

Public-Private Mix for TB Care and Control

Report of the Seventh Meeting of the Subgroup on
Public-Private Mix for TB Care and Control

Lille, France
23-24 October 2011



World Health
Organization

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Stop TB Partnership

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Abbreviations

ACSM	Advocacy, Communication and Social Mobilization
DEWG	DOTS Expansion Working Group
DOTS	The internationally recommended strategy for TB control
FHI	Family Health International
GDF	Global Drug Facility
GLI	Global Laboratory Initiative
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
HRD	Human Resource Development
ISTC	International Standards for Tuberculosis Care
JATA	Japan Anti-Tuberculosis Association
KNCV	Royal Netherlands TB Association
MDG	Millennium Development Goal
MDR-TB	multidrug-resistant tuberculosis
MSH	Management Sciences for Health
NGO	nongovernmental organization
NTP	national tuberculosis control programme
PEPFAR	The US President's Emergency Plan for AIDS Relief
PP	private provider
PPM	public–private mix
PPM Subgroup	Subgroup on Public–Private Mix for TB care and control
TB	tuberculosis
TBCAP	Tuberculosis Control Assistance Programme
The Union	International Union against Tuberculosis and Lung Disease
USAID	United States Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization
XDR-TB	extensively drug-resistant tuberculosis

1. Introduction

Engaging all care providers in TB care and control through public–private mix (PPM) approaches and promoting the International Standards for Tuberculosis Care (ISTC) are among the core components of the global Stop TB Strategy. Strengthening health systems through the involvement of all relevant health-care providers outside the national TB programmes (NTPs) is essential to meet the TB-related Millennium Development Goals and reach the targets for tuberculosis (TB) control set out in the Global Plan to Stop TB 2006–2015. The Stop TB Partnership’s Subgroup on Public–Private Mix for TB Care and Control (PPM Subgroup) has been instrumental in assisting countries to enhance collaboration among diverse public, private, voluntary and corporate care providers to improve access to high-quality TB care to all who need it.

The seventh meeting of the PPM Subgroup, supported by the TB CARE Program of the United States Agency for International Development (USAID), was organized in Lille, France, on 23 and 24 October 2011.

The seventh meeting was organized at a critical juncture with several countries implementing scaled- up PPM programmes and reporting contribution of PPM to TB case notifications for publication in WHO’s annual global TB control report. However, a large proportion of non-programme public, voluntary, private and corporate care providers still remain unlinked to national TB programmes. Large scale misuse of TB medicines outside TB programmes has not declined and few countries have embarked on complementary approaches such as mandatory case notification, accreditation of care providers or addressing irrational use of TB medicines. New TB diagnostics such as

line probe assays and Gene Xpert have been introduced and new TB drugs are on the horizon. Taking stock of the significant global, regional and country level progress on PPM expansion since the last meeting, the 7th meeting reviewed country approaches to regulate irrational use of TB medicines and discuss how PPM programmes can facilitate introduction and expansion of new diagnostics and new drugs to non-programme care providers. Further, taking into account the ongoing restructuring of the Working Groups of the Stop TB Partnership, the meeting also addressed key components of a biennial action plan that could help a potential new structure to continue addressing engagement of all care providers in TB care and control.

This report summarizes the proceedings of the seventh meeting. The objectives and expected outcomes are presented in Section 2. Section 3 briefly outlines the presentations and discussions at the meeting, while the fourth section lists the major conclusions and recommendations.

2. Objectives and expected outcomes

2.1 Objectives

1. To review the global and regional progress on PPM;
2. To share processes and outcomes of PPM scale up by national TB programmes in Asia and Africa;
3. To discuss the potential of PPM in the introducing new diagnostics and new drugs for TB;
4. To identify key components and activities of a biennial global action plan on engaging all care providers through PPM approaches.

2.2 Expected Outcomes

1. A review of global, regional and working examples of national progress in scaling up engagement of all care providers through PPM approaches;
2. Possible ways to use PPM platforms to introduce new diagnostics and new TB drugs and ways to promote their rational use;
3. Identification of key components and activities of a biennial global action plan on engaging all care providers through PPM approaches;
4. Recommendations for sustaining and expanding work on PPM for TB care and control.

3. Summary of presentations and discussions

The presentations, discussions and in-depth deliberations in break- out groups over the two days covered a wide range of topics. These included: overall progress in PPM implementation from global, regional and country perspectives; innovative initiatives such as engaging pharmacists in TB care and control and country experiences with ensuring rational use of TB drugs; and implications of introduction of new diagnostics and new drugs for TB for PPM. Ways to harnessing resources for PPM expansion and a comprehensive “white paper” on “increasing the effectiveness of the Stop TB Partnership in engaging all care providers” were also discussed. Facilitated by area experts, the participants formed small groups to discuss actions required under four specific areas: strengthening country capacity for PPM scale up, engaging pharmacists in TB care and control, using PPM programmes for introducing new diagnostics and drugs and strengthening advocacy and surveillance for PPM.

