DEWG Meeting

StopTB Partnership

Public Private Mix for TB Care and Control Subgroup

Summary of Seventh meeting, Lille 23, 24 October, 2011
Seventh Meeting: objectives

• To review the global and regional progress on PPM;

• To share processes and outcomes of PPM scale up by national TB programmes in Asia and Africa;

• To discuss the potential of PPM in the introducing new diagnostics and new drugs for TB;

• To identify key components and activities of a biennial global action plan on engaging all care providers through PPM approaches.
<table>
<thead>
<tr>
<th>WHO REGION AND COUNTRY</th>
<th>TYPES OF NON-NTP CARE PROVIDERS ENGAGED</th>
<th>COVERAGE</th>
<th>NUMBER OF NEW TB CASES NOTIFIED IN 2010</th>
<th>CONTRIBUTION TO TOTAL NOTIFICATIONS OF NEW TB CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFRICAN REGION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angola</td>
<td>Diverse private and public providers</td>
<td>Countrywide</td>
<td>15,676</td>
<td>37%</td>
</tr>
<tr>
<td>Ghana</td>
<td>Diverse private and public providers</td>
<td>Countrywide</td>
<td>2,032</td>
<td>14%</td>
</tr>
<tr>
<td>Kenya</td>
<td>Private clinics and hospitals, NGOs and diverse public providers</td>
<td>Countrywide</td>
<td>7,706</td>
<td>8.1%</td>
</tr>
<tr>
<td>Madagascar</td>
<td>Diverse private and public providers</td>
<td>Countrywide</td>
<td>6,749</td>
<td>29%</td>
</tr>
<tr>
<td>Nigeria</td>
<td>Private clinics and hospitals</td>
<td>Countrywide</td>
<td>31,656</td>
<td>39%</td>
</tr>
<tr>
<td>UR Tanzania</td>
<td>Private, faith-based organizations and NGO hospitals</td>
<td>Countrywide</td>
<td>11,156</td>
<td>19%</td>
</tr>
<tr>
<td>REGION OF THE AMERICAS</td>
<td></td>
<td></td>
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<tr>
<td>Haiti</td>
<td>Private practitioners, NGOs and prison services</td>
<td>Countrywide</td>
<td>5,030</td>
<td>36%</td>
</tr>
<tr>
<td>Peru</td>
<td>Social security organizations and other public and private providers</td>
<td>Countrywide</td>
<td>5,993</td>
<td>21%</td>
</tr>
<tr>
<td>EASTERN MEDITERRANEAN REGION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iran (Islamic Republic of)</td>
<td>Diverse private and public providers</td>
<td>Countrywide</td>
<td>1,271</td>
<td>4.3%</td>
</tr>
<tr>
<td>Pakistan</td>
<td>Private clinics and hospitals</td>
<td>Countrywide</td>
<td>31,563</td>
<td>20%</td>
</tr>
<tr>
<td>Egypt</td>
<td>Health insurance organizations, NGOs and other public providers</td>
<td>Countrywide</td>
<td>2,112</td>
<td>24%</td>
</tr>
<tr>
<td>Sudan</td>
<td>Diverse private and public providers</td>
<td>Countrywide</td>
<td>2,389</td>
<td>9.4%</td>
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<tr>
<td>EUROPEAN REGION</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Ukraine</td>
<td>Prison and military services</td>
<td>Countrywide</td>
<td>1,540</td>
<td>4.9%</td>
</tr>
<tr>
<td>SOUTH-EAST ASIA REGION</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Bangladesh</td>
<td>Hospitals, medical colleges, prison services and other public providers</td>
<td>Countrywide</td>
<td>44,732</td>
<td>29%</td>
</tr>
<tr>
<td>India</td>
<td>Diverse private, public and NGO providers</td>
<td>14 large cities (total population 50 million)</td>
<td>35,025</td>
<td>45% of new smear-positive cases</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Public and private hospitals</td>
<td>Countrywide</td>
<td>48,391</td>
<td>16%</td>
</tr>
<tr>
<td>Myanmar</td>
<td>Diverse private, public and NGO providers</td>
<td>Countrywide</td>
<td>24,250</td>
<td>19%</td>
</tr>
<tr>
<td>WESTERN PACIFIC REGION</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>China</td>
<td>General public hospitals</td>
<td>Countrywide</td>
<td>36,7607</td>
<td>42%</td>
</tr>
<tr>
<td>Philippines</td>
<td>Private clinics and hospitals</td>
<td>Countrywide</td>
<td>12,081</td>
<td>7.2%</td>
</tr>
<tr>
<td>Republic of Korea</td>
<td>Predominantly private providers</td>
<td>Countrywide</td>
<td>33,167</td>
<td>85%</td>
</tr>
</tbody>
</table>

