Public-Private Mix for TB Care and Control A Toolkit

World Health Organization

Stop TB Partnership

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Introduction

Background

Recognizing that strengthening DOTS implementation by national TB control programmes (NTPs) is essential but not enough to meet the global TB control targets, the Stop TB Strategy of the World Health Organization (WHO), adopted by most countries, recommends systematic engagement of all care providers in TB care and control through public-private mix (PPM) approaches.

It is common knowledge that people with symptoms suggestive of TB approach a wide range of health care providers outside the purview of NTPs. These may include care providers within the public sector (general and specialty hospitals; academic institutions; prison, military or railway health services; health insurance organizations, etc.), within the voluntary sector (nongovernmental organizations, community-based or faith-based organizations, etc.) and within the private and corporate sectors (formal and informal private practitioners including traditional healers and, pharmacies, and private and corporate hospitals and institutions). PPM implies engagement of diverse care providers in TB care and control led, guided and supported by NTPs.

The diversity of health care providers and their capacities to contribute to TB care and control vary greatly across and within countries. WHO guidelines to help implement PPM for engaging diverse care providers provide only broad principles of engagement of individual and institutional care providers within and outside the public sector. There has been a felt-need and demand for more specific guidance to NTPs on working with diverse care providers based on country experiences. This toolkit attempts to address this need.

It is hoped that the toolkit will help NTPs engage non-NTP care providers to deliver services in line with national guidelines based on International Standards for Tuberculosis Care.

Introduction

The toolkit

This toolkit is designed to provide information at a glance and practical guidance. It may be necessary to adapt the guidance provided in the tools to suit the country needs and contexts.

The toolkit consists of 14 tools, the first seven tools outline basic aspects of PPM implementation, while the remaining seven tools address engagement of specific types of care providers. The tools are listed below.

1. Rationale and generic approach
2. National situation assessment
3. Operational guidelines
4. Advocacy, communication and social mobilization
5. Monitoring and evaluation
6. International Standards for Tuberculosis care
7. Resources and budgeting
8. Engaging private practitioners
9. Engaging hospitals
10. Engaging nongovernmental organizations
11. Engaging workplaces
12. Engaging social security organizations
13. Engagement for TB/HIV collaboration
14. Engagement for programmatic management of drug-resistant TB

Each tool provides references to background documents where additional information may be obtained. Soft copies of the tools and reference documents can be found in the compact disc (CD) provided with this toolkit.

The toolkit is also available online:
http://www.stoptb.org/wg/dots_expansion/ppm/toolkit.asp
The online version will serve as a living document for revising existing tools, adding new tools and updating background references.

Abbreviations

ACSM	Advocacy, Communication and Social Mobilization
ART	antiretroviral treatment
ATS	American Thoracic Society
CPT	co-trimoxazole preventive therapy
DEWG	DOTS Expansion Working Group
DOTS	The internationally recommended strategy for TB control
FHI	Family Health International
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBC	high TB-burden country
HDL	hospital DOTS linkage
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
ILO	International Labour Organization
ISTC	International Standards for Tuberculosis Care
JATA	Japan Anti-Tuberculosis Association
KNCV	Royal Netherlands TB Association
MDG	Millennium Development Goals
MDR-TB	multidrug-resistant tuberculosis
MSH	Management Sciences for Health
NGO	nongovernmental organization
NTP	national tuberculosis control programme
PLHIV	people living with HIV
PP	private provider
PPM	public–private mix
PPM Subgroup	Subgroup on Public–Private Mix for TB care and control
TB	tuberculosis
The Union	International Union against Tuberculosis and Lung Disease
USAID	United States Agency for International Development
WHO	World Health Organization
XDR-TB	extensively drug-resistant tuberculosis

Rationale and generic approach

This tool provides the rationale and generic approach for implementing PPM to engage all care providers in TB care and control, highlighting how PPM is beneficial to country programmes.

Rationale

In most resource-poor countries with a high TB-burden, patients with symptoms suggestive of TB seek care from a wide array of health-care providers. These care providers, often not linked to public sector-based NTPs, may serve a large proportion of TB suspects. The size, types and roles of these care providers vary greatly within and across countries. In some settings there is a large private commercial sector and numerous NGOs while in others there are public sector providers (such as general and specialized hospitals) that operate outside the scope of NTPs. Evidence suggests that failure to involve all care providers used by TB suspects and patients hampers case detection, delays diagnosis, leads to inappropriate and incomplete treatment, contributes to increasing drug resistance and places an unnecessary financial burden on patients.

