LOCAL SOLUTIONS FOR A GLOBAL PROBLEM

Public-Private Mix for TB care and control

Whilst access to treatment for tuberculosis (TB) has increased dramatically in the last ten years, not everyone has the same standard of care opportunities. Every day, thousands of TB patients are exposed to low-quality TB care. This not only causes unnecessary suffering and death, often with high costs for patients, but also damages the reputation of health facilities and health staff.

PPM encompasses diverse strategies such as Public-Private, Public-Public or Private-Private Mix that enable developing partnerships for delivery of TB care in national and local efforts to control TB. This benefits all - the sick patient, the community, the health care provider, the TB programme, and ultimately, the health of the whole nation.

DEMONSTRATED BENEFITS OF PPM

PPM contributes to the following six public health dimensions

1 Enhanced quality of diagnosis, treatment and patient support
PPM reduces malpractice by fostering evidence-based TB diagnosis and treatment in line with the International Standards for TB Care. This improves cure rates and reduces risks of drug resistance. It also limits misdiagnosis of TB and unnecessary and often costly treatments.

2 Increased case detection and reduced diagnostic delays
PPM helps increase TB case detection and reduces diagnostic delays by involving all health care providers in timely referral and diagnosis of TB.

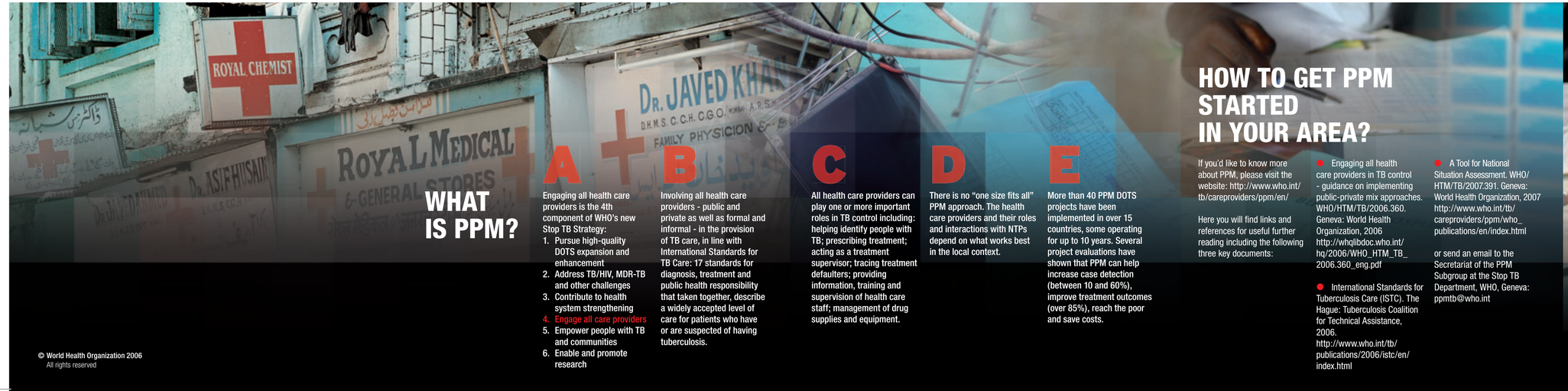
3 Improved and equitable access
PPM improves access to treatment by involving health care providers from whom the poor, marginalised and most vulnerable seek care.

4 Reduced cost of care and financial protection for the poor
PPM reduces costs to patients by ensuring that TB medicines are 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.

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

6 Improved management capacity
PPM improves the management capacity of both the public and the private sectors and can contribute to health systems strengthening in general.

PUBLIC-PRIVATE MIX (PPM) FOR TB CARE AND CONTROL IS AN EVIDENCE-BASED APPROACH, DEVELOPED FROM COUNTRY EXPERIENCES



WHAT IS PPM?

