ISSUE
01
JULY
2009

A NEWSLETTER ON ENGAGING ALL CARE PROVIDERS IN TB CARE AND CONTROL

PPMNews

Upcoming events

FIRST CONSULTATION ON ENGAGING WORKPLACES IN TB CARE AND CONTROL

12 OCTOBER 2009, GENEVA

This meeting will review existing evidence and experiences in implementation of TB workplace programmes and facilitate the development of a consensus framework for guiding engagement of workplaces in TB care and control

DOTS EXPANSION WORKING GROUP MEETING

13-14 OCTOBER 2009, GENEVA

The focus of this year's DEWG meeting is increasing case detection. The meeting will serve as a platform to share a range of new interventions and approaches in TB control among countries and partners, and discuss ways to accelerate progress in TB control particularly in case detection.

The Secretariat of the PPM Subgroup is provided by the WHO Stop TB Department

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Public-Private Mix: Genesis and Evolution

Nearly a decade has passed since the Stop TB Department of the World Health Organization (WHO) initiated efforts to help Member States systematically engage all care providers in the control of tuberculosis (TB) through public-private mix (PPM) approaches. Since then, TB control has expanded beyond the traditional realm of the public health sector to encompass a wide range of health-care providers outside the purview of national TB control programmes (NTPs). These include, for example, private clinics operated by formal and informal practitioners, and institutions owned by the public, private, voluntary, and corporate sectors (e.g. general and specialty public hospitals; non-governmental organizations (NGOs); faith-based organizations (FBOs); prison, military, and railway health services; and health-insurance organizations).

Governments have recognized the importance of engaging these providers, as they are approached by and manage a large proportion of patients with TB symptoms, including the very poor. Of further significance is the uneven and low quality of care delivered in the private sector, compounded by poor management practices and absence of patient follow up. Allowing irrational practices to continue tends to dilute the efforts of NTPs and also contributes to the growing incidence of hard-to-treat drug-resistant TB. There is special need to work with non-NTP providers to help them standardize and deliver TB care and services in line with international standards. This first issue of the PPM newsletter clarifies the concept of PPM and outlines its evolution over the past 10 years.

What is PPM ?

PPM may be defined as context-specific approaches to involve all relevant health care providers - public and private as well as formal and informal - in the provision of quality-assured TB care.

How did it evolve?

The first step in engaging all care providers in TB began in 1999-2000,with a global assessment spanning 23 countries across six WHO regions, to understand working approaches and develop a convincing case to encourage national programmes to work with the private health sector.

As a second step, WHO facilitated local PPM initiatives at diverse sites in Asia and Africa during 2000-2002. A systematic documentation of processes and outcomes of these and other projects provided evidence for their feasibility and effectiveness. This was followed by the establishment of the Subgroup on Public-Private Mix for TB care and control (PPM Subgroup) as part of the global DOTS Expansion Working Group (DEWG) to build on the work undertaken in

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engaging all care providers and to address the issue urgently and effectively.

The Subgroup secretariat based within the Stop TB Department took the lead on PPM, facilitating the establishment of additional learning projects, and developing practical tools such as the national situation assessment tool, the International Standards for TB Care (ISTC) and a policy guidance document to help national programmes initiate and scale up PPM.

How has PPM advanced TB control?

PPM has facilitated a shift in perception among countries about the importance of engaging all care providers and enhanced collaboration among diverse health care providers in various settings. Once excluded, private providers are now integral to global and national TB control strategies. Furthermore, engaging all care providers -- public, private, corporate, voluntary -- is now one of the six core components of WHO's Stop TB Strategy. PPM implementation has expanded from pilot projects to scaled up, nation-wide programmes across 14 high TB-burden countries (HBCs). Furthermore, 58 countries are receiving support for PPM implementation from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Several project evaluations have shown that PPM could help increase case detection (between 10% and 60%), improve treatment outcomes (over 85%), reach poor populations and save costs. In Karachi (Pakistan), for instance, PPM initiatives contributed to 53% of all TB cases detected in 2007.

PPM E-Learning Lab

What is the PPM E-Learning Lab ?

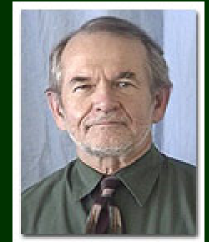
The PPM e-Learning Lab is a new tool designed to serve as a platform for collaboratively creating, sharing and using information on PPM. In a format similar to Wikipedia, it allows users to co-create a dynamic, open, high quality and useful resource for PPM.

What can it do?

The lab fosters and invites discussion from contributors on topical PPM issues. The lab also has an up-to-date section on the resources available for PPM. It is essentially a one-stop-shop for PPM.