Average contribution 26%
Global TB Control: Challenges

- Case notifications stagnating
- Incidence decline too slow, stagnant in SE Asia

- Detect and cure all TB cases, not just 70/85
- Progress from "care" to "cutting transmission"
PPM in Africa: Kibuga

• Diverse but uptake universally accepted in the Region

• Different models
  – Fully private
  – Semi-subsidized
  – Fully Government subsidized
  – Mixed

• Difficult to give figures of PPM contribution due to integrated nature of activities (Reports on substantial contribution from Nigeria, Ghana, Tanzania, Kenya among others)
PPM WPR: Hospital Engagement
China Model: Nishikiori

• Infectious disease law (2004)
  – Internet-based mandatory notification, referral, follow-up of non-arrivals
  – Contribution to case detection +39.8% in 2010 (367,607 / 923,308)

• Task shift:
  TB dispensary (public health)
  \[\downarrow\]
  designated hospitals (comprehensive TB services in clinical facilities)
## PPM SEAR: Impact on case finding: Hyder

<table>
<thead>
<tr>
<th>Partner</th>
<th>Site</th>
<th>Increment in case notifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>NGOs</td>
<td>Bangladesh</td>
<td>~30-35%</td>
</tr>
<tr>
<td>Private Hospitals, Private practitioners</td>
<td>Hyderabad, India</td>
<td>23%</td>
</tr>
<tr>
<td></td>
<td>Lalithpur, Nepal</td>
<td>21%</td>
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<tr>
<td></td>
<td>Delhi, India</td>
<td>29%</td>
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<tr>
<td></td>
<td>N. Sumatra, Yogyakarta and Palembang, Indonesia</td>
<td>24%</td>
</tr>
<tr>
<td></td>
<td>Taunggyi, Myanmar</td>
<td>10%</td>
</tr>
<tr>
<td>Medical Schools</td>
<td>India</td>
<td>10-20%</td>
</tr>
<tr>
<td>Industry, workplaces</td>
<td>EPZs, Bangladesh</td>
<td>Increments in case finding among young women up to 20%</td>
</tr>
<tr>
<td></td>
<td>Tea Estates, India</td>
<td>~24%</td>
</tr>
</tbody>
</table>
The Indonesia PPM Model

1. Basic DOTS Services At Puskesmas
- Approach: Surveillance System Strengthening and MIFA, Improving quality of care, increasing coverage of TB/HIV, reaching un-reach pop at remote area (DTPK), increasing referral to Quality DOTS Services
- Leading: NTP
- TA: WHO, FHI and other partners

2. Public/Private Hospital Services
- Approach: Hospital Accreditation, Implementation TB DOTS as Minimum Standard requirement for accreditation of Hospitals
- Leading: Directorates of Referral Health Services
- TA: KNCV

3. Quality DOTS services by Private Practitioners and Specialist
- Approach: Implementation of ISTC for all TB care and treatment from all care providers, increasing professional responsibility to cure TB patients, rewarding through cumulative credits mechanism for licensing/certification
- Leading: IMA
- TA: ATS

4. Qualified TB Diagnostic
- Approach: Strengthening lab network and Quality Assurance (public and private) → DST, Culture and Microscopic
- Leading: Directorate of Medical Support
- TA: KNCV and JATA

5. Quality of anti TB Drug Dispensing and rational Use of Drug
- Approach: law enforcement, establishment of networking and monitoring system, WHO prequalification
- Leading: Pharmacist Association, DG of Pharmaceutical Services, FDA
- TA: USP and MSH

6. Community System Strengthening
- Function as advocate → raise fund and commitment,
- Increase public awareness, function as public watch to ensure deliveries of quality services,
- Increasing awareness of right and responsibility of the patients (patient’s charter).
- Social Mobilization, suspect identification, increasing demand creation, intensifying the services of TB in slum areas and prison
- Leading: NGO, FBO, CSO
- TA: FHI, other partners
Proportion all forms of TB patients contributed by NTP and other reporting units (2010)

