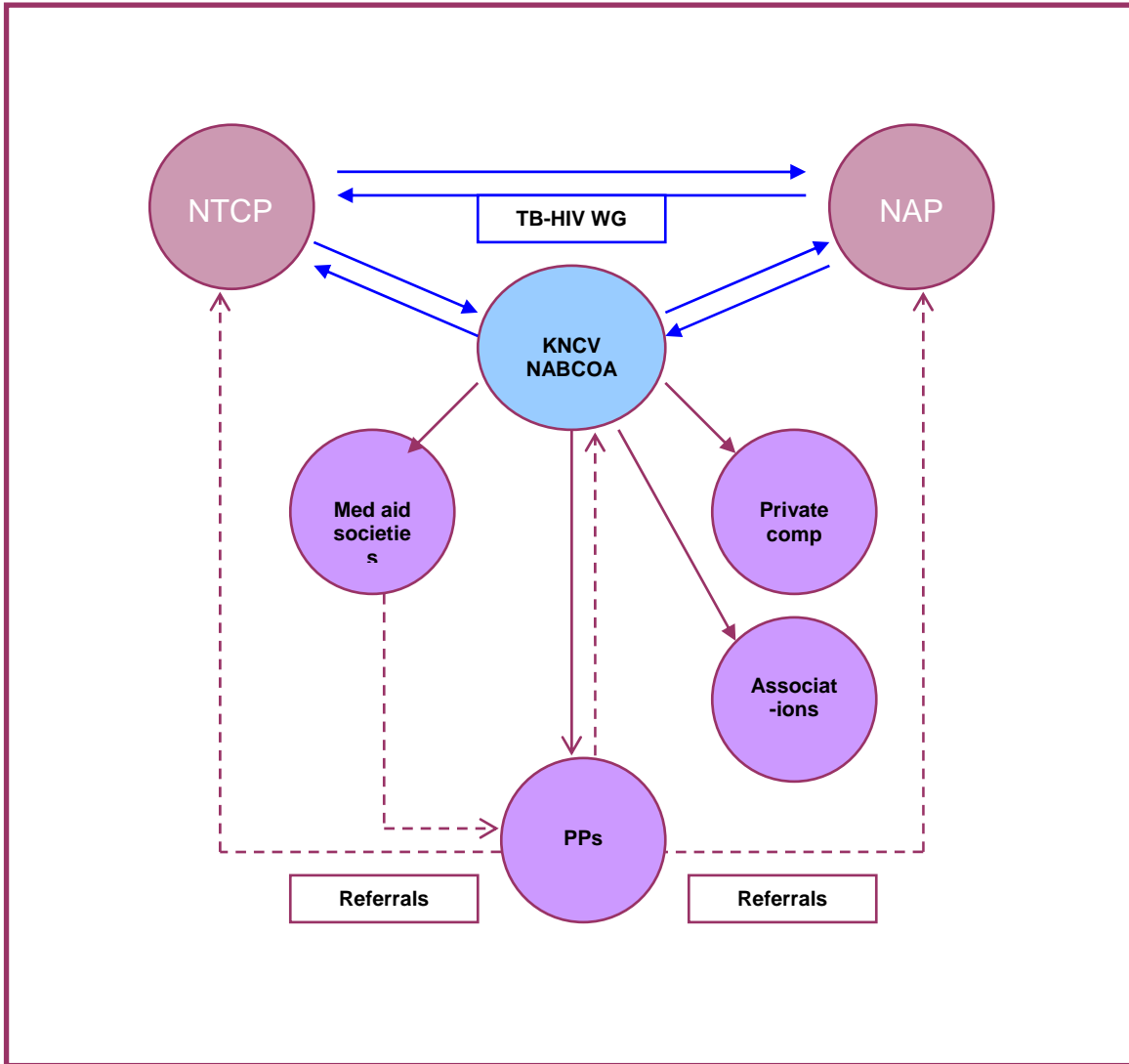
NTCP has begun discussions with other medical aid societies to follow suit. HIV care standardization between private and public sector has begun with Medscheme and My Health managing HIV care for the private Medical Aid Societies in Namibia except the government medical Aid. The scheme involve standardization of diagnostic practices, defining criteria for initiating therapy, standardizing regimens in line with international and national regimens for first line, second line and third line therapy. Patients on these medical aid societies can only get ARVs when the medical aid authorizes the prescription. The prescription can only be authorized if the standards set are met; the prescribing doctor will have provided the rationale for initiating therapy and supporting evidence that is reviewed by nurses and doctors employed by medical aid to run the HIV programs.

