



# Public-Private Mix for TB Care and Control

Report of the Inter-Regional Planning Workshop on Public-Private Mix for Tuberculosis Control

25–28 February 2007

World Health Organization

Regional Office for the Eastern Mediterranean

Cairo, Egypt



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Stop TB Partnership

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## Contents

Abbreviations	ii
1. Introduction	1
1.1 Background	1
1.2 Collaboration with the Tuberculosis Control Assistance Program	1
1.3 The Inter-Regional Planning Workshop	1
2. Specific objectives and expected outcomes	3
2.1 Specific objectives	3
2.2 Expected outcomes	3
3. Summary of presentations, discussions and group work	4
3.1 Presentations and group work	4
3.2 Discussion: Areas for Priority Action and Way forward	4
4. Summaries of National Situation Assessments and Operational plans	6
Annex 1. Agenda	55
Annex 2. List of participants	57
Annex 3. National Situation Assessment Tool - A Summary	61
Annex 4. Evaluation of the Workshop	67

## Abbreviations

AIDS	Acquired immunodeficiency syndrome
BPHS	Basic package of health services, Afghanistan
DOTS	The internationally recommended strategy for TB control
Fidelis	Fund for Innovative DOTS Expansion through Local Initiatives to Stop TB
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GLRA	German leprosy and tuberculosis relief association
HIV	Human immunodeficiency virus
IEC	Information, education and communication
ISTC	International standards for tuberculosis care
LGA	Local government area in Nigeria
MDR TB	Multidrug-resistant tuberculosis
NGO	Nongovernmental organization
NSA	National situation assessment
NTP	National TB programme
PHP	Private health provider
PPM	Public–private mix
PPM DOTS	Public–private mix for DOTS expansion
TB	Tuberculosis
TBCAP	Tuberculosis Control Assistance Program
TB/HIV	The intersecting epidemics of TB and HIV
USAID	United States Agency for International Development
WHO	World Health Organization

# **1. Introduction**

## **1.1 Background**

The World Health Organization (WHO) has been making significant efforts to enhance the role of private and public care providers working outside the national tuberculosis programme (NTP) in providing tuberculosis (TB) care and control services. Engaging all care providers in TB control through public–private mix (PPM) approaches, with the help of the new international standards for tuberculosis care (ISTC), is a core component of the new Stop TB Strategy (2006–2015). Realization of the need, feasibility and effectiveness of PPM based on evidence from successful initiatives has pushed PPM to the forefront of many national agendas for TB control. Currently, 11 countries with a high burden of TB (Bangladesh, China, the Democratic Republic of the Congo, India, Indonesia, Kenya, Mozambique, Myanmar, the Philippines, the United Republic of Tanzania and Viet Nam) have started scaling up PPM for TB care and control. Cambodia, Nigeria, Pakistan, Thailand and Zimbabwe have developed PPM guidelines and are preparing to scale up implementation, while the remaining high-burden countries are either initiating or preparing for PPM pilot projects. In addition, over ten countries have PPM programmes supported in their early stages by the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund); these include Ghana from the WHO African Region (2 grants) and Pakistan from the Eastern Mediterranean Region.

Several Asian countries with a large private sector are making reasonable progress with PPM and already have success stories under their belts. In the African and Eastern Mediterranean Regions, however, NTPs require additional support to scale up TB control efforts and effectively tap the significant potential of their rapidly growing private sector. This is particularly important for the African Region, where the characteristics of the private sector are somewhat different from those of other regions. There are more informal than formal private providers, faith-based hospitals play an important role, and the corporate health sector (the mining and tea industries for instance) could potentially contribute significantly to controlling TB and TB/HIV coinfection.

## **1.2 Collaboration with the Tuberculosis Control Assistance Program**

The United States Agency for International Development (USAID) supports a five-year programme for international TB control – the Tuberculosis Control Assistance Program (TBCAP) – which offers an excellent opportunity to make rapid progress on PPM. TBCAP provides USAID priority countries with technical assistance on TB control through a coalition of technical agencies. Various PPM activities were initiated under TBCAP's work plan for 2005–2006 (APA1): consultants were trained in PPM implementation; a national situation assessment (NSA) tool for PPM was developed; and the tool was reviewed and endorsed at a PPM subgroup meeting in September 2006, at which participants from TBCAP countries were briefed on PPM. The NSA tool was then used, with TBCAP support, to carry out situation assessments in five countries in the Eastern Mediterranean Region and four in the African Region.

## **1.3 The Inter-Regional Planning Workshop**

The Inter-Regional Planning Workshop on Public–Private Mix for Tuberculosis Control, organized in Cairo, Egypt from 25 to 28 February 2007 and hosted by the

WHO Regional Office for the Eastern Mediterranean, was also supported by TBCAP. The participants included national TB programme managers and national PPM focal points from the six Eastern Mediterranean Region countries and five African Region countries that had carried out NSAs for PPM. Pakistan and Uganda were exceptions: Pakistan had completed an independent assessment and Uganda was unable to complete the assessment in time for the workshop. The workshop offered hands-on support to the participants in preparing short- to medium-term plans for PPM implementation. Participants were introduced to the new WHO planning and budgeting tool to aid them in preparing budgets for their operational plans. The planning and budgeting tool is specifically designed to help countries develop plans and budgets for TB control at national and sub national levels within the frameworks provided by the Global Plan and the Stop TB Strategy. Following the workshop, countries are being supported in implement their plans through advice and, if required, visit(s) by trained PPM consultants.

Workshop presentations and discussions are summarized in Section 3 of this report. Summaries of the situation assessments and operational plans for each country are presented in Section 4. The agenda of the meeting and the list of participants are reproduced in Annexes 1 and 2, respectively.



**Opening of the Workshop**

## **2. Specific Objectives and expected outcomes**

The overall objective of the Workshop was to assist NTP managers in preparing sound, budgeted and action-oriented operational plans for PPM implementation in their respective countries. The specific objectives and outcomes expected of the meeting were as follows.

### **2.1 Specific objectives**

1. To review progress made in involving all TB health care providers in TB control activities in the participating countries.
2. To discuss the results of the PPM NSAs in the participating countries.
3. To support countries in developing realistic, country-specific, short- to medium-term PPM operational plans, together with budgets, based on the NSAs and available collective global experience and resources.

### **2.2 Expected outcomes**

1. An improved version of the NSA tool for wider use.
2. Country-specific, action-oriented, operational plans for PPM initiation and/or expansion, including a detailed budget, for the first two years.

### **3. Summary of presentations, discussions and group work**

#### **3.1 Presentations and group work**

The Workshop was opened by the Assistant Regional Director of the WHO Regional Office for the Eastern Mediterranean. This was followed by presentations on the objectives and framework of the workshop and the basic concepts, tools and evidence for PPM. Countries then presented the main results of their NSAs, and this was followed by in-depth discussion and input from other country representatives as well as facilitators.

On the second day, the NSA tool was jointly evaluated and feedback from participants was collated. The tool received positive feedback, the participating countries reporting it to be very comprehensive and user-friendly and an invaluable asset in conducting situation analysis. Nevertheless, it was acknowledged that the tool only provided a framework for carrying out a situation assessment in the country and that it had to be tailored to individual country settings. Some NSAs, such as those of Afghanistan and Pakistan, had modified the tool to include additional components such as SWOT analyses. A template had been designed by the WHO Regional Office for the Eastern Mediterranean to facilitate preparation of the NSA, and this was greatly appreciated and found useful by countries. The tool is in the process of being finalized for direct use by countries. A summary of the NSA tool is reproduced in Annex 3.

The participants then divided into groups, each comprising a country NTP manager, national PPM focal point and facilitator, for in-depth discussions and to design a two-year national operational plan using a pre-designed template. The facilitators provided guidance and helped to keep the focus on key points of relevance. In addition, the participants were introduced to and provided with hands-on training on the planning and budgeting tool. The tool was utilized in the preparation of budgets for country operational plans.

Periodic plenary sessions were held through the Workshop to discuss certain aspects of the operational plan and to ensure that all countries were on the right track. In the plenary on the final day, each country presented the highlights of its plans and budget for PPM implementation, with details of the immediate next steps for 2007. Each country also identified resource requirements and funding gaps as well as any need for technical assistance from WHO.

#### **3.2 Discussion: areas for priority action and way forward**

The country representatives deliberated on several crucial areas for the implementation of PPM in their countries and formulated their national vision for PPM, areas for priority action over the first year, and the way forward. They incorporated the important elements of: government commitment; funding; sufficient time for dialogue and planning with all relevant stakeholders; clearly defined role division and responsibilities; initial “hand-holding” and ongoing supervision by the NTP; simple tools to improve referral and information systems; and availability of an interface, such as a local nongovernmental or professional organization, into the operational plans. There was general consensus on the need to start with functional pilot projects that demonstrated desirable outcomes before scaling up.

### **Capacity building**

Training constituted a significant portion of the main priority activities for PPM implementation for all the countries in both regions. One of the key considerations for the development of training modules for non-NTP providers included the need to ensure a process of continuous dialogue and involvement of the non-NTP sector. The involvement of medical or professional associations in this process and the cultivation of “champions” for PPM from the non-NTP sector were acknowledged to be advantageous and effective. The need to train NTP staff on PPM and clarify their responsibilities vis-à-vis collaborating providers was also stressed.

### **Resource mobilization**

During the discussion, several participants expressed concern about the constraints on mobilizing resources for their operational plans. The need for pilot initiatives with positive results was found to be imperative in this regard, in order to gain donor support. Participants were advised to apply for funding from the Global Fund’s Round 7. USAID funding is available at country level through TBCAP, and countries were encouraged to apply for this. Countries with approved Global Fund proposals were asked to consider initiating and expanding PPM implementation with the Global Fund resources already available to them. Some countries resolved to re-programme their Global Fund budgets to fund their PPM operational plans.



**Participants from the Syrian Arab Republic and facilitators working on the operational plan**

## 4. Summaries of NSAs and operational plans

### A. AFGHANISTAN

#### Situation assessment

##### TB EPIDEMIOLOGY

Incidence (all cases/100 000 population/year)	168
Incidence (ss+ cases/100 000 population/year)	76
Prevalence (all cases/100 000 population)	288
Mortality (deaths/100 000 population/year)	35
New adult TB cases HIV-positive (%)	0.0
New MDR TB cases in 2004 (%)	1.7
Notification rate (new & relapsed cases/100 000 population/year)	73
Notification rate (new ss+ cases/100 000 population/year)	33
DOTS case detection rate (new ss+ cases) (%)	44
DOTS treatment success (new ss+ cases) (%)	89

##### UTILIZATION OF HEALTH SERVICES

#### Health-care-seeking behaviour in the public and private sectors

- The not-for-profit NGOs are the main implementers in the health system in Afghanistan, particularly in the implementation of the Basic Package of Health Services (BPHS). BPHS coverage is estimated at 82% of the total Afghan population, operating primarily in the main cities and relatively secure areas.
- The for-profit private sector is usually the first point of contact for the patient for any ailment.
- In Kabul, 55% of TB patients seek health care in the private sector.
- A study in Nangarhar indicated that 79% of the population use pharmacies or private practitioners as their primary source of health care.

#### Cost of care

- Unqualified private providers charge less than qualified doctors. Specialist general practitioners (GPs) are the most expensive care providers.
- The fee charged by GPs is in the range 100–200 afghanis (US\$ 2–4). Newly graduated doctors charge 50–100 afghanis (US\$ 1–2).

- Laboratory charges for sputum smear microscopy are again variable, depending on the type of laboratory, and range between 300 and 400 afghanis (US\$ 6–8).

#### Access to care

- The health services in the rural areas of Afghanistan are scanty.
- The NGO sector is gathered around the main cities.
- BPHS implementation is restricted owing to a destroyed or nonexistent infrastructure and security problems in rural areas.
- Accessibility of services for a large section of the population is affected by extreme weather such as snow and floods.

#### Delays and discontinuities in treatment

- In addition to delays on the part of service providers, the ability of patients to reach health facilities is a major constraint.
- Poor communication, lack of (4 x 4) transportation and affordability of transportation are the major impediments for the patient in accessing care at an early stage.

## COMPOSITION AND CHARACTERISTICS OF THE NON-NTP CARE PROVIDERS

- TB services are given priority in the BPHS and NTP plays a significant role in the execution and monitoring of TB component in the BPHS and technical support to the NGOs.
  - The major public and semi-public health services outside the Ministry of Public health and the NTP are the Military Health Services, health services under the Ministry of Justice (Prisons), the Ministries of the Interior, Education and Higher Education, and the Afghan Red Crescent Society.
  - For-profit private providers are the most popular health care providers in the community and are mostly found in urban areas. They comprise private practitioners (some of whom work in both the public and private sectors), specialist doctors, private pharmacies, private hospitals, private laboratories, bio medically unqualified practitioners, mobile drug sellers in urban and rural areas, *hakims* and traditional healers.
  - The not-for-profit providers are mainly NGOs working with the Ministry of Public Health, as part of the BPHS or individually.
- Capacity for DOTS in the private sector**
- BPHS implementers have the capacity to sustain partnership activities provided that funding from the Ministry of Public Health and donors continues. Their technical strengths need to be regularly enhanced to sustain the quality of DOTS.
  - The for-profit private sector needs to be prepared for providing potential partners.

## PREPAREDNESS OF THE NTP

- The NTP has vast experience of PPM. It is already involved in partnerships with various private providers under the BPHS.
- In addition, it has several TB professional partners outside the BPHS. These include not-for-profit NGOs working under their own resources or through funding from donors outside the Ministry of Public Health's grant management system.
- The NTP has a strategic plan for PPM activities, a strong management and operational capacity, guidelines for TB case management, and the ability to support an enabling environment.
- A national PPM officer has been assigned.
- A national PPM task force has been established.
- There are nevertheless many areas that need to be strengthened if effective PPM for TB care and control is to be established. These include further strengthening of NTP technical capacity and enhancing the role of NTP in BPHS.

## POLICY AND REGULATORY ENVIRONMENT

There are policies and regulations for the registration of medical practitioners, pharmacies and laboratories, and for the

quality control of medicines. However, detailed information on these was unavailable.

## Operational plan

### OBJECTIVES

#### Main objectives

- To increase case detection by enhancing the ability of private health providers to identify and diagnose pulmonary TB cases.
- To increase treatment success rate by improving the quality of TB care received by patients attending private facilities.
- To reduce drug resistance due to inappropriate TB treatment and management.
- health care providers in TB case management.
- To build the TB case-management capacity of non-NTP health care providers.
- To reduce the delay in diagnosing of suspected TB patients seeking health care from non-NTP health care providers.
- To improve the TB case recording and reporting system in the non-NTP health care sector.
- To reduce the direct and indirect costs to TB patients.

#### Specific objectives

- To improve access to quality TB services for the poor population by involving of non-NTP

### DESCRIPTION OF THE PROPOSED PPM STRUCTURE

- A special department for PPM implementation is to be established by the NTP and known as the "New Initiative Department".
- National PPM officer to be assigned within the NTP to coordinate activities for establishing PPM DOTS with the cooperation of the NTP team and stakeholders.
- National PPM task force to be established to exclusively oversee TB-related partnership activities at central level.
- Provincial PPM coordination committees to be established to support PPM activities at provincial level.
- Regional and provincial TB coordinators to be appointed who will be responsible for coordinating PPM DOTS activities in related areas.