A Engaging all health care providers is the 4th component of WHO's new Stop TB Strategy:

1. Pursue high-quality DOTS expansion and enhancement
2. Address TB/HIV, MDR-TB and other challenges
3. Contribute to health system strengthening
4. Engage all care providers
5. Empower people with TB and communities
6. Enable and promote research

B Involving all health care providers - public and private as well as formal and informal - in the provision of TB care, in line with International Standards for TB Care: 17 standards for diagnosis, treatment and public health responsibility that taken together, describe a widely accepted level of care for patients who have or are suspected of having tuberculosis.

C All health care providers can play one or more important roles in TB control including: helping identify people with TB; prescribing treatment; acting as a treatment supervisor; tracing treatment defaulters; providing information, training and supervision of health care staff; management of drug supplies and equipment.

D There is no "one size fits all" PPM approach. The health care providers and their roles and interactions with NTPs depend on what works best in the local context.

E More than 40 PPM DOTS projects have been implemented in over 15 countries, some operating for up to 10 years. Several project evaluations have shown that PPM can help increase case detection (between 10 and 60%), improve treatment outcomes (over 85%), reach the poor and save costs.

HOW TO GET PPM STARTED IN YOUR AREA?

If you'd like to know more about PPM, please visit the website: http://www.who.int/tb/careproviders/ppm/en/

Here you will find links and references for useful further reading including the following three key documents:

- Engaging all health care providers in TB control - guidance on implementing public-private mix approaches. WHO/HTM/TB/2006.360. Geneva: World Health Organization, 2006 http://whqlibdoc.who.int/hq/2006/WHO_HTM_TB_2006.360_eng.pdf
- International Standards for Tuberculosis Care (ISTC). The Hague: Tuberculosis Coalition for Technical Assistance, 2006. http://www.who.int/tb/publications/2006/istc/en/index.html
- A Tool for National Situation Assessment. WHO/HTM/TB/2007.391. Geneva: World Health Organization, 2007 http://www.who.int/tb/careproviders/ppm/who_publications/en/index.html

or send an email to the Secretariat of the PPM Subgroup at the Stop TB Department, WHO, Geneva: ppmtb@who.int

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OUR EXPERIENCES

Dr. Hafizur Rahman

"village doctor" who runs a small pharmacy/clinic in the Tangail District of Bangladesh.

"My patients are very happy because they were treated and it didn't cost them any money. They now trust me and so come to my shop to buy other medicines.

My advice is to get trained and get involved in the TB control programme."

Dr Stefaan Van der Borght

Medical Adviser for Heineken. Heineken established a TB clinic in its brewery in Kinshasa in D R Congo.

"Now, workers and their families are seeing the benefits. There's been a reduction in the time it takes for TB diagnosis, treatment is easier, and the number of defaulters has decreased.

For anyone considering setting up a PPM project, you need perseverance, clear objectives and a clear definition of the problem and the solution. Finding the right person who has the authority to move things forward is also a real asset."

Dr Jaime Y. Lagahid

Director II, Infectious Disease Office, National Center for Disease Prevention and Control, Department of Health, Philippines.

"Through PPM we have now seen a significant increase in case detection, and cure rates exceeding the 85% benchmark. Identifying TB champions among private practitioners and creating public private coalitions against TB were important steps.

My advice to anyone wanting to create a PPM project is to make sure you have a strong DOTS programme, and also seek alliances with the private sector, NGOs, other government agencies, and the community."

Dr. L.S. Chauhan

Director of the Revised National TB Control Programme in India.

"Today we are able to see the benefits of PPM and we now know, for example, medical colleges – public and private – have made a sizeable contribution to TB control and so this is an area of work which is a programme priority. PPM has also strengthened the infrastructure and performance of the public sector due to greater responsibilities and expectations. The presence of a strong national TB control programme, led by the public sector, is crucial. PPM also needs to be introduced in a systematic manner, backed by resources, and planning around the involvement of the different health sectors."

Dr. Aung Tin Oo

General practitioner and member of the "Sun Quality Health" social franchise scheme run by Population Services International (PSI), Myanmar.

"GPs are the first point of contact for the community, especially the TB patients who are mostly poor with many social problems. Before joining the programme, I could not help them much. I was not aware of standard treatment guidelines, I could not do proper monitoring and supervision and it was difficult to ask the already poor patients to buy the full course of drugs.