- **Developing referral mechanisms:** Although the issue has been discussed at the trainings; the practical aspects are still to be finalized. The general agreement is that the *trainings provide a platform for standardization of care*, especially with ART care. If patients in private care are managed by the same regimens as in the public sector, referral of such patients to the public sector (for one reason or the other) will not present challenges. For example, current world economic recession has affected the Namibian mining sector and has seen a number of businesses associated with the industry closing down; this has resulted in large numbers of patients who were on ARVs under medical aid being retrenched and being forced to be managed in the public sector.

Most private practitioners do not manage TB and only refer to the public sector. Some have expressed frustrations when they refer patients for TB care to the private sector since their patients are not attended to timely; and sometimes the patients are given conflicting messages by the health care workers. The NTCP has undertaken to spearhead the development of SOPs for use by the private sector when referring TB patients to the state sector. The NTCP with TBCAP support will develop and print a pamphlet on the role of the private practitioners in managing TB in Namibia; including the referral mechanism. The public sector will from 2010 record patients who have been referred from the private sector so that the country can quantify the contribution of the private sector in TB diagnosis.

Engaging associations: HIV clinicians association, pharmacy association and the medical associations are useful partners in disseminating information to their constituent members especially when it comes to announcing planned meetings and capacity building initiatives. Formalizing MoUs with the associations for PPM was considered to be ineffective as membership to these organisations is voluntary and associations had no legal mandate to enforce their agreements with organisations on to their members.

Figure 4: Role of stakeholders in Namibia project



Discussion

The studies in Mumbai and Namibia reveal that involvement of all stakeholders including public structures (NTP/NAP), non-governmental organizations; community based organizations, private practitioners, medical aid societies are imperative to initiate implementation of collaborative TB-HIV activities.

Mumbai experience

Participation of all stakeholders including district health functionaries (MDACS and MDTCS), nongovernmental organizations, community based organizations and a private practitioner was crucial to begin PPM TB-HIV activities in target population. InterAide as a technical assistance and nodal agency for pilot implementation facilitated public-private mix (NGO-NGO, NGO-PPs and NGO-Public) for TB-HIV activities.

Involving NGO's in collaborative TB-HIV activities in M/E ward demonstrated an improvement in access to HIV testing among TB patients. NGO referrals to ICTC during the implementation period have increased from 7% to 36%. The increase in referrals for HIV testing during Q 1 2009 (15 fold) and Q 2 2009 (8 fold) and a corresponding increase in co-infected patients put on CPT (24 patients) and ART (6 patients) was apparent during the pilot period. This increase in referrals may be attributable among many factors, to pilot activities involving NGO's to actively counsel and refer TB patients among target population for HIV testing. Other significant factor that may have contributed to this increase may be concomitant adoption and implementation of the 'routine referral' policy by RNTCP that makes it essential for all TB patients in high HIV prevalent settings (includes Mumbai) to be offered HIV testing.

Involving HIV NGO's to enhance access to TB diagnosis among PLHWA both in M/E ward and Kamathipura did not see a perceptible improvement during the pilot period. Social mobilization activities including IEC activities were the main focus to improve awareness among high-risk groups during the pilot implementation. A longer time frame may well be required to study the impact of these interventions.

Initial outcome analysis involving private practitioners reveal their interest to be involved in collaborative activities. While the implementation revealed few referrals from PPs to ICTC, again a short implementation period made it difficult to evaluate the impact of collaborative activities involving PPs.