### PPM OPERATIONAL GUIDELINES OUTLINE

#### Task mix

Task	NTP	BPHS implementers and non-state public health providers	Private hospital	Individual private provider	Private laboratory	Private pharmacy/ non-qualified provider
Identify and register TB suspects						
Refer TB suspects						
Collect sputum samples						
Perform smear microscopy						
Diagnose TB						
Notify/record cases						
Prescribe treatment						
Inform patients about TB						
DOT						
Report						
Supervise treatment support staff						
Follow up on defaulters						
Train care providers						
Supervision						
Quality assurance for laboratories						

Monitor						
Evaluation						
Manage drugs and supplies						
Provide stewardship						

### Practical tools to help implementation

- PPM operational guidelines
- Recording/reporting tools
- Referral forms
- Supervisory and monitoring forms

### Training

- Training modules to be developed for different health care providers based on training needs in relation to assigned tasks.
- Existing NTP curriculum to be used and adapted for non-state public health providers and private hospitals. Modules to be developed for general practitioners, private pharmacies and unqualified providers.
- Planned training of two master trainers in the provinces.
- Initial and refresher training course and structure for follow-up after training, with link to ongoing programme supervision activities.
- Training materials and training programmes to be revised periodically based on evaluation.

### Contractual mechanisms

- Certification/accreditation: NTP to acknowledge and certify institutions and individual providers based on certain criteria and attendance for training.
- Non-monetary incentives: access to free TB drugs, training and certification, and opportunity to serve society through TB services.
- Monetary incentives: during scaling up of PPM activities, private laboratory technicians will receive a fee according to the number of confirmed slides examined and private providers will receive a fee for each patient

cured or on successful completion of treatment.

### Advocacy

- IEC materials to be developed for the general public and non-NTP providers.
- Flowchart of standardized management plan to be developed for diagnosis and follow-up of TB cases.
- Chart for TB treatment management to be developed and provided to all private hospitals, general practitioners and private pharmacies.
- Sputum examination chart to be provided to all private laboratory technicians involved in PPM DOTS.
- A name board or sticker with the message "Free TB drugs are available" to be developed and distributed to all general practitioners and private pharmacies involved in the programme.
- ISTC to be advocated to all health providers.

### Supervision, monitoring and evaluation

- Regional TB coordinator, provincial TB coordinator, various committees, BPHS implementers and other involved partners to be responsible for supervision and monitoring of PPM DOTS.
- Schedule to be developed for regular supervision of the PPM DOTS unit in the area.

## LOCAL IMPLEMENTATION

### Preparation

- A local PPM task force may be established to engage all relevant partners in planning and implementation of PPM in local level.

### Mapping of health care facilities nationwide

- During local implementation of PPM at district level, all public and private health care providers to be mapped by district PPM field officer.

### Selection of providers

- During local implementation, provincial TB coordinator to assess the potential contribution made by different health care providers in the area for involvement in PPM.
- Health care providers to be prioritized by determining their TB management practices, the number and proportion of TB cases they detect, and treatment outcomes among their patients.

### Implementation proper

- The regional, provincial and district PPM DOTS coordinators are to initially approach potential non-state health care providers with a view to establishing a partnership agreement.
- Interested health care providers are to be formed into units based on geography and the laboratory to be selected for partnership.
- All parties to agree on the roles and responsibilities undertaken and the support to

be provided by the provincial TB coordinator/NTP.

- Each unit will be formed from 10–15 general practitioners, 5–10 private pharmacies and 2–3 private laboratories.
- Memorandum of understanding or letter of agreement to be signed with each willing institution of individual health care provider.

## IMPLEMENTATION AND SCALE-UP PLAN

Main activities	
2007	2008
<ul style="list-style-type: none"><li>• Establish PPM DOTS task force, the members to meet once a month during 2007/2008.</li><li>• Develop national operational guidelines for private hospitals, private pharmacies and private general practitioners with the involvement of all stakeholders.</li><li>• PPM DOTS task force to modify and adapt existing NTP recording and reporting tools for demonstration and implementation of PPM DOTS.</li><li>• Develop training modules for different health care providers in 2007, translated into local languages (Pashto and Dari).</li><li>• Demonstrations of three projects (pilots):<ul style="list-style-type: none"><li>– involvement of private pharmacies in PPM DOTS</li><li>– involvement of general practitioners with private laboratories in PPM DOTS</li><li>– involvement of private hospitals in PPM DOTS.</li></ul></li></ul>	<ul style="list-style-type: none"><li>• Monitoring and evaluation of pilots and planning for scale-up.</li><li>• Developing and printing of IEC materials.</li><li>• Organization of three training of trainers courses.</li><li>• National PPM DOTS review meeting (end of 2008).</li></ul>

## B. EGYPT

### Situation assessment

#### TB EPIDEMIOLOGY

Incidence (all cases/100 000 population/year)	25
Incidence (ss+ cases/100 000 population/year)	11
Prevalence (all cases/100 000 population)	32
Mortality (deaths/100 000 population/year)	<1
New adult TB cases HIV-positive (%)	0.6
New MDR TB cases in 2004 (%)	0.0
Notification rate (new & relapsed cases/100 000 population/year)	15
Notification rate (new ss+ cases/100 000 population/year)	7
DOTS case detection rate (new ss+ cases) (%)	63
DOTS treatment success (new ss+ cases) (%)	70

#### UTILIZATION OF HEALTH SERVICES

##### Health-care-seeking behaviour in the public and private sector

- Chest hospitals and clinics were the first port of call for 65% of the population in the case of chest conditions.

##### Cost of care

- The average cost per admission by diagnosis for TB patients is around 2300 Egyptian pounds for the length of stay. The average cost per bed day by diagnosis is around 60 Egyptian pounds for TB.

##### Delays and discontinuities in treatment

- The median diagnostic delay and total delay were 42 and 44 days (average 55.9 and 57 days), respectively, of which the median patient delay, defined as the duration between onset of symptoms and seeking health care, was only 12 days (average 24.3 days).
- The median system delay, defined as the duration between seeking health care and treatment, was 18 days (average 33.6 days).

#### COMPOSITION AND CHARACTERISTICS OF THE NON-NTP CARE PROVIDERS

- The private sector delivery structure tends to be unorganized and fragmented, but amounts to a significant proportion of both inpatient and outpatient services.
- Private sector provision of services covers everything from traditional healers and midwives to private pharmacies, private doctors and private hospitals of all sizes. Also in this sector are a large number of NGOs providing services, including faith-based clinics and other charitable organizations, all of which are registered with the Ministry of Social Affairs.
- Physicians represent the most powerful professional group in the health sector. Doctors are permitted to work simultaneously for the Government and in the private sector. Those who are employed by the Government but run a private practice because of their low salaries account for a large portion of private providers.
- The remaining physicians include well-established and qualified senior physicians, who are usually faculty members in the major medical schools or shareholders in modern private hospitals.
- In the private sector, there are also a number of private voluntary organizations providing care through polyclinics and small hospitals, which are usually affiliated to charitable or religious organizations.
- The Health Insurance Organization (HIO) functions as a staff model health maintenance organization. As a provider of health care, HIO manages about 661 general practice clinics inside and outside factories, 129 specialist clinics or polyclinics, 263 school health clinics and 27 hospitals.
- The Ministry of Defence has its own medical facilities providing health care to their staff; prisons are linked to the NTP.
- The Curative Care Organization is an important semi-public provider of inpatient care (fee-for service).

## PREPAREDNESS OF THE NTP

- The Ministry of Health and Population established the National Tuberculosis Control Programme in 1979. There are three levels of responsibility for ensuring efficacy of TB control.
  - **Peripheral level (district and health unit).** This is the actual implementation level, with the delivery of TB control services. Initially limited to chest facilities, TB services are now increasingly offered through primary health care units. Most districts in Egypt are served by a chest facility. Usually, the director of the facility acts as the district coordinator for TB.
  - **Governorate level.** At this level lies the responsibility for local level planning; programme implementation; governorate intersectoral collaboration; monitoring and evaluation of the peripheral level; and provision of training. The Governorate Coordinator for Tuberculosis discharges these responsibilities as the governorate representative of the NTP.
  - **Central level.** The central level is responsible for policy-making; planning and logistics; programme coordination; training development; laboratory services (in collaboration with the Central Laboratories for Tuberculosis); and programme monitoring and evaluation. The office of the NTP manager is located in the Directorate-General of Chest Diseases in the Ministry of Health and Population.
- The NTP has established a documented manual for TB drug management covering selection, procurement, storage and distribution.

## POLICY AND REGULATORY ENVIRONMENT

- **Supreme Council for Health.** The prime responsibility of the Supreme Council for Health is to set the direction for national health policy and overall coordination among major health organizations.
- **People's Assembly Health Committee.** The People's (National) Assembly is the legislative body elected by the Egyptian people to represent them and holds a mandate to protect the rights and the interests of the public. The Health Committee of the Assembly deals with social protection issues such as universal insurance coverage and primary health care for all. The Committee approves any new health sector legislation, bylaws or decrees, or modification of existing ones. It also approves the endorsement or amendment of cooperative agreements with bilateral or international organizations in the health sector. The Committee is a powerful legislative body that would be very likely to move health policy in favour of PPM if thus employed. Improved communication and access to technical expertise in the Ministry of Health and Population would enhance its effectiveness, as it lacks technical expertise.

## Operational plan

### OBJECTIVES

#### Main objective

- To bring all TB care providers together under the NTP in order to provide TB care according to international standards and improve detection and treatment outcomes.

#### Specific objectives

- To enrol all TB patients in the programme system.
- To train and upgrade the skills of the staff responsible for TB activities and to monitor and evaluate their activities.
- To build political commitment in the leaders of private organizations/providers.
- To ensure the availability of the necessary anti-TB drugs.
- To detect cases of MDR TB and treat them according to guidelines.
- To ensure the adherence of all TB care providers to standardized treatment guidelines.
- To motivate all private not-for-profit and for-profit doctors to use NTP facilities (referral) to treat their patients.
- To supply all TB care providers with updated data and information on TB.
- To set up a complete network for all TB care providers to follow-up and receive feedback.
- To include the National Tuberculosis Control Programme in the curricula of medical schools.

### DESCRIPTION OF THE PROPOSED PPM STRUCTURE

- **National level PPM focal point/team**  
NTP manager, NTP PPM focal point, NTP PPM coordinator, NGO focal point  
staff (programmer, financial analyst, data entry staff, secretary)
- **Human resources available at central level**  
NTP staff (PPM coordinator, advocacy, communication and social mobilization coordinator, private sector coordinator), national health information personnel, private practitioners working in the public sector, NGO practitioners working in the public sector, consultative committee's members working in the public sector
- **Human resources available at governorate level**  
PPM panel headed by an undersecretary, private sector director, NGO representative and consultative committee for the governorate
- **Human resources needed at central level**  
Epidemiologist (on task basis), health economist (on task basis), administrative
- **Human resources needed at governorate level**  
Administrative staff (programmer, financial analyst, data entry staff, secretary)
- **Task force/steering committee**

## PPM OPERATIONAL GUIDELINES OUTLINE

### Task Mix:

Task	NTP	Private not-for-profit	Public or private institution	Individual private provider	Private/public laboratory	Non-physician/pharmacy
Identify symptomatic TB patients						
Collect sputum samples						
Refer TB suspects						
Notify/record cases						
Supervise treatment						
Perform smear microscopy						
Diagnose TB						
Prescribe treatment						
Inform patients about TB						
Identify and supervise treatment support staff						
Follow up on defaulters						
Train care providers						
Supervise						
Carry out quality assurance for laboratories						
Monitor and evaluate						
Manage drugs and supplies						
Provide stewardship: financing and regulation						

### Practical tools to help implementation

- Referral letter, private to NTP facilities, including feedback.
- Laboratory request form.
- Patient treatment card.
- Patient ID card.
- TB register.
- Laboratory register.
- Suspect register.
- Case finding report.
- Sputum conversion report.
- Treatment outcome report.

### Training

- NTP to develop, in close collaboration with private sector representatives, a training module for each task based on the revised NTP guidelines and in line with new Stop TB strategy. The training courses will utilize task-based modules based on the task mix table.

- Training of trainers will be organized for different facilitators according to different providers.
- The monitoring and evaluation committee is to be responsible for measuring the impact of training according to standard indicators and in-service evaluation is to be conducted.
- Horizontal and vertical feedback with peer review is to take place (feedback to the facility and to the higher central levels).
- Orientation on and promotion of ISTC and the patients' charter.

### Contractual mechanisms

- Certification/accreditation. Based on the NSA document and in accordance with experience from other sectors (family planning, health sector reform) TB care providers will be subject to a standardized accreditation and only those who are

accredited will be allowed to provide the service. This process will take place every

two years. The accreditation process will be implemented through an independent quality control agency. The legislation for the PPM accreditation will be organized through a ministerial decree after proper consultation with all sectors and partners concerned.

- Non-monetary incentives. Free services for diagnosis and treatment through Ministry of Health facilities.
- Monetary incentives. During scaling up of PPM activities, private laboratory technicians will receive a fee according to the number of confirmed slides examined and fee for private DOT provider will receive a fee for each patient cured or on successful completion of treatment.

#### **Advocacy**

- Information, education and communication (IEC) for providers.

- Improved knowledge of TB control policies, services and activities among TB care providers.
- Building up of two-way communication between TB care providers and TB patients.
- Mobilizing societies and communities in the campaign to integrate all TB care providers into the NTP.

#### **Supervision, monitoring and evaluation**

- Memorandum of understanding to be signed between the NTP and TB care providers. This will include all areas of activity needed from the provider and the agreed supervision mechanism, which will include peer review and a quality assurance team.
- Supervision to be carried out quarterly with feedback to the provider to maintain a high level of quality.
- Peer review: organized teams of providers, including private practitioners, NGOs, public providers and university professors, will be responsible for supervision and measuring indicators.

### **LOCAL IMPLEMENTATION**

#### **Pilot (demonstration areas)**

- Demonstration Governorates will be selected according to low case detection rates in the previous two years and level of socioeconomic status, such as slum areas and underserved populations (Giza, Menofia, Cairo).

#### **Preparation**

- Establishment of a PPM DOTS panel.

#### **Mapping of health care facilities nationwide**

- Operational field research for health requirements and TB care providers

#### **Selection of providers**

- Providers to be selected according to catchments area and willingness to cooperate.

#### **Implementation proper**

- Legislation and contractual procedures to be established.

#### **Advocacy**

- Local TV channels advocating PPM.

### **IMPLEMENTATION AND SCALE-UP PLAN**

<b>Main activities</b>	
<b>2007</b>	<b>2008</b>
<ul style="list-style-type: none"> <li>• Finalization of NSA and operational plan in consultation with consultative committee.</li> <li>• Preparation for demonstration area: consultation on selection of different providers, and assessment of the provider's current input in TB control, to enable measuring the impact of PPM later on.</li> <li>• Start implementation in demonstration area (30%): printing and distributing of forms, training and start implementation.</li> </ul>	<ul style="list-style-type: none"> <li>• Complete implementation in demonstration areas.</li> <li>• Supervision.</li> <li>• Evaluation of PPM activities.</li> </ul>

## C. MALAWI

### Situation assessment

#### TB EPIDEMIOLOGY

Incidence (all cases/100 000 population/year)	409
Incidence (ss+ cases/100 000 population/year)	66
Prevalence (all cases/100 000 population)	518
Mortality (deaths/100 000 population/year)	97
New adult TB cases HIV-positive (%)	52
Level of TB/HIV coinfection (%)	72
New MDR TB cases in 2004 (%)	0.4
Notification rate (new & relapsed cases/100 000 population/year)	214
Notification rate (new ss+ cases/100 000 population/year)	66
DOTS case detection rate (new ss+ cases) (%)	40
DOTS treatment success (new ss+ cases) (%)	75

#### UTILIZATION OF HEALTH SERVICES

##### Health-care-seeking behaviour in the public and private sectors

- Some 70% of TB patients initially visited a provider of biomedical care, while 30% visited traditional healers, grocery shops and other types of provider.
- In Lilongwe, 30% of all first care-seeking visits were to grocers; the same percentage was found in rural areas. Further, in rural areas, 6% of all first visits and 5% of second visits were to traditional healers.
- Overall rural patients were more likely to use informal providers than their urban counterparts, with 14% of all visits being made to grocers and 4% to traditional healers compared with 7% and 0.8% respectively in urban areas.

