



## A TOOL FOR NATIONAL SITUATION ASSESSMENT

Public-Private Mix for TB Care and Control



World Health  
Organization

Stop TB Partnership

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# Contents

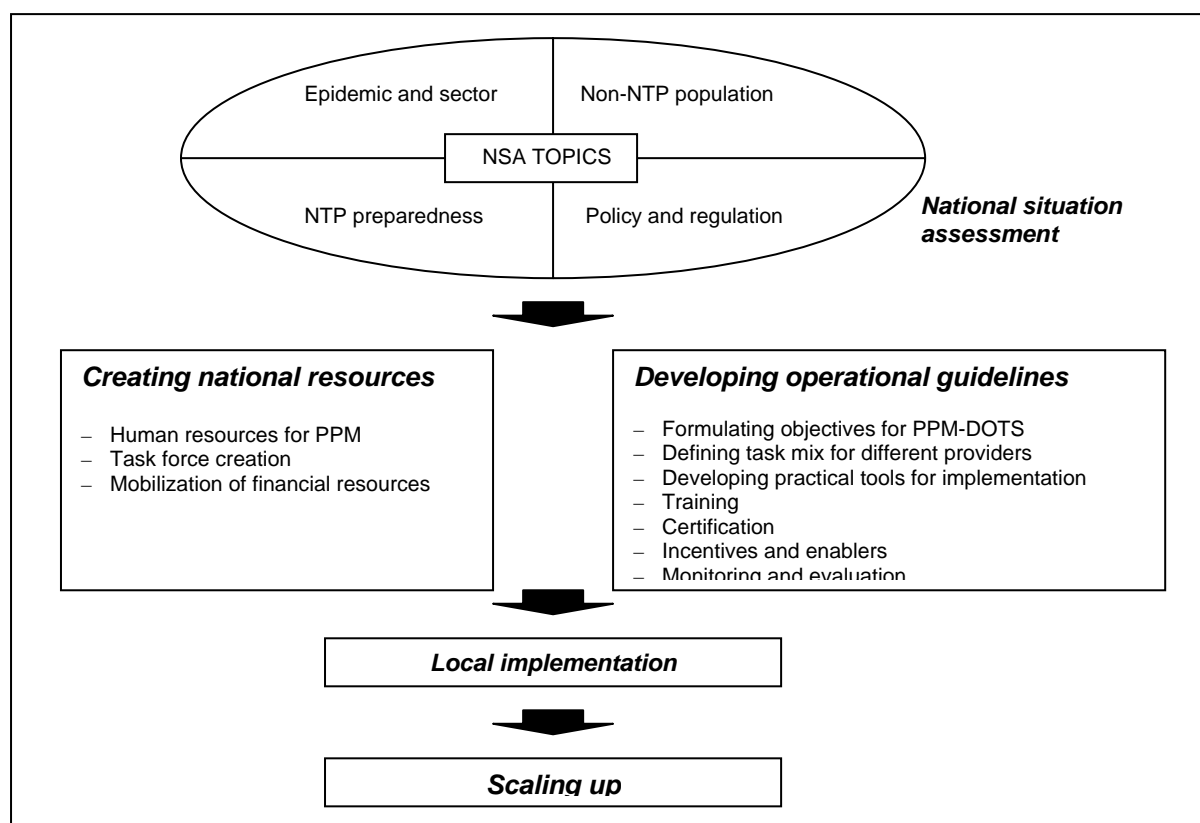
<b>1. Introduction</b>	<b>1</b>
<b>2. An Overview of the NSA tool</b>	<b>2</b>
2.1 Aim of the NSA tool	2
2.2 A tool for country specific information	2
2.3 The process of situation assessment	3
<b>3. Steps in conducting the NSA</b>	<b>4</b>
<b>4. Information to be collected with the NSA tool</b>	<b>6</b>
4.1 Epidemiology of TB	6
4.2 Utilization of health services by people seeking care	6
4.3 Composition and characteristics of the non-NTP sector	7
4.4 Preparedness of the NTP	8
4.5 Policy and regulatory environment	9
<b>5. Using the outputs of NSA</b>	<b>12</b>
<b>6. Way forward</b>	<b>14</b>
<b>Annexes</b>	
<b>Annex 1</b> Summary of areas of enquiry, sources of information and outputs of the NSA	15
<b>Annex 2</b> Indicative DOTS task mix for different provider categories	18
<b>Annex 3</b> Some examples of PPM National Situation Assessments	21

# 1. INTRODUCTION

In most countries with a significant burden of tuberculosis (TB), patients with symptoms of TB seek and receive care from a wide variety of providers, including those outside the network of national TB programmes (NTPs). These include private providers and public sector health care institutions outside the purview of the NTP. These providers frequently do not follow the recommended DOTS strategy for managing TB and hence the TB patients they serve are often deprived of the benefits of standard and rational treatment.