It may be highlighted that coordination challenges to bring both TB and HIV stakeholders on to a common platform was observed, these may be possibly addressed with persistent advocacy targeting all stakeholders. Other challenges related to the pilot were setting up data management; and formalizing MoUs with HIV NGO's given their reluctance as pilot was conceived as a lost-cost initiative by HIV NGOs.

Planning stage of the pilot involved sensitizing local NGOs to seek their involvement in implementing TB-HIV collaborative activities. The Mumbai experience reveals that the key drivers involved in implementing pilot activities were the community based NGO's. Advocacy and improving awareness levels of private (NGOs) facilitated the involvement of NGOs and PPs in TB-HIV activities.

The fact that nodal agency, TB NGOs and PPs were already involved in PPM-DOTS over the last few years facilitated introduction and implementation of PPM-TB-HIV activities in the target population. Implementation facilitated building operational linkages between private – private (TB NGOs such as LSS with HIV NGOs in M/E ward); public – private (NGOs with DMC's/ICTC).

Namibian experience

Early experiences introducing PPM-TB-HIV reveal that public sector has to take leadership and drive engagement of private sector. Pilot implementation in Namibia highlights the willingness of private sector to engage with the public sector in managing TB-HIV collaborative activities. Private sector providers for both TB and HIV are keen to participate in TB-HIV training and capacity building initiatives led by public sector (NTP/NAP).

NGO led initiatives to involve private sector companies and introduce work place interventions aimed at promoting and strengthening their response for TB and HIV. This initiative revealed that private sector companies were willing partners for work place interventions aimed to prevent and mitigate TB and HIV.

Engaging associations such as HIV clinicians association, pharmacy association and the medical associations was feasible and this has a potential role in disseminating TB-HIV information to their constituent members. Engaging medical aid societies through a structured dialogue allows them to work with both public and private sector so as to harmonize and standardize TB-HIV care in target population.

Recording and reporting of TB and HIV data presents a real challenge as the private care providers are many, and fragmented. Most patients visit multiple private practitioners and their compliance to treatment under one practitioner is perceivably in question. The study notes that activities constituting PPM for TB-HIV are in place, although not structured and will need documentation for sharing.

Conclusion

Quantitative evidence from Mumbai and qualitative evidence from Namibian studies reveal that there are opportunities for the Public and Private sectors to be engaged in different modalities depending on the country contexts for furthering TB-HIV collaborative activities.

There is a clear recognition that public sector leads implementation of TB-HIV collaborative activities, but may not carry the burden of HIV and TB alone, and needs to tap in services of private sector where available. Advocacy and actively seeking involvement of private sector providers will encourage their involvement to implement TB-HIV activities in alignment with national guidelines.

There is increasing recognition by both sectors that PPM collaboration is a public good that will ultimately benefit society. In countries where sizeable medical insurance schemes exists as is the case in Namibia; these can collaborate with public institutions to harmonize management of TB and HIV across all sectors; recognizing that public programs are in line with international best practices for both TB and HIV care. Introducing PPM-TB-HIV services may be effective in contexts where PPM-DOTS already exists as reflected in the Mumbai experience.

The protocol developed by WHO was found to be useful in all stages of planning, implementation and monitoring/evaluation of the pilots. The protocol guided in defining the essential packages and modality of delivery of collaborative TB-HIV activities. However, it may be noted that concrete and critical evidence base in terms of quantifiable impact on improved case notifications and treatment outcomes is only possible with a much longer timeframe of implementation.

The 2 pilots only add credence to the growing evidence that collaborations between public and private providers hold considerable potential to advance TB-HIV collaborative activities. It is expected that the data from these pilots will contribute to a wider body of evidence that will assist WHO to develop final guidelines. Adequate resources will be required to engage private sector and it is essential to evaluate activities over a prolonged period of time to examine cost-effectiveness of such interventions.