##### Access to health services

- Some 46% of the population in rural areas and 16% in urban areas have poor access to public health facilities.

##### Cost of care

- In most cases, health care costs are out-of-pocket (especially among the underprivileged).

- There are high costs to patients, particularly in relation to their “disposable” income, i.e. income after deducting basic food costs. In urban areas, it costs the poor an average of six months’ income to obtain a “free” diagnosis; in rural areas, this increases to ten months’ income.
- Some people, mainly the employed, have medical schemes.

##### Delays and discontinuities in treatment

- The median delay from onset of cough to diagnosis of smear-positive pulmonary TB was eight weeks. Health system structural barriers were the main reasons for delays in diagnosis, including requirement for hospital attendance, delays in symptom recognition and receipt of sputum results, and the misconception that negative smears excluded TB.
- Compliance with anti-TB treatment is generally good (the default rate in Malawi is 3%).

## COMPOSITION AND CHARACTERISTICS OF THE NON-NTP SECTOR

- **Public sector other than Ministry of Health:** Ministry of Defence, Ministry of Home Affairs, Ministry of Local Government and Ministry of Forestry, Energy and Mining.
- **Private not-for-profit sector:** Nongovernmental organization (NGO) clinics and company clinics.
- **Private hospitals:** There are four main private hospitals in Malawi, run by a group of individual specialists and doctors.
- **Private clinics:** There are 240 registered private clinics in the country, run either by doctors and paramedical officers (clinical officers and medical assistants). Only a few of these clinics are involved in TB control activities, mainly DOT and identification and referral of suspected cases.
- **Pharmacies:** There are few pharmacies; no private pharmacy keeps anti-TB drugs.
- **Laboratories:** Private laboratories are not involved in sputum smear microscopy. Only a very small number of company laboratories are involved in sputum smear microscopy.
- **Not-for-profit clinics/hospitals:** These are mainly owned by private companies and NGOs. These clinics offer DOT for patients within their jurisdiction.
- **Semi-governmental sector:** These are mainly the Christian Health Association of Malawi hospitals, which provide about 30% of the health services in the country.

## PREPAREDNESS OF THE NTP

- The NTP has been in existence since 1964 and has implemented the DOTS strategy since the 1980s.
- Political commitment to TB control in Malawi has been high.
- In each of the administrative regions, TB control activities are coordinated by TB officers at zonal and district levels.
- Nurses, clinical officers, medical assistants and laboratory technicians at hospitals and health centres form the interface with patients and implement the strategy.
- This supervisory network provides a strong base for supervising activities under PPM.
- There are constraints in terms of a deficiency of human resources.

## POLICY AND REGULATORY ENVIRONMENT

- There are no laws prohibiting private retail pharmacies from stocking anti-TB drugs, but the NTP has nevertheless managed to keep anti-TB drugs off the shelves of these pharmacies.
- All private health care practitioners and the premises where they practice must be registered and licensed by the Malawi Medical Council.

## Operational plan

### OBJECTIVES

#### Main objective

- To engage all health care providers in TB care and control.

#### Specific objectives

- To improve case detection by ensuring that all health providers are engaged in TB case finding and diagnosis.
- To help improve equity in access and reach the poor and vulnerable by engaging providers who are used by these groups of people.

- To reduce TB case fatality due to delayed diagnosis.
- To scale up TB/HIV collaborative activities (screening for HIV in TB patients, co-trimoxazole preventive therapy, provision of anti-retroviral drugs in HIV-positive TB patients).

### DESCRIPTION OF THE PROPOSED PPM STRUCTURE

- The NTP PPM secretariat will incorporate other officers within the NTP (TB/HIV Officer, Information, Education and Communication (IEC) Officer and Training Officer) to form the PPM task force. Other members may be added to the task force based on recommendations of the subcommittee.,
- At a national/ ministerial level, the PPM structure is planned to fit into the NTP Technical Working Group.
- At a lower level (NTP level), it is planned to form a PPM subcommittee that will focus specifically on PPM issues in Malawi.

### PPM OPERATIONAL GUIDELINES OUTLINE

#### Task mix

Task	NTP	HIV /AIDS Programme	Public or Private Institution	Individual Private Provider	Private/ Public Laboratory	Retail Pharmacist	NGO/ Community groups	Grocers & Traditional healers
Identify TB Suspects								
Collect Specimens								
Refer Suspects								
Notify/Record Cases								
Smear microscopy								
Perform HIV counselling and testing								
Culture and DST								
Prescribe treatment								
Patient education								
Identify and support treatment supporters								
Trace defaulters								
Training providers								
Supervision								
Quality Assurance for laboratories								
Monitoring and evaluation								
Drugs and supplies management								
Provide Stewardship								

### Practical tools to help implementation

- Referral and back referral forms.
- Request form.
- Supervision form.
- Tuberculosis treatment card.
- Tuberculosis laboratory register.
- Chronic cough register.
- Health centre tuberculosis register.
- TB DOT monitoring form for guardian.
- Monthly anti-TB drugs balance book.
- Supervision form.

### Training

- The training content is to be in line with the level of PPM involvement and also ISTC.
- The training methods and material are to be tailored to the local context.

### Contractual mechanisms

- Certification/accreditation: in consultation with other stakeholders, the NTP is to come up with a means of certification and accreditation.

### Supervision

- NTP staff will carry out quarterly support visits to monitor TB activities.
- The NTP will also identify some well established private practitioners and institutions to assist with supervision of PPM activities.
- The NTP recommends that private practitioners meet at district and zonal level to share their experiences in implementing TB control activities.

## IMPLEMENTATION AND SCALE-UP PLAN

Main activities	
2007	2008
<ul style="list-style-type: none"><li>• Advocacy meetings with Parliamentary Committee on Health and Senior management of Ministry of Health</li><li>• Stakeholder meetings: NTP central level, zones</li><li>• Regular meetings:<ul style="list-style-type: none"><li>– annual review PPM meetings</li><li>– quarterly PPM subcommittee meetings</li><li>– quarterly zonal review meetings</li></ul></li><li>• Finalization of guidelines in consultation with stakeholders</li><li>• Selection of providers and establishment of terms of reference</li><li>• Development of training modules for all levels and module for training of trainers</li><li>• Preparation and development of advocacy materials</li></ul>	<ul style="list-style-type: none"><li>• Evaluation of PPM activities for 2007/2008</li><li>• Annual stakeholder meeting to review progress and plan for the future</li><li>• Relevant operational research on PPM</li><li>• District inventory of all care providers</li></ul>

## D. NAMIBIA

### Situation assessment

#### TB EPIDEMIOLOGY

Incidence (all cases/100 000 population/year)	697
Incidence (ss+ cases/100 000 population/year)	286
Prevalence (all cases/100 000 population)	577
Mortality (deaths/100 000 population/year)	77
New adult TB cases HIV-positive (%)	40
Level of TB/HIV co infection (%)	60
Notification rate (new & relapsed cases/100 000 population/year)	735
Notification rate (new ss+ cases/100 000 population/year)	257
DOTS case detection rate (new ss+ cases) (%)	90
DOTS treatment success (new ss+ cases) (%)	68

#### UTILIZATION OF HEALTH SERVICES

##### Health-care-seeking behaviour in the public and private sectors

- No studies have been carried out on the health-care-seeking behaviour of TB suspects and patients in Namibia.
- In general, however, people who are members of a medical aid fund or have medical insurance seek care in the private health sector.
- It is suspected that patients “shop around” quite a lot while seeking this care.
- The poor, too, may also be seeking care in the private health care sector, where they have to pay the required out-of-pocket fee. The extent to which the poor obtain care in

the private health care setting is not known but is suspected to be low.

##### Cost of care

- It is reported that 70% of public servants are covered by medical aid, while about 30% of private-sector employees have similar medical cover.
- The costs of TB care in the private sector include the cost of consulting a doctor, which averages N\$ 150 (US\$ 25) per visit, and the cost of drug treatment at about N\$ 380 (US\$ 63).

#### COMPOSITION AND CHARACTERISTICS OF THE NON-NTP SECTOR

- Health care provision in Namibia is shared among the state (public) sector, faith-based/mission facilities and the private for-profit sector. The faith-based or mission health care facilities support the government health care system.
- The public health care system, including the faith-based institutions, caters for 95% of health care provision, while the private sector is responsible for only about 5%.
- Independent entities established by the state also offer health services to those who serve in them and are very closely linked to the state health care system. These entities include the National Defence Health Care System, the Prisons Health Service and the

University of Namibia. Health care worker DOT is strictly enforced within the military and prison health services, with patients reporting to relevant sick bays on a daily basis. The University of Namibia health service offers health care to the student population of the university.

- The private for-profit health care sector is made up of a number of hospitals, polyclinics, clinics and primary health care clinics.
- The private not-for-profit health care sector includes industrial clinics and faith-based/mission facilities

## PREPAREDNESS OF THE NTP

- Namibia adopted the DOTS strategy for TB control in 1993 and within two years the country had achieved 100% DOTS coverage. All the elements of the DOTS strategy are in place.
- The National Institute of Pathology (NIP), an independent state corporation, provides laboratory services to the national health service and has recently started competing with private health care providers for the provision of laboratory services in the private health sector.
- There is a network of 34 NIP laboratories in the country, 30 of which offer quality-assured sputum smear microscopy services. This is equal to about one laboratory for every 67 000 people.
- Although the human resource base for TB control in Namibia is deemed to be inadequate, it is important to note that TB control is represented at all levels of the health care system.

## POLICY AND REGULATORY ENVIRONMENT

- There are no apparent policies or regulatory issues that would hamper the implementation of PPM in Namibia.
- The public health act in Namibia demands that all TB patients are reported to the Ministry of Health. Most private practitioners appear to be aware of this, a fact that could be used to reinforce the public–private link in TB care and prevention.

## Operational plan

### OBJECTIVES

#### Main objective

- All TB patients in Namibia to be managed according to the national guidelines in

conformance with the ISTC. The aim is to engage all health care providers in Namibia in implementing PPM.

### DESCRIPTION OF THE PROPOSED PPM STRUCTURE

- A working group is to be created, consisting of representatives from the national Tuberculosis Control Programme (NTCP) and private providers.
- A focal point, based in the Ministry of Health, is to be appointed to coordinate PPM activities in the country.
- In addition, the HIV coordinator, currently based in the Namibian Business Coalition on HIV/AIDS, will be used to implement TB activities in corporate business workplaces.

### PPM OPERATIONAL GUIDELINES OUTLINE

#### Task mix

Task	NTCP	Public Health Institution	Private Health Institutions	Individual Private Provider	Public Labs	Private Labs	Retail Pharmacist	Corporate Workplaces
Identify TB Suspects								
Collect Specimens								
Refer Suspects								
Notify/Record Cases								
Carry out Smear microscopy								
Carry out HIV counselling and testing								
Carry out Culture and DST								
HIV/AIDS Management								
Prescribe Treatment								
Patient Education								
Identify and support treatment supporters								
Trace defaulters								
Training of providers								
Supervision								
Quality assurance for laboratories								
M&E								
Drug and supplies management								
Provide Stewardship								

### **Practical tools to help implementation**

- ISTC used as an assessment tool to identify constraints or gaps in the system.
- Adaptation of case notification forms to learn where the case was identified or referred from.

### **Training**

- Training for private providers in both procedural and factual information about the TB programme.
- Incorporation of ISTC training modules for all health cadres.
- Adapt existing training materials to the private sector.
- Follow-up after training, evaluation and revision based on feedback.

### **Contractual mechanisms**

- NTCP will sign a memorandum of understanding with private providers to ensure a more structured partnership.

- CPD (continuing professional development) points will be offered to private practitioners for participating in additional training.
- Representation of professional bodies in the national steering committee.
- Technical assistance for private providers to conduct training, for materials, etc.

### **Advocacy**

- Use of ISTC assessment as an advocacy tool for all providers to see TB as a public health problem and to realize the importance of partnership as a platform for mobilizing resources.
- Use of patient's charter in private and corporate setting (advocacy and training).
- Materials defined for the private sector (e.g. TB in the workplace, TB in the private sector, what every health care worker should know).
- Materials for private providers to give to their patients.

## **LOCAL IMPLEMENTATION**

### **Preparation**

- Select and organize committee and PPM focal person
- Review and adapt existing forms
- Draft new forms if necessary
- Define new procedures

### **Mapping and first contact**

- Determine distribution of providers and cases

### **Selection of providers**

- Corporate businesses: focus on those with existing programmes, and mining (years 1 & 2)
- Private health sector: begin with larger private hospitals (years 1 & 2) and expand to individual private providers (year 3)

### **Implementation proper**

- Stakeholder briefing and analysis
- Establish local working group for PPM
- Identify and recruit PPM focal points
- Distribute referral forms to the private sector
- Ensure supervision in place and that the supervision plan includes the private sector
- Adapt, revise and develop new tools for the private sector

## IMPLEMENTATION AND SCALE-UP PLAN

<b>Main activities</b>	
<b>2007</b>	<b>2008</b>
<p><i>Organize stakeholders at national Level</i></p> <ul style="list-style-type: none"> <li>• Create job description for PPM focal point</li> <li>• Identify/hire PPM focal points</li> <li>• Develop terms of reference for PPM working group</li> <li>• Create PPM working group as part of the National Steering Committee</li> <li>• Convene four meetings of PPM working group:               <ul style="list-style-type: none"> <li>– Introductory</li> <li>– Adaptation of ISTC assessment tool</li> <li>– Findings from ISTC assessment</li> <li>– Review of existing training materials for different health care providers, and existing forms, procedures, etc.</li> </ul> </li> <li>• Consult, discuss, determine with respective representing bodies issues related to certification, accreditation, incentives, methods for collaboration</li> <li>• Develop memoranda of understanding at Ministry of Health between private sector and NTCP</li> <li>• Identify/prioritize key private providers and corporate businesses with workplace programmes</li> <li>• Organize and sensitize key stakeholders for PPM:               <ul style="list-style-type: none"> <li>– Organize three two-hour breakfast meetings for private providers</li> <li>– Share NSA findings</li> </ul> </li> <li>• Adapt existing ISTC assessment tool for Namibia PPM</li> <li>• Conduct analysis to identify constraints to implementation of ISTC</li> <li>• Request external technical assistance with ISTC implementation analysis</li> <li>• Reconvene PPM working group to develop operational plan and strategy for implementation</li> <li>• Convene one-day advocacy workshop to present plan to partners</li> <li>• Training (two demonstration areas for PPM)               <ul style="list-style-type: none"> <li>– Private general practitioners – TB case management: receive CPD points, ISTC-certified attendance certificate; three evenings for three hours each</li> <li>– Nurses/occupational nurses – TB case management: three days for six hours each</li> <li>– Workplace focal persons – Patient education, patient management (treatment supervision and adherence, DOT and follow-up), recording and reporting, TB/HIV: two-day workshop for six hours</li> </ul> </li> </ul>	<p><i>Extend implementation of PPM into Otjikoto, Oshana and Karas regions</i></p> <ul style="list-style-type: none"> <li>• Convene two meetings of PPM working group in Windhoek (review progress, work on new developments and new issues, roll-out plan to local level)</li> <li>• Identify/prioritize key private providers and corporate businesses with workplace programmes in Otjikoto, Oshana and Karas regions</li> <li>• Organize and brief key stakeholders for PPM in Otjikoto, Oshana and Karas regions               <ul style="list-style-type: none"> <li>– Organize two meetings for local private providers (one for Karas and one for Otjikoto and Oshana regions together)</li> </ul> </li> <li>• Convene one-day advocacy workshop for local leaders on TB and PPM activities</li> <li>• Training (six in total, one set of training per category of provider)               <ul style="list-style-type: none"> <li>– Private general practitioners – TB case management: receive CPD points, ISTC-certified attendance certificate; three evenings for three hours each</li> <li>– Nurses/occupational nurses – TB case management: three days for six hours each</li> <li>– Workplace focal persons – patient education, patient management (treatment supervision and adherence, DOT and follow-up), recording and reporting, TB/HIV: two-day workshop for six hours</li> </ul> </li> <li>• Monitoring and evaluation               <ul style="list-style-type: none"> <li>– Supervision and support</li> <li>– Review of PPM implementation</li> <li>– Documentation of implementation process</li> <li>– Operational research</li> <li>– Analysis of collected data (process and outcome indicators)</li> </ul> </li> </ul>

## E. NIGERIA

### Situation assessment

#### TB EPIDEMIOLOGY

Incidence (all cases/100 000 population/year)	283
Incidence (ss+ cases/100 000 population/year)	123
Prevalence (all cases/100 000 population)	536
Mortality (deaths/100 000 population/year)	76
New adult TB cases HIV-positive (%)	19
New MDR TB cases in 2004 (%)	1.7
Notification rate (new & relapsed cases/100 000 population/year)	48
Notification rate (new ss+ cases/100 000 population/year)	27
DOTS case detection rate (new ss+ cases) (%)	22
DOTS treatment success (new ss+ cases) (%)	73

#### UTILIZATION OF HEALTH SERVICES

##### Health-care-seeking behaviour in the public and private sectors

- Private not-for-profit health institutions (mainly mission hospitals) are the main health care providers for patients in the country.
- In many of the states in the southern part of Nigeria, where private providers proliferate, it is estimated that 60–70% of health care is provided by private hospitals.
- People seek care for TB from between 2 and 6 other providers before coming to the DOTS centres. The first action for almost 50% is to seek advice and treatment from a chemist, while some 30% first present at a hospital (presumably not offering DOTS). This pattern is the same in rural and urban settings.