To address this weakness in global TB control, it has been envisaged that NTPs should develop public-private mix (PPM) programmes to involve all relevant health care providers in TB control. Considerable evidence on the implementation of PPM is now available from different countries, and has led to the preparation of a guidance document\* by WHO's Stop TB Department. The guidance document underlines systematic steps to be taken by a NTP in implementing PPM, of which a national situation assessment (NSA) is the first (Fig. 1). This tool has been prepared with support from the United States Agency for International Development's (USAID's) Tuberculosis Control Assistance Program (TBCAP) and should be used in conjunction with the guidance document. It suggests a plan for conducting a NSA through a process of consultation and knowledge management. The tool was reviewed and endorsed at a PPM subgroup meeting in September 2006, which also included participants from TBCAP countries.

**Fig. 1. NSA as part of the larger scheme of PPM implementation**



\* World Health Organization. *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)).

## 2. AN OVERVIEW OF THE NSA TOOL

### 2.1 Aim of the NSA tool

The aim of the NSA is to collect and collate information on all aspects of PPM for TB care and control in the country, and to facilitate the use of this information to assist the systematic implementation of PPM.

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

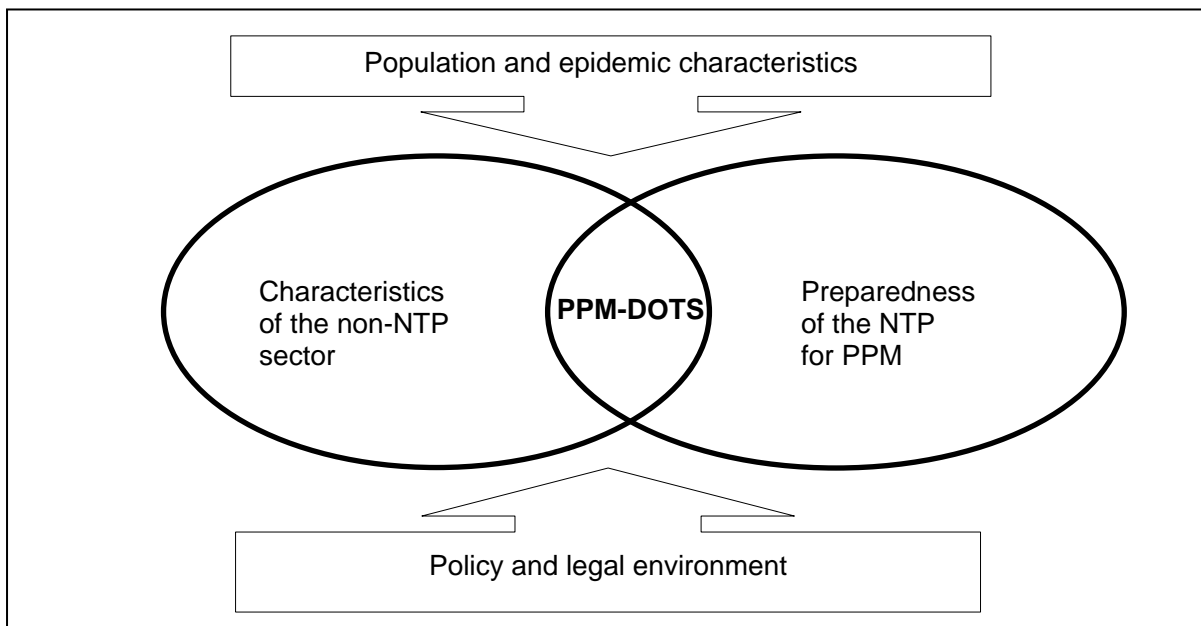
- When and where should PPM be implemented?
- What inputs are needed in order to do so?

### 2.2 A tool for country-specific information

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.

Broadly, PPM implementation is a function of two sets of variables: the characteristics of the non-NTP sector and the preparedness of the NTP for PPM (Fig. 2). Implementation of a successful PPM also depends on contextual factors that comprise a country's or province's policy and legal environment, and on characteristics of the population and the TB epidemic in the region.