Limitations

- One year timeframe including pre and post pilot workshops under TBCAP APA 3 offered an 8-9 month pilot implementation period. This short duration of pilot implementation only provided early insights on feasibility of involving private sector in collaborative TB-HIV activities. However a longer duration of implementation to study the impact of the involvement of private sector may be essential.
- It may also be noted that the two pilot studies provides only early experiences involving private sector in the context of India and Namibia.

Generalizability

- Since the international community generally agrees on the best practices for TB and HIV; it is increasingly getting apparent that care in the public sector and private sector needs to be standardized. This necessitates for wider engagement of public as well as private providers for the good of common denominator; the patient being served. The initial experiences from the two sites, although diverse may not necessarily be representative of all PPM experiences worldwide. There are countries where the private sector or public sectors are not defined the same way as the two pilot areas therefore making it intricate to generalize the experiences of the two sites.
- The two sites show that under completely different circumstances; where the definitions of private and public are different; PPM-TB-HIV activities are feasible as long as all stakeholders are involved and public sector drives the engagement.
- PPM does not need to be an expensive undertaking; it may be merely bringing stakeholders already on ground to collaborate and implement TB-HIV collaborative activities.

Policy implications

- Public health players to consider the role of the private sector in their planning and implementation of TB-HIV programs in a contextual setting where there is an active private sector.
- Protocol for TB-HIV-PPM is a useful tool to plan, define essential packages and modalities for delivery of TB-HIV activities involving all providers.

References

1. TB India 2009 – RNTCP Status Report
2. India report: HIV Sentinel Surveillance 2007
3. Namibia Demography and Health Survey (DHS) 2006/7
4. Namibia NTLCP annual report; 2009/2008

Annexes

Protocol applicability – Mumbai

Planning stage	
	Pilot findings
<ul style="list-style-type: none"> ▪ 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. 	<p>Inter Aide is working at the field level directly with the beneficiaries of the national programmes and cannot influence the functioning of the District level TB-HIV coordination committee. However, the intervention was presented to and permission to implement it was received from the District level authorities of both the programmes.</p>
<ul style="list-style-type: none"> ▪ Add PPM TB-HIV activities to the terms of reference of the national or local TB-HIV coordinating bodies. 	<ul style="list-style-type: none"> ▪ Same as above
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Mentioned in the report on Pg 5 and 6.
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Situational analysis done at local level. Objectives and activities of the pilot based on that.
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Not done
<ul style="list-style-type: none"> ▪ Assess current and potential future role of the national health insurance scheme, if applicable and define their implication for PPM TB-HIV activities. 	<ul style="list-style-type: none"> ▪ Not applicable in Mumbai
<ul style="list-style-type: none"> ▪ Address incentives and enablers for the full engagement of the providers, in accordance to national and local context and existing norms. 	<ul style="list-style-type: none"> ▪ Incentives to HIV-NGOs planned according to existing RNTCP guidelines ▪ Incentives to TB NGOs planned

	for their outreach workers for the additional workload due to the add-on activities
<ul style="list-style-type: none"> Define drug regimens in accordance to the national policy and ensure an effective supply management system in the local context. 	<ul style="list-style-type: none"> Already existing
<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Proposal developed after initial workshop in New Delhi.
<ul style="list-style-type: none"> Determine process and outcome indicators to be monitored in accordance to the monitoring and evaluation guidance (see below) 	<ul style="list-style-type: none"> Done as a part of the proposal
<ul style="list-style-type: none"> Identify and justify selection of initial implementation and expansion sites and categories of providers based on the implementation model. 	<ul style="list-style-type: none"> Done during proposal preparation
<ul style="list-style-type: none"> Involve relevant agencies in advocating for political and financial commitment including from the national government. 	<ul style="list-style-type: none"> MDACS and MDTCS involved
<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> The local responsible authorities and workers from RNTCP and NACP involved. Local partners including existing TB NGO partners and new HIV NGO partners trained. Documentation processes established
Preparation stage	
<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Done individually with all stakeholders involved