##### High-risk groups

- The main populations vulnerable to TB are those living with HIV/AIDS and people living below the poverty line.

##### Cost of care

- In a study by the German Leprosy and Tuberculosis Relief Association (GLRA), only 6% of patients said that they found the cost of TB treatment too high, while an additional 5% said that the DOTS centre was too far away.

##### Delays and discontinuities in treatment

- The average delay from onset of symptoms to the first treatment was 10 days, while the average delay in initiating DOTS was 92 days (GLRA study).
- While most patients (44%) delayed seeking care because they did not consider their symptoms to be very serious, an additional 23% did not want to go to a DOTS centre because of the attitude of the government health workers.
- Patient perception, preferences and low awareness of available effective, low-cost DOTS treatment seem to be the primary barriers to access to DOTS, rather than distance and associated time and transport costs.

#### COMPOSITION AND CHARACTERISTICS OF THE NON-NTP SECTOR

- The private sector in Nigeria consists of several categories of provider, differing according cost, size and level of care.
- The not-for-profit private providers are NGOs, dominated in Nigeria by missions and the hospitals they run. These providers, in addition to being not-for-profit, also operate according to charitable, community development or humanitarian goals and therefore adapt well to public health initiatives.
- In the northern zones of Nigeria, mission hospitals are the dominant type of private provider, since for-profit providers are fewer than in the southern zones.
- Most for-profit health care providers register either as clinics or as hospitals. Many of these facilities are often individual practices.
- Private for-profit pharmacies, also called chemists, proliferate in Nigeria. These are registered with the government and licensed to sell prescription drugs. In these pharmacies, it is possible to find individual

anti-TB drugs such as rifampicin. Pharmacies are supposed to require a doctor's prescription to sell these and other prescription-only drugs, but it is well-known that enforcement of this rule is lax.

- Herbalists are also an important source of care for TB patients, constituting 15% of the total visits TB patients make before they reach DOTS centres

#### **Capacity for DOTS in the private sector**

- There is substantial potential for professional, medical and nursing organizations to do DOTS awareness

building among their members, monitor for TB case notification and provide continuous medical education on ISTC or DOTS training as an incentive for private providers to engage with the National Tuberculosis and Leprosy Control Programme (NTBLCP).

- There may also be potential for private provider associations to support the NTBLCP's DOTS quality assurance activities.

### **PREPAREDNESS OF THE NTP**

- Several states and local government areas (LGAs) are successfully implementing DOTS in public facilities and are ready to begin or expand engagement of private providers.
- However, laboratory capacity, including internal and external quality assurance, is not sufficiently implemented and needs to be strengthened in order to assure proper laboratory quality in the expansion phase.
- In LGAs involving only a few private providers, the existing staff capacity may be sufficient to cope with the expected increase in supervision and quality assurance workload. In LGAs with larger numbers of providers (up to 150) that may be targeted for PPM DOTS, however, the supervisory capacity (additional staff and financial inputs) may need to be increased as expansion is undertaken.

### **POLICY AND REGULATORY ENVIRONMENT**

- TB is a notifiable disease in Nigeria. Disease surveillance and notification officers present in each LGA are supposed to report monthly on new TB cases in their area. For the private sector, however, there is no policy or regulation on TB case notification.
- There is no policy or regulation on the sale of anti-TB drugs. In principle, these drugs are only provided on prescription. In practice, however, this regulation is not applied and first-line TB drugs can be bought in private pharmacies and some drug stores without prescription from a doctor.

## Operational plan

### OBJECTIVES

#### Main objective

- To engage all health care providers in TB care and control according to the NTBLCP guidelines.

#### Specific objectives

- To engage private not-for-profit facilities not implementing DOTS
- To engage for-profit facilities in implementing PPM DOTS
- To further engage non-NTBLCP providers, such as tertiary-level hospitals, military

hospitals and health delivery facilities in prisons, the police and other paramilitary organizations.

- To ensure that PPM data are captured in the existing programme monitoring and evaluation framework.
- To engage professional associations for advocacy and awareness creation.

### DESCRIPTION OF THE PROPOSED PPM STRUCTURE

- National level: NTBLCP focal point and WHO focal point.
- Zonal level: WHO zonal professional officers.
- State level: state focal points.
- LGA level: Tuberculosis and Leprosy Supervisor (TBLS) overseeing PPM activities at facility level.
- Health facility level: facility focal point for every PPM facility.

### PPM OPERATIONAL GUIDELINES OUTLINE

#### Task mix

Task	NTP	Public or private Institution	Individual private provider	Private/public laboratory	Non-physician/pharmacy
Identify symptomatic TB patients					
Collect sputum samples					
Refer TB suspects					
Notify/record cases					
Supervise treatment					
Do smear microscopy					
Diagnose TB					
Prescribe treatment					
Inform patients about TB					
Identify and supervise treatment support staff					
Follow up on defaulters					
Train care providers					
Supervise					
Carry out quality assurance for laboratories					
Monitor and evaluate					
Manage drugs and supplies					
Provide stewardship: financing and regulation					

### **Practical tools to help implementation**

- Memoranda of understanding
- Referral forms for TB suspects for evaluation, diagnosis and treatment (patients already diagnosed)
- Feedback mechanism on all forms
- Facility TB register
- Laboratory register
- Patient TB treatment card

### **Training**

- Training content for different providers, such as doctors, focal points in the formal sector, informal sector, laboratory scientists and/or technicians
- Training for TBLS and state PPM focal points on supervision and national PPM team on PPM implementation

### **Contractual mechanisms**

- Certificates to be issued to providers after signing of memorandum of understanding, and a sticker issued to them signifying that the facility is a designated DOTS centre
- Non-monetary incentives could include free anti-TB drugs, access to laboratory equipment and materials as determined by programme capacity, provision of recording and reporting materials, and training

- Financial incentives to be given to participating facilities depending on the number of slides examined

### **Advocacy**

- Already existing IEC materials developed by NTBLCP to be adapted to the local languages for dissemination
- NTBLCP to mobilize professional, medical and nursing associations for the dissemination of developed materials
- Production and dissemination of ISTC and patients' charter

### **Supervision**

- At national level, PPM supervision in each state once every two years
- At state and zonal levels, PPM supervision to be integrated into the normal programme supervision
- A LGA level, all facilities supervised once every two weeks (currently normal practice in the public sector)

## **LOCAL IMPLEMENTATION**

### **Preparation**

- Finalize the PPM guidelines
- Develop briefing and training materials
- Adapt existing tools to capture PPM data
- Identify PPM human resource needs at all levels
- Establish PPM subcommittee within the national Stop-TB Committee

### **Mapping of health care facilities nationwide**

#### **Selection of providers**

- Establish selection criteria
- Select providers based on criteria

### **Implementation proper**

- Consensus meeting (NTP, providers and stakeholders)
- Situation analysis
- Training activities
- DOTS services delivery

### **Advocacy**

- Identify target audience
- Adapt existing advocacy material
- Conduct advocacy with target groups

## IMPLEMENTATION AND SCALE-UP PLAN

<b>Main activities</b>	
<b>2007</b>	<b>2008</b>
<ul style="list-style-type: none"> <li>• Three consensus meetings for implementation of PPM in the selected 22 states.</li> <li>• Seven consultants to be recruited to undertake situation analysis in the 22 states, taking an inventory of all health care providers in the states.</li> <li>• One PPM consultant to be recruited at the national level.</li> <li>• PPM guidelines, referral forms, training materials and ISTC to be developed, printed and distributed.</li> <li>• In the 22 states, training to be conducted in three categories: doctors, facility PPM focal points, and laboratory personnel.</li> <li>• An incentive payment of US\$ 3 will be made to selected facilities for every TB suspect screened; it is estimated that 40 000 people will be screened for acid-fast bacilli (a facility screening average of one patient per day).</li> <li>• One monitoring meeting to be held.</li> </ul>	<ul style="list-style-type: none"> <li>• Two consensus meetings to be held for PPM implementation in an additional six states.</li> <li>• Two consultants to be recruited to cover the additional six states that will implement PPM in 2008.</li> <li>• The services of the PPM consultant to be retained.</li> <li>• PPM guidelines, booklets of referral forms and ISTC to be distributed.</li> <li>• 24 training sessions to be conducted in three categories: doctors, facility PPM focal points and laboratory personnel in the additional six states.</li> <li>• An incentive payment of US\$ 3 will be made to selected facilities for every TB suspect screened; it is estimated that 80 000 people will be screened.</li> <li>• One monitoring meeting to be held.</li> </ul>

## F. PAKISTAN

### Situation assessment

#### TB EPIDEMIOLOGY

Incidence (all cases/100 000 population/year)	181
Incidence (ss+ cases/100 000 population/year)	82
Prevalence (all cases/100 000 population)	297
Mortality (deaths/100 000 population/year)	37
New adult TB cases HIV-positive (%)	0.6
New MDR TB cases in 2004 (%)	1.9
Notification rate (new & relapsed cases/100 000 population/year)	87
Notification rate (new ss+ cases/100 000 population/year)	30
DOTS case detection rate (new ss+ cases) (%)	37
DOTS treatment success (new ss+ cases) (%)	82

#### UTILIZATION OF HEALTH SERVICES

- Some 70% of the population visit private sector practitioners.
- There are some 42 700 private registered facilities providing health care. The majority of these are clinics, chemists (69%) and medical stores (27%). There are also 550 private hospitals.
- Some doctors work in both the public and the private sectors.
- GPs are usually the first-line health care providers in urban areas. Most of the clinics run by GPs are in one or two rooms and provide outpatient services only. In addition to consultation, they provide some medicines (analgesics/antipyretics, vitamins etc.) from their own clinics and prescribe others (e.g. antibiotics) for the patient to buy from a pharmacy. Charges range between Rs 50 and Rs per 100 patient, which includes the consultation fee and the cost of some medicines.
- Specialist doctors are a higher level of private provider, most of whom are affiliated to private hospitals. If a patient needs hospitalization or surgical intervention, he/she is referred to that hospital for further management. The consultation fee per patient ranges from Rs 300 to Rs 500.

#### COMPOSITION AND CHARACTERISTICS OF THE NON-NTP SECTOR

- A large number of doctors in Pakistan serve as GPs, mostly in urban areas. The majority are graduates and are registered with the Pakistan Medical and Dental Council. GPs work full- or part-time. Most of the part-time GPs work in the evenings and have day jobs either in the public sector or in private hospitals.
- Specialist doctors have postgraduate degrees in a specific area and have specialist areas of practice such as skin diseases, general surgery, medicine, and gynaecology and obstetrics. They prescribe medicines, and most of them have an affiliation with a private hospital.
- Not-for-profit private providers such as NGOs provide a variety of services to society, such as environmental, health and social services.

## PREPAREDNESS OF THE NTP

- The NTP in Pakistan has now achieved 100% DOTS coverage (by district) and has had favourable WHO reviews in recent years.
- The programme has a large number of highly qualified professionals working for the efficient implementation of TB control at national and provincial levels. It also has a well established network of health care providers at district and grass-roots levels.
- The NTP has a strong and efficient monitoring system. Its surveillance system is analysed quarterly and annually to provide national information on the case detection rate and treatment outcomes.
- There is regular physical verification of the quality of services through programme reviews and visits by National Programme Officers.
- Quarterly meetings are held at district, provincial and national levels.
- The NTP has coordinated a nationwide consultation process to formulate a national strategic framework for PPM development in TB control. To initiate public-private partnership activities, the NTP has included PPM as a major component of its strategy, comprising 39% of the total five-year budget

## POLICY AND REGULATORY ENVIRONMENT

- At present, the Government of Pakistan has a policy of privatization. Private sector involvement in health care has been a priority area in the recommendations of the ninth and recently the tenth five-year national development plan.
- There is little regulation of the provision of private health care in Pakistan, and thus legal restrictions on the provision of DOTS in the private sector are very limited.
- Medical practice is regulated by the Pakistan Medical and Dental Council, which is responsible for the registration and regulation of medical practitioners. Similarly, there are other councils responsible for regulating the health practices of homeopathic doctors and qualified *hakims* (National Council for Homeopathy, Rawalpindi, and National Council for Tibb, Islamabad).
- There are some regulatory issues that need to be addressed urgently for PPM. For example, the NTP needs to identify and implement means of providing government-owned logistics to the private sector

## Operational plan

### OBJECTIVES

#### Main objective

- To have an effectively functioning PPM in all districts of Pakistan, by June 2011, to ensure that all patients in the country get quality TB care as per NTP guidelines.

#### Specific objectives

- To increase case detection by enhancing the ability of private health providers to identify and diagnose pulmonary TB.
- To increase treatment success rate by improving the quality of TB care received by patients attending private facilities.

### DESCRIPTION OF THE PROPOSED PPM STRUCTURE

- At national level, a post of PPM coordinator has been established. The successful candidate will be responsible for implementing the strategies and operational guidelines.
- The National PPM coordinator will be supported by a steering or PPM coordination committee, which would meet 2–3 times a year (perhaps more frequently in the early stages). The committee will comprise a Ministry of Health representative and/or NTP manager and representation from private organizations (both for-profit and not-for profit).
- At provincial level and for Azad Jammu Kashmir and the Northern Area, PPM coordinators are to be designated from the existing personnel pool and will be responsible for overseeing public–private partnerships in their provinces and for identifying partners.