**Fig. 2. Factors influencing PPM implementation**



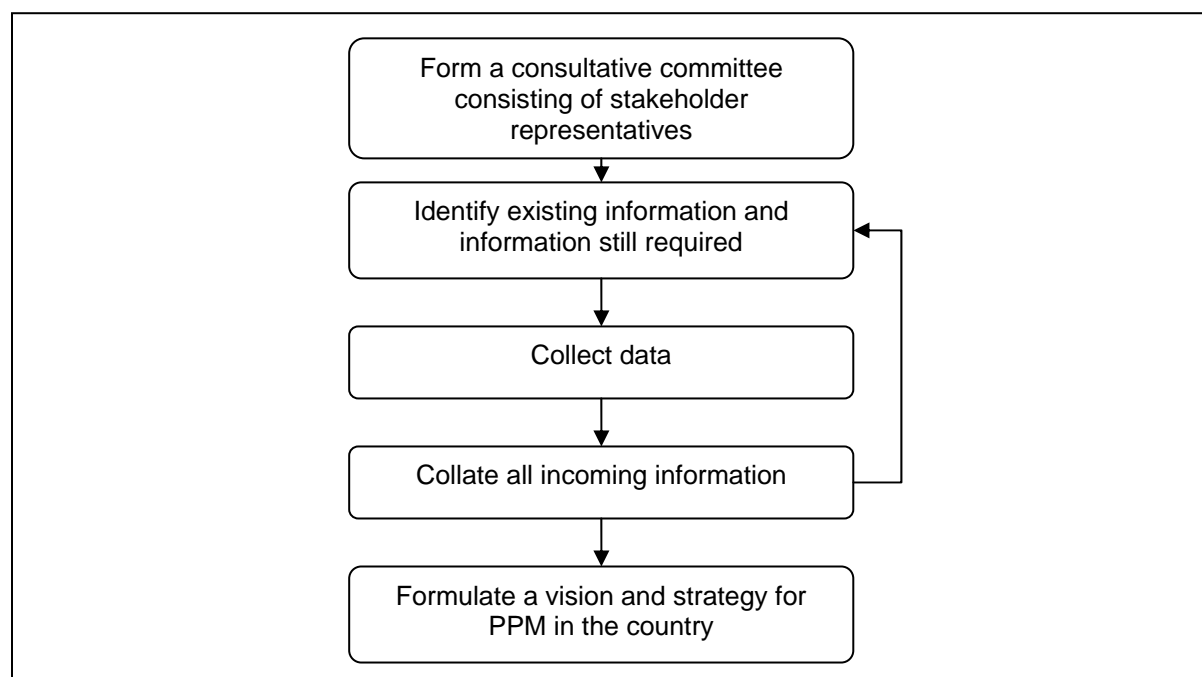
Detailed lists of these topics of enquiry and likely sources of information are outlined in Table 1 in the section entitled “Information to be collected”.

### 2.3 The process of situation assessment

The NSA should follow a participatory process. Representatives of stakeholder groups, such as the health ministry, regulatory agencies, academic institutions, professional organizations, civil society, consumer organizations and the pharmaceutical industry, should be approached to form a consultative committee for the NSA. Through a process of consensus and dialogue, a vision for the NSA should be developed, taking into account the positions of the various stakeholders. Existing information should be shared with the consultative committee, gaps in the knowledge identified, and priorities for the NSA determined. Suggested topics set out below can be used and modified according to national priorities and needs.

The NSA can be conducted by the NTP using secondary sources of information such as existing surveillance data and government and funding agency reports, and through consultation with the steering group and programme staff. Useful sources of existing information are summarized in the relevant sections below. In addition, certain areas in which information is seen to be deficient can be flagged for conducting or commissioning new research studies. Whatever data is collated as part of the NSA must periodically be fed back to the committee and the cycle repeated. The steps in conducting a NSA are outlined in Fig. 3 and in more detail in the following section.

**Fig. 3. Steps in conducting a NSA**



### 3. 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. Stakeholders who may be consulted are listed in Box 1. The consultative committee can subsequently feed into the creation of national resources for PPM, including an expert PPM task force.

