

The image features a decorative graphic consisting of three blue circles of varying sizes, each with a lighter blue ring around its center. These circles are arranged in a diagonal line from the top right towards the bottom right. Two thin, light blue lines intersect at the top left and extend diagonally across the page, framing the central text and the circles. The text is positioned in the lower-left quadrant of the page.

**Scaling up PPM: lessons from
design and implementation
of the Global Fund TB grants**



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Abbreviations

ACSM	Advocacy Communication and Social Mobilization
AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral (drug)
ATS	American Thoracic Society
BRAC	Bangladesh Rural Advancement Committee
CCM	Country Coordination Mechanism
DEWG	DOTS Expansion Working Group
DOT	Directly observed treatment
DOTS	The internationally recommended strategy for TB control
GDF	Global Drug Facility
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBCs	High TB-burden countries
HIV	Human immunodeficiency virus
ILO	International Labour Organization
KNCV	The Royal Netherlands Tuberculosis Foundation
MDG	Millennium Development Goal
MDR-TB	Multidrug-resistant tuberculosis
MoU	Memorandum of understanding
NAP	National AIDS Programme
NGO	Nongovernmental organization
NSA	National Situation Assessment
NTP	National TB programme
PPM	Public–private mix
TB	Tuberculosis
TBCAP	Tuberculosis Control Assistance Programme
TB-IC	Tuberculosis Infection Control
WHO	World Health Organization
XDR-TB	Extensively drug-resistant tuberculosis

1. Introduction

1.1 Background

Engaging all care providers is a key component of WHO's Stop Tuberculosis (TB) Strategy. Several countries are now implementing this component using various tools and strategies developed for the purpose, including WHO's guidance document and toolkit on how to engage all care providers in TB control using Public-Private Mix (PPM) approaches. These approaches consist of initiatives that aim at increasing systematic, coordinated collaborations between public-public, public-private and private-private health care providers and involve a clear distribution of tasks between the different providers to achieve improved case detection and treatment success for the national TB programme.

The Global Fund to Fight AIDS, Tuberculosis, and Malaria (The Global Fund) – a major source of funding for NTPs – is a public–private partnership. It provides around 63% of all international financing for TB control globally¹; which between 2002 and 2009 amounted to US\$ 3.2 billion of approved funds. It encourages the creation and expansion of government/private/NGO partnerships by the grant recipients at the program implementation level. The Global Fund fosters a model where government and other parts of society together take responsibility for the planning, coordination and implementation of health programs. At country level, the Country Coordinating Mechanism (CCM) facilitates development of proposals and strategies as the result of a close partnership between governments, civil society, the private sector and affected communities. The Global Fund has been supporting PPM by providing assistance to TB grants that have PPM as a component.

To date, the Global Fund has supported numerous PPM projects from the beginning of the grant disbursement process in 2003. As of January 2009, 51% of TB grants in approximately 40 countries have a PPM component and 9% of the principal recipients' budget overall has been allocated to PPM activities. However, although PPM activities have received a significant portion of Global Fund support, there has been no systematic review of the successes and failures of these activities and the lessons learned have not been consolidated.

1.2 Project purpose

The aim of this project is to undertake a detailed analysis of and draw lessons from Global Fund PPM projects, focusing particularly on scaled-up programmes. This analysis will benefit not only the countries scaling-up or planning to scale-up PPM for TB care and control but also the technical and financial partners who advise and support countries in PPM scale-up.

The analysis will also focus on documenting utilization of available tools as well as the extent and ways of using the ISTC and the roles of national professional associations. The discussion paper will also help countries strengthen their PPM components while applying for Global Fund support.

1.3 Structure

This document is divided into four sections

Section 1 provides the background and rationale for the project

Section 2 discusses the methodology and activities undertaken by WHO, ATS and the Global Fund to implement the project.

Section 3 describes the results and outcomes of the review and site visits undertaken by WHO and partners.

Section 4 presents the conclusion.

The appendices include profiles of counties reviewed, outlining PPM activities in their Global Fund grants along with a short analysis, and the template used for the desk review.

2. Project methodology

The project was undertaken jointly by WHO, ATS and the Global Fund. The Global Fund team facilitated the initiation and implementation of the project by providing the team with technical and financial information on the TB proposals that have PPM components.

2.1 Activities

The project comprised of the following activities:

1. Review and analysis of Global Fund information

As a first step, the team reviewed and analyzed information on the evolution of support to PPM for TB care and control in Global Fund-supported TB grants as reflected in its official documents and mapped the distribution and characteristics of PPM initiatives within the Global Fund-supported programs. The financial details of these projects were also analysed.

2. Desk review

A consultant was then identified and recruited to undertake a desk review. The consultant first developed a template for the reviews with inputs from the team. Please find a copy of the template in Appendix 2. Using information from the Global Fund, countries were identified for the desk review based on the amount of funding received from the Global Fund for PPM activities (countries with highest amounts of funding for PPM). An in-depth analysis of the selected country grant proposals was then undertaken jointly by ATS and WHO. An overview and analysis of grant proposals by country is presented in the appendix.

3. Site visits

Site visits were undertaken to two countries- Ghana and India, to document the Global Fund supported PPM programs that are functioning on the ground and to highlight the lessons learned. The visit to Ghana was undertaken jointly by ATS and WHO, while the visit to India was undertaken jointly by WHO and the Global Fund.

4. Presentation at the sixth PPM Subgroup Meeting

An overview of the extent and scope of Global Fund support to PPM in national TB grants was presented and extensively discussed at the sixth PPM Subgroup meeting in Istanbul, Turkey in February, 2010. The presentation included data on the mapping of grants undertaken jointly by WHO and the Global Fund.

5. Report

A report was developed including evidence and experiences from the analysis of Global Fund information, the desk review and site visits. Based on the analysis undertaken in this project, a tool on Resource mobilization was drafted and included in the TBCAP-supported

PPM toolkit. A special case study on PPM in Global Fund grants was highlighted in a text box in this tool.

6. Feedback to the Global Fund

A paper was developed on PPM in Global Fund grants by WHO and the Global Fund. The paper was published in the Tropical Medicine and International Health journalⁱⁱ. This was followed by a technical seminar where the results of the paper were presented to staff from the Global Fund and extensively discussed.