Every GP has the potential to become involved in DOTS and has a duty in the fight against this deadly but curable disease. If we fail to do that as professional people, history would record us. We should work together until TB is no longer a health problem in our community."

Dr Carmelia Basri

Ex-NTP manager from Indonesia.

"Many TB patients prefer to be treated, not in health centres but in public and private hospitals not integrated into the National TB Programme. To address this, we began PPM projects to improve links between hospitals and health centres.

The International Standards for TB Care have been tremendously important in this process, especially for introducing quality standards in the hospital sector.

My advice is to take a stepwise approach with PPM. Don't be too ambitious, but be strategic. Make sure you strengthen your networks, have good training and staffs who are fully equipped."

Dr J.M. Chakaya

Chairman of the DOTS Expansion Working Group of the Stop TB Partnership, and former Manager of the National Leprosy and TB Programme in Kenya.

"We introduced PPM because there was previously no comprehensive approach to involving all relevant health care providers in TB control in Kenya. We also needed to ensure that all health services provide care in line with the International Standards for TB Care.

PPM has improved links between the National TB Programme and the public, private and voluntary sectors.

If you are considering creating a PPM project, it is a good idea to try and involve all stake holders. It really can improve collaboration and help standardize care given to TB patients."

COUNTRY EXAMPLES

Bangladesh – Engaging "village doctors"

Bangladesh is unique in its large NGOs undertaking DOTS implementation across the country with support and supervision from the national TB programme. It has an equally big private health sector as well, including a very large number of semi-formal "village doctors".

One of the large NGOs involved in TB control implementation, Damien Foundation Bangladesh (DFB), has successfully engaged the "village doctors". Currently, over 12,000 village doctors have been trained in a population of about 26 million. In 2006, they referred 28,376 TB suspects, among them 2,330 were diagnosed with smear positive TB (15% of all TB patients detected in the DFB areas). Between 1998 and 2006, around 32,000 TB patients received DOT from village doctors with a treatment success rate of about 90%.

The NTP is piloting involvement of other private providers such as workplaces (over 25 companies) and private practitioners in urban areas in Bangladesh, notably in Dhaka and Chittagong.

China – Hospital-TB Dispensary collaboration

The National Prevalence Survey in the year 2000 revealed that about 57% TB symptomatics had visited various health facilities for clinical consultation. Of these, about 91% first visited non-TB health facilities, i.e. general hospital, health unit in township and village, private clinic and other kind of health unit. Only about 4% and 1% of these symptomatics visited TB control units and TB hospitals, respectively.

Recognizing the potential of involving public hospitals in contributing to case detection and case notification rates, the Ministry of Health (MOH) established a national PPM (public-public mix) policy in 2005, encouraging hospital-TB dispensary collaboration using an innovative internet-based TB reporting system for TB suspect referral. Further, the MOH along with other international partners initiated various interventions to facilitate this collaboration, which included the formation of leading and supervisory groups at different levels, large scale training of hospital staff, compensation to county hospitals for management, incentives to doctors for referral of cases, equipping laboratories in a few "designated" hospitals for smear microscopy and training of laboratory technicians in external quality assurance (EQA).

A WHO review conducted in 2008 revealed that much progress has been achieved due to the efforts by the MOH to set up hospital-TB dispensary collaboration. Currently, a large proportion of TB suspects and cases, about 40% to 70%, which presented to the TB dispensaries, came from general hospitals. Overall, engaging hospitals has contributed to about 30% of all the detected TB cases in the country.

India – Mainstreaming PPM

The real benefits of PPM – improved treatment results and reduced costs of care to patients – were evident from many successful initiatives aimed at engaging India's vast number of private health care providers. Building on these, the Revised National TB Control Programme (RNTCP) has developed guidelines to institutionalize involvement of NGOs and private practitioners. As of December 2007, the RNTCP was engaging with 2,946 NGOs and 17,695 private practitioners.