- NTP: 80.8%
- Hospital: 3.0%
- MSF-H: 2.1%
- PSI: 12.1%
- MMA: 1.6%
- MDM: 0.2%
- AHRN (Shan North): 0.2%
PPM Nigeria

- Total TB cases registered (All forms) - 90447

- New smear positive cases – 45416

- PPM care providers (including non-NTP public providers such as Teaching hospitals) contributed. 35% (31 656 cases) of the cases notified in 2011
Engaging pharmacists in TB Control

THE ROLE OF PHARMACISTS IN TUBERCULOSIS CARE AND CONTROL

Background

Every year, more than 9 million new cases of tuberculosis (TB) occur and nearly 2 million people die of the disease. Nearly half a million cases have the multidrug-resistant form of the disease.

While Asia bears the largest burden of the disease, sub-Saharan Africa has the highest incidence of drug-susceptible TB and Eastern Europe has the highest incidence of multidrug-resistant TB (MDR-TB).
Engaging pharmacists in TB Control

2004-2005
2 ODs in Phnom Penh

2005-2006
Total 4 ODs in Phnom Penh, Sihanouk Ville and Kampong Cham provinces

2006-2007
Kandal, Takeo and Kampong Speu province

2008-2009
Pursat, Kratie, Battambang, Siem Ream, Banthey Mean Chey provinces
Private sector overuse of inappropriate diagnostic assays

Proportion of testing
Total ~4000/mo.

<table>
<thead>
<tr>
<th>Assay</th>
<th>Price (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Microscopy</td>
<td>4.5 - 7</td>
</tr>
<tr>
<td>Culture</td>
<td>16</td>
</tr>
<tr>
<td>IGRA</td>
<td>55</td>
</tr>
<tr>
<td>Molecular</td>
<td>45-90</td>
</tr>
<tr>
<td>Serology</td>
<td>12</td>
</tr>
</tbody>
</table>

Source: private communication, India
Uptake of Xpert
1st line private markets are variable and, in some countries, LARGE [Measured relative to each country’s TB burden]

- These 10 countries = 60% of global burden.
- Average 67% public sector case detection.
- Average 66% of incidence potentially covered by private sector drugs.
How can the health sector prepare for the introduction of new TB drugs?

- How to mitigate this threat to new TB drugs?
  First category of response is to improve the current delivery landscape
  - Expansion of public-private mix (PPM) programs
  - Expand the reach of public TB programs
  - Improve regulatory oversight for marketing approvals
  - Expand public sector diagnosis and treatment of MDR-TB
  - Improve the quality of care in the private sector, e.g., less fragmentation (franchises etc), better financing (insurance, vouchers, contracting), and integrate high quality TB treatment into these mechanisms.
Woven throughout –
All TB Components Need the Private Sector
GFATM: PPM Budgets and expenditures

- Only 3.6% of the TB funding of the Global Fund allocated to PPM in 2010.
- Spending of Global Fund grants with PPM component on PPM was 4.2% of total TB expenditure.
- Top two regions with highest share of their budget allocated to PPM: East Asia and the Pacific and West & Central Africa (7.3% and 4.9% respectively).
- Largest PPM investments were in China, Indonesia and Ghana: US$ 25.5 million, US$ 7.8 million and US$ 4.9 million, respectively.

Source: 2010 EFR
Increasing the effectiveness of the Stop TB Partnership in engaging all care providers

A “White Paper” of the PPM Subgroup
Objectives

• To contribute to the goal of universal access to high quality diagnostic, treatment, and prevention services through appropriate engagement of care providers, healthcare facilities and laboratories:

• To strengthen health systems through promotion of effective engagement of all providers:

• To promote best practices for implementation and scale-up for engagement of all providers by providing guidance and tools for global, regional, country-specific policies, strategies and plans:

• To ensure that the current and/or potential role of non-program providers is taken into account in the activities of all components of the Stop TB partnership:
Next Steps

• Seek full working group status as the “Working Group to Engage all Providers” with representation on the Partnership Coordinating Board.

• Revise the Core Group terms of reference as follows:
  
  – oversight and coordination of the activities of the working group
  – coordination of the activities of the working group with those of other Partnership working groups
  – oversee the preparation of a strategic plan and annual work plans to implement the strategic plan
  – coordinate any revisions of the Global Plan to Stop TB as they relate to the engagement of private sector providers
  – serve as the liaison between the Partnership and the Stop TB Department’s activities in engaging all providers