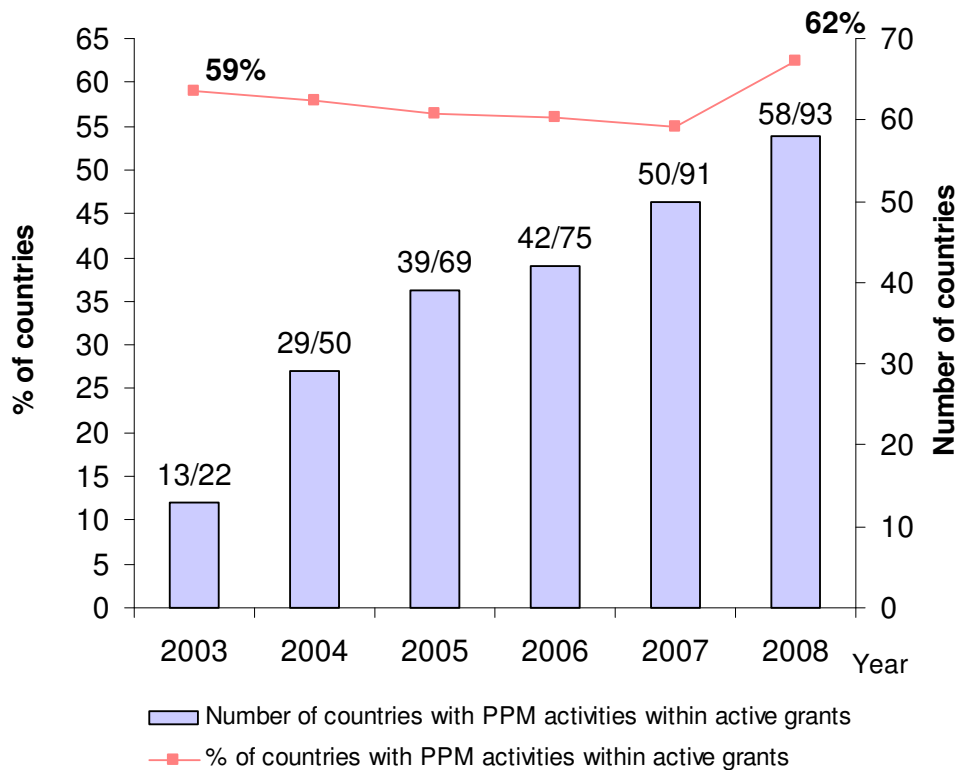
3. Results and outcomes

3.1 Analysis of Global Fund information

Distribution and characteristics of PPM initiatives

The number of countries with PPM activities within the active TB grants supported by the Global Fund increased from 13 in 2003, the first year of Global Fund disbursement for TB, to 58 in 2008. Figure 1 shows the incremental numbers of proposals with PPM components.

Figure 1: Proportion and number of countries which received Global Fund support for PPM activities, by year



N=Number of countries with active TB grants that include PPM component; D=Number of countries with active TB grants

Figure 2: Number of countries with Global Fund support for PPM activities (proportion of the total number of active TB grants), by region and by year

The proportion of Global Fund grants with PPM activities was highest in Southeast Asia (82%) and lowest in Sub-Saharan Africa (52%) (Figure 2)

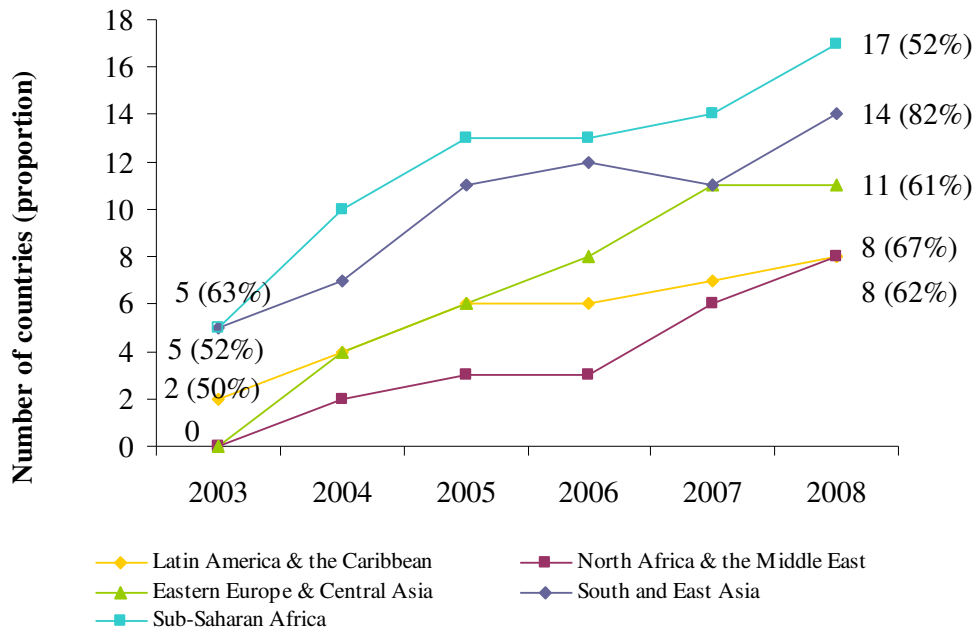
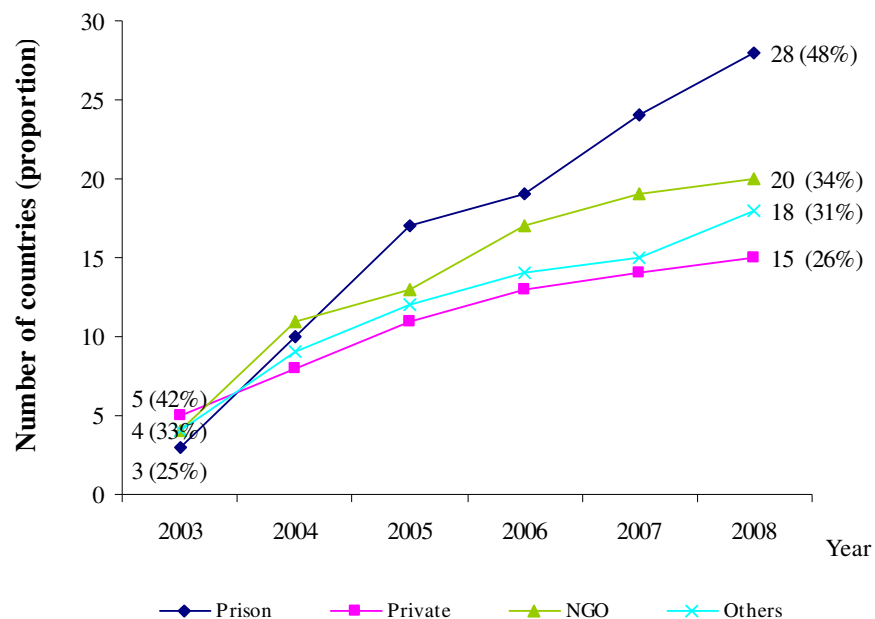


Figure 3 shows the types of care providers engaged in PPM. Between 2003 and 2008, while collaborations with NGOs and the for-profit private sector also increased, there was a sharp rise in NTPs engaging prison health services, predominantly in countries of Eastern Europe (Figure 3).