#### Box 1. List of potential PPM stakeholders

- Ministry of Health, its departments, and subnational counterparts
- Other ministries (Labour, Interior, Defence, etc.)
- Regulatory agencies and councils for medical establishments, medical education, insurance, diagnostic laboratories, and pharmaceutical production and sale
- Official bodies for accreditation and quality control
- Donor and funding agencies
- Medical colleges and other academic institutions
- Professional associations, such as medical and pharmacists' associations
- Agencies involved in provider training, capacity building and in-service education
- Social welfare programmes for the poor and marginalized
- Social franchising and marketing organizations
- Pharmaceutical industry
- Health insurance agencies and companies
- Public and private corporations providing employee health services
- Major charitable or voluntary agencies involved in providing health care
- Consumer organizations

*Please note:*

- For some countries, a SWOT analysis on the NTP and the private sector was carried out. The prospects for collaboration/partnership were then discussed and finalized as part of the group work at the consultative meeting.
- Users of the NSA tool in some countries have suggested that individual meetings with stakeholders be used as a first step in collecting information, as this was found to be more effective. The next step could then involve the organization of consultative workshops as these were found to be a good platform for information sharing, consensus building and advocacy for shaping policy.

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

The topics of information listed below (and summarized in Annex 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. 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.

## **4. INFORMATION TO BE COLLECTED WITH THE NSA TOOL**

Most of the information needed can be obtained from secondary sources, such as existing surveillance and research reports of the government and development agencies, and through consultations with the steering group and programme staff. Information that is readily available should be gathered first. A list of useful sources of information plotted against areas of enquiry can be found in Table 1.

Suggested topics on which information should be collected are:

- epidemiology of TB
- utilization of health services by people seeking care
- composition and characteristics of the non-NTP sector
- preparedness of the NTP
- policy and regulatory environment.

### **4.1 Epidemiology of TB**

A proper understanding of the spread and distribution of TB is useful in planning PPM activities. Areas of enquiry should include, by region, available measurements of the prevalence or incidence of TB disease, such as TB notification, and of TB/HIV coinfection and multidrug-resistant TB (MDR TB). Routine reports of the NTP and the national AIDS programme, and reports of agencies such as WHO and the World Bank, should reveal this information. Any independent research that has been done on these subjects can also be used.

### **4.2 Utilization of health services by people seeking care**

Knowledge of the utilization of health services by people seeking care is necessary for understanding the importance of the private sector in a community. Information about health care seeking in the private sector, costs of care, and delays and discontinuities in treatment provides evidence for the need for PPM, and points out sections of the private sector that should be targeted. Populations that have poor access to public health facilities, people with HIV/AIDS, slum dwellers and industrial workers can be at greater risk of morbidity and mortality from TB. PPM can especially aid vulnerable populations by ensuring access to continuous, quality-assured TB care, and hence knowledge of location of vulnerable populations may be useful. Much of the relevant information can be found in reports of government and other agencies such as the World Bank, WHO and the International Labour Organization (ILO), from the national HIV/AIDS programme, and from any independent research that may have been conducted.

### 4.3 Composition and characteristics of the non-NTP sector

First of all, it is important to obtain basic information about the non-NTP sector. The health sector, whether private or public, varies in composition from country to country, and provides TB care in different ways. Together with the consultative committee and programme staff, the NTP should decide on a suitable categorization of non-NTP institutions and providers that can be applied nationwide in PPM documentation.<sup>†</sup> The criteria listed in Box 2 can be used to categorize non-NTP providers. The numbers of health care staff in the different provider categories should be ascertained, and lists of non-NTP institutions should be maintained for each region/district/TB reporting unit. Wherever data on the number and distribution of health care providers already exists (such as in membership lists of professional associations, records of medical registration, directories of services, reports from the government, WHO, the World Bank, etc.) this information can be utilized. Eventually, implementation of PPM should in itself help to provide this information on a regular basis.

At the same time, enquiries can be made about the extent of managed or organized health care (such as private and social insurance companies and schemes for employees), private chains or franchises of health care, and nongovernmental organizations (NGOs) and faith-based organizations involved in providing health care on a large scale.

#### Box 2. Criteria that can be used to categorize non-NTP providers

##### *Private health institutions*

- Institutions/Individual practitioners
- Hospitals/clinics/sanatoria/laboratories/pharmacies
- Primary/secondary/tertiary
- For-profit/not-for-profit
- Formal/informal/traditional
- Systems of medicine
- Specialist/generalist

##### *Public sector institutions (not under NTP)*

- Primary health clinics/dispensaries/general hospitals/specialist hospitals
- Academic institution (medical college)/non-academic
- Catering to lay public/insured people/employees/special populations (such as prisons)
- Free/paid services
- Accountability to which ministry/department of local/municipal/provincial/central administration

##### *TB diagnosis and management*

- Extent to which TB patients are diagnosed or treated or otherwise cared for

<sup>†</sup> See Annex 2 for an indicative task mix for different provider categories.