To access meeting presentations please click on this link,

<http://www.who.int/tb/careproviders/ppm/sevenths subgroupmeeting/en/index.html>

4. Recommendations

The meeting concluded with full agreement on the following recommendations:

To the DOTS Expansion Working Group and the Stop TB Coordinating Board:

1. **Accord the PPM Subgroup full Working Group status (or equivalent in the new structure).** Engaging all care providers through context-specific PPM approaches is widely accepted now as integral and essential to achieving universal access to quality TB care. Successive global TB control reports have shown significant and increasing contribution of non-programme care providers to TB care and control. The need and potential of further PPM scale up to help address stagnating case notifications and slow decline in TB incidence are very clear. PPM approaches should also be incorporated into other components of the Stop TB Strategy including programmatic management of MDR-TB, collaborative TB/HIV activities, operational research on the introduction and uptake of new diagnostics and drugs, and ACSM (Advocacy, Communication and Social Mobilization) strategies. In the restructuring of Stop TB Partnership's Working Groups currently under way, according the PPM Subgroup full Working Group status would help accelerate expanding access to quality TB care through PPM scale up and enable achieving much needed mainstreaming of PPM into the various components of the Stop TB Strategy.
2. **Communicate effectively to Stop TB Partners and NTPs the PPM approaches with proven impact on TB care and control.** Evidence from PPM scale up in diverse country settings shows that significant increase in case notifications while maintaining high treatment success rates is achievable by prioritizing engagement of

large hospitals and large faith-based and non-governmental organizations. Country experiences also indicate that productive involvement of private practitioners is greatly facilitated by entrusting the task of engaging them to intermediary agencies such as professional associations and social franchising organizations. There is also a need to prioritize workplace TB programmes.

3. **Disseminate the WHO/FIP Joint Statement widely and promote engagement of pharmacy associations and drug regulatory bodies in national partnerships to Stop TB.** Pharmacists have been shown to contribute to TB care and control in various ways including early referral of TB symptomatics, treatment support and ensuring rational use of TB drugs. Enhancing the engagement of pharmacists will require: monitoring and evaluation of working approaches to engage pharmacists, compiling and disseminating country experiences on best practices. Contribution of pharmacists to TB care and control should be highlighted in the global TB report. Pharmacy engagement should be undertaken in an integrated, health systems approach that also incorporates TB care and control.
4. **Track sale and use of new diagnostics in public and private sectors in collaboration with national authorities and manufacturers.** Availability of new diagnostic tests for TB such as geneXpert MTB/RIF has opened up new possibilities to strengthen and expand collaboration between the public and private sectors. Tracking sale of new machines and cartridges in the private sector should go hand in hand with ensuring recommended protocols for diagnosis and treatment of TB and drug-resistant TB. For this purpose, a coordinated approach to set up collaboration among NTPs, the manufacturers, private sector laboratories and care providers is recommended.
5. **Develop the public health case for protecting new TB drugs from irrational use and work with stakeholders to identify channels through which new TB drugs should be made available.** Evidence shows that large quantities of TB drugs are misused outside NTPs especially in countries with a large private sector. Irrational use of TB drugs leads to emergence and spread of drug-resistant TB. In order for them to remain effective, new TB drugs need to be protected from potential irrational use. It is important therefore to develop the public health case on the extent to which sales, distribution, prescription and dispensing rights for new TB drugs should be restricted.

Furthermore, it is also essential to determine effective ways of ensuring rational use and wide availability of new TB drugs. This will require all stakeholders including NTPs, regulatory authorities, and drug manufacturers working closely together to address the issue.

- 6. Advise ways to secure and sustain resources for PPM scale up.** In view of the likelihood of fewer resources being available to scale up and sustain PPM programmes, countries need to be advised and assisted to secure funding through available and new TB-specific resources as well as those available for multi-sectoral, integrated initiatives.