Figure 3: Number of countries with Global Fund support for PPM activities (proportion of the total number of countries with Global Fund support for PPM activities), by implementer type and year



Care providers involved in PPM varied by region (Table 1). Collaboration with the for-profit private sector was greater in South Asia and East Africa while that with NGOs was common in North Africa and Middle East as well as South Asia. Linkages with prison health services were present in other regions including Eastern Europe and Central Asia, Latin America and the Caribbean as well as West and Central Africa.

Table 1: Distribution of PPM implementers within countries with Global Fund support for PPM as of end 2008, by region.

Region (N)	% of countries with Global Fund-supported PPM:				
	NGOs	Prisons	Private sector	Other	Not specified
East Asia & the Pacific (8)	38	38	25	38	0
Eastern Europe & Central Asia (11)	36	91	18	27	9
Latin America & the Caribbean (8)	25	63	0	50	0

North Africa & the Middle East (8)	63	25	38	25	13
South Asia (6)	50	17	67	17	50
East Africa (5)	0	40	40	0	20
Southern Africa (4)	25	0	0	50	50
West & Central Africa (8)	25	63	25	38	13
All regions (58)	34	48	26	31	16

N=Number of countries with Global Fund support for PPM activities, per region; Green cells – the regions with the highest proportion of countries with the specific PPM implementer

Finances allocated to PPM activities in TB Grants supported by the Global Fund

Analysis of budget and expenditure data showed that by 2008, US\$ 38.3 million (4.4%) of TB funding in the budgets of Global Fund-supported grants, was allocated to PPM (

Table 2). The expenditure for PPM activities as a proportion of total expenditure in TB grants amounted to 5.4%, higher than that initially budgeted; 99% of the funding budgeted for PPM activities was utilized, compared to 80% for the TB budget for all activities.

Table 2: Budgets and expenditures on PPM and ISTC (International Standards for TB Care), by region

Region	Budget (US\$, 000s)	% of regional TB budget allocated to PPM activities	Expenditure (US\$ 000s)	% of regional TB expenditure allocated to PPM activities
East Africa	388	0.4	366	0.4
East Asia & the Pacific	25,684	10.4	26,200	12.8
Eastern Europe & Central Asia	3,295	1.9	3,737	2.7
Latin America & the Caribbean	332	0.4	443	0.6
Northern Africa & the	336	0.4	165	0.3

Middle East				
South & West Asia	2,343	4.0	1,683	3.7
Southern Africa	1,338	2.0	1,194	2.8
West & Central Africa	4,598	6.9	3,988	6.8
Entire portfolio	38,314	4.4	37,776	5.4

The median amount budgeted in Global Fund grants for PPM activities was 5% of total. However, this amount ranged from 0.03% to 69% of total, with Kyrgyzstan and Swaziland allocating over 50% of their funding to PPM. In most proposals this does not include cost of drugs and other consumables for the diagnosis and treatment of TB in the targeted health facilities, which falls under other budget headings.

For PPM activities, the investments in China, Indonesia and Ghana were \$US 18.8 million, \$US6.1 million and \$US3.5 million respectively. The top two regions with highest share of their budget allocated to PPM were East Asia and the Pacific and, West & Central Africa (10.4% [US\$ 25.7 million] and 6.9% [US\$ 4.6 million] respectively). While the share of the TB budget allocated to PPM in Eastern Europe & Central Asia, and Latin America & the Caribbean, is lower compared to other regions, both regions have many grants for collaboration with prison health services, which are not always reported as a part of PPM.

The expenditure data is based on budget-line that relates to PPM and ISTC yet excludes some grants which did not report on their expenditure.

3.2 Desk review

The following countries were selected for desk review, based on information provided by the Global Fund on level of highest PPM funding in TB grant proposals.

African Region: Ghana, Swaziland

Americas' Region: Dominican Republic

Eastern-Mediterranean Region: Pakistan, Afghanistan

Europe Region: Kyrgyzstan, Romania

South-East Asia Region: India, Nepal, Thailand

Western Pacific: China, The Philippines

An overview and analysis of PPM in Global Fund grants by country is presented in Appendix 1.

A few of the main findings from the desk review are highlighted below:

- The PPM activities in the grants covered the engagement of diverse care providers, based on the country context. Some countries targeted different care providers in each proposal/grant.
- PPM activities in all countries generally revolved around training initiatives for private providers.
- The indicators to monitor the impact of PPM in these grants and to measure the contribution of providers were very weak.

3.3 Site visits

Country visits were organized to two countries Ghana and India. The purpose of the site visits were to:

- Study the implementation of PPM components of approved Global Fund grants
- Draw lessons for future activities related to Global Fund supported PPM components and PPM scale up.

Ghana

The visit to Ghana was undertaken jointly by ATS and WHO in June 2010. Ghana has been among the first countries in Africa that have embraced "engaging all care providers in TB care control through PPM approaches" as a component of a national policy to strengthen TB control. Ghana's success in stopping availability of anti-TB drugs outside the National TB Programme (NTP) has helped the country in seeking collaboration with the private sector from a position of strength. PPM implementation in Ghana has been supported mostly from the Global Fund grants. A strategy to set up collaboration with private health institutions was designed and implemented first in the cities of Accra and Kumasi under the Global Fund's Round 1 grant (2003 -2006). PPM implementation was scaled up to four additional urban areas as part of the Global Fund Round 5 grant (2007-2011).

The main instrument to strengthen TB control in all public sector facilities and strategically engaged private sector institutions has been an "Enablers Package". The package incorporates direct financial and non-financial enablers and incentives to institutions, public as well as private. The package is designed to help them address the genuine needs of TB patients, those of the health staff engaged in patient care and those of the health facility to enable delivery of standardized TB care. The enablers package was costed at US\$ 100 per patient diagnosed and treated within the Round 1 Global Fund grant and was adjusted to US\$ 40 within the Round 5 grant. Selected private laboratories and treatment facilities in the six urban areas have benefitted from the enablers package.

Findings:

The mission to review PPM DOTS implementation as part of the Global Fund grant, observed the following:

- Both the public and private sector counterparts were generally satisfied with mutual collaboration in place over the years.
- Some problems related to timely provision of laboratory supplies and disbursement of payments to private facilities under the enablers package have persisted. Apparently, the suggested distribution of expenses in the enablers package -- 50% for the patient, 30% for the health staff and 20% for the health facility -- has only been a recommendation that affords a level of flexibility to collaborating institutions. Any specific guidelines on the break up of the expenditure or ways to monitor it have not been in place. Instances of institutions not extending due benefits to patients have been observed.
- "The national tuberculosis health sector strategic plan for Ghana" which also incorporates PPM as a strategy for TB control claims that PPM has contributed to improving access to TB care and increasing TB case notification as well as treatment success rates and proposes its phased countywide scale up. To that effect, Standard Operating Procedures to help scale up PPM are being drafted.
- Recent efforts also include involving some pharmacies in referring TB suspects and providing DOT to TB cases living in the vicinity.