### PPM OPERATIONAL GUIDELINES OUTLINE

#### Task mix

Task	Public health system	NGO Clinics	Solo general practitioners	Private clinics/hospitals	Informal providers
Identify symptomatic TB patients					
Collect sputum samples					
Refer TB suspects					
Notify/record cases					
Supervise treatment					
Perform smear microscopy					
Diagnose TB					
Prescribe treatment					
Inform patients about TB					
Identify and supervise treatment support staff					
Follow up on defaulters					
Train care providers					
Supervise					
Carry out quality assurance for laboratories					
Monitor and evaluate					
Manage drugs and supplies					
Provide stewardship: financing and regulation					

### **Practical tools to help implementation**

- Referral form.
- Supervision form.

### **Training**

- The public sector is responsible for training master trainers, who will then train private partners in PPM DOTS.
- The training will be the first practical activity in the PPM. It is therefore important that the public sector demonstrates commitment to and respect for the participants at this time to establish a positive start to the relationship.

### **Contractual mechanisms**

- A memorandum of understanding is required to ensure that all parties have a clear and documented understanding of what the partnership is trying to achieve and what each party is expected to contribute.
- Once a provider has completed training, he or she may be “certified” as a partner of the NTP. Certification demonstrates that the District TB Control (DTC) and the Executive District Officer health (EDOH) officially acknowledge that a provider has met the appropriate criteria to provide the services outlined in the memorandum of understanding.

### **Advocacy**

- The general public needs to be informed about partnerships between the public and private sectors to ensure that: (a) they are able to benefit from mechanisms intended to increase their access; and (b) they know where they can get free drugs and why the drugs are free.

- Patient perceptions of quality of service can be addressed and the process can be used to increase knowledge about TB. Such communication should occur once the partnerships are established and working, to avoid creating false expectations and risking negative perceptions about partnerships in the initial stages. Patients should be informed which partners are involved and where they are located. This could benefit the partners through free advertising.
- General TB behaviour change communication (BCC) messages can also be used to address patient expectations concerning the diagnostic and treatment process. This will also ensure that private providers are accountable to a more informed patient base.

### **Supervision**

- Supervision of the private sector will be based up supervisory guidelines for the public sector and adapted to the roles of the different providers.
- The same records should be maintained for both sets of providers and the same physical checks should be performed by the laboratory supervisors, DTCs and field officers regarding the quality of microscopy, diagnosis, treatment and treatment supervision.
- The field officer should review the monitoring data provided; any indication of a problem should result in a supportive mentoring visit to the NGO.

## **LOCAL IMPLEMENTATION**

### **Preparation**

- Workshops describing the need for a PPM policy and programme, explaining the models and allowing concerns to be discussed should first be held with national level staff, provincial TB managers and coordinators. Provincial managers should then hold similar workshops in their provinces with EDOHs, DTCs and field officers. The DTCs, in turn, should hold workshops with facility-level staff. Some districts already have ad hoc partnerships in place; these will still require some sensitization to the broader concept, since the types of provider they engage with may change over time.
- Pakistan has very decentralized political and administrative systems. It is not, therefore, only the TB or health personnel who must

agree to develop partnerships with the private sector, but also the district politicians (*nazims* and counsellors) and administrative managers (DCOs). The EDOH will need to be the advocate for PPM DOTS at this level. It may also be that the NGOs and medical practitioners organizations, such as branches of the Pakistan Medical Association, will have influence at this level and be able themselves to advocate for PPM.

### **Mapping of providers**

- The districts first need to identify patient provider preferences, categorized into NGO clinics, for-profit clinics, for-profit GPs, for-profit laboratories, other NGO/community-based organization/social franchising organizations and informal providers. This can be done through patient or household

- surveys or through speaking to groups of private practitioners about their client base.
- Once a provider has been selected, it should be approached by the DTC to understand its current role in TB service provision and also its potential role in PPM. The DTC should explain DOTS to the provider and outline the public sector's need for private partners in order to reach more patients. He/she should also explain the benefits that can accrue to the private provider. The private provider should be given time to think about such engagement and to discuss it with colleagues, so an appointment for a return visit by the public provider should be arranged. During the return visit, agreement should be reached as to whether the provider wants to form a partnership. If he/she does, then an outline of how the partnership would be

operated will be discussed, based on the above models, highlighting their adaptability to the needs of individual providers.

- As more private providers become partners, the district TB officer should mark their locations on a map of the district to help in identifying gaps in service provision. These should be categorized and colour-coded into those that charge fees and those that do not, to assess not only geographical coverage but also equitable coverage.

#### **Implementation proper**

- Develop memoranda of understanding.
- Train private partners.
- Provide resources to private partners.

### **IMPLEMENTATION AND SCALE-UP PLAN**

<b>Main activities</b>	
<b>2007</b>	<b>2008</b>
<ul style="list-style-type: none"> <li>• Strengthening the national, four provincial and AJK/FANA (Azad Jammu Kashmir/Federally Administered Northern Area) programmes by assigning public-private partnership development coordinators.</li> <li>• Enhancing the district capacity by strengthening the district TB coordinator and field officer.</li> <li>• Providing free drugs, preferably in fixed dose combinations (FDCs), for patients attending private sector facilities.</li> <li>• Arranging training for private sector providers (including providing trainers, training materials and logistics).</li> <li>• Arranging subsidized or free quality controlled microscopy services for patients attending private sector providers. This will be done either through public sector facilities or private sector (NGO) laboratories. The private sector laboratories will be strengthened by supplementing equipment, reagents and recording/reporting materials and through supervision in addition to the training noted above.</li> <li>• Developing proposals for other PPM models (not included in the plan)</li> </ul>	<ul style="list-style-type: none"> <li>• Implementing tertiary hospital PPM (16 hospitals).</li> <li>• Supervision.</li> <li>• Conducting quarterly review meetings with participation from the EDHO, DTC and participating private sector partners to review progress, discuss problems and take collective decisions.</li> </ul>

## G. SOMALIA

### Situation assessment

#### TB EPIDEMIOLOGY

Incidence (all cases/100 000 population/year)	224
Incidence (ss+ cases/100 000 population/year)	100
Prevalence (all cases/100 000 population)	286
Mortality (deaths/100 000 population/year)	40
New adult TB cases HIV-positive (%)	7
Level of TB/HIV co infection (%)	4.6
Notification rate (new & relapsed cases/100 000 population/year)	86
Notification rate (new ss+ cases/100 000 population/year)	157
DOTS case detection rate (new ss+ cases) (%)	86
DOTS treatment success (new ss+ cases) (%)	91

#### UTILIZATION OF HEALTH SERVICES

##### Health-care-seeking behaviour in the public and private sectors

- Private practitioners (for-profit) are the first point of contact for care for an estimated 70% of the urban population.

##### Cost of care

- The average cost of care is US\$ 3–4 per patient.
- Laboratory charges for sputum smear microscopy US\$ 2–3 per patient.

##### Delays and discontinuities in treatment

- The health care delivery institutions have suffered greatly from civil strife; government hospitals and other health institutions were seriously damaged or completely looted. This insecurity and chaos makes health services inaccessible for a lot of people, leading to delays in access to diagnosis and treatment.

#### COMPOSITION AND CHARACTERISTICS OF THE NON-NTP SECTOR

- The private health sector consists of doctors and qualified nurses who run their own private clinics or private pharmacies.
- International and local NGOs also act as health providers in some rural areas.
- The Fidelis programme was undertaken in Somalia from October 2005 to September 2006, under which 293 health

workers were trained, including those from private, army, police, prison and corporate health services involved in TB diagnosis and treatment. Six sputum collection sites were established in the north-west zone (three were private centres; the others were from the army, the police and the central prison).

#### PREPAREDNESS OF THE NTP

- The National Tuberculosis Control Programme of Somalia is urban-based and donor-dependent, with 46 sites currently functional throughout the country. It is supported by WHO and the Global Fund.
- The DOTS strategy is used at all TB centres. Patients are observed daily by a health worker at the clinic. A system of appointing a guarantor at the start of treatment helps in assuring compliance.
- There are three national TB programme coordinators, in three different zones and financially supported by the Global Fund.
- Quality drugs are procured by WHO and distributed to all centres.
- WHO-recommended recording and reporting procedures are in place.
- A system for laboratory quality assurance and quality control is also in place.

## POLICY AND REGULATORY ENVIRONMENT

- Regulatory agencies exist for medical services, medical education, diagnostic laboratories and drug monitoring.
- Anti-TB drugs are available in the retail market and can be accessed by non-qualified as well as qualified providers. It is not difficult to obtain TB drugs, even without a prescription.

## Operational plan

### OBJECTIVES

#### Main objective

- To halt the increase in TB prevalence and reverse its incidence, and to halve TB morbidity and mortality through PPM DOTS collaboration and partnership by the year 2015.

#### Specific objectives

- Identification and recruitment of one national, one assistant and four zonal PPM focal points through interview by the Ministry of Health and WHO by the end of 2007.
- Formation of a PPM DOTS stakeholder team composed of all non-NTP and NTP providers. A total of 25 PPM DOTS partnerships to be formed in 2007.

- Operational guidelines and supporting documents for PPM DOTS to be developed and printed by PPM DOTS team by the end of 2007.
- Training sessions to be designed and prepared for NTP PPM partners by the Ministry of Health and WHO in 2007 (20 session per year).
- Monitoring and evaluation checklist to be updated in line with NTP/WHO policy.

### DESCRIPTION OF THE PROPOSED PPM STRUCTURE

- A PPM programme manager to be appointed.
- A WHO Somali office, particularly the designated TB medical officer, based in Nairobi to give overall leadership and coordination to all PPM activities in Somalia.
- Health officers of the 25 PPM DOTS partners to support the projected PPM DOTS activities.

### PPM OPERATIONAL GUIDELINES OUTLINE

#### Task mix

Task	NTP	Public or private institution	Individual private provider	Private/ public laboratory	Non-physician/ pharmacy
Identify symptomatic TB patients					
Collect sputum samples					
Refer TB suspects					
Notify/record cases					
Supervise treatment					
Perform smear microscopy					
Diagnose TB					
Prescribe treatment					
Inform patients about TB					
Identify and supervise treatment support staff					
Follow up on defaulters					
Train care providers					
Supervision					
Quality assurance for laboratories					
Monitor and evaluate					
Manage drugs and supplies					
Provide stewardship					

### Practical tools to help implementation

- PPM operational guidelines.
- Recording/reporting tools.
- Monitoring and evaluation forms.

### Training

- Select staff to be trained from among health providers.
- Investigate their current role in the TB programme.
- Prepare necessary training materials.

### Contractual mechanisms

- Memorandum of understanding between WHO, the health authority and institutional providers.

### Advocacy

- Organize consultative and advocacy meetings.
- Develop IEC materials.
- Advocacy through drama and competitions.
- Design and develop health education materials.

### Supervision, monitoring and evaluation

- The PPM manager and his colleagues will monitor all PPM DOTS activities, following the NTP/WHO monitoring and evaluation system.
- Activity schedule to be developed.
- NTP/WHO will submit to Stop TB a mid-term evaluation report.

## LOCAL IMPLEMENTATION

### Preparation

- Clear written messages have been prepared on the importance of PPM to NTP management.
- Operational guidelines have been developed for local implementation.
- Training materials are in place.
- Implementation tools are to hand.
- Staff have been briefed about PPM and their tasks and responsibilities.
- A plan of Implementation is in place.

### Mapping of health care facilities nationwide

- The local health NTP unit is mapped to enable identification of all providers in the public and private sectors.
- The map provides a general idea of individual and institutional providers, so that everybody can understand their current and potential contribution to TB control.

### Selection of providers

- Selection gives priority to the active collaboration and skills of providers.

- Medical Colleges, general public hospitals and corporate health care institutions to be selected because of the large number of TB cases they handle.
- Private practitioners to be selected based on case load, low diagnostic delay and cost of care to the patients.
- Poor patients generally approach NGOs. This element needs to be taken into consideration and NGOs operating in poor areas to be selected.

### Implementation proper

- NTP staff is obliged to commit to following whatever procedures are mutually agreed on.
- Proper recording and reporting are carried out.
- Collaborating providers are required to conform to the guidelines.
- Problems identified should be referred to the NTP.

## IMPLEMENTATION AND SCALE-UP PLAN

Main activities	
2007	2008
<ul style="list-style-type: none"><li>• NTP/WHO to contact and discuss the PPM DOTS initiative with non-NTP providers.</li><li>• Identification and recruitment of national and subnational PPM focal points.</li><li>• Design and development of NTP-based training materials.</li><li>• Design and development of operational guidelines.</li><li>• Design and development of IEC materials.</li><li>• Organization of a consultative and advocacy meeting.</li></ul>	<ul style="list-style-type: none"><li>• Training of health workers at subnational level</li><li>• Organization and implementation of joint monitoring and evaluation.</li></ul>

## H. SYRIAN ARAB REPUBLIC

### Situation assessment

#### TB EPIDEMIOLOGY

Incidence (all cases/100 000 population/year)	37
Incidence (ss+ cases/100 000 population/year)	17
Prevalence (all cases/100 000 population)	46
Mortality (deaths/100 000 population/year)	4
New adult TB cases HIV-positive (%)	0.0
New MDR TB cases in 2004 (%)	4.41
Notification rate (new & relapsed cases/100 000 population/year)	23
Notification rate (new ss+ cases/100 000 population/year)	7
DOTS case detection rate (new ss+ cases) (%)	42
DOTS treatment success (new ss+ cases) (%)	86

#### UTILIZATION OF HEALTH SERVICES

##### Health-care-seeking behaviour in the public and private sectors

- Some 80% of TB patients first contact the non-NTP sector.
- The proportion of TB cases diagnosed in the private sector was 70.2% in 2006. The proportion of cases diagnosed in the public sector (NTP and other public) decreased from 37.7% in 2005 to 29.8% in 2006.

##### Cost of care

- While all medical visits and tests are free of charge in the public sector, the cost in the private sector is about US\$ 8 for a chest X-ray, US\$ 3 for a smear examination and US\$ 10 for a medical visit.

##### Access to care

- While 90% of people have easy access to different health centres, the remaining 10% of the population needs

more than half an hour to access the PHC centre. Health services are not evenly distributed throughout the country

##### Delays and discontinuities in treatment

- The main delay between beginning of symptoms (TB suspect) and starting of TB treatment is about 80 days: the patient delay is about 53 days, the health system delay is 27.6 days, the diagnostic delay is 77.6 days, and treatment delay is around 3 days.
- Delays are more frequent in rural and poor areas, where TB is considered a stigma and where accessibility to health centres is sometimes very difficult.
- Delays may also depend on a lack of information, knowledge, awareness and skills in both patients and health care providers.

#### COMPOSITION AND CHARACTERISTICS OF THE NON-NTP SECTOR

- **Public other than Ministry of Health:** this sector is composed of the medical services of other ministries such Defence, Higher Education (medical universities), Interior Affairs and Social Affairs.
- **Semi-public sector:** This is composed of clinics and hospitals of semi-public organizations, syndicates and associations.
- **Private sector:** This is composed of all providers outside the public sector and includes international organizations, individual providers/clinics, hospitals, paramedical workers, diagnostic facilities (X-ray and laboratory) and private pharmacies.

#### PREPAREDNESS OF THE NTP

- The NTP has the commitment and support of the Ministry of Health for funding salaries, drugs and laboratory supplies.
- At the national and provincial level, the NTP has adequately trained staff to take on a leadership role.

## **POLICY AND REGULATORY ENVIRONMENT**

- There is a ban on the sale of anti-TB drugs. These drugs are distributed to patients only via Ministry of Health facilities.
- There is mandatory notification of TB.
- The NTP has a protocol of cooperation with other sectors (defence, police, prisons) for the implementation of DOTS.

## Operational plan

### OBJECTIVES

#### Specific objectives

- To improve the quality of diagnosis, case management, the referral system and the recording/reporting system.
- To improve case detection and success rate, and to reduce mortality and drug resistance.
- To reduce TB incidence, prevalence and mortality.
- To improve access to health facilities among the poor.