To National TB Programmes / Ministries of Health

- 1. Prioritize scaling up PPM and ensure documentation and reporting of contributions of non-programme care providers.** The global TB report of 2011 shows that non-programme public and private care providers contributed about 20% to 40% of the notified TB cases in 20 countries including 10 high TB-burden countries¹. A general observation however has been that the proportion of private care providers actively collaborating with NTPs still remains modest. In order to detect all TB cases and detect them early, NTPs need to prioritize scaling up engagement of private formal and informal care providers. Further, in some instances, NTPs do not report cases managed by long-term partners such as faith-based organizations, academic institutions or corporate health institutions under PPM contributions. In order to both determine and acknowledge input from all collaborating health facilities and to facilitate standardized reporting across countries, NTPs should ensure that records related to referral, diagnosis and treatment of TB cases by all non-programme care providers are maintained, analyzed and reported at the national as well as global levels.
- 2. Intensify engagement of large hospitals to improve case notifications and treatment success of large proportions of people with TB presenting to hospitals.** In many countries a large proportion of TB symptomatics and cases present themselves to

¹ For one country viz. India, the reported contribution was from 14 large cities covering 50 million population only, where a PPM surveillance system is in place

and are managed in large hospitals. Evidence from some settings shows that significant proportions of these cases are not managed according to national or international recommendations and are not notified. Setting up mechanisms for interdepartmental coordination within hospitals and linkages with peripheral public and private health facilities for referral and follow up has been shown to help increase case notification and improve care.

3. **Consider using intermediary agencies to scale up engagement of formal and informal private practitioners.** While engaging solo private practitioners has been shown to increase early case detection, working with a large number of formal and informal private practitioners, training and orienting them, supervising them and providing them adequate support poses challenges for NTPs. Experiences in several countries have shown that intermediary agencies such as social franchising organizations, non-governmental organizations and professional associations can be very effective in engaging private practitioners in TB care and control.
4. **Adapt and implement the WHO/FIP joint statement on the role of pharmacists in TB care and control.** Pharmacists are the first point of contact for many people with symptoms of TB and have been shown to contribute to TB care and control in various ways including, for example, early identification and referral of TB symptomatics. The recently launched statement on the role of pharmacists in TB care control jointly by WHO and the International Pharmaceutical Federation describes how pharmacists can collaborate with TB programmes and urges NTPs and national pharmacy associations to work together to tap the potential of pharmacists in enhancing early case detection and improving TB treatment and care.
5. **Secure resources through TB specific and multi-sectoral channels to help scale up PPM programmes.** In many countries PPM initiatives are being implemented with support from external project-based funding. Scaling up and sustaining PPM programmes will require continued availability of resources. In preparing for a potential shortfall in the availability of external finances, NTPs should secure funding to sustain and expand PPM initiatives not only through traditional channels but also multi-sectoral and multi-programme initiatives designed to achieve synergy and improve efficiency.

6. **Strengthen the system for monitoring of importation of new diagnostics and set up a system of quality assurance, regulation and accreditation for the users of new diagnostics.** Introduction of new tests such as geneXpert MTB/RIF for the diagnosis of TB and drug-resistant TB will increase the monitoring responsibilities of NTPs. NTPs should use the opportunity not only to strengthen their own system of laboratory quality assurance but also to monitor sale of the new machines in the private sector and institute methods for certifying and accrediting private providers using new diagnostics. Further, NTPs should also ensure that all patients diagnosed as TB receive appropriate treatment and care.

7. **Work with drug regulatory authorities and other stakeholders to address availability new TB drugs to non-programme care providers and ensure their rational use.** Considering global evidence on massive misuse of first-line TB drugs in the private market in many high TB-burden countries, NTPs should be alert as to how the “precious few” new TB drugs when available, will be made accessible to and used appropriately in the private market. In collaboration with stakeholders including drug manufacturers, drug regulatory authorities, pharmacy associations, civil society and Stop TB partners, NTPs should assess the extent to which the availability of new TB drugs to the private sector should or should not be restricted and ways of effectively enforcing any restriction.

To the PPM Subgroup Secretariat

1. **Support documentation and dissemination of innovative and effective PPM approaches being implemented in diverse country settings and facilitate scaling up of successful initiatives.** The PPM Subgroup secretariat, advised by the PPM Core Group, should coordinate documentation and dissemination of innovative approaches such as engaging pharmacists in TB care and control, diverse PPM-related interventions being implemented within TB REACH supported projects and introducing new diagnostics and drugs in the private sector.

2. **Pursue strategies and activities outlined in the white paper on engaging all care providers to increase effectiveness of the Stop TB Partnership.** The white paper

lists clear objectives and strategies to further PPM expansion and the PPM tool-kit provides the tools to help implement many of the strategies outlined.

3. **Continue supporting countries to strengthen and improve PPM implementation including surveillance.** Precise data on the contribution of PPM initiatives to TB control have now been reported in two successive reports on global TB control. It is important to ensure that there is continuity in this reporting. The Secretariat should follow up and help produce PPM specific data for the global TB report from an increasing number of countries.

Appendix 1.