India

India was one of the countries chosen for a field visit, especially because it has some unique models like Indian Medical Association (IMA)/Catholic Bishops' Conference of India (CBCI) involvement in PPM. Two cities were visited in India: New Delhi and Hyderabad in October 2010.

In New Delhi, the team comprising of representatives from the Global Fund and WHO met with Dr LS Chauhan, Deputy Director General (TB), of the Central TB Division. Dr Chauhan highlighted the various positive strides made in engaging the private sector especially through IMA and CBCI with the support of the Global Fund and also described the Round 9 proposal where strong efforts were being made to work with civil society. This was followed by a visit to the IMA headquarters. The IMA project mainly trains private doctors and encourages them to collaborate with the RNTCP through formal schemes for private practitioners (DOT centre, microscopy centre, sputum collection centre etc.). The team then visited CBCI, the team from CBCI presented an overview of their project supported by the Global Fund. CBCI involves catholic health facilities through the NGO schemes of the RNTCP. IMA covers 16 states and CBCI covers 19 states through a network of consultants.

In Hyderabad, field sites of the IMA and CBCI in the city as well as in the tribal district of Warangal were visited. This was followed by a debriefing by the local IMA team in Hyderabad.

Findings

- The Global Fund supported PPM activities have facilitated engagement between the RNTCP and various care providers.
- A key facet is that one of the grants supported the engagement of a professional association: IMA in TB control efforts.
- The major component of the PPM activities in the TB grants were training of private practitioners, however there was inadequate follow up with the practitioners following training.
- The contribution of private providers in referring patients to the public sector or in behaviour change following training was not systematically documented. Therefore it is difficult to assess the contribution of PPM in the Global Fund grant.

4. Conclusion

The engagement of all care providers is crucial for TB control. Evidence points to growth globally in the number and size of non-public sector health care providers in TB control, with a significant proportion of TB patients managed by them, albeit often with poor quality of care. But proactive engagement of them can yield substantial benefits for TB control. There is also a growing body of evidence, over the past decade, which indicates that in some countries PPM has helped improve programme performance by increasing case detection from between 10% to 60% while maintaining the treatment success rates over 85%ⁱⁱⁱ. Importantly, in some settings, for-profit private providers engaged through PPM, have been able to improve their treatment success rates from levels that are often below 50% to above the global target of 85%^{iv}.

The importance and the scope of PPM are not reflected often at a level commensurate with the evidence, in the TB proposals and budgets submitted by countries. Over a third of the countries with active TB grants do not have PPM as a component. While the number of countries with active TB grants has increased from 22 in 2003, to 93 in 2008, the proportion of countries with PPM has not increased in this period despite additional Global Fund support for PPM. Of particular concern is the relatively low proportion of countries in sub-Saharan Africa with PPM supported by the Global Fund.

There are also concerns regarding the nature of PPM and the way in which countries plan for PPM. Judging upon the PPM-related indicators used by countries on which Global Fund-supported programs report, many focus merely on training of providers, without a clear strategy on how to establish effective and sustainable collaboration. Proposals submitted to the Global Fund often lack explicit mention of what enablers and incentives (financial or non-financial) will be used for private sector engagement, such as supply of anti-TB drugs free of charge to private practitioners on the condition that they follow DOTS principles for diagnosis and case management. Larger health care institutions taking on more complex roles in TB control will normally require financial compensation mechanisms, such as contracting on a capitation or fee-for-service basis. These aspects are rarely highlighted in proposals. Similarly, the support structure for PPM, such as continuous supervision, monitoring and evaluation are often inadequately described. Finally, in the reports submitted to the Global Fund there is often little information on the proportion of non-public health care providers involved and the percentage contribution by different providers^{v vi}. All this, will require more ambitious and better designed PPM plans to expand the engagement of non-public sector institutions in TB control to scale up services and improve outcomes.

Wide implementation of PPM requires good collaboration between the public and other health sectors. Innovative mechanisms appropriate to the nature of the settings such as certification of provider and financial incentives should be put in place to ensure such cooperation. There are good examples from countries like India where NTP tries to encourage and formalize PPM through initiatives that develop guidance documents to facilitate PPM partners to formally engage in PPM activities. There is a need for robust case studies to illustrate further examples of good practice that has resulted in improved outcomes. Mechanisms aimed at providing appropriate incentives and providing online reporting tools to establish and sustain such collaborations are to be considered based on the relevance in specific settings.

PPM has been shown to be cost-effective in diverse country settings^{viiiviii}. A deeper analysis of PPM components of Global Fund country proposals and that of the performance related to PPM could be of immense benefit not only to countries themselves but also to the technical and financial agencies supporting them. South-South learning opportunities should be encouraged and lessons learned from country cases more carefully harnessed and disseminated. Clearly, significant untapped potential still exists in scaling up PPM across countries, particularly in light of the increase in TB funding in recent years.

Appendix 1

Overview of country grant portfolios

Thailand

Background:

With a population of approximately 64 million Thailand ranks 18th in the list of 22 high TB burden countries. The prevalence of TB was estimated at 192 per 100 000 population for all forms in 2007, with an incidence rate of 62 new smear-positive cases per 100 000 population. The country has achieved full DOTS coverage, maintaining the global target for case detection since 2003. A case detection rate of 72 % was achieved in 2007. The treatment success rate for the cases reported for 2006 was 77%. The low treatment success rate is attributed to high default and mortality rates and incomplete reporting from the city of Bangkok.

Global Fund country grant portfolio

Thailand is the recipient of three grants **Round 1, Round 6 and Round 8.**

Grants Summary:

Round 1: Strengthening National Prevention and Care of Tuberculosis

The main objectives of this grant were to:

- To strengthen access to TB care among marginalized populations
- To strengthen TB services along the border area (and trans-border populations-Thai - Myanmar, Thai-Cambodia) and establish care/referral systems across the borders.
- To create a model of comprehensive HIV/TB integrated care for People Living with HIV.

PPM component

There is no explicit PPM component, however NGOs and the private sector have been involved in the implementation of the grant.

Findings: The results in the performance report only look at cases detected, treatment success, number HIV-TB coordinators and local staff trained on integrated care, etc. There is no indication of the process used and the roles of providers and partners.