Engaging all relevant health care providers in TB care and control through public-private mix approaches is an essential component of the WHO's Stop TB Strategy. PPM for TB care and control represents a comprehensive approach for systematic involvement of all relevant health care providers in TB control to promote the use of the ISTC and achieve national and global TB control targets. PPM encompasses diverse collaborative strategies such as public-private (between NTP and the private sector), public-public (between NTP and other public sector care providers such as general hospitals, prison or military health services and social security organizations), and private-private (between an NGO or a private hospital and neighborhood private providers) collaboration. PPM also implies engaging relevant care providers in prevention and management of MDR-TB and in the implementation of TB/HIV collaborative activities.

Country experiences and scientific evaluations have amply demonstrated that PPM contributes to the six public health dimensions (please refer to the box).

Rationale and generic approach

Evolution and evidence of PPM

The evolution of PPM for TB care and control dates back to 1999-2000, when WHO conducted a global assessment on the role of private providers in TB control in 23 countries across six WHO regions. This was followed by a detailed evaluation of a few pilot PPM initiatives, leading to the development of practical tools for PPM implementation.

The DOTS Expansion Working Group (DEWG) of the Stop TB Partnership established a Subgroup on Public-Private Mix for TB care and control (PPM Subgroup) in 2002. The Subgroup has further stimulated country action with a focus on:

- Providing a platform for sharing of country experiences on initiating and expanding PPM activities;
- Widening the scope of PPM to include all public and private health care providers not formally linked to NTP;
- Intensifying advocacy and technical assistance for PPM to overcome barriers for its scaling up; and
- Stimulating evaluation and operational research to strengthen the evidence base for PPM.

Currently, nearly all high TB-burden countries are implementing PPM activities. Fifty-eight of 93 countries and multi-country recipients of Global Fund-supported TB grants had PPM activities in 2008. Several project evaluations have shown that PPM could help increase case detection (between 10% and 60%), improve treatment outcomes (over 85%), reach the poor and save costs. A full list of evaluation reports and scientific publications is provided on the CD. Further information, including country case studies can be found on the PPM website:
http://www.who.int/tb/careproviders/ppm/en/

The generic PPM approach

The WHO policy on engaging all care providers in TB care and control provides guidance on practical steps that countries should undertake to involve various providers in TB control efforts. There is no one-size-fits all PPM approach. It is crucial that PPM is planned based on a national situation assessment.

Box *PPM contribution to public health*

Enhanced quality of diagnosis, treatment and patient support

PPM can reduce malpractice by fostering evidence-based TB diagnosis and treatment in line with the ISTC. This improves cure rates and reduces risks of drug resistance. It also limits misdiagnosis of TB and, unnecessary and often costly treatment.

Increased case detection and reduced diagnostic delays

PPM can help increase TB case detection and reduce diagnostic delays by involving all health care providers in timely referral and diagnosis of TB. This also helps cut the chain of transmission at an early stage.

Improved and equitable access

PPM can improve access to treatment and help overcome barriers such as stigma, by involving health care providers from whom the poor, marginalized and most vulnerable seek care.

Reduced cost of care and financial protection for the poor

PPM reduces costs to patients by ensuring that treatment for TB is free of charge and all other costs are kept to a minimum. PPM can also reduce indirect costs for patients by providing services closer to their homes or workplace.

Ensured gathering of essential epidemiological data

PPM contributes towards completeness of epidemiological surveillance on TB when all care providers who diagnose and treat TB follow proper TB recording and reporting routines linked to national information systems.

Improved management capacity

PPM improves management capacity of both the public and the private sector, and can contribute to health systems strengthening in general.

Rationale and generic approach

In PPM, the NTPs are mandated to shoulder the stewardship role, to ensure that technical standards are met, drugs are provided free of charge to patients, and that all aspects of coordination, training, contracting, supervision and surveillance are carried out as per NTP guidelines. Suitable roles for different health care providers should be allocated according to the need of the programme, and the capacity and willingness of different health care providers.

The generic PPM approach involves the following main steps each of which requires provision of adequate human and financial resources:

1. A national situation assessment

National situation assessment is the first step to determine the need and possible ways to implement PPM interventions. Please refer to tool 2 for detailed information.