Agenda

23 October 2011		
8:30 - 9:00	Registration	
<i>Session I: Introduction</i>		<i>Chair: Phil Hopewell</i>
9:00 - 9:10	Welcome, objectives and agenda	<i>Phil Hopewell</i>
9:10 - 9:15	Opening remarks	<i>M Raviglione / D Weil</i>
9:15 - 9:30	Discussion on the meeting agenda	All
<i>Session II: Panel: Global and regional progress</i>		<i>Chair: Cheri Vincent</i>
9:30 - 10:00	Global progress and issues	<i>Mukund Uplekar</i>
10:00 -10:30	Panel discussion: Regional perspectives	<i>Regional Advisors / their representatives: AFR, AMR, EMR, EUR, SEAR, WPR</i>
<i>COFFEE 10:30 – 10:45</i>		
<i>Session III: Spotlight: Country progress</i>		<i>Chair: D'Arcy Richardson</i>
10:45 -11:15	Scaling up PPM in Nigeria	<i>J Obasanya</i>
11:15 -11:45	Scaling up PPM in Indonesia	<i>D Mustikaveti</i>
11:45 -12:15	Scaling up PPM in Myanmar	<i>Thandar Lwin</i>
12:15 - 12:30	Social franchising for TB care: global experience	<i>May Sudhinaraset</i>
<i>LUNCH 12:30 – 13:30</i>		
<i>Session IV: Innovative approaches</i>		<i>Chair: S Egwaga</i>
13:30 – 14:00	Systematic approach to engaging hospitals: Philippine experience	<i>L Vianzon</i>
14:00 - 14:30	Engaging pharmacies: country experiences	<i>D'Arcy Richardson</i>
14:30 - 15:00	WHO-FIP joint statement on role of pharmacists in TB care and control	<i>Xuanhao Chan and Monica Dias</i>
15:00 -15:15	Rational use of TB drugs: country approaches	<i>Mukund Uplekar</i>
<i>COFFEE 15:15 – 15:30</i>		
<i>Session V: New tools and approaches</i>		<i>Chair: L Vianzon</i>
15:30 -16:00	New TB drugs and the private market	<i>William Wells</i>
16:00 -16:30	Gene Xpert and the private sector	<i>Evan Lee</i>
16:30 -17:00	PPM in TB REACH	<i>S Sahu</i>

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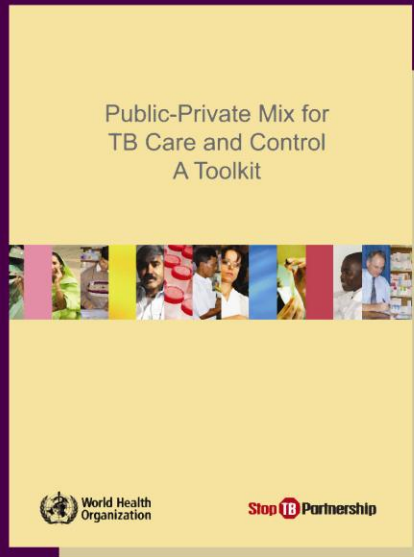
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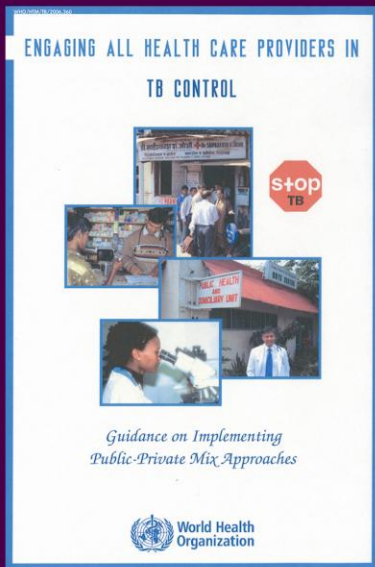
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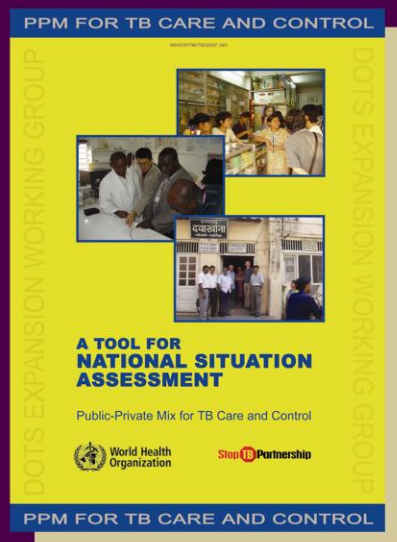
Four useful tools for PPM planning, implementation and advocacy



"The PPM toolkit"



"The PPM Guidance Document"



"The National Situation Assessment tool"



"The PPM Advocacy Brochure"

These and other PPM documents can be downloaded from the PPM homepage at:

www.who.int/tb/careproviders/ppm

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