Round 6: Reduction of TB Morbidity in Vulnerable Populations

The goal of this proposal is to reduce TB morbidity in vulnerable populations over a period of five years, beginning January 2007. The overall strategy is to expand the NTP's partnership with civil society and the private sector to address gaps in the NTP. Three civil society partners, World Vision Foundation of Thailand (WVFT), the American Refugee

Committee (ARC), and the Thailand Business Coalition on AIDS (TBCA), will implement TB control initiatives in the migrant and workplace populations. Meanwhile the NTP/MOPH will strengthen its public health systems to improve the quality of TB care in these target populations and nationwide.

PPM component:

To reduce TB morbidity in the workplace

- To support workplaces in the development of supportive policies on TB, HIV and TB/HIV
- To promote knowledge and awareness of TB and HIV in prevention, care support and treatment
- To develop a national monitoring support structure to oversee treatment services for TB and TB/HIV patients and workplace progress
- To institutionalize an accreditation mechanism that certifies, NGOs, and businesses in providing preventive, treatment and care services for TB and HIV

To reduce TB morbidity among non-Thai migrant in six border provinces

- To expand quality TB services to achieve increased case detection and treatment success among migrant populations
- To develop a service delivery system to ensure coordinated TB-HIV care for non-Thai migrants
- To empower non-Thai communities to reduce their TB burden through public awareness and patient support
- To increase the capacity of World Vision and ARC to implement TB control in non-Thai migrant populations.

The target populations and institutions include:

- 335,000 non-Thai migrants in five border provinces;
- Two million private sector workers in 10,000 companies located in 25 provinces,
- 109 private hospitals;
- Potentially close to 25 million beneficiaries of NTP and laboratory network services nationwide.

Main findings:

- A taskforce was created to guide implementation of the PPM activities
- A provincial-level GO-NGO coalition for coordinated TB/HIV care for migrant populations to conduct quarterly meetings was convened
- Guidelines for TB in the workplace were developed
- Training sessions were organized for staff in workplaces and hospitals
- Advocacy material was developed and circulated at workplaces

PPM investment: The budget for workplace program to expand TB control into the private

sector is 6,900,000 USD over five years.

Round 8: Strengthening Quality TB Control Among Vulnerable Populations in Thailand

The overall goal of this proposal is to reduce morbidity and mortality due to TB in Thailand, with an emphasis on vulnerable populations, particularly children, the HIV infected, prisoners, and the economically disenfranchised. This goal should be accomplished through three general objectives within 10 service delivery areas.

Objective 1: Pursuing high quality DOTS implementation

Objective 2: Address TB/HIV, MDR-TB, and other challenge

Objective 3: Empowering people with TB and communities

PPM component

This proposal does not focus on PPM, except for the below activity under partnerships with the private sector: Engagement of the Private Hospital Association (PHA) to contribute to activities in the grant. Private hospitals which are members of PHA participating in the GFATM TB R1 and R6 grants have received training, program supervision, and technical assistance from NTP in TB care and management. In TB R8, they will continue refer TB suspects who could not afford for TB diagnosis to public hospitals for further investigation.

Swaziland

Background

TB poses a serious public health problem to Swaziland. It is one of the top causes of illness and has been the leading cause of death in adults since 1977. The country has the highest estimated incidence (1257 per 100,000 populations) and highest TB/HIV co infection rate in the world (around 83% of TB patients with HIV co infection).

Global Fund country grant portfolio

Swaziland is the recipient of two grants **Round 3** and **Round 8**.

Grants summary

Round 3. Coordinated Country Response to Fight Tuberculosis

The overall goal of this grant was to reduce TB transmission, morbidity and mortality. The objectives were

- 1) To improve the programme management capacity of the NTP
- 2) To strengthen the implementation of DOTS
- 3) To integrate TB and HIV/AIDS activities.

PPM component

PPM activities encompassed the engagement of NGOs, CBOs and private sector organizations already working on TB. At the start of the project in 2002, there were only 5 NGOs working on TB. The aim of these activities was to engage 10 non-NTP institutions in the first year and 16 in the next.

PPM investment: USD 4000

Findings: The number of NGOs and CBOs engaged are not clearly reported on. The indicator for the PPM objective lists the number of TB diagnostic facilities participating in community DOTS but does not indicate if they are NTP or non-NTP facilities.

Round 8

The goal of this proposal is “To reduce the morbidity, mortality, disease transmission and socio-economic burden of TB, including the TB/HIV co-infection, while minimizing the risk of drug-resistance”. It is centered around three main objectives which are a prioritized sub-set of the Swaziland National TB Strategic Plan 2006-2011 and fully in line with the priorities of the WHO new Stop TB Strategy. The three objectives of his proposal are:

- Increase access to high-quality DOTS in order to improve case detection & treatment outcomes
- Implement and strengthen TB/HIV collaborative activities
- Address MDR-TB control

PPM component:

There is no clear PPM component in this proposal, however there are linked activities for community TB care which includes the engagement of NGOs, CBOs and traditional in providing or facilitating community DOTS. There is also an activity on targeting TB patients in prison

Findings: There are no indicators in the performance report to monitor the activity above in the grant

Romania

Background

TB remains a serious public health issue in Romania. Over the past 20 yrs, Romania has been reported to have one of the highest adult TB rates in the whole of Europe; from 1995 to 2007 over 23,000 cases·yr⁻¹ were recorded, which corresponds to greater than 100 TB cases per 100,000 populations. Romania's TB caseload also overlaps with the nation's most vulnerable population defined as having the lowest income, highest unemployment, and low educational achievement.

Global Fund country grant portfolio

Romania is the recipient of two grants **Round 2** and **Round 6**.

Grants summary

Round 2. Rising to the challenges of Tuberculosis: a comprehensive, coordinated multi-sectored response in Romania

The program supported by this grant focused on expansion of the DOTS strategy for TB control, and improvement of the national TB surveillance and monitoring systems. It enabled the country to focus on health staff training, developing strategies to improve TB control among children and high-risk groups such as prisoners, Roma, and people living with HIV. The program also sought to improve TB diagnosis and the treatment of multidrug-resistant TB, including provision of second-line TB drugs. It also provided support for laboratories and prison facilities, and the development of a centralized TB data collection system.

PPM component:

The following PPM activities were undertaken as part of this grant:

- Training of specialists in lung diseases, epidemiologists, GPs/FDs and laboratory staff, and promoting joint meetings between these, with the exception of laboratory staff
- Improve the curricula Schools of Medicine, as well as those involved in continuous medical training by adding TB guidelines
- Printing and distribution of new Strategy/Guidelines for TB Control in prisons

Findings:

- Number of medical staff (pneumologists, epidemiologists, family doctors, nurses from the TB and the family doctors network, laboratory staff) trained in DOTS activities: 17549
- Number of prisoners receiving IEC sessions in TB: 25 008

PPM investment: Approx Euros 953 640

Round 6: Scaling up tuberculosis control in Romania by focusing on poor and vulnerable population

The program supported by the grant aims to reduce the TB burden in the country. Focusing on 19 high-priority regions and the capital, Bucharest, program activities include training of public and private-sector health providers, targeted education and adherence programs for the poor, homeless, prisoners, Roma and rural communities. A key objective is also to scale up multidrug-resistant TB (MDR-TB) control through provision of high-quality MDR-TB treatment. The program seeks to contribute to expanding the National TB Program capacities to manage and coordinate national and local TB efforts and to develop community support and political commitment to TB control.

