

TB REACH Wave 8

Private Provider Engagement (PPE)

Background

Through much of the last 25 years, TB care and prevention activities have generally focused on the provision of services by public sector providers overseen directly by National TB Programs (NTP). However, a majority of people first seek care in the private sector, even among the very poor (1), because private providers and facilities are viewed as more accessible and thought to be more responsive. However, patients who are managed by private providers are often not properly diagnosed for TB, or if diagnosed are not notified to NTPs, resulting in treatment of uncertain quality (1). This is one of the key reasons that there are still millions of people with TB who are “missed”. The systematic involvement of all relevant health care providers in delivering effective TB services to all segments of the population is an essential component of the Global Plan to End TB (2).

Since 2006, engaging private sector has been recognized in global TB strategies (3). However, some early models to engage private providers involved mainly training and a passive demand to follow NTP models, which has had limited impact on notifications. More recent PPE models have emerged that take into account private sector realities and thus have the potential to greatly increase the numbers of care providers detecting, treating, and notifying people with TB (4-6). Additional scalable approaches are needed (5-7) given the massive numbers of people accessing care in the private sector in most countries and the diversity of health system settings in high TB burden countries.

With a few notable exceptions, large-scale efforts to engage the private sector have focused primarily on Asian countries. Efforts in other regions, especially in Africa, have been limited despite evidence that initial health seeking behavior is focused on private providers. Finally, PPE activities have generally benefitted from the use of intermediary agencies, which act as an interface between the NTP and private providers; however, the number of domestic organizations in high burden countries with this expertise remains limited in both Asia and Africa. More efforts are needed to develop and to scale successful approaches to better involve the myriad of different providers of care for people with TB.

Therefore, in the 8th funding cycle, TB REACH seeks new and scalable PPE models led by local organizations from the following 24 priority countries to better involve private healthcare providers to detect and notify more people with TB.

Eligible countries:

Afghanistan, Bangladesh, Cambodia, Democratic Republic of Congo, Ethiopia, India, Indonesia, Kenya, Kyrgyzstan, Malawi, Mozambique, Myanmar, Nigeria, Pakistan, Philippines, South Africa, Tajikistan, Tanzania, Uganda, Ukraine, Uzbekistan, Vietnam, Zambia, and Zimbabwe

Areas of Consideration

Successful applications should address one or some of the below areas of consideration.

Provider Mapping

Mapping the private providers practicing in the implementing geography is an essential first step to define the target universe (denominator). Alternatively, if mapping activities are not feasible, applicants can obtain information or estimates from NTP sources, professional associations, and literature searches. Pharmacies are also a good source of information about doctors. Applicants must

provide an estimate of targeted providers available in the implementation area(s) in Section 4, Table 2.

Appropriate Approaches and Strategies

There are two general strategies to engage private care providers:

- regulatory approaches and;
- the provision of enablers.

In a given country, usually a mix of both is required, but the existing public sector response may put too great of an emphasis on regulatory solutions. It is important to consider the health system context to select the appropriate mix of approaches and strategies:

Regulatory:

- Mandatory notification of TB diagnosis and/or treatment by the private sector;
- Punitive measures
- Banning diagnostics and drugs;
- Mandatory notification of TB drug sales.

Enabler:

- Training (knowledge incentive);
- Free diagnostics and drugs;
- Financial incentives (could be performance based);
- Supportive functions provided by intermediary agencies – such as assistance with recording and reporting, contact investigation, patient linkages between provider types, and patient adherence support;
- Provision of helpful information and communications technology – such as apps for notification, decision making and adherence support. However, it is strongly discouraged to use TB REACH funds to develop completely new ICT solutions as app development is rather time consuming and TB REACH’s projects have a shorter duration. Simple adaptations of existing app solutions may be considered.

Intermediary Agencies

NGOs often act as intermediary agencies to provide the interface between the NTP and private health providers. The intermediary agencies build an NTP–NGO–private link by aggregating, mobilizing, training and supervising private health providers, as well as notifying cases to NTPs and coordinating with NTPs for free diagnostics and drugs, which also relieves the stress on overburdened NTP staff. Intermediary agencies generally also conduct in-person or virtual trainings to improve knowledge and technical capacity of private TB health care workers, in collaboration with the NTP and professional associations.

Different Engagement Approaches Based on Provider Types

There are multiple types of private health care providers that are present in different numbers and with different skill sets across countries and implementation areas. The [PPM toolkit \(8\)](#) developed by the WHO and the Stop TB Partnership’s PPM working group enumerates many of the different private healthcare provider types and organizations. The for-profit sector includes formal (qualified) health practitioners and facilities (high-end corporate hospitals, mid-size hospitals, GPs, chest specialists, etc.),

informal (unlicensed) health providers and facilities (traditional healers, unlicensed medical practitioners, non-allopathic practitioners), private pharmacies and drug stores, and private laboratories. Tailored engagement approaches are needed depending on the provider type. Some providers may be focused solely on referrals, while others focus more on treatment. Applicants are required to provide a detailed “task mix” plan in Section 4.4, Table 1.