### DESCRIPTION OF THE PROPOSED PPM STRUCTURE

- At national level: PPM focal point (TB programme manager) and administrative support (two part-time technical assistants).
- At provincial level: 14 provincial focal points (full-time).
- Two doctors to be appointed to act as coordinators between NTP and other players.
- Task force/steering committee with representation from public and private sectors.

### PPM OPERATIONAL GUIDELINES OUTLINE

#### Task mix

Task	NTP	Private not-for profit	Public or private institution	Public health clinic	Private/public laboratory	Non-physician/pharmacy
Identify symptomatic TB patients						
Collect sputum samples						
Refer TB suspects						
Notify/record cases						
Supervise treatment						
Perform smear microscopy						
Diagnose TB						
Prescribe treatment						
Inform patients about TB						
Identify and supervise treatment support staff						
Follow up on defaulters						
Train care providers						
Supervision						
Quality assurance for laboratories						
Monitor and evaluate						
Manage drugs and supplies						
Provide stewardship: financing and regulation						

### Practical tools to help implementation

- Laboratory request forms.
- Referral forms.
- Feedback or back-referral forms.
- Treatment cards.
- Contact-tracing records supervision form with checklist.
- Coordination and collaboration should be carried out through memoranda of understanding and letters of agreement.

### Training

- Training to be adapted to the task mix, with separate training modules designed for different tasks.
- Post-training follow-up.
- Training materials and training programmes to be revised periodically, based on evaluation.

### Contractual mechanisms

- Standard certification models for the different providers to be drawn up and evaluated periodically according to established criteria.

### Advocacy

- To generate and sustain interest in PPM DOTS, advocacy should reach both NTP staff and counterparts among private and public providers, addressing in particular the issues of stigma and delay in diagnosis.
- Communication campaigns to advocate ISTC.

### Supervision, monitoring and evaluation

- Supervisory team to visit different levels on quarterly basis, using supervisory checklist that will be completed at the end of each visit.

## LOCAL IMPLEMENTATION

### Preparation

- NTP staff to be oriented about PPM and their tasks and responsibilities to be defined.
- A plan of implementation to be established according to defined PPM objectives.
- A sub-task force at the provincial level to be established to engage all relevant partners in the process of planning and implementation.
- Operational responsibilities for briefing, training, supervision and quality control to be defined.
- Mapping and first contact.

### Selection of pilot areas

- NTP to begin a pilot project in selected areas (Aleppo, Damascus, rural Damascus and Deir Elzor) with existing providers, to be expanded to other provinces in the next phase depending on results obtained.
- Providers to adhere to the adopted forms for PPM.
- Continuous dialogue to take place between the providers involved to identify problems and avoid potential conflict.

## IMPLEMENTATION AND SCALE-UP PLAN

Main activities	
2007	2008
<ul style="list-style-type: none"><li>• Workshop to develop PPM guidelines, PPM training materials (modules) and information material (posters/ brochures).</li><li>• Consultative meeting of task force and establishment of four subcommittees at provincial level</li><li>• Training course for physicians (defence, police, prison, university, NGOs) on 15–30 September.</li><li>• Training course for patient support staff (defence, police, prison, university, NGOs) on 1–10 October.</li><li>• Training course for laboratory technicians on 11–20 October in collaboration with the Syrian laboratory board.</li></ul>	<ul style="list-style-type: none"><li>• Pilot projects.</li></ul>

## I. UGANDA

**Situation assessment** (to be completed by November 2007)

### Operational plan

#### OBJECTIVES

##### Main objective

- To improve programme performance by engaging private health providers (PHPs) in TB control (increasing the case detection rate to 60% and treatment success to 70% over two years).
- To ensure a regular supply of quality anti-TB drugs.
- To strengthen TB and HIV collaborative interventions in the PHP sub sector.
- To improve the mechanisms of referring suspects and patients in the country.
- To improve monitoring and evaluation in the PHP sub sector.

##### Specific objectives

- To engage the PHP sub sector in DOTS implementation.
- To increase access to quality TB diagnostic services in the PHP sub sector.

#### DESCRIPTION OF THE PROPOSED PPM STRUCTURE

- A national-level PPM focal point/team will be put in place.
- The programme's human resources capacity is limited. With good collaboration the PHP sub sector can augment what is available in the public sector.
- A task force/steering committee will function as a subcommittee of the DOTS expansion working group of the Uganda Stop TB Partnership, of which both the national programme and the Uganda Private Medical Practitioners' Association (UPMPA) are members.

#### PPM OPERATIONAL GUIDELINES OUTLINE

##### Task mix

Task	NTP	Private not-for-profit	Public or private institution	Individual private provider	Private/public laboratory	Non-physician/pharmacy	Traditional and complementary medical practitioners
Identify symptomatic TB patients							
Collect sputum samples							
Refer TB suspects							
Notify/record cases							
Supervise treatment							
Perform smear microscopy							
Diagnose TB							
Prescribe treatment							
Patient information							
Identify and supervise treatment support staff							
Follow up on defaulters							
Train care providers							
Supervise							
Quality assurance for laboratories							
Monitor and evaluate							
Manage drugs and supplies							
Provide stewardship							

### **Practical tools to help implementation**

- PPM guidelines
- TB/HIV collaborative activities guidelines
- Memoranda of understanding/contracts
- ISTC
- Referral and back referral forms
- Registers – TB registers, laboratory, facility/treatment
- Laboratory request form
- Supervision checklists
- Monitoring and evaluation tools (notification forms, cohort forms)

### **Training**

- Training content for different providers:
  - training of trainers on DOTS, logistics, STB/HIV support supervision, and monitoring and evaluation
  - orientation on PPM DOTS for all private providers
  - orientation on TB/HIV collaborative activities
  - training on logistics management, monitoring and evaluation, data analysis, and use of private health practitioners
- Tailor training methods and material to local context
- Follow up technical support supervision after training
- Evaluation and revision based on feedback

### **Contractual mechanisms**

- Certification/accreditation to be performed after each training. Memoranda of understanding and contracts between NTLP and private health practitioners to be entered into after accreditation.
- Accreditation criteria to be developed for selection of participating PHP facilities. This is to be undertaken with involvement of the UPMPA.
- Free tools and TB drugs to be available to all accredited PHPs. Free laboratory reagents to be available to all accredited PHP laboratories (revision of fees expected).
- Regular feedback on data reported (using agreed national programme format) to be

made available every quarter (with feedback to PHPs).

- Refund of transport costs for attendees at training/seminars run by PHPs and facilitators.
- Professional fees/facilitation fees or per diem for facilitators.

### **Advocacy**

- Consensus building workshops for central and local government officials.
- IEC materials on PPM, coordinating board, TB/HIV for providers.
- Revision and printing of guidelines.
- Distribution of guidelines.
- ISTC (dissemination) and Global Plan to Stop TB.
- Patient charter (dissemination).

### **Supervision**

- Joint support supervision monthly/quarterly depending on patient load and human resource capacity.
- During supervisory missions, feedback to be provided accompanied by on-the-job training.

### **Monitoring and evaluation**

- Process indicators:
  - number of TB suspects referred by TCMP and PHPs (laboratory technicians/ assistants, pharmacists, nurses and midwives)
  - proportion of all TB patients notified by PHP facilities
  - number of TB patients treated in PHP facilities
  - number of stock outs of laboratory reagents and drugs in PHPs
  - number of TB patients offered HIV counselling and testing in PHP facilities.
- Outcome indicators: proportion of PHPs participating in PPM DOTS, case notification rates, treatment outcomes.

## **LOCAL IMPLEMENTATION**

### **Preparation**

- Preparation to be in phases, starting with Kampala and peri-urban areas followed by phased roll-out
- Identify funding sources
- Situation analysis/mapping for the PHP subsector
- Advocacy and sensitization of the national programme/leadership on PPM presentation,

and briefing the public–private partnership in health (PPPH) working group on the PPM proposal

- Identify PPM working subgroup
- Adapt PPM policy, guidelines and tools, print and disseminate
- Consensus building among stakeholders
- Training of trainers
- Sampling of initial PHPs to be engaged

- Training of PHPs

**Implementation proper**

- Distribution of drugs, tools, reagents, IEC materials and registers.

- Support provided for supervision, monitoring and evaluation, contracting, accreditation and preparation of memoranda of understanding.

**IMPLEMENTATION AND SCALE-UP PLAN**

<b>Main activities</b>	
<b>2007</b>	<b>2008</b>
<ul style="list-style-type: none"> <li>• PPM DOTS implementation is to be initiated in Kampala region and expanded thereafter to other regions (zones), with a target of full coverage of the PHP subsector by 2009.</li> <li>• Consultative/advocacy meetings are to be conducted both centrally and at local government levels (at least four sessions at each level per year).</li> <li>• Operational guidelines are to be finalized in the first year of PPM implementation through consultative and advocacy meetings with key stakeholders, politicians and ministries.</li> <li>• The PPM coordination structure is to be established.</li> <li>• The NSA will be phased in, initially covering Kampala region then spreading to other regions to cover the entire PHP subsector nationwide.</li> </ul>	<ul style="list-style-type: none"> <li>• Consultative/advocacy meetings are to be conducted both centrally and at local government levels (at least four sessions at each level per year).</li> <li>• PPM implementation guidelines/ IEC materials/tools are to be developed, printed and disseminated.</li> <li>• PPM training materials are to be developed.</li> <li>• Memoranda of understanding, contracts and criteria for accreditation of PHP facilities implementing PPM are to be developed.</li> <li>• Training of trainers and of PHPs will be conducted</li> <li>• Support, supervision &amp; monitoring of the PPM will be carried out.</li> <li>• Quarterly review and monitoring meetings will be organized.</li> <li>• Quarterly visits to PHP laboratories for quality assurance will be carried out.</li> </ul>

## J. YEMEN

### Situation assessment

#### TB EPIDEMIOLOGY

Incidence (all cases/100 000 population/year)	82
Incidence (ss+ cases/100 000 population/year)	37
Prevalence (all cases/100 000 population)	13
Mortality (deaths/100 000 population/year)	10
New adult TB cases HIV-positive (%)	<1
New MDR TB cases in 2004 (%)	3.1
Notification rate (new & relapsed cases/100 000 population/year)	28
Notification rate (new ss+ cases/100 000 population/year)	15
DOTS case detection rate (new ss+ cases) (%)	41
DOTS treatment success (new ss+ cases) (%)	82

#### UTILIZATION OF HEALTH SERVICES

##### Health-care-seeking behaviour in the public and private sectors

- Some 88% of those with TB consulted a health care provider with the onset of symptoms, while 27.4% visited TB centres, 31.6% visited public facilities, 32.1% visited private practitioners, 1.7% visited primary health care units and 7% visited other care providers.
- Patients first went through an average of 1.6 consultations (range 0–6) with several health care providers before diagnosis.

##### Cost of care

- Before being diagnosed, around half of TB patients had spent approximately US\$ 8 in shopping for health care providers (average amount spent US\$ 20).

##### Access to care

- Health facilities are widely distributed, and more than 50% of patients can reach a health facility in less than 30 minutes and another 30% within an hour.
- The use of health services varies from urban to rural areas, where the private sector is scarce and has a negligible effect. Around 50% of the population use public services in urban areas, compared to 95% in rural areas.

##### Delays and discontinuities in treatment

- The average delay between onset of symptoms and diagnosis was 59 days. Significant risk factors for patient delays were: female sex (twofold increased risk) and inadequate knowledge of TB.

#### COMPOSITION AND CHARACTERISTICS OF THE NON-NTP SECTOR

- Yemen has a dense network of private health care providers. There are three government medical colleges and two private medical colleges. About 600 doctors are trained in these institutes annually.
- Most doctors working in the public sector work as private practitioners in the evenings.
- The private sector does not adhere to the NTP guidelines in the diagnosis and treatment of TB patients.
- Most pharmacies keep anti-TB drugs, which are sold on a monthly basis.
- The private sector, although it works for profit, is willing to collaborate with the NTP. However, the NTP needs to create a positive environment to foster such a partnership.

#### PREPAREDNESS OF THE NTP

- The NTP has a very strong central management team with excellent coordination among the team members.
- The recording and reporting system is comprehensive. The reports are compiled at governorate, district and national level and

are analysed for case detection rates and treatment outcomes.

- The NTP diagnosis and treatment network exists throughout the country and there is about one laboratory for every 82 000 people. All laboratories are quality controlled.
- At district level, the district TB coordinator is responsible for diagnosis, treatment, follow-up, training, supervision and logistics

support. At the health unit level, health workers are responsible for identifying suspects and supervising drug intake.

- There is a need for NTP to develop its human resource capacity in connection with PPM DOTS at all levels. The NTP also needs to identify focal points for PPM at central and governorate levels.

## **POLICY AND REGULATORY ENVIRONMENT**

- No regulations exist for notification of TB cases diagnosed or treated outside NTP facilities.

- Anti-TB drugs are available on the open market and are sold with or without prescription.

## Operational plan

### OBJECTIVES

#### Main objective

- To involve non-NTP health care providers in DOTS implementation in order to increase case finding, improve treatment success rate and increase accessibility of patients to quality DOTS by the end of 2010.

#### Specific objectives

- To involve all non-NTP providers in the main cities of the 22 governorates (one per governorate). These providers will be engaged in DOTS implementation according to an agreed model.
- To build non-NTP capacity in DOTS implementation.

### DESCRIPTION OF THE PROPOSED PPM STRUCTURE

- Steering committee: general director for disease control and surveillance, NTP manager, focal point for PPM in the NTP, general director for private administration in the Ministry of Public Health and one representative for each non-NTP sector.
- National-level focal point and team.
- Private governorate TB coordinator (P-GTC) and focal point (additional staff depending on the workload).
- Private district coordinators (P-DTCs) in the 333 districts.

### PPM OPERATIONAL GUIDELINES OUTLINE

#### Task mix

Task	NTP	Public hospital	Military	Ministry of the Interior	University	Semi-private	GP	Laboratory	Radiology centre	Private hospital /clinic	NGO	Injection clinic	Pharmacy
Identify symptomatic TB patients													
Refer TB suspects													
Perform smear microscopy													
Diagnose TB													
Prescribe treatment													
Record and report													
Provide health education													
Supervise treatment													
Trace contacts													
Trace defaulters													
Train care providers													
Supervise													
Quality assurance for laboratories													
Manage drugs													
Provide stewardship : financing and regulation													

### **Practical tools to help implementation**

- Outpatient department register.
- TB suspect register.
- Referral form.
- Sputum request form.
- Laboratory register.
- TB register.
- TB treatment card.
- Patient booklet (appointment and medical examination).
- Quarterly reports on case finding.

### **Training**

- NTP public hospitals.
- Military hospitals.
- Interior hospital service.
- University hospitals.
- Semi-private hospitals.
- GPs.

### **Contractual mechanisms**

- Non-NTP training.
- Incentives:
  - ATT
  - training workshops
  - monetary incentives

### **Advocacy**

- Using IEC for providers and promoting the ISTC.
- Promoting the Stop TB strategy
- Including the ISTC in the agenda of medical associations/syndicates.
- Promoting the participation of the private sector in PPM through medical associations/syndicates

- Quarterly reports sputum conversion.
- Quarterly reports treatment success.
- IEC.
- Visual aids.
- Training modules.
- Contact register.
- Supervision checklist.
- Supervisory reports.

- Laboratories.
- Radiology centres.
- Private hospitals.
- Specialized clinics.
- Pharmacies.

- participation in World TB Day and national conferences
- annual recognition and congratulation for being PPM members.