An important part of mainstreaming PPM in India has been the public and private medical colleges. The RNTCP has constituted five zonal taskforces and seven nodal centers to steer and involve medical colleges across the country. Over 250 medical colleges were involved with the RNTCP as of December 2007 and approximately 10% of sputum positive cases were diagnosed at medical college microscopy centers.

Recognizing the potential of involving the corporate sector, the RNTCP is working with over 150 corporate houses through the Confederation of Indian Industries (CII), Federation of Indian Chamber of Commerce and Industry (FICCI) and the World Economic Forum to provide TB control in the workplace.

The RNTCP is also working closely with the Indian Medical Association to engage its broad network of 160,000 medical practitioners, with support from a five year – "Umbrella Model" project under the Global Fund.

The RNTCP's approach to other public sector institutions is directed at three levels: the central TB unit generates policy directive from the relevant ministries to health facilities under their jurisdiction; state-level RNTCP staff pursues it through; and local-level staff undertake training, implementation, support and monitoring.

The special initiative launched by the Central TB Division in India in 2003, to scale up PPM in 14 large urban areas came to a successful close at the end of 2007. Evaluations show important contributions to increased case detection and improved treatment results. A phased countrywide expansion is ongoing.

Indonesia – Linking public and private hospitals to the NTP

Since a large number of TB patients are managed in general and speciality lung hospitals, linking all public and private hospitals to the national TB programme has been the primary focus of PPM in Indonesia.

Inspired by a successful pilot project in Yogyakarta, the involvement of lung clinics and hospitals in PPM is expanding rapidly. By 2004, all 34 speciality lung hospitals, over 30% of all public and private general hospitals, and 7 medical college hospitals had become involved in DOTS implementation and contributed substantially to increased case detection. These facilities together with chest clinics contributed to 55% of all cases detected in the province in 2004, with a treatment success rate of 78% for hospitals and 85% for chest clinics.

The International Standards for TB Care have been endorsed and widely disseminated. Other pilot projects include schemes to involve NGOs, individual private practitioners, small private clinics and workplaces in PPM.

Kenya – Engaging private chest specialists

In 2000, a brand new strategy was launched aimed at engaging Nairobi's private chest physicians in TB control. The initiative allowed doctors to receive anti-TB drugs at reduced rates if they agreed to follow guidelines and keep records of TB patients, and report outcomes to the national TB control programme.

Still in its scale up phase, PPM in Nairobi is showing a positive impact. In 2005, 9% of 20,000 cases notified were managed by the private sector and their contribution is expected to rise to 20%. Similar schemes are now under way in four other major cities of Kenya. Altogether, 88 private sector DOTS centres have been established covering a population of about 5 million.

The focus of PPM is also broadening to include frontline private care providers – nurses and clinical officers. Training courses, based on the TB national guidelines, are also being offered through professional associations.

The Philippines – Public-Private Coalition Against TB

The first PPM DOTS (PPMD) project in the Philippines was set up in 1995 by a private infectious disease specialist based in a university hospital. Since then, several PPMD projects have been in place with support and encouragement from the Department of Health (DoH). These include initiatives in diverse settings such as hospitals, corporate health facilities, family practices and the workplace.

Evaluations of these projects convincingly demonstrated the feasibility of effectively engaging different types of health care providers in DOTS implementation. Collectively PPMD projects have shown a sustained impact on case detection and treatment success rates.

To facilitate large scale expansion of PPM, the DoH has received drugs from the Global Drug Facility and grants from the Global Fund and other donors. National and regional coordinating committees for PPMD have been created, operational guidelines for PPMD developed, training materials prepared, and over 220 PPMD units established across the country. As of December 2007, around 5000 physicians were trained and 48,206 patients were treated with high success rates at the PPMD units, over 60% of which were accredited by PhilHealth.

The Philippines Coalition Against Tuberculosis (PhilCAT), the 'TB DOTS outpatient benefit package' of PhilHealth – the national health insurance organization, and a large private sector project for TB control – PhilTIPS – have all contributed to effectively engaging all stakeholders in TB control.

ENGAGING ALL PUBLIC AND PRIVATE CARE PROVIDERS IN TUBERCULOSIS CONTROL

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