More detailed contextual information about the characteristics of those employed in the private sector can be useful, such as their income from practice and sources of income, their training needs, their career goals, their attitudes towards public health and the public health sector, and their needs from a partnership. Discussions with stakeholder groups and feedback from any existing programmes in partnership with the private sector may yield this information. In addition, knowledge of their existing practices in diagnosing and managing TB, including adherence to DOTS guidelines and treatment success rates, may occasionally be available. A picture of resources for clinical management available in the private and public (non-NTP) sectors, such as availability of drugs and formulations, microscopy services and capacity for patient supervision, can be obtained from discussions with the stakeholder representatives. Information about prior involvement with the NTP, use of DOTS and willingness to adopt DOTS should also be obtained.

Certain agencies and organizations, such as professional associations, NGOs and corporations, may be undertaking or have the ability to undertake public health tasks such as training, advocacy and even supervision of PPM for TB care and control, either for their own clients or employees or for the general population. Discussions with representatives of these organizations should be conducted to get a clear idea of any public health tasks presently undertaken by them and of potential for further involvement in PPM.

Discussions with stakeholders from accreditation agencies and social franchising schemes for clinics and laboratories, if any, will reveal whether they incorporate DOTS or the international standards for tuberculosis care (ISTC)<sup>‡</sup> in their norms and standards of practice. Enquiries should be conducted with agencies involved in developing medical curricula at national and subnational levels to see whether DOTS is included in medical curricula. Discussions with heads of medical colleges will reveal whether students are instructed in the importance of DOTS and the primacy of short-course chemotherapy as a regimen for treating TB. In-service continuing medical education certificate and distance-learning programmes, if any, should also be examined to see if they include DOTS or the ISTC.

Support for PPM in the form of funding and advocacy of DOTS or ISTC may be available from donor agencies and other stakeholder groups.

#### **4.4 Preparedness of the NTP**

To be able to engage other health care providers in TB control, NTPs should have demonstrated how DOTS can be successfully implemented. PPM can be successfully undertaken if functioning microscopy units and treatment and supervisory services are available locally within the public sector. Regions/districts/reporting units successfully implementing DOTS and that meet NTP

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<sup>‡</sup> *International standards for tuberculosis care: diagnosis, treatment, public health*. The Hague, Tuberculosis Coalition for Technical Assistance, 2006 ([http://whqlibdoc.who.int/publications/2006/istc\\_report\\_eng.pdf](http://whqlibdoc.who.int/publications/2006/istc_report_eng.pdf), accessed 22 August 2007).

targets for case detection and treatment may be earmarked for PPM implementation. An existing system of laboratory quality assurance and quality control should also be in place. Routine reports of the NTP and of quality assurance schemes should be consulted for this information and suitable regions/districts/reporting units listed.

In some cases, the NTP may need additional capacity to set up and support a sustainable partnership. This includes training for the staff in PPM for TB care and control and, to deal with the additional case load that the PPM may bring, assurance of a continuous and adequate drug supply and of human and material resources for microscopy and patient supervision. NTP documentation can be used to estimate the adequacy of these additional resources. Attitudes towards the private sector should be ascertained from discussions with programme staff. Additional staff and financial inputs may also be required in exceptional cases. Discussions with the consultative committee and a review of experience and feedback from any existing PPM projects will also provide a basis for the kind of additional inputs of training and resources required to implement PPM.

#### **4.5 Policy and regulatory environment**

PPM for TB care and control should not go against the law of the land; at the same time, it should take advantage of laws and regulations that may facilitate its implementation. The NTP should familiarize itself with all existing laws, policies and regulations that may affect PPM. There may also be opportunities to advocate for policies and regulations that would help implement PPM.

Regulatory agencies may exist for medical education, medical services and diagnostic laboratories, and for pharmaceutical production and sale. The existence of such official regulatory agencies should first be ascertained, and their rules studied. Laws and policies pertaining to health care and drug production should also be studied. This information can be obtained through discussion with stakeholders from regulatory agencies, and should not require a detailed review of government legislation.