We invite you to join in this space for creative dialogue and learning. The learning lab can be accessed at this link: PPMlearninglab

MESSAGE



Dr Phil Hopewell
CHAIR
PPM Subgroup

Considerable progress has been made in engaging all care providers in TB control, since WHO first launched the PPM approach more than a decade ago. Currently, all 22 HBCs which have adopted the Stop TB Strategy, also have explicit policies on engaging all relevant care providers in TB control. An increasing number (more than 12 countries) have large scale PPM programmes. The number of HBCs scaling up PPM interventions has more than tripled between 2005 and 2007, from 4 to 14 countries. Nearly 95 countries including 14 HBCs have incorporated the International Standards for Tuberculosis Care into the curricula of medical schools; while nearly 76 countries (including 13 HBCs) have integrated the standards into NTP training material. Furthermore, various initiatives to engage non-NTP providers ranging from private doctors to traditional healers and the corporate sector are under way. Information and data from these initiatives are valuable to help assist other countries and regions undertake similar collaborations.

This newsletter serves as a medium to facilitate the sharing of experiences and ideas on engaging all care providers in TB control.

Working together to put TB on the business agenda

According to the report on Global Employment Trends published by the International Labour Organization in 2008, there are currently 3 billion people in the world of work. Of these nearly 1.3 billion do not earn enough to lift themselves out of poverty, and it is often these poor workers and their families who are most affected by TB, HIV and other diseases. Studies suggest that on average, an employee with TB loses 3-4 months of work, resulting in potential losses of 20-30% of annual household income pushing the patient and the family deeper into poverty. Further, some workplaces are hotbeds for disease transmission, with employees spending long periods of time in close proximity. One study of garment workers in Bangladesh showed that they are 2.4 times more likely to develop active TB than the general population (960/100,000 prevalent TB cases among garment workers compared with 406/100,000 among the general population). In addition, a lot of the barriers to accessing TB and HIV associated TB (TB/HIV) services are linked to work-related concerns such as loss of wages or job discrimination.

Addressing TB and TB/HIV in the context of the workplace can help overcome these barriers and also provide access to essential services, for those in need as well as the general population.

There are myriad ways in which businesses can contribute to TB and collaborative TB/HIV efforts in the workplace and beyond. Some of these require little or no investment and may prove cost-effective for the company, the community and the country as a whole. These include: raising awareness among workers, families and the community; identifying TB cases among workers; TB and HIV testing, counseling, treatment and care at the workplace; inclusion of TB prevention, diagnosis and treatment in HIV workplace programmes; and comprehensive TB and HIV care programmes for workers, families and communities.

For workplace programmes to be truly sustainable there is a need not only for commitment and motivation from the business sector but also support from the public sector. In most countries NTPs work extensively with partners such as NGOs, private practitioners and in some cases businesses. In Bangladesh, Kenya and the Philippines, NTPs collaborate with businesses, providing their workplace programmes with anti-TB drugs as well as diagnostic reagents and microscopes. The technical expertise and knowledge available under national TB and AIDS programmes, combined with the investments made by businesses, can provide a critical mass of resources and play a crucial role in successful TB and TB/HIV care and control.

In the realm of health care especially in the face of debilitating epidemics such as TB and HIV, interventions by a spectrum of businesses are essential and should be considered more as a *corporate social duty*. Businesses of all sizes can contribute constructively to TB and HIV prevention, diagnosis and treatment. It involves taking the first step forward, and initiating TB and HIV care and control efforts in their own workplaces first.

The Stop TB Department is in the process of organizing a first consultation on engaging workplaces in TB control in Geneva, Switzerland on 12 October 2009.

FROM THE DEWG SECRETARIAT

Dr LEOPOLD BLANC
DOTS Expansion Working Group
Stop TB Partnership

The Millennium Development Goal (MDG) target of reducing prevalence and deaths from TB can be achieved if TB control efforts approach as closely as possible the global goals for case detection and cure rates. Although, cure rates are approaching the global goal, case-finding are still very low in many countries, and considerably below the rate needed to achieve the TB-related MDGs. Improving the rates of case detection, in particular, will require greater involvement from the private sector in TB control. PPM efforts need to be considerably scaled up in countries, using innovative approaches to engage a diverse range of providers based on the country setting. Furthermore there is need to document and share PPM experiences and initiatives to motivate and guide non-PPM countries to initiate efforts to engage all care providers.

I would like to take this opportunity to encourage all of you to contribute and share your experiences through this newsletter.

EYE ON IT

PPM in the Literature

Pantoja A, Floyd K, Unnikrishnan K. P, Jitendra R, Padma M. R, Lal S. S et al. **Economic evaluation of public-private mix for tuberculosis care and control, India. Part I. Socio-economic profile and costs among tuberculosis patients.** Int J Tuberc Lung Dis. 2009 Jun;13(6):698-704.