PPM component

The grant has a specific component on PPM which aims to scale up training of family physicians to provide quality-assured TB care and adhere to international and NTP standards. The activities include:

- Develop training curricula for providers focused on DOTS strategy and working with vulnerable
- Strengthen and develop the knowledge and skills of 2,500 private-sector practitioners to communicate and support patients in completing TB treatment
- Develop provider educational resources in support of private practitioner patient management and quality of care
- Improve the coordination of care between the TB dispensaries and private practitioners including involvement of the pneumology network

In addition to this, an activity on prisons was included.

Findings:

- As part of the PPM initiative, 4190 new smear positive cases were detected among the general population (the target was 4800 patients)
- Around 3840 new smear positive TB cases were registered under DOTS and were successfully treated
- 1945 penitentiary staff were trained in TB prevention, education and control activities

PPM investment: Eur 545 300

Afghanistan

Background

In Afghanistan, tuberculosis (TB) is one of the main public health burdens. According to the World Health Organization's (WHO's) Global Tuberculosis Control Report 2009, approximately 46,000 new TB cases occur annually in Afghanistan, and 8,200 people in the country died from TB in 2007. Unlike many countries, more than twice as many women are infected as compared to men; almost 70 percent of Afghanistan's notified cases are women. In 1997, Afghanistan's National TB Control Program (NTCP) adopted the DOTS (the internationally recommended strategy for TB control) strategy. By the end of 2002, the country reported 38 percent DOTS coverage. While this was an indicator of progress, coverage was still low, and TB services were predominantly provided by a patchwork of nongovernmental organizations (NGOs) and government health facilities. With increased support, improved regional coordination, and greater collaboration between private providers and communities, DOTS coverage is now at 97 percent; national estimates of case detection are 64 percent, below the WHO global target of 70 percent, though reflective of the operational challenges in the country. Treatment success also fell below 85 percent after four years of being above the target of 85 percent. The management of multidrug-resistant (MDR) TB, extensively drug-resistant TB, and diagnostic capacity is extremely limited.

Global Fund country grant portfolio

Afghanistan is the recipient of three grants **Round 2**, **Round 4** and **Round 8**.

Grants summary

Round 2: Building Afghanistan's Capacity to Address AIDS, TB and Malaria

This grant was an integrated grant between all three diseases- TB, HIV/AIDS and Malaria. The goal of the grant was to develop the capacity for communicable disease control (with special reference to TB, malaria and HIV/AIDS) by strengthening management and administrative functions of the MoPH, together with building partnerships and developing new mechanisms for technical support and coordination.

PPM component

- To build partnerships, identify implementing partners and develop detailed strategic and implementation plans for TB
- To undertake a pilot study of private sector ITN sales in urban centers

Findings: There were no clear indicators with data in the performance report, however the PPM activities on initiating partnerships and undertaking a pilot study were implemented

Round 4: Scaling up the Afghan response to Tuberculosis Control

The goal of the TB component of this grant was to detect 70% of the expected pulmonary sputum positive cases and have a success rate of 92% in the areas covered by DOTS. The objectives were to make DOTS available in 90% of the districts covered by the basic package of health services (BPHS) in Afghanistan, to ensure quality DOTS and prevent MDR-TB and to improve access to TB early diagnosis and effective treatment.

PPM component

All three objectives in the grant have elements of PPM involved in them. The objectives and associated activities are listed in brief below:

Objective 1: Make DOTS available in 90% of the districts covered by BPHS in Afghanistan.

Under this objective 70% of the services will be delivered by non-governmental organizations and 10% of the services will be delivered by the private sector to the general population and mobile populations. It will also include training of 70% of NGO partners and 10% of private sector partners.

Objective 2: Ensure quality DOTS and prevent MDR-TB.

This objective will be supported by both NGO and private sector partners. 70% of the services under this objective will be delivered by NGOs and 10% of the services will be delivered by the private sector to the general population and mobile populations. It will also include training of 70% of NGO partners and 10% of private sector partners.

Objective 3: Improve access to TB early diagnosis and effective treatment.

This objective especially covers the engagement of the private sector. 10% of services in this area will be delivered by the government, 70% by NGOs and 20% by the private sector. It will also include training of 70% of NGO partners and 10% of private sector partners.

Some key PPM activities under the above mentioned objectives include:

- Involvement of NGO partners in the national planning process
- Training of NGO partners in TB control
- Orientation of private sector on quality assured drugs through dissemination of national guidelines to private practitioners
- Legislation for the regulation of the sale of TB drugs in the private sector
- Set up review meetings and mechanisms for identification and adoption of corrective measures in collaboration with NGOs
- Operational research on feasibility and acceptability of DOTS delivery through private sector.
- Dissemination of national TB control guidelines and other relevant printed material to private practitioners.
- Recruitment of volunteer practitioners for orientation on DOTS.
- Incentives to private practitioners involved in DOTS.
- Recording and reporting material distribution to private practitioners.
- Supervisory activities by provincial communicable diseases department.

- Mid-term and final evaluation on private practitioners performance.

PPM Investment: USD 276307

Findings: Most of the activities highlighted above have not been reported in the grant performance report.

Round 8

The aim of this proposal is to reduce TB burden of Afghanistan by 2015 in line with MDG and Stop TB partnership targets. The proposal has five objectives, which are in line with the stop TB strategy. All necessary activities for prioritized areas are classified in these five objectives, pursue high quality DOTS expansion and enhancement, address TB/HIV, MDR-TB and other challenges, engage all care providers, empower people with TB and communities and enable and promote research.

PPM component

Objective 4 of the grant focused on engaging all care providers. The objective aimed at starting and scaling up PPM activities by engaging not only providers in private sector but also those in non-NTP public sector. Quality TB services will be ensured through training, guidelines formulation and regular supportive supervision. The Proposal is expected to engage 45% of such facilities in 5 years.