<ul style="list-style-type: none"> Identify national and local resources to create or build capacity to manage and supervise PPM TB-HIV activities. 	<ul style="list-style-type: none"> National TB-HIV training module used to suit short trainings Supervision from lead implementing agency – LSS
<ul style="list-style-type: none"> Prepare generic local implementation tools for each of the activities defined in the package of the implementation model depending on national and local contexts. 	<ul style="list-style-type: none"> Brochure, Pamphlet, referral pads Not done at the beginning of the project but during the course of the project based on the experience gained
<ul style="list-style-type: none"> Develop training materials for target provider group(s) based on existing guidelines in accordance to national policy and programme guidance. 	<ul style="list-style-type: none"> Existing training module used as basis for trainings
<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> First trainings to sensitize about the programmes.... then about the new responsibilities
<ul style="list-style-type: none"> Establish effective referral mechanisms between different HIV and TB service delivery sites and means of ensuring that the referrals are practiced 	<ul style="list-style-type: none"> Done after discussions with all the stakeholders involved
<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Incentives planned were not acceptable to the involved stakeholders and they were willing to participate without the incentives
<ul style="list-style-type: none"> 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 behaviors that impair the utilization of these services. 	<ul style="list-style-type: none"> Awareness activities for target groups planned GPI for HIV referrals
<ul style="list-style-type: none"> 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 formalize the collaboration. Generic letter of Agreement can be developed for individual service providers. 	<ul style="list-style-type: none"> Format for MoU prepared and presented to the stakeholders but they were not willing to sign MoU. The pilot project worked on an informal relationship between all stakeholders
<ul style="list-style-type: none"> Develop accreditation and certification mechanisms for providers engaged in PPM TB-HIV activities as a means of incentive or quality ensuring mechanism. 	<ul style="list-style-type: none"> Existing in the national programmes
<ul style="list-style-type: none"> Ensure key services needed for PPM TB-HIV activities are in place or a referral mechanism exist to access them. This 	<ul style="list-style-type: none"> Ensured

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)	
Local implementation	
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Coordination done at individual control societies
<ul style="list-style-type: none"> ▪ Undertake physical mapping and sensitization of providers (with use of communication tools), and if applicable donors, partners and patient groups to mobilize them for PPM TB-HIV activities. 	<ul style="list-style-type: none"> ▪ Done
<ul style="list-style-type: none"> ▪ Define role and responsibilities of target providers depending on local context. This will include, if applicable, the localization of the task mix that is developed during the preparation stage. 	<ul style="list-style-type: none"> ▪ Task mix used. ▪ Details of task mix in report on Pg. 13-15
<ul style="list-style-type: none"> ▪ Enhance networking and sharing of experiences among the engaged service providers and ensure their knowledge is up the level and up to date. 	<ul style="list-style-type: none"> ▪ Individual contacts with service providers ▪ Common meeting at the end of project to share experiences
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Done
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Meeting for PPs ▪ One-to-one contact with PPs and TB-HIV brochure
<ul style="list-style-type: none"> ▪ Provide accreditation and certificates for involved providers. 	<ul style="list-style-type: none"> ▪ Not done
<ul style="list-style-type: none"> ▪ Ensure contractual agreement either through memorandum of understanding with institutions or letter of agreement with individual providers. 	<ul style="list-style-type: none"> ▪ Not accepted by the partners as that would formalize the relation and bring in issues of accountability. This was not acceptable in the absence of "project funding"
<ul style="list-style-type: none"> ▪ Promote the work of the involved providers through local advocacy and communication 	<ul style="list-style-type: none"> ▪ Awareness activities among the target population to inform about

means.	the services available through the project	
<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Supervisory staff introduced in LSS Intermittent supervision from Inter Aide 	
<ul style="list-style-type: none"> 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. 		
<ul style="list-style-type: none"> Ensure sustainable system of commodities supply and management at the local level. 	<ul style="list-style-type: none"> Done by the national programme 	
Monitoring and Evaluation- indicators		
Planning	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 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