2. Creating national resources for PPM

It is important that a PPM focal point, and where required a steering committee and a team of consultants for support, should be appointed at the central level to coordinate and facilitate PPM implementation.

3. Developing national operational guidelines on PPM

Operational guidelines, to clarify the roles and responsibilities of NTP staff and non-NTP health care providers,

should be developed and implemented in consultation with relevant stakeholders. Please refer to tool 3 for detailed information.

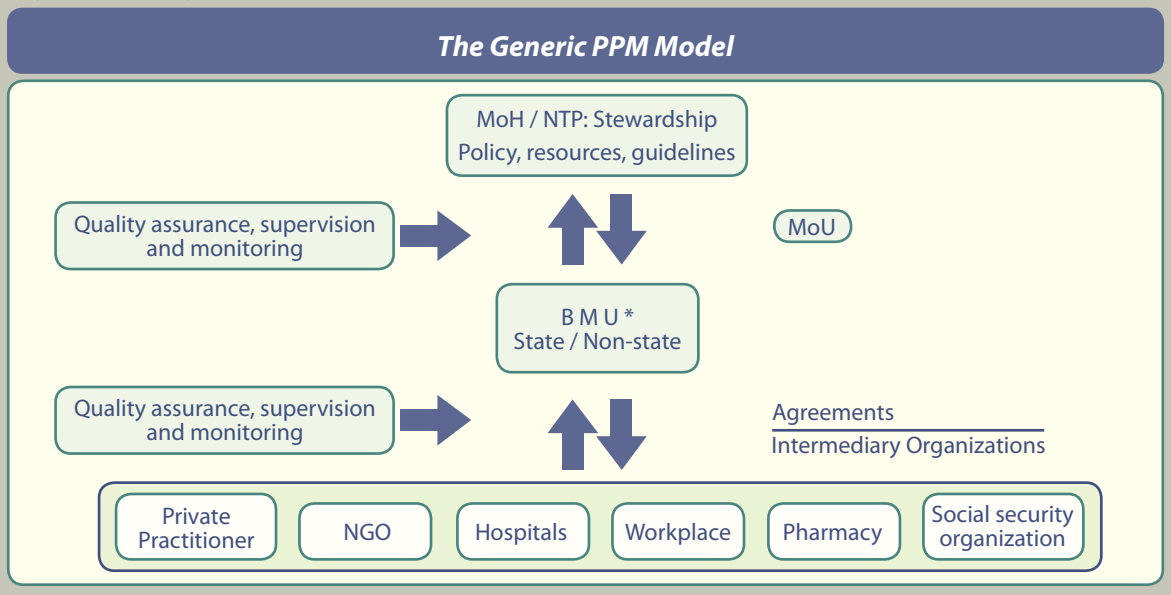
4. Local implementation

The key steps in local implementation of PPM for TB control include:

- Preparation
- Mapping of providers
- Proper implementation
- Advocacy and communication

Please refer to tool 3 for detailed information.

Figure 1. The generic PPM model



* Basic Management unit

5. Supervision and monitoring

The main aim of implementing PPM is to improve case detection and case management by bringing all patients managed by diverse health care providers under DOTS. Supportive supervision is important to monitor the progress of PPM in relation to defined objectives. This activity could be coordinated by the NTP and carried out in collaboration with professional associations or NGOs.

The details of the different steps, and special considerations for different types of providers are further discussed in other tools in this toolkit.

Key background reading

- Engaging all health care providers in TB control - guidance on implementing public-private mix approaches. Geneva: World Health Organization, 2006 (WHO/HTM/TB/2006.360). http://whqlibdoc.who.int/hq/2006/WHO_HTM_TB_2006.360_eng.pdf

CASE STUDY: Pakistan

Pakistan's large and diverse private health sector (both profit and not-for-profit) is extensively used by TB patients. In recent years, successive NTP managers have given high priority to developing viable partnerships with health care providers in this sector by using a systematic approach that is consistent with the steps recommended in WHO guidelines.

Introducing PPM began with a situational analysis that was used to design a range of PPM models suitable for the following types of providers: NGO clinics with and without laboratories; individual general practitioners (GPs); GPs who are grouped in clusters or linked to NGOs involved in social franchising; private clinics and hospitals; and informal providers (including both those who practice conventional medicine and those who do not).

Developing national operational guidelines as a foundation for countrywide implementation was followed by establishing and funding staff positions specifically

identification and selection of private partners; the