Existing regulations or legal restrictions may pertain to such areas as DOTS and ISTC, restrictions on over-the-counter sales of drugs, notification of TB cases, and access to essential drugs and medicines. Free supplies of anti-TB drugs to non-NTP providers may be linked to a system of certification to ensure their proper use. Few developing countries have a policy for notifying all TB cases diagnosed or treated outside NTP facilities. If such legislation exists, PPM should facilitate its enforcement. Other ways of enforcing existing regulations that are beneficial for DOTS should be explored. Guidance documents of regulatory agencies will provide most of the relevant information.

**Table 1. Essential sources of information for the NSA**

<b>Sources</b>	<b>Areas of enquiry</b>
1. Reports and documents of the NTP	<ul style="list-style-type: none"> <li>– Notification of TB: geographical variation and time trends</li> <li>– Prevalence and distribution of TB/HIV coinfection</li> <li>– Prevalence and distribution of MDR TB</li> <li>– Status of DOTS expansion in the country</li> </ul>
2. Discussions with consultative committee	<ul style="list-style-type: none"> <li>– General pattern of health care utilization in private and public sectors</li> <li>– Health care utilization for TB in private and public sector</li> <li>– Delays in diagnosis and treatment for TB</li> <li>– Stigma related to TB and HIV impeding access to health care</li> <li>– Different categories of health care institutions and providers in the non-NTP sector</li> <li>– Volume of private health care institutions in the different categories</li> <li>– Distribution of private institutions</li> <li>– Presence of organized or managed health care in the non-NTP sector</li> <li>– Non-NTP provider characteristics and needs from partnership</li> <li>– Existing TB diagnosis and management in the non-NTP sector</li> <li>– Private sector: resources for clinical management of TB</li> <li>– Non-NTP public sector facilities: resources for clinical management of TB</li> <li>– Political will to implement DOTS (non-NTP public sector)</li> <li>– Non-NTP agencies and mechanisms of support, including funding and advocacy of ISTC</li> <li>– Preparedness of regions/districts/TB units and additional resources required to undertake PPM</li> <li>– List of official regulatory agencies for medical establishments, pharmacies and diagnostic laboratories</li> </ul>
3. Discussions with NTP programme staff	<ul style="list-style-type: none"> <li>– Different categories of health care institutions and providers in the non-NTP sector</li> <li>– Volume of private health care institutions in the different categories</li> <li>– Distribution of private institutions</li> <li>– Distribution of public (non-NTP) facilities</li> </ul>

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<ul style="list-style-type: none"> <li>– Presence of organized or managed health care in the non-NTP sector</li> <li>– Non-NTP provider characteristics and needs from partnership</li> <li>– Private sector: resources for clinical management of TB</li> <li>– Non-NTP public sector facilities: resources for clinical management of TB</li> <li>– Political will to implement DOTS (non-NTP public sector)</li> <li>– Status of DOTS expansion in the country</li> <li>– Preparedness of regions/districts/TB units and additional resources required to undertake PPM</li> </ul>	<hr/>
<p>4. Consultations with relevant stakeholders (see Box 1)</p>	<ul style="list-style-type: none"> <li>– Presence of organized or managed health care in the non-NTP sector</li> <li>– Non-NTP provider characteristics and needs from partnership</li> <li>– Political will to implement DOTS (non-NTP public sector)</li> <li>– Capacity of professional associations to undertake public health tasks</li> <li>– NGOs and voluntary bodies with capacity to undertake public health tasks</li> <li>– Corporate social responsibility programmes</li> <li>– Corporate workplace health programmes</li> <li>– Existing accreditation and certification schemes for hospitals, clinics, laboratories that incorporate DOTS or ISTC</li> <li>– Social franchising schemes for clinics, laboratories which require that empanelled providers use DOTS or ISTC.</li> <li>– Medical curriculum development and use of DOTS or ISTC</li> <li>– Teaching in public/private colleges and use of DOTS or ISTC</li> <li>– In-service training initiatives and programmes and use of DOTS or ISTC</li> <li>– Non-NTP agencies and mechanisms of support, including funding and advocacy of ISTC</li> <li>– Existing relevant regulations or legal provisions</li> <li>– Means of enforcing existing regulations, if any</li> </ul> <hr/>