In addition to considering these distinct “task mixes” of individual provider types, applicants are encouraged to develop proposals that link together different types of providers, especially if these efforts strengthen nascent structures and relationships already existing in the private healthcare sector. This could include methods to link referring providers to diagnosing providers, and to link from diagnosing providers to laboratories and pharmacies that provide diagnostics and drugs, respectively.

Engage Frontline Health Care Providers

Collaborating with large hospitals or large NGOs that are not reporting people with TB are likely to provide a high yield of cases per facility engaged. However, to reach all of those in need, interventions should also engage the frontline, primary care providers who are first approached by people with TB. These include, but are not limited to, formal and informal private practitioners, private laboratories, retail pharmacies, practitioners of alternative systems, and traditional healers. However, these frontline providers are more difficult to engage because of their large numbers, the relatively low case yield per provider, low administrative capacities and the fact that in many cases they operate on the borders of legality. Consequently, frontline health care providers often remain non-engaged and largely uninterested in partnering with NTPs. However, they are critical to not only enhance case detection, but also reduce diagnostic delays, cut disease transmission and minimize direct and indirect costs of care for patients and the society at large.

Incentive structure

Performance-based financial incentives can be a useful (though not always necessary) approach to improve private sector participation and performance. Financial incentives can be for diagnosing, reporting and/or retaining TB patients in care. Financial incentives come with challenges for record verification and timely and transparent disbursement. Financial incentives based on clinical diagnosis may provide perverse motivation for over-diagnosis. Good recording and verification systems and other checks and balances are needed to avoid this. Ideally, financial incentives to private providers would be part of a national system, such as a national health insurance payment – any opportunities along these lines should be pursued, at least by initiating a policy dialogue. Financial payments should also be dependent on certain measures of the quality of care (see below).

In some settings, financial incentives are not as important as other incentives such as motivation, public recognition, moral persuasion, provider trainings, the provision of timely feedbacks on referrals, and free extras. Some projects have reported that private providers were willing to collaborate without financial incentives since it is important for them to maintain a good professional reputation and meet the expectation of patients (while avoiding any significant loss of income).

Additionally, free services can be offered to patients as an incentive, such as vouchers for free anti-tuberculosis drugs and laboratory tests (such as chest X-rays, sputum smears and Xpert® MTB/RIF). Private providers also appreciate their patients receiving support with adherence and treatment completion.

Appraisals and Training to Ensure High-Quality of Care

There is considerable evidence that quality of TB care is suboptimal in the non-NTP sector [11]. The essence of private sector engagement is to replace low-quality, expensive and inefficient health care provision with rapid, affordable, and correct diagnosis and treatment and to link people already being treated in the private sector with national notification systems. Private practitioners may not believe or agree with NTP regimens, and manage people with TB differently, and possibly sub-optimally. Therefore, quality of care should be monitored, and targeted feedback provided to improve performance over time. Quality of care also includes notification and adherence monitoring (see below).

Notification and Adherence Monitoring

Non-NTP practitioners, even those who are highly qualified, typically struggle to undertake two critical non-clinical tasks: prompt recording and reporting of required data; and adherence monitoring. Thus, applicants should explicitly outline their interventions to assist in these two areas.

Applicants are encouraged to make use of technology for both tasks and to connect with and between providers. This could include the development of software, procurement of portable equipment for data entry at field level, use of call centers, and the training of staff on data entry and management.

Market-Driven Interventions and Access to Domestic Financing

Long-term growth and sustainability of efforts to engage private sector providers will require access to domestic financing – which could include out-of-pocket payments but would ideally consist of government financing through either contracts or insurance payments. Applicants should consider any opportunities or activities to allow them to tap into these income streams in the longer term.

Social businesses provide one possible model for private provider engagement efforts. The key characteristic of social business model is the integration of multiple disease areas: multi-disease activities provide greater patient volumes, an income streams to support the TB activities, and a greater draw for providers, but TB is included as a requisite part of the business model. In the future, social businesses could make ideal recipients for results-based financing from governments and for payments from national health insurance schemes. Income from these businesses could in theory lead to more sustainable programs.

Demonstrate learning from previous or current efforts in private provider engagement

Three recently published documents provide important context, history and lessons learned in private provider engagement for TB: a landscape analysis of TB private provider engagement (9); a public-private mix for TB prevention – a roadmap (10); and the Stop TB Field Guide on engaging private providers (11). Applicants are encouraged to review the landscape analysis, in particular, for strategic lessons that are relevant to their proposed area of work, and the field guide for invaluable practical advice. Applications that build on these concepts will be more likely to succeed than those that are “reinventing the wheel”.

Conclusion

A systematic involvement of all relevant health care providers in delivering effective TB services to all segments of the population is essential to reach the 90-(90)-90 targets set up in the Global Plan and the End TB Strategy. It is clear that business as usual approaches are no longer adequate to deal with the vast, fragmented and largely unregulated private care sectors in many countries. The missing millions will remain invisible until the private sector is engaged to offer better quality care of persons with TB or TB symptoms.

In the Wave 8 call for proposals, TB REACH provides a unique opportunity to explore newer ways to engage private care providers in TB, exploit new tools and attempt to go beyond pilots to scale interventions at the national level.

Reference

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