Protocol applicability- Namibia

Planning stage	
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ This was applicable to Namibia. In fact as a result of this pilot; the TB-HIV working group which had been dormant was activated and started regularly. The need to include stakeholders from outside the public sector was realized and they have been invited to be part of the group.
<ul style="list-style-type: none"> ▪ Add PPM TB-HIV activities to the terms of reference of the national or local TB-HIV coordinating bodies. 	<ul style="list-style-type: none"> ▪ Applicable; The TORs of the TB-HIV were revisited and PPM added
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Both; this could entail a self assessment by the NTCP which was driving the PPM agenda. One could say the NTCP realized that preparedness was low due to the dormancy of the TB-HIV working group and by reviving this group; TB-HIV activities could be rejuvenated and with them PPM activities.
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Applicable, but because we did not apply in full we ended up with the kind of short comings that we experienced. A lot of activities have been happening which are PPM but are not stated as such; e.g. work place DOT takes place in a number of facilities country wide; this is a well defined intervention in the National Guideline and it is taught to doctors, nurses and pharmacists in the National TB guideline trainings. Some health workers then apply this in their every day work but the NTCP does not ask them to report on it. The NTCP does not have a policy on what the private practitioner should or should not do and as a result sometimes find it hard to answer private practitioner's questions when they ask on what the NTCP expects of them; different PPs are in different situations and one answer does not suit all of them.

<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Applicable but not carried out. Although Namibia has a well defined epidemiological situation of TB, TB-HIV and HIV, the NTCP did not carry out a KAP study on health seeking behaviors. The information used in the pilot is anecdotal.
<ul style="list-style-type: none"> ▪ Assess current and potential future role of the national health insurance scheme, if applicable and define their implication for PPM TB-HIV activities. 	<ul style="list-style-type: none"> ▪ Applicable and done. This is an exciting part of the Namibian PPM. It is hoped that the medical insurance companies will be the gate keepers to prevent non standardized prescriptions and malpractices in TB and TB-HIV care.
<ul style="list-style-type: none"> ▪ Address incentives and enablers for the full engagement of the providers, in accordance to national and local context and existing norms. 	<ul style="list-style-type: none"> ▪ Not applicable.
<ul style="list-style-type: none"> ▪ Define drug regimens in accordance to the national policy and ensure an effective supply management system in the local context. 	<ul style="list-style-type: none"> ▪ Applicable and applied.
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Applicable though it was not well defined for the Namibia project. A lot of initial ideas were/are changed as dictated by the practicalities on the ground. M&E is not as straight forward in the private sector as it might be in the public sector. Namibia still grapples with how the M&E for TB-HIV should be developed; but will most probably lean on medical insurance providers to get reports on numbers being started on treatment and numbers completing treatment.
<ul style="list-style-type: none"> ▪ Determine process and outcome indicators to be monitored in accordance to the monitoring and evaluation guidance (see below) 	<ul style="list-style-type: none"> ▪ Applicable for process indicators; the outcome indicators as stated above have not been thought through. The public sector is already performing very well and the inclusion of private sector data may in the initial stages result in lowering of the good outcome indicators up to the point that the private sector will improve and have favourable outcomes for

