Framework for the engagement of all health care providers in the management of drug resistant tuberculosis

THE END TB STRATEGY

World Health Organization

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Abbreviations and acronyms

ADR	adverse drug reaction
CAP-TB	Control and Prevention of Tuberculosis
DOH	department of health
DOT	directly observed treatment
DOTS	core approach underpinning the Stop TB strategy for TB control
DR-TB	drug-resistant tuberculosis
DS-TB	drug-susceptible tuberculosis
DST	drug susceptibility testing
FLD	first-line tuberculosis drug
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GP	general practitioner
M&E	monitoring and evaluation
MDR-TB	multidrug-resistant tuberculosis
MMA	Myanmar Medical Association
MMD/MOJ	Main Medical Department of the Ministry of Justice (Azerbaijan)
MOH	ministry of health
MOU	memorandum of understanding
MSF	Médecins Sans Frontières
NGO	nongovernmental organization
NSP	national strategic plan
NTP	national tuberculosis programme
PhilCAT	Philippine Coalition Against Tuberculosis
PMDT	programmatic management of drug-resistant tuberculosis
PPM	public–private mix (can also be public–public mix or private–private mix)
PPM DR-TB	public–private mix for the management of drug-resistant tuberculosis
PPM DS-TB	public–private mix for the management of drug-susceptible tuberculosis
PSI	Population Services International
QA	quality assurance
R&R	recording and reporting
RR-TB	rifampicin-resistant tuberculosis
SA	service agreement
SLD	second-line tuberculosis drug
SOP	standard operating procedure
TB	tuberculosis
WHO	World Health Organization

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Foreword

Global efforts to further improve case detection, treatment and care for drug-resistant tuberculosis (DR-TB) are urgently needed. In 2013, only 45% of the estimated 300 000 cases of patients with multidrug-resistant TB (MDR-TB; i.e. resistance to at least rifampicin and isoniazid) were detected among all notified pulmonary TB cases worldwide. The missing 55% of MDR-TB cases were either not detected or were managed outside of the national tuberculosis programmes (NTPs) and therefore not reported. In addition, the gap between diagnosis and treatment is growing rapidly in a number of countries. This is due to a rapid expansion of diagnostic capacity that has not been matched by an increase in management capacity. Hence, patients diagnosed with MDR-TB are being placed on "waiting lists" for treatment with second-line drugs. Finally, treatment outcomes for MDR-TB are poor, with only 48% successfully treated in the cohort of MDR-TB patients in 2011.

Public–private mix (PPM) for TB care and control has been implemented and scaled up in many countries. PPM initiatives in a number of high TB burden countries have regularly demonstrated increased case notification and levels of treatment success equal to those seen in the effective public sector. In 2013, non-NTP health-care providers contributed a significant proportion (up to 40%) of the notified TB cases in several countries or settings.

In a major milestone for the history of TB control, in May 2014, the End TB Strategy was adopted by the World Health Assembly of WHO. The End TB Strategy highlights that if we continue with business as usual, ending the TB epidemic will remain a long distant dream. PPM is something that cuts across the three pillars and the 10 components of the new strategy. In particular, it calls for the "… early diagnosis and universal drug susceptibility test (DST)…" (Component 1A), "… treatment of all people with TB including DR-TB …" (Component 1B), "… engagement of all public and private care providers …" (Component 2B) and "… Universal Health Coverage and regulatory frameworks …" (Component 2C). We need to prepare and start working immediately on all these areas if we are to achieve the new target of ending TB established by the World Health Assembly.

Engaging all relevant health-care providers in the management of DR-TB cases is an important intervention to achieve the goal of universal access to DR-TB care and services. Although good practices of PPM DR-TB have been demonstrated in different countries and settings, overall progress in engaging non-NTP health-care providers remains limited. The objectives of the *Framework for engagement of all health-care providers in the management of drug-resistant tuberculosis* are to describe the rationale of, the approaches to, and best practices in engagement of different health providers and partners in the management of DR-TB patients; and to describe the necessary components in planning and implementation of PPM DR-TB activities. This document, that must be seen as one of the complementary recommendations that WHO is issuing to support implementation of the End TB Strategy, will help guide NTPs and partners in rolling-out of PPM DR-TB approaches in different countries and settings.

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Executive summary

The Framework for engagement of all health-care providers in the management of drug-resistant tuberculosis has been developed to support countries in the implementation of public–private mix (PPM) for drug-resistant tuberculosis (DR-TB). This document complements other guidance and practical tools on PPM for TB control and prevention. It serves as a guidance document for countries in engaging providers and partners from outside the national TB programmes (NTPs) to address the complexity of the programmatic management of DR-TB.

The framework describes approaches for engaging different health-care providers and partners in diverse aspects of DR-TB care and management, including clinical care, public health tasks, patient-centred care, advocacy, funding mobilization, regulation and social protection. It describes the engagement of non-NTP providers and partners, which is not limited to diagnosis and treatment, but also includes other important aspects of DR-TB care, depending on the capacity and preference of the non-NTP providers and partners.

Approaches to engagement in PPM DR-TB are described by category of health-care provider: individual health-care providers (physician or non-physician individuals); public or private health institutions (e.g. hospital, or medical or health centre); public or private laboratories; nongovernmental organizations (NGOs); professional associations or societies; affected groups; and other public or private organizations. Each approach includes a description, eligibility, potential roles of the health provider, roles of the NTP, implementation considerations and case studies.

The case studies present and highlight best practices in PPM DR-TB in different countries and settings. They have been collected during in-country assessments and reflect contributions from colleagues in the NTPs, the WHO country and regional offices, and other partners working in the area. However, the case studies presented in the document do not represent all the PPM DR-TB best practices currently ongoing; rather, they provide a snapshot of what is happening. To add to the body of evidence presented in the document, a webpage hosted by the WHO Global TB Programme will serve as a repository that will be regularly updated with additional case studies contributed by NTPs and PPM DR-TB partners around the world.

The last section of the framework describes the necessary components or steps for planning and implementation of PPM DR-TB, for adoption by NTPs and partners, and adaptation for their specific settings. An assessment tool (see *Annex 1*), will support national situational assessments, which are crucial for informing the planning of PPM DR-TB in each country or setting.