Findings: Number and percentage of private and public non NTP health providers collaborating with the National TB Program: 249 (25%)

PPM Investment: Euros 341,648

The Philippines

Background

According to WHO's *Global Tuberculosis Control Report 2010*, the Philippines ranks eighth on the list of 22 HBCs. In 2009, 145,075 cases (new and relapse) of TB were notified to NTPs. In 2007, approximately 100 Filipinos died each day from the disease, but significant strides have been made in increasing case detection and treatment. In 2004, the country achieved a TB case detection rate of 72 percent, exceeding WHO's target of 70 percent, and reached 75 percent in 2007. The DOTS (the internationally recommended strategy for TB control) treatment success rate reached WHO's target of 85 percent in 1999 and has remained around 88 percent since then.

While the national performance levels are already high, many provinces are still below target levels due to various systemic and social factors, including the difficulty of breaking down the stigma of TB, which keeps many of those infected from seeking care. The management of multidrug-resistant (MDR) TB is expanding, however, WHO has reported extensively drug-resistant TB in the Philippines. The availability of over-the-counter TB drugs and self-medication by patients continue to contribute to the emergence of TB drug resistance.

Global Fund country grant portfolio

The Philippines is the recipient of two grants **Round 2** and **Round 5**.

Grants summary

Round 2- Part 1. Accelerating the Response to Tuberculosis

The program supported by this grant aims to set up the operational structure for a public-private mix DOTS strategy; improve the quality of DOTS in the public sector through training of health staff in DOTS, training of laboratory staff, introduction of DOTS in government hospitals, and strengthening of TB diagnostic committees. The program also aims to create a social demand for DOTS services through social marketing and advocacy, community organizations, peer support group development and promoting innovative approaches.

PPM component:

The following PPM activities were undertaken

- Setup the operational structure of PPMD
- Install PPMD package (second step) comprised of:
 - Symposia
 - Training
 - Launching / MOU signing

- Monitor and evaluate PPMD implementation

Findings:

- Number of new private practitioners participating in DOTS: 1133
- Number and percent of new smear positive TB cases detected under DOTS reported through PPMD units: 9027 (18.2%)
- Number and percent of new smear positive TB cases registered under PPM DOTS successfully treated: 1013 (92.2%)
- Number of service deliverers trained (including private physicians who are expected to contribute patients to PPMD
- units, medical technologists and microscopists, doctors and nurses trained on NTP policies and on revised manual procedures: 2641
- Number of staff in public and private centres trained in the diagnosis and treatment of MDR-TB: 913

PPM investment: Approx. USD 6 405 280

Round 2- Part 2. Sustaining TB Control and Ensuring Universal Access to Comprehensive Quality TB Care

As part of this grant, funds will be used to continue the implementation of a program financed by a Round 2 Global Fund grant and will scale-up multidrug-resistant TB treatment outside of the Manila metropolitan area, including enrolling patients in programmatic management on drug-resistant TB for a period of three years, while establishing 37 new treatment centers to assuage the country of the burden of multidrug-resistant TB.

PPM component:

This component is a follow up of PPM activities from Round 2 –part 1.

Findings:

- Number and percentage of new smear positive TB patients referred by non-NTP providers among the new smear positive TB patients reported to the national health authority: 3512
- Number of non-NTP care providers collaborating with NTP: 1305

Round 5: Scaling up and Enhancement of the National Tuberculosis Program in the Philippines

The overall goal of the program supported by this grant is to reduce the prevalence, incidence and deaths related to TB by half. The program aims to enhance the quality of DOTS implementation in the public sector through increasing access to and the quality of

DOTS services; increase demand for DOTS services in public and private DOTS facilities by removing barriers to access through social mobilization and social marketing for underserved populations; ensure access to quality DOTS; increase treatment of multidrug-resistant TB; and sustain and strengthen TB and HIV collaboration in an epidemiological scenario where the TB prevalence is high and HIV burden is low.

PPM component:

The main PPM activities in this grant are listed below:

- Train 154 NTP public hospital coordinators representing 77 public hospitals on DOTS referral for Public-Public Mix DOTS implementation
- Train 102 NTP public hospital coordinators in 51 public hospitals on DOTS service provision for Public-Public Mix DOTS implementation
- Train 51 NTP public hospital laboratory staff on basic microscopy for Public-Public Mix DOTS implementation
- Orient other key government agencies working for the urban poor on Public-Public Mix DOTS implementation
- Strengthen the service linkage between public health units and public hospitals through Public-Public Mix DOTS strategy (77 public hospitals trained as DOTS referral centers in 5 years)
- Strengthen the service linkage between public health units and public hospitals through Public-Public Mix DOTS strategy (51 public hospitals trained as DOTS service providers in 5 years)
- Conduct symposium on Public-Public Mix DOTS for the urban poor
- Strengthen coordination of C.U.P. members involve with the urban poor for Public-Public Mix DOTS implementation
- Conduct DOTS certification (5 DOTS facilities/CHD/year) – this activity was initiated by NTP in 2003 and currently, there are 118 certified DOTS facilities (public and PPMDs).
- Organize 3-Day DOTS Providers Training on the NTP policies and procedures for 130 Physicians and Nurses (60 from the private initiated PPMD units) of the 100 PPMD units to be installed.
- Develop and implement PPMD and the PhilHealth Outpatient Anti-TB DOTS Benefit Package over 2 years.
- Provision of Free Anti-TB Drugs, procured through GDF, to 63,101 TB cases (including 27435 new sputum smear positive cases) for the 216 PPMD units over 5 years.

PPM investment: unclear (no clear figure indicated)

Findings:

- Number of new smear positive cases detected through various initiatives: urban poor areas, (NTP) PPMD (PhilCAT),CMT (WWDF): 5691
- Number of service points (PPMD units) supported: 99

Round 4																		
Round 5																		
Round 6																		
Round 7																		
Round 8																		

NOTE (a): Template framework adapted from WHO “Engaging All Health Providers in TB Control: Guidance on Implementing Public-Private Mix Approaches,” Annex 3: Generic Format for Budgeting PPM DOTS Projects, pages 43-44, (see examples of budgeted activities).

NOTE (b): In “Country Details” specify involvement/activities by provider type: (Public: general hospitals, specialty hospitals and academic institutions, HIV and other health institutions under government corporations and ministries, prison health services, army health services, labs, etc.) and (Private: medical societies, private hospitals and clinics, corporate health services, NGO hospital and clinics, individual private physicians/nurses/midwives/clinical officers, pharmacies and drug shops, practitioners of traditional medical systems, informal/non-qualified practitioners, labs, etc.).

NOTE(c): Is Variable (from Agreement) “Budgeted?” and (from Progress Reports) “Reported?”; if Y(es), provide details; if N(o), indicates not identified, but may exist in programme.