	patients under their care.
<ul style="list-style-type: none"> ▪ Identify and justify selection of initial implementation and expansion sites and categories of providers based on the implementation model. 	<ul style="list-style-type: none"> ▪ Applicable:
<ul style="list-style-type: none"> ▪ Involve relevant agencies in advocating for political and financial commitment including from the national government. 	<ul style="list-style-type: none"> ▪ Applicable:
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Applicable
Preparation stage	
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Applicable:
<ul style="list-style-type: none"> ▪ Identify national and local resources to create or build capacity to manage and supervise PPM TB-HIV activities. 	<ul style="list-style-type: none"> ▪ Applicable.
<ul style="list-style-type: none"> ▪ Prepare generic local implementation tools for each of the activities defined in the package of the implementation model depending on national and local contexts. 	<ul style="list-style-type: none"> ▪ Not applicable
<ul style="list-style-type: none"> ▪ Develop training materials for target provider group(s) based on existing guidelines in accordance to national policy and programme guidance. 	<ul style="list-style-type: none"> ▪ Applicable
<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ Applicable but not carried out.
<ul style="list-style-type: none"> ▪ Establish effective referral mechanisms between different HIV and TB service delivery sites and means of ensuring that the referrals are practiced 	<ul style="list-style-type: none"> ▪ Applicable and already in existence as part of normal care with the public health care settings.
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Applicable: the incentive used was free CPD points for practitioners and maybe free dinner

<ul style="list-style-type: none"> ▪ 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 behaviors that impair the utilization of these services. 	<ul style="list-style-type: none"> ▪ Applicable but not used in Namibia. Maybe because we did not have baseline information on health seeking behaviors in the first place.
<ul style="list-style-type: none"> ▪ 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 formalize the collaboration. Generic letter of Agreement can be developed for individual service providers. 	<ul style="list-style-type: none"> ▪ Not applicable: The NTCP and the NACOP are in the same directorate and do not need MoUs to collaborate; they are expected to work as one unit since they are in the same directorate. The MoUs between MOHSS and Health associations will probably not bind members and so are not applicable to the Namibia context; working with associations does help in getting messages to the constituent members. ▪ An MOU was however signed with NABCOA as it was receiving funding to do TB-HIV in the work place.
<ul style="list-style-type: none"> ▪ Develop accreditation and certification mechanisms for providers engaged in PPM TB-HIV activities as a means of incentive or quality ensuring mechanism. 	<ul style="list-style-type: none"> ▪ Not applicable
<ul style="list-style-type: none"> ▪ 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) 	<ul style="list-style-type: none"> ▪ Applicable: Namibia took up the PPM
<p>Local implementation</p>	
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Applicable. In fact the national TB-HIV working group is the driving force for the PPM activities.
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Applicable.
<ul style="list-style-type: none"> ▪ Define role and responsibilities of target providers depending on local context. This 	<ul style="list-style-type: none"> ▪ Applicable though what is planned in the tax mix may not

will include, if applicable, the localization of the task mix that is developed during the preparation stage.	necessarily be practical. The planners need not be dogmatic about their plans and probably have to adapt to the situation.
<ul style="list-style-type: none"> ▪ Enhance networking and sharing of experiences among the engaged service providers and ensure their knowledge is up the level and up to date. 	<ul style="list-style-type: none"> ▪ Applicable: This is probably the greatest activity for the Namibia PPM
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Yes and No. Orientation was applicable and so was training; the training was not task based though.
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ In deciding how and when to train private practitioners in Namibia a lot of consultation took place; the day of the week the time and duration of the trainings are all critical if the training is to be successful in getting the target audience. The timing and place were all different for the different places where the trainings took place.
<ul style="list-style-type: none"> ▪ Provide accreditation and certificates for involved providers. 	<ul style="list-style-type: none"> ▪ Not applicable;
<ul style="list-style-type: none"> ▪ Ensure contractual agreement either through memorandum of understanding with institutions or letter of agreement with individual providers. 	<ul style="list-style-type: none"> ▪ Not applicable as discussed above.
<ul style="list-style-type: none"> ▪ Promote the work of the involved providers through local advocacy and communication means. 	<ul style="list-style-type: none"> ▪ Not applicable
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Not applicable
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Not applicable
<ul style="list-style-type: none"> ▪ Ensure sustainable system of commodities supply and management at the local level. 	<ul style="list-style-type: none"> ▪ Not applicable

Monitoring and Evaluation- indicators		
Planning	Appointed PPM TB-HIV focal point	Yes
	Situation analysis done	Yes
Preparation	Mapping of providers done	Yes
Local implementation	Partial	