5. Professional association membership lists, medical registration records and directories of services	<ul style="list-style-type: none"> <li>– Numbers of health staff in the private sector</li> <li>– Distribution of private institutions</li> <li>– Numbers of private health care institutions in the different categories</li> <li>– Presence of organized or managed health care in the non-NTP sector</li> <li>– Distribution of public (non-NTP) facilities</li> </ul>
6. Reports and documents of the Ministry of Health and other government ministries and departments	<ul style="list-style-type: none"> <li>– Poverty mapping</li> <li>– Populations with poor access to health care</li> <li>– Populations especially vulnerable to TB</li> <li>– General pattern of health care utilization</li> <li>– Health care utilization for TB in the private and public sectors</li> <li>– Different categories of health care institutions and providers in the non-NTP sector</li> <li>– Numbers of private health care institutions in the different categories</li> <li>– Distribution of private institutions</li> <li>– Number of health staff in private sector</li> <li>– Number of health care staff in the (non-NTP) public sector</li> <li>– Distribution of public (non-NTP) facilities</li> </ul>
7. Reports of HIV/AIDS programme	<ul style="list-style-type: none"> <li>– Prevalence and distribution of TB/HIV coinfection</li> <li>– Populations especially vulnerable to TB (high HIV prevalence)</li> </ul>
8. Independent research papers and articles	<ul style="list-style-type: none"> <li>– Notification of TB: geographical variation and time trends</li> <li>– Prevalence and distribution of TB/HIV coinfection</li> <li>– Prevalence and distribution of MDR TB</li> <li>– Populations with poor access to health care</li> <li>– General pattern of health care utilization</li> <li>– Health care utilization for TB in the private and public sectors</li> <li>– Delays in diagnosis and treatment for TB</li> <li>– Costs associated with seeking health care for TB</li> <li>– Stigma related to TB and HIV impeding access to health care</li> <li>– Non-NTP provider characteristics and needs from partnership</li> <li>– Existing TB diagnosis and management in the non-NTP sector</li> </ul>



9. Reports and research of WHO, World Bank and ILO	<ul style="list-style-type: none"> <li>– Notification of TB: geographical variation and time trends</li> <li>– Prevalence and distribution of TB/HIV coinfection</li> <li>– Prevalence and distribution of MDR TB</li> <li>– Poverty mapping</li> <li>– Populations with poor access to health care</li> <li>– Populations especially vulnerable to TB</li> <li>– General pattern of health care utilization</li> <li>– Health care utilization for TB in the private and public sectors</li> <li>– Delays in diagnosis and treatment for TB</li> <li>– Costs associated with seeking health care for TB</li> <li>– Proportion of health care expenditure that is out-of-pocket</li> <li>– Stigma related to TB and HIV impeding access to health care</li> <li>– Different categories of health care institutions and providers in the non-NTP sector</li> <li>– Numbers of private health care institutions in the different categories</li> <li>– Distribution of private institutions</li> <li>– Number of health staff in the private sector</li> <li>– Presence of organized or managed health care in the non-NTP sector</li> <li>– Existing TB diagnosis and management in the non-NTP sector</li> </ul>
10. Reports of official quality assurance/ quality control schemes	<ul style="list-style-type: none"> <li>– Status of DOTS expansion in the country</li> </ul>
11. Feedback from existing PPM	<ul style="list-style-type: none"> <li>– Non-NTP provider characteristics and needs from partnership</li> <li>– Existing TB diagnosis and management in the non-NTP sector</li> <li>– Private sector: resources for clinical management of TB</li> <li>– Non-NTP public sector facilities: resources for clinical management of TB</li> <li>– (Political will to implement DOTS (non-NTP public sector)</li> <li>– Preparedness of regions/districts/TB units and additional resources required to undertake PPM</li> </ul>
12. Policy documents of regulatory agencies and councils	<ul style="list-style-type: none"> <li>– Existing relevant regulations or legal provisions</li> <li>– Means of enforcing existing regulations, if any</li> </ul>

## 5. USING THE OUTPUTS OF THE NSA

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.

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. Members of the NSA consultative committee of stakeholder representatives may also join the national PPM task force.

The broad outputs of the NSA are listed along with corresponding action points for the programme.

1. Extent and severity of the epidemic by region and presence of vulnerable populations.
2. Clients' use of different provider types, and associated treatment delays and costs.

***ACTION POINTS:** The information from outputs 1 and 2 can help in developing objectives for PPM for TB care and control, such as adapting services to the poor and improving disease management. Information about worst-affