Exercise 8: Public-Private Public-Public Mix DOTS (PPM)

Assessing the number of cases that are being treated by private providers

Objectives:
- To review different approaches and methods for assessing case load in private sector not linked to NTP
- To discuss prioritization of different approached in relation to desired level of precision and available time and resources

Summary of two approaches: Viet Nam and Myanmar

A. Ho Chi Minh City, Vietnam
A comprehensive assessment of TB health seeking, diagnosis and treatment in the private sector was undertaken in Ho Chi Minh City (HCMC), between 1996 and 2000, as part of a PhD research project (1). At the time when these studies were conducted, the notification rate of new smear positive TB had been fluctuating around 100/100,000 for about 10 years. The estimated incidence of new smear positive cases in Vietnam was around 80/100,000, and therefore it might have appeared as if the case detection rate in HCMC was above 100%. However, the latest tuberculin survey (from 1994) indicated that ARTI was about 3%, which, using the "Styblo rule", suggested that the incidence might be as high as 150/100,000. Several tuberculin surveys had also indicated that the TB incidence was much higher in the southern parts of the country, where HCMC is located, than in the north. HCMC is the largest city in Vietnam (with an official population of >5 million) and had experienced a long period of rural-urban migration with increased population density. It was therefore plausible that the incidence was considerably higher than the national estimate. Furthermore, it was well known that the rapidly growing private sector was treating a substantial, but not quantified, proportion of the TB patients, without notifying to the NTP. One of the main objectives of the PhD research was therefore to estimate the magnitude of health seeking, diagnosis and treatment in the private sector.

Two qualitative interview studies of private doctors and patients respectively were initially performed in order to obtain a general understanding of the role of the private sector in TB control (2,3). This was followed by a retrospective survey of health seeking among patients registered for treatment in the NTP (4,5), and a survey of dispensing practices and TB knowledge among private pharmacists (6). In addition, a cohort study of treatment practices and treatment outcomes was conducted in a semi-private clinic (a clinic that was operated as a private for-profit-clinic, but inside a public hospital) (7). Finally, a survey of patients that had dropped out after diagnosis and before treatment initiation ("initial defaulters") in NTP was conducted (8).

Key findings were that 30% of people with TB had first sought help in a private pharmacy, 18% with a private doctor, and 27% with various public facilities other than NTP facilities. 27% had been in contact with a private doctor at any time during the health seeking, before treatment in NTP. There were no major differences in use of private sector between people from higher and lower socio-economic groups. The delay to diagnosis was considerable for many patients, and the most important reason was poor diagnostic routines in private sector and poor referral routines between private and public providers. It was estimated that about 40% of all the TB drug
dispensing took place outside NTP, while none of the cases treated in the private sector were notified to health facilities. Treatment success rate was about 50% in the private sector. Initial default was 8%, and 65% of these patients (initial defaulters) reported had started treatment elsewhere when interviewing them 4 weeks after diagnosis in NTP.

Following these descriptive studies, and intervention study was conducted to try to establish better collaboration between NTP and the private sector. This resulted in an 18% increase in case notification (9) in the districts where notification and referral from private sector had been improved. However, treatment success rate improved only marginally (10).

**B. Myanmar**

Myanmar embarked on a public-private mix (PPM) approach in the end of the 1990s, after it had become apparent that a large proportion of people with TB were being treated in the private sector (11). No formal descriptive research was conducted in order to quantify the case load in the private sector prior to starting interventions, though a research project was conducted in parallel with the implementation of PPM in order to further determine peoples’ health seeking behaviour and attitudes and practices among private practitioners (12).

Two different PPM initiatives were evaluated by monitoring the routine referral notification data from the private sector that was generated from the time of the PPM implementation, and which was integrated with the NTP recording and reporting system. Both evaluations showed that case notification increased considerably. In one site it increased with 85% in the PPM areas as compared to 57% in control sites which had general DOTS intensification activities, but no PPM (13).

The estimated incidence of new smear positive TB in Myanmar at the time of these initiatives was 76/100,000. One of the PPM was mostly rural, and there the notification increased from around 50/100,000 before to about 85/100,000 after the PPM initiative. The second PPM focused on private practitioners working in poor neighbourhoods and slums of the largest city in Myanmar, Yangon. In the Yangon townships (the BMU in Myanmar) where this PPM was done the notification of new smear positive cases in NTP (not including private sector cases) was around 150/100,000 (200% case detection rate based on the national estimate) even before the PPM initiative started. The combined NTP +PPM notification increased to around 200/100,000 (260% case detection rate) after PPM (14).

Additional operation research was conducted, by means of a patient survey, which showed that the vast majority of patients diagnosed and treated by the private practitioners that had become engaged through PPM were from the lower socio-economic groups, that the diagnostic delay was relatively short among those patients, and that the cost of treatment was low. However, the cost related to health seeking and diagnosis was still considerable for many poor patients (14).

**Task**

1. Discuss the results and implications of the two approaches (see attached additional reading)
2. Discuss the methods used, the amount of work involved in the two approaches, the feasibility, and the usefulness of the information generated. Which approach is preferred?

References