* Country Details, next page

Activity 1: Preparation for PPM

Country Details by Variable (explain Y(es) responses):

1. Country 1, Rounds _____:

a. Appointed a PPM focal point:

-
-
-

b. Creation of a task force:

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c. Situational analysis done:

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d. Operational guideline printed and distributed:

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-

e. Other:

-
-
-

PPM Analysis of GF PPM Activities (a), (b), (c)

Version 2 03 April 2010 Country: (#), (county name)	Activity 2: Training for PPM																			
	2A: Training of NTP staff on PPM DOTS										2B: Sensitization, training, certification									
	•Training sessions (in detail, indicate number of sessions)				• Health care facilities trained/certified (in detail, indicate number by type of provider and DOTS function)				•Health care cadres trained (in detail, indicate numbers by type of health care staff)				•Supervision visits (in detail, indicate numbers by supervised type of provider)				•Other			
	Budgeted		Reported		Budgeted		Reported		Budgeted		Reported		Budgeted		Reported		Budgeted		Reported	
Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	
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Country Details, next page

Activity 2: Training for PPM

Country Details by Variable (explain Y(es) responses):

2. Country 1, Rounds _____:

a. Number of training sessions:

-
-
-

b. Number of health care facilities trained/certified, by type of provider and DOTS function:

-
-
-

c. Number of health care cadres trained, by type of health care staff:

-
-
-

d. Number of supervision visits, by type of provider:

-
-
-

e. Other:

-
-
-

PPM Analysis of GF PPM Activities (a), (b), (c)

Version 2 03 April 2010	Activity 3: Demand creation (Advocacy and Communication) for PPM																
	<p>3A: Inform all relevant health care providers and other stakeholders about DOTS and PPM</p> <p>3B: Inform TB suspects and patients on PPM DOTS and treatment options</p> <p>3C: Inform the general population about TB, DOTS, and PPM DOTS</p>																
	Country: (#), (county name)	•Information events/Material targeting <u>providers</u> (in detail, indicate number of events/material)				•Information events/Material targeting <u>patients</u> (in detail, indicate number of events/material)				•Information events/Material targeting <u>population</u> (in detail, indicate number of events/material)				•Other			
		Budgeted		Reported		Budgeted		Reported		Budgeted		Reported		Budgeted		Reported	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	
Round 1																	
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Round 8																

NOTE (a): Template framework adapted from WHO “Engaging All Health Providers in TB Control: Guidance on Implementing Public-Private Mix Approaches,” Annex 3: Generic Format for Budgeting PPM DOTS Projects, pages 43-44, (see examples of budgeted activities).

NOTE (b): In “Country Details” specify involvement/activities by provider type: (Public: general hospitals, specialty hospitals and academic institutions, HIV and other health institutions under government corporations and ministries, prison health services, army health services, labs, etc.) and (Private: medical societies, private hospitals and clinics, corporate health services, NGO hospital and clinics, individual private physicians/nurses/midwives/clinical officers, pharmacies and drug shops, practitioners of traditional medical systems, informal/non-qualified practitioners, labs, etc.).

NOTE(c): Is Variable (from Agreement) “Budgeted?” and (from Progress Reports) “Reported?”; if Y(es), provide details; if N(o), indicates not identified, but may exist in programme.

*Country Details, next page

Activity 3: Demand Creation (Advocacy and Communication) for PPM

Country Details by Variable (explain Y(es) responses):

- 3. Country 1, Rounds _____:
 - a. Number of information events/material targeting **providers**:
 -
 -
 -

 - b. Number of information events/material targeting **patients**:
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 -

 - c. Number of information events/material targeting **population**:
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 - d. Other:
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PPM Analysis of GF PPM Activities (a), (b), (c)

Version 2 03 April 2010	Activity 4: Local delivery of TB services through PPM																											
	4A: Establish local service delivery infrastructure																											
	4B: Delivery of DOTS services by partnering providers																											
	Country: (#), (county name)	•Districts/ cities/ provinces with PPM initiative (in detail, indicate number in %)				• Mapping done				•Local task force created				•Cases detected through referral/ diagnosis by different providers (in detail, indicate proportion)				•Patients receiving DOT by different providers (in detail, indicate proportion)				•Treatment outcome (in detail, indicate by provider type)				•Other		
Budget ed		Reporte d		Budget ed		Reporte d		Budget ed		Reporte d		Budgete d		Reporte d		Budget ed		Reporte d		Budget ed		Reporte d						
Y		N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
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Activity 4: Local delivery of TB Services through PPM

Country Details by Variable (explain Y(es) responses):

4. Country 1, Rounds _____:

a. Number (%) of districts/cities/provinces with PPM initiative:

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-
-

b. Mapping done:

-
-
-

c. Local task force created:

-
-
-

d. Proportion of cases detected through referral/diagnosis by different providers:

-
-
-

e. Proportion of patients receiving DOT by different providers:

-
-
-

f. Treatment outcome, by provider type:

-
-
-

g. Other:

-
-
-

PPM Analysis of GF PPM Activities (a), (b), (c)

Version 2	Activity 5: Monitoring and evaluation																			
03 April 2010	<i>5A: Ensure appropriate recording and reporting routines</i>																			
	<i>5B: Design and implement operation research projects</i>																			
Country: (#), <i>(county name)</i>	•Number of additional surveillance staff appointed				•Number of staff trained on operational research <i>(in detail, indicate number of staff trained)</i>				•Implementation of e-register/ reporting				•Evaluation of pilot(s) completed and disseminated				•Other			
	Budgeted		Reported		Budgeted		Reported		Budgeted		Reported		Budgeted		Reported		Budgeted		Reported	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

Round 1																				
Round 2																				
Round 3																				
Round 4																				
Round 5																				
Round 6																				
Round 7																				
Round 8																				

NOTE (a): Template framework adapted from WHO “Engaging All Health Providers in TB Control: Guidance on Implementing Public-Private Mix Approaches,” Annex 3: Generic Format for Budgeting PPM DOTS Projects, pages 43-44, (see examples of budgeted activities).

NOTE (b): In “Country Details” specify involvement/activities by provider type: (Public: general hospitals, specialty hospitals and academic institutions, HIV and other health institutions under government corporations and ministries, prison health services, army health services, labs, etc.) and (Private: medical societies, private hospitals and clinics, corporate health services, NGO hospital and clinics, individual private physicians/nurses/midwives/clinical officers, pharmacies and drug shops, practitioners of traditional medical systems, informal/non-qualified practitioners, labs, etc.).

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Country Details, next page

Activity 5: Monitoring and evaluation

Country Details by Variable (explain Y(es) responses):

5. Country 1, Rounds _____:

a. Number of additional surveillance staff appointed

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-
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b. Number of staff trained on operational research:

-
-
-

c. Implementation of e-registering/reporting:

-
-
-

d. Evaluation of pilot(s) completed and disseminated:

-
-
-

e. Other:

-
-
-

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