Pantoja A, Lönnroth K, Lal S. S, Chauhan L. S, Uplekar M, Padma M.R et al. **Economic evaluation of public-private mix for tuberculosis care and control, India. Part II. Cost and cost-effectiveness.** Int J Tuberc Lung Dis. 2009 Jun;13(6):705-12.

Ahmed J, Ahmed M, Laghari A et al. **Public private mix model in enhancing tuberculosis case detection in District Thatta, Sindh, Pakistan**. Pak Med Assoc. 2009 Feb;59(2):82-6.

Krishnan N, Ananthakrishnan R, Augustine S, Vijayalakshmi NK, Gopi PG, Kumaraswami V, Narayanan PR. **Impact of advocacy on the tuberculosis management practices of private practitioners in Chennai City, India**. Int J Tuberc Lung Dis. 2009 Jan;13(1):112-8.

CONTACT US:

We look forward to receiving your experiences, feedback and comments.
You can reach us at ppmtb@who.int

Sound Bytes from the Regions

Feedback from six WHO TB Regional Advisers on PPM progress in their regions

Dr Bah Keita
Regional Adviser-TB, Regional Office for Africa

A wide variety of health care providers in the African region operate outside the ambit of NTPs, including formal (private hospitals, medical practitioners, faith-based institutions and paramedical practitioners) and informal providers like traditional healers, play a very significant role in health care including TB care. Recognizing the need to incorporate these providers in national TB control efforts and ensure that they provide care in line with international standards, a regional PPM framework was drafted in 2004. Country support to implement various PPM concepts in NTPs has taken place since. Currently, formal PPM initiatives are in place in at least 14 African countries.

Dr Mirtha Del-Granado
Regional Adviser-TB, Regional Office for the Americas

An important challenge in the Americas is the poor engagement and participation of the private sector and some institutions of the public sector not working in line with international standards. Currently, PPM activities are primarily focused on engaging non-NTP public sector providers such as social security organizations, prisons, military and police. All 12 TB control priority countries have engaged these providers in TB control to some extent. Around five countries (Bolivia, Brazil, the Dominican Republic, El Salvador and Mexico) have initiated situation assessments for PPM implementation in pilot areas, while Ecuador has conducted a national situation assessment to scale up PPM.

Dr Akihiro Seita
Regional Adviser-TB, Regional Office for the Eastern Mediterranean

Among all communicable diseases, TB is still the number one killer of adults in the Eastern Mediterranean Region. Effective engagement of care providers in the public and private sectors in TB care is considered essential to improve case detection rate and ensure wider access to TB control services. Of the 22 countries in the region, Afghanistan, Egypt, Pakistan, Somalia, Sudan, the Syrian Arab Republic and Yemen have conducted situation assessments on PPM implementation, established task forces, developed PPM operational guidelines and plans, to implement PPM initiatives. These seven countries as well as the Islamic Republic of Iran, Lebanon, Jordan and Iraq, have started several PPM approaches according to defined tasks of each health sector. Results of PPM implementation are reflected in the quarterly case finding report that is submitted by all countries online, through the "QD online" available at: http://www.emro.who.int/stb

Dr Richard Zaleskis
Regional Adviser-TB, Regional Office for Europe

In Europe the problem of drug resistance dominates the overall TB situation. Of particular importance in the region is the engagement of public health care providers especially prisons, where transmission of multidrug-resistant TB (MDR-TB) is often prevalent. Efforts are under way to integrate TB control in prisons within the sphere of influence of NTPs. A thorough situation assessment is required to understand the scope of PPM in the region.

Dr Nani Nair
Regional Adviser-TB, Regional Office for South-East Asia

The South-East Asia Region has a strong private health sector. PPM is therefore key to effective TB control in the region. PPM initiatives in the region began in the early 1990s. All five HBCs in the region (Bangladesh, India, Indonesia, Myanmar and Thailand) have conducted situation assessments, appointed focal points in their NTPs, developed guidelines and are implementing PPM with a range of providers.

Dr Pieter van Maaren
Regional Adviser-TB, Regional Office of the Western-Pacific

PPM is a priority for four HBCs in the Western Pacific Region (Cambodia, China, the Philippines and Viet Nam). In all four countries, PPM operational guidelines have been developed or are in the process of development and the International Standards for Tuberculosis Care have been translated into local languages. Hospital-DOTS linkages are being piloted with intended scale up in China and the Philippines, and are planned in Cambodia and Viet Nam. Furthermore, the Philippines is applying the PPM approach for its MDR-TB programme.