- Increasing the involvement of chest physicians in TB control.
- Enhancing collaboration with the HIV/AIDS programme in reducing the burden of TB among AIDS patients.

## **LOCAL IMPLEMENTATION**

### **Preparation and initial steps in implementation**

- Inform the steering committee about the plan and procure its endorsement.
- Meet with GTCs to inform them about the plan and distribute tasks for its preparation and implementation.
- Mapping: get the list of all health care providers in all governorates from the governorate health directorates (by GTCs).
- Start with underserved governorates and invite their non-NTP providers to meetings to

agree on the plan and sign the memorandum of understanding. This could be done by organizing an event or through local professional associations.

- Train non-NTP providers in the targeted governorates.
- Run a media campaign about the initiation of PPM activities.

## IMPLEMENTATION AND SCALE-UP PLAN

Main activities	
2007	2008
<ul style="list-style-type: none"><li>• Start with the four underserved governorates of Hodeidia, Sanaa City, Taiz and Aden (total of 25 districts in major cities) and invite their non-NTP providers to a meeting to agree on the plan and sign a memorandum of understanding.</li><li>• Media campaign about the initiation of the PPM.</li><li>• Training:<ul style="list-style-type: none"><li>– training of trainers for the P-GTC and P-DTCs and non-NTP providers in the targeted governorates (four days of training).</li><li>– training for all non-NTP in the four governorates (n = 832)</li><li>– training of trainers and then all non-NTP in the seven governorates</li><li>– training of trainers and then all non-NTP in the eleven governorates.</li></ul></li></ul>	<ul style="list-style-type: none"><li>• Implementation in four governorates (demonstration sites).</li><li>• Implementation in seven governorates (demonstration sites).</li><li>• Implementation in eleven governorates (demonstration sites).</li></ul>

## K. ZAMBIA

### Situation assessment

#### TB EPIDEMIOLOGY

Incidence (all cases/100 000 population/year)	600
Incidence (ss+ cases/100 000 population/year)	247
Prevalence (all cases/100 000 population)	618
Mortality (deaths/100 000 population/year)	118
New adult TB cases HIV-positive (%)	39
New MDR TB cases in 2004 (%)	—
Notification rate (new & relapsed cases/100 000 population/year)	425
Notification rate (new ss+ cases/100 000 population/year)	127
DOTS case detection rate (new ss+ cases) (%)	52
DOTS treatment success (new ss+ cases) (%)	83

#### UTILIZATION OF HEALTH SERVICES

- Currently only a limited percentage of health expenditure goes to the private sector.
- Factors influencing health provider choices include cost, access, service quality, provider attitude and awareness.

#### COMPOSITION AND CHARACTERISTICS OF THE NON-NTP SECTOR

- **Public sector other than Ministry of Health.** This sector is composed of the medical services of other ministries such as Ministry of Defence, Ministry of High Education (medical universities) and Ministry of Home Affairs.
- **Semi public sector.** This is composed of clinics and hospitals of semi-public organizations, syndicates and associations. The most prominent in this sector are the faith-based organizations or mission facilities under the umbrella of the Churches Health Association of Zambia (CHAZ).
- **Private sector.** This is composed of corporate and individual private clinics and hospitals. It includes mine hospitals.
- The private sector in Zambia is regulated by the Zambia Medical Council, which is the statutory body regulating medical practice in the country.
- The practitioners are organized under the Zambian Faculty of Private Practitioners, which meets regularly every month.
- There are 432 corporate and individual private providers. This number excludes faith-based facilities, which are managed under the umbrella of CHAZ.

#### PREPAREDNESS OF THE NTP

- The NTP is fully integrated into the primary health care system and implemented throughout the three tiers of government.
- At national level, the NTP is staffed by one medical officer (TB specialist), a nurse and a clinical officer.
- There are nine provincial TB focal points responsible for coordination of TB control activities at the provincial level.
- Each of the 72 districts has a district TB coordinator.
- Establishing effective partnerships is one of the key principles of the Zambian health reforms.
- Support for the purchase of TB drugs has been provided by the United Kingdom's Department for International Development, the Swedish International Development Cooperation Agency, the Japan International Cooperation Agency and the Global Drug Facility through WHO.

## POLICY AND REGULATORY ENVIRONMENT

- Medical practice is regulated by the Medical Council of Zambia. It is responsible for the registration and regulation of medical practice. .
- There is currently no regulation limiting the participation of private providers in TB control. The involvement of private providers in health care delivery is recognized in the National Health Strategic Plan, the National TB Strategic Plan and the National TB Workers Manual.
- In Zambia, it is not a problem for private facilities to receive government-owned drugs and other supplies. This is evident from the example of existing PPM collaborations. The National Programme on Immunization partners with the private sector by providing vaccines free of charge.
- Rifampicin-containing tablets, as well as second-line anti-TB drugs, are available and dispensed freely by private pharmacies and health practitioners. This is a main area of regulatory concern with regard to the abuse of anti-TB medications in private pharmacies.

## Operational plan

### OBJECTIVES

#### Main objective

- To engage all care providers in TB control in order to improve case detection and standards of care for all TB patients by 2010.

#### Specific objectives

- To have reliable and standard recording and reporting tools in the private sector.
- To increase case detection through private sector participation.
- To involve the private sector in TB control activities.

- To improve quality-assured laboratory capacity in the private sector.
- To provide quality-assured TB drugs free to patients through the private sector.
- To improve coordination of all stakeholders involved in TB control, including the affected communities.
- To build capacity for TB and TB/HIV activities.
- To conduct resource mobilization and operations research.

### DESCRIPTION OF THE PROPOSED PPM STRUCTURE

- The Ministry of Health has formed a subcommittee for PPM (a subcommittee of the national steering committee for TB control), which includes representation from professional bodies and the private sector.
- Central coordination is provided by this subcommittee.
- The national steering committee will draft the terms of reference for the PPM subcommittee in 2007.
- The NTP is to appoint one existing staff member as PPM focal point (part time).
- All new providers are to be involved in PPM to link with the TB officer in each district (catchments area). This is the entry point into the NTP system

### PPM OPERATIONAL GUIDELINES OUTLINE

#### Task mix

Task	NTP	Public or private institution	Individual private provider	Public/private laboratory	Non-physician/pharmacy
Identify symptomatic TB patients					
Collect sputum samples					
Refer TB suspects					
Notify/record cases					
Supervise treatment					
Perform smear microscopy					
Diagnose TB					
Prescribe treatment					
Inform patients about TB					
Identify and supervise treatment support staff					
Follow up on defaulters					
Train care providers					
Supervise					
Carry out quality assurance for laboratories					
Monitor and evaluate					
Manage drugs and supplies					
Provide stewardship: financing and regulation					

### Practical tools to help implementation

- Referral forms
- Registers
- Notification forms

### Training

- The training content is to be organized according to the clinical skills of individual providers.
- Separate training packages are to be available from the NTP for clinicians, nurses, environmental health technicians, private institutions, private practitioners and laboratory technicians.
- Initial training is to be coordinated and provided by the central NTP.
- Follow-up is to be coordinated with the district TB officer.

### Contractual mechanisms:

- Memoranda of understanding are to be signed with the medical services of the Ministry of Defence, the Prisons Medical Service, private institutions, private laboratories and private practitioners (drugs only, not microscopy). Each of these facilities is to be linked to the district health management team within its catchment area.
- The NTP is to provide first-line drugs, reagents for smear microscopy, training, notification forms, laboratory registers, technical support and quality assurance for the laboratories.

## LOCAL IMPLEMENTATION

### Preparation

- Brief the PPM subcommittee
- Share the plan with the TB officers in the initial demonstration areas
- Identify private providers to be engaged in the demonstration areas

### Implementation proper

- Orient the TB officers in the three initial demonstration areas
- Share the plan with the TB officers in the initial demonstration areas

## IMPLEMENTATION AND SCALE-UP PLAN

Main activities	
2007	2008
<ul style="list-style-type: none"><li>• Finalization of the operational plan</li><li>• Orientation of the TB officers in the three initial demonstration areas.</li><li>• Development of guidelines for PPM implementation</li><li>• Identification of private providers to be engaged in the demonstration areas</li></ul>	<ul style="list-style-type: none"><li>• Develop memoranda of agreement and possible contractual arrangements</li></ul>



09:15–09:30	Discussion	
09:30–10:00	Planning and budgeting tool	<b>Ms Pantoja</b>
10:00–10:30	Group work instructions	<b>Dr Lönnroth Dr Baghdadi</b>
10:30–11:00	Coffee break	

**Session 4: Working groups**

11:00–13:00	Work groups: Preparation of PPM country-specific draft plans with budgets	<b>Facilitators</b>
13:00–14:00	Coffee break	
14:00–17:00	Work groups: Preparation of PPM country-specific draft plans with budgets	<b>Facilitators</b>

**Tuesday, 27 February 2007**

09:00–10:30	Plenary on country plans and feedback	<b>Country Representatives</b>
10:30–11:00	Coffee break	
11:00–13:00	Working groups: Preparation of PPM country-specific draft plans with budgets	<b>Facilitators</b>
13:00–14:00	Coffee break	
14:00–15:30	Working groups: preparation of PPM country-specific draft plans with budgets	<b>Country Representatives</b>
15:30–16:00	Coffee break	
16:00–17:30	Working groups: Preparation of PPM country-specific draft plans with budgets	<b>Country Representatives</b>

**Wednesday, 28 February 2007**

09:00–10:30	Preparation of final draft of country plans	<b>Country Representatives</b>
10:30–11:00	Coffee break	
11:00–13:00	Preparation of final draft of country plans	<b>Country Representatives</b>
13:00–14:00	Coffee break	
14:00–16:00	Presentation of country plans	<b>Country Representatives</b>
16:00–17:00	Next steps and Closing Session	<b>Dr Uplekar Dr Hopewell Dr Seita</b>

## Annex 2

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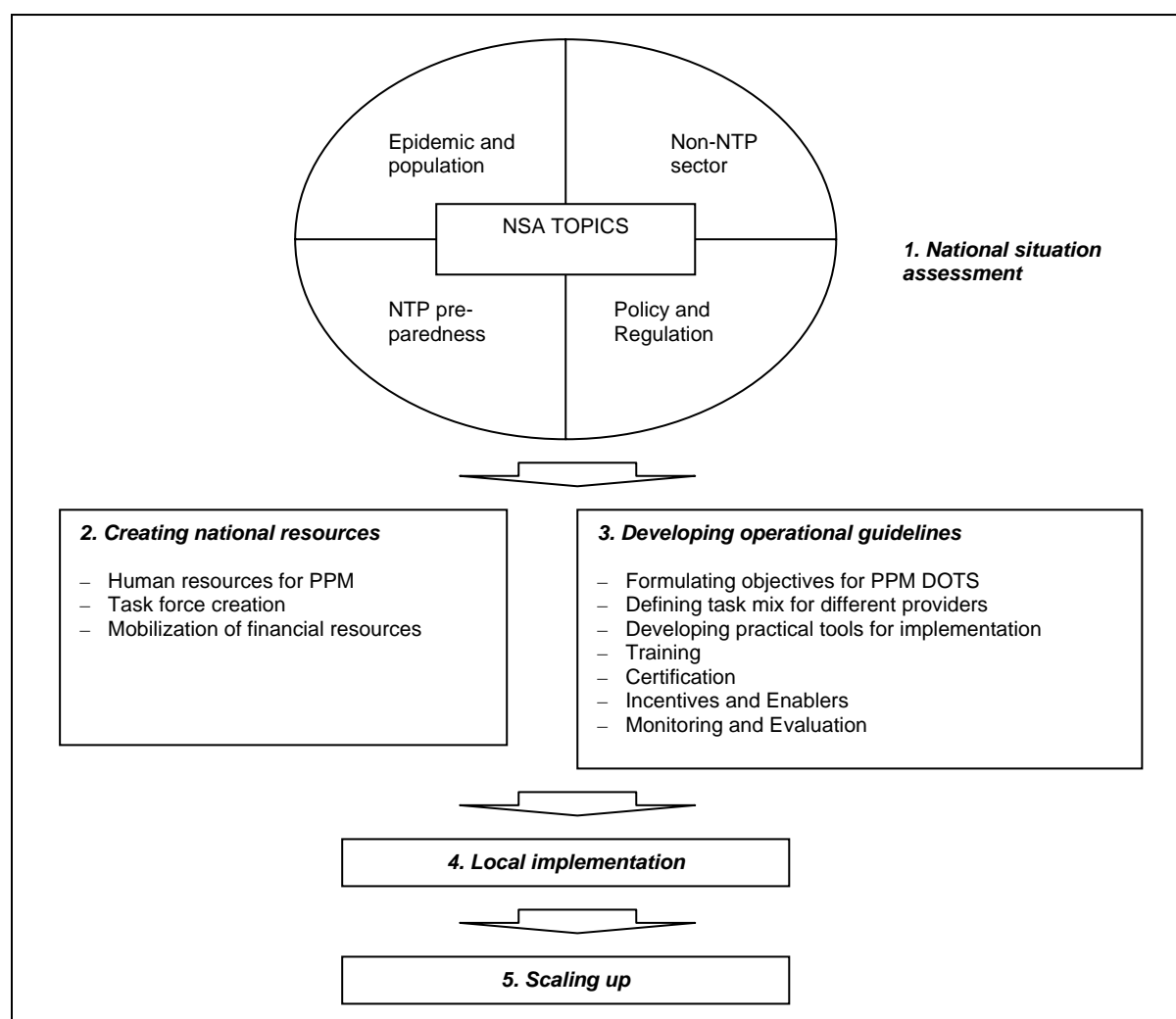
## Annex 3

# National situation assessment tool – a summary

## Introduction

The guidance document *Engaging all health care providers in TB control*,<sup>1</sup> produced by WHO's Stop TB Department, underlines systematic steps to be taken by a NTP in implementing PPM, of which a national situation assessment (NSA) is the first. This tool suggests a plan for conducting a NSA through a process of consultation and knowledge management. All countries cannot have the same PPM policy. The local context, including the composition of the non-NTP sector and its characteristics, the use of non-NTP providers by the population, the state of the epidemic and the readiness of the NTP vary greatly across countries. This tool will help the NTP to collect and collate information on all these different areas, and to use that knowledge to inform the development of national guidelines for PPM implementation. The tool should be used in conjunction with the guidance document.

**Fig. A3.1. NSA as part of the five-step scheme of PPM implementation outlined in the WHO PPM guidance document**



<sup>1</sup> Uplekar M, Lönnroth K. *Engaging all health care providers in TB control: guidance on implementing public-private mix approaches*. Geneva, World Health Organization, 2006 ([http://whqlibdoc.who.int/hq/2006/WHO\\_HTM\\_TB\\_2006.360\\_eng.pdf](http://whqlibdoc.who.int/hq/2006/WHO_HTM_TB_2006.360_eng.pdf), accessed 19 August 2007).

## **Aim of the situation assessment tool**

The aim of the situation assessment tool is to collect and collate information on all aspects of PPM for TB care and control in the country, and to enable the use of this information in the systematic implementation of PPM.

## **The process of situation assessment**

The situation assessment can be conducted by the NTP using secondary sources of information such as existing surveillance data and government and funding agencies' reports, and from consultations with the steering group and programme staff. The assessment should ideally follow a participatory process. Representatives of stakeholder groups, such as the ministry of health, regulatory agencies, academic institutions, professional organizations, civil society, consumer organizations and the pharmaceutical industry, should be approached to form a consultative committee for PPM. The information gathered should be shared with this consultative committee, gaps in knowledge identified, and priorities for collecting missing but essential information determined. Through a process of consensus and dialogue, a vision for PPM in the country should then be developed, taking into account available information and the positions of the various stakeholders. Whatever data is collated as part of the NSA should be fed back to the committee periodically and the cycle repeated. These steps are outlined in detail in the following section.

## **Using the tool**

Country programmes are invited to use the situation assessment tool for developing their own strategies and guidelines for implementing PPM. The tool will assist NTPs in organizing essential information on these topics and using the information for implementation at local level. It is important to note that the tool provides only a general framework for conducting a NSA. It is expected that countries will tailor the tool to match their national context so that it covers country-specific issues.

After the NSA is complete, the programme should be able to answer the following questions.

- When and where to should PPM be implemented?
- What inputs are needed in order to do so?

The NSA will yield knowledge that which will inform the creation of national resources and contribute to the development of a country-specific operational plan for implementation of PPM.

## **Steps in conducting the NSA**

### **Step 1: Form a consultative committee of stakeholder representatives**

From an early stage, it is necessary to adopt an inclusive approach. Stakeholder interests may play an important role in the progress of PPM, and all groups of actors should be included in deliberations. A consultative committee can be created, with members drawn from the various stakeholders and programme staff, to formulate a vision for the NSA, define priorities and review the available information. The consultative committee can subsequently feed into the creation of national resources for PPM, including an expert PPM task force.

### **Step 2: Identify existing information and information still required**

The topics of information listed in Table A3.1 may be used as a checklist for the NSA. Existing information should be shared with the consultative committee, gaps in knowledge identified, and priorities for further exploration or research determined.

### **Step 3: Collect data**

To a large extent, data will be available through secondary sources of information such as reports of the government and funding agencies, independent research studies, and through consultations with experts, stakeholders and programme staff. As a guide, likely sources of information are listed below (Table A3.1). If there is a deficiency of readily available information on necessary topics, fresh

research studies or secondary literature reviews may have to be conducted. These can also be commissioned from independent research agencies.

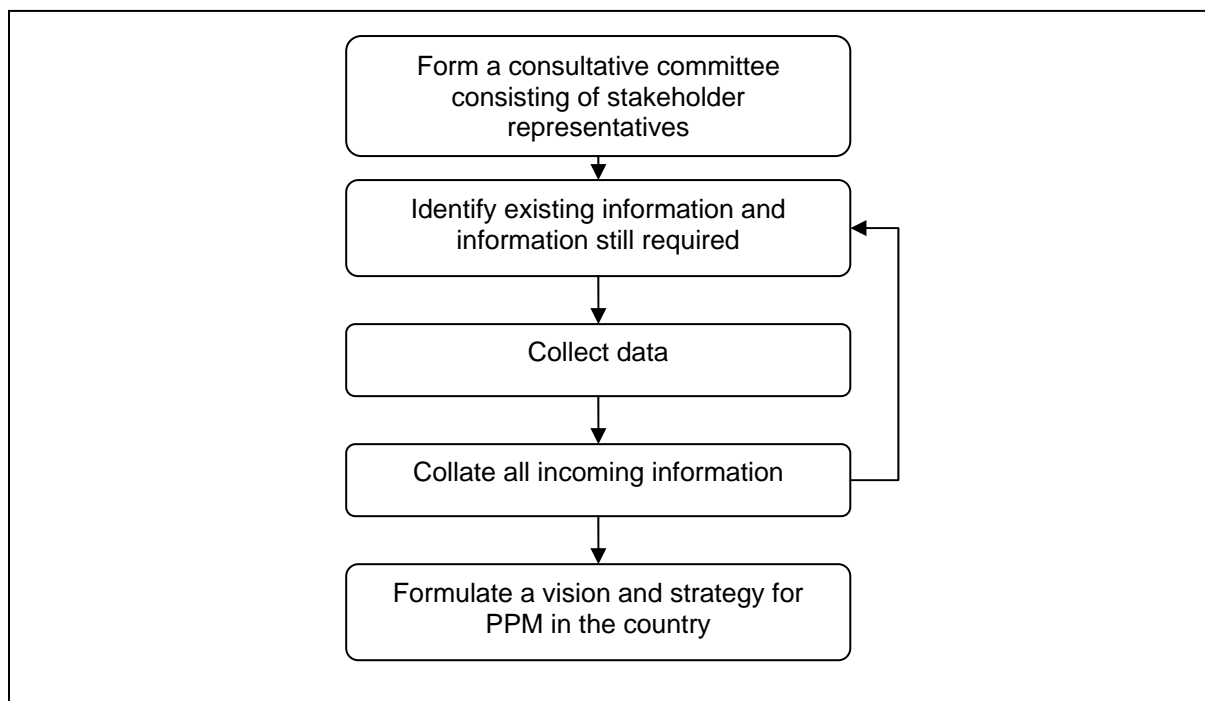
**Step 4: Collate all incoming information**

Information from the NSA on the listed topics, including secondary research, any new primary research and PPM monitoring data, should be managed by the PPM focal point at a central level. This information should be regularly updated and fed back to the consultative committee.

**Step 5: Formulate a vision and strategy for PPM in the country**

One of the main purposes in undertaking a NSA is to help formulate a vision and strategy for PPM in the country. This should be developed through a process of consensus. The consultative team of stakeholder representatives and programme staff may be called together for meetings or a workshop to decide on a vision and strategy for a phased implementation of PPM in the country. Key issues such as which provider groups should be involved, when, in which sequence, for what purpose, how, and the roles and responsibilities of stakeholders should all be sorted out jointly through consensus.

**Fig. A3.2. Steps in conducting a NSA**



**Table A3.1 Summary of areas of enquiry and outputs of National Situation Assessment**

	<b>Areas of enquiry</b>	<b>Outputs of NSA</b>	
<b>Epidemiology of TB</b>	Notification of TB: geographical variation and time trends	Lists of regions/districts/TB reporting units categorized by extent of epidemic and prevalence of TB/HIV and MDR TB	
	Prevalence and distribution of TB/HIV coinfection		
	Prevalence and distribution of MDR TB		
<b>Utilization of health services by people seeking care</b>	Poverty mapping	List of regions/districts/TB reporting units with vulnerable populations	
	Populations with poor access to health care	Data on clients' usage of different provider types, delays in care and costs to patients	
	Populations especially vulnerable to TB (high HIV prevalence, slum dwellers, industrial workers)		
	General pattern of health care utilization in private and public sectors		
	Health care utilization for TB in private and public sectors		
	Delays in diagnosis and treatment of TB		
	Costs associated with seeking health care for TB		
	Proportion of health expenditure that is out-of-pocket		
	Stigma related to TB and HIV impeding access to health care		
	<b>Composition and characteristics of the non-NTP sector</b>		Different categories of health care institutions and providers in the non-NTP sector
Numbers of private health care institutions in the different categories			Lists of organized or managed health care networks in the private and public sectors
Numbers of health staff in the private sector			
Distribution of private institutions			
Organized or managed health care		Lists and distribution maps of public (non-NTP) health care institutions and providers by region / district / TB reporting unit	
Numbers of health care staff in the non-NTP sector		Knowledge about non-NTP providers' needs from a partnership	
Distribution of public (non-NTP) facilities			
Non-NTP provider characteristics and needs			
Existing TB diagnosis and management			
		Detailed information on resources available in	

	Private sector: resources for clinical management	the non-NTP sector
	Non-NTP public sector facilities: resources for clinical management	Knowledge about will to partner with NTP
	Political will to implement DOTS (non-NTP public sector)	Information on public health tasks presently undertaken by associations, and potential for involvement
	Professional associations' capacity to undertake public health tasks	
	NGOs and voluntary bodies with capacity to undertake public health tasks	Information on potential for involvement of NGOs in public health tasks
	Corporate social responsibility programmes	
	Corporate workplace health programmes	Information on potential for involvement of corporate bodies in public health tasks
	Existing accreditation and certification schemes for hospitals, clinics, laboratories that incorporate DOTS or ISTC standards as part of their norms	Information on potential for involvement of public and private corporations in public health tasks
	Social franchising schemes for clinics, laboratories that require that empanelled providers use DOTS or the ISTC	Lists of accreditation and franchising agencies and medical educational institutions adopting DOTS or ISTC norms
	Medical curriculum development	
	Teaching in public/private colleges	Information on additional sources of support and opportunities to promote DOTS
	In-service training initiatives and programmes	
	Non-NTP agencies and mechanisms of support	
<b>Preparedness of the NTP</b>	State of DOTS expansion in the country	List of regions/districts/reporting units with essential requirements for initiating PPM in place
	Preparedness to undertake PPM:	
	<ul style="list-style-type: none"> <li>• Regions/districts/TB units with all essential resources for undertaking PPM, including trained staff and buffer resources for additional load</li> <li>• Additional resources needed for PPM, including human resources, training and financial inputs</li> <li>• Experiences from existing PPM projects, pilot projects and summaries of lessons learnt</li> <li>• Staff attitude towards the private sector</li> </ul>	<p>List of reporting units presently unprepared to undertake PPM</p> <p>Evidence for training and resource addition required to enable PPM implementation</p>

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<b>Policy and regulatory environment</b>	List of official regulatory agencies for medical establishments, education, pharmacies and diagnostic laboratories  Existing regulations or legal provisions pertaining to DOTS and ISTC, prescription of drugs, restrictions on sales of drugs or formulations over the counter, notification of TB cases, access to essential drugs and medicines, and other relevant areas  Means of enforcing existing regulations, if any	Knowledge of existing laws and regulations that may facilitate PPM DOTS or require its modification
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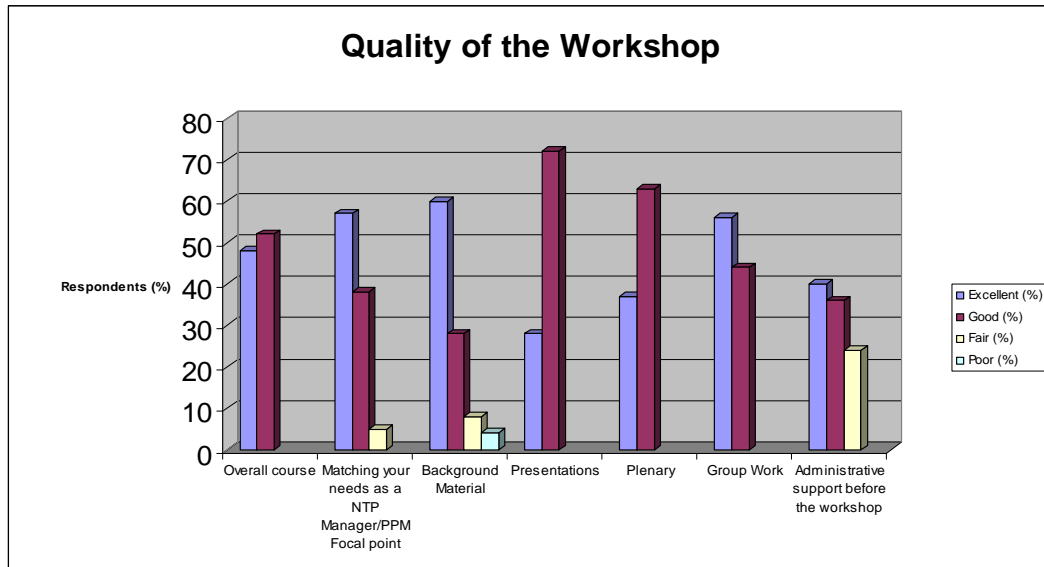
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## Annex 4

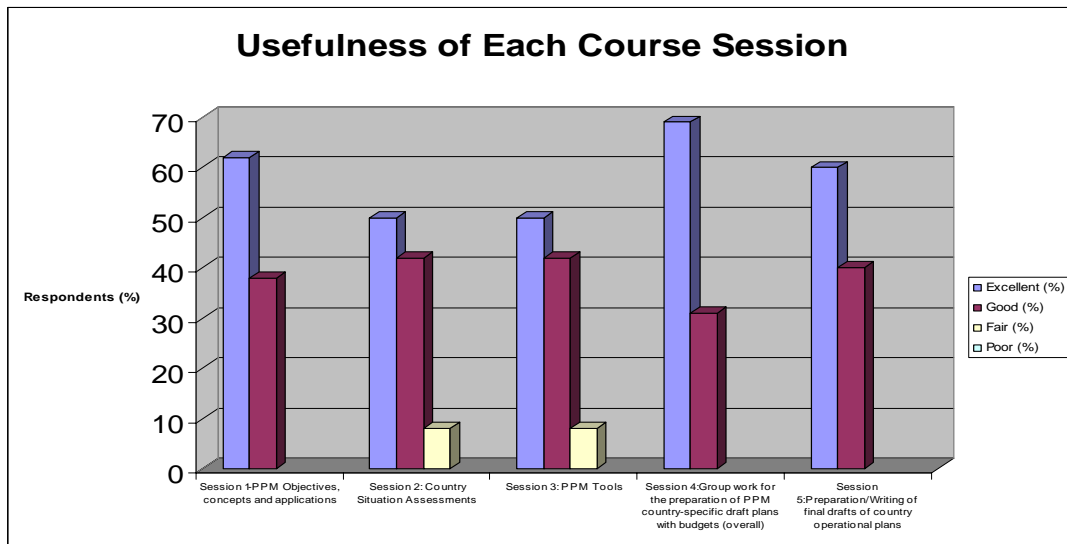
### Evaluation of the Workshop

On the last day, a formal evaluation of the Workshop was held. The Workshop was well appreciated by participants: they had learned a lot, had liked the general course format and content and the group exercises, and had appreciated the opportunity to share their experiences and learn from those of other countries. The participants' quality rating of different aspects of the Workshop is displayed in Fig. A4.1. Their rating of how useful the different sessions were, with regard to developing the skills necessary for PPM implementation, is shown in Fig. A4.2.

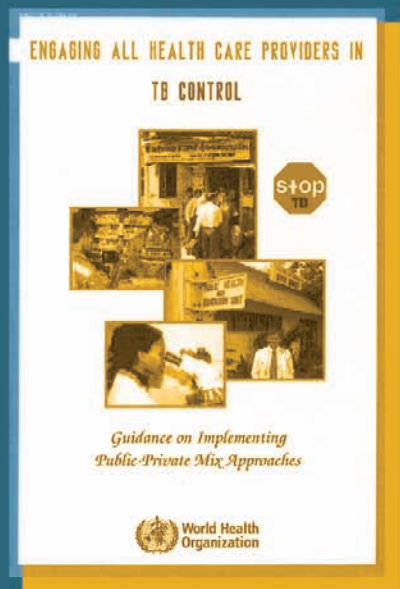
**Fig. A4.1. Participants' quality rating of different aspects of the workshop**



**Fig. A4.1. Participants' rating of how useful the different workshop units were with regard to developing the skills necessary for PPM implementation**



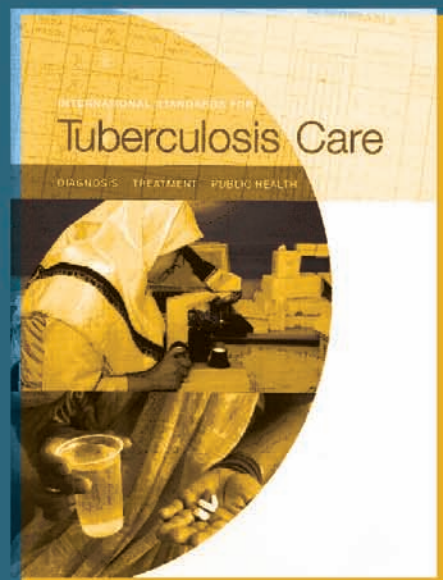
## Three useful tools for PPM planning, implementation and advocacy



*"The PPM Guidance Document"*



*"The PPM Advocacy Brochure"*



*"The International Standards for TB Care"*

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

<http://www.who.int/tb/dots/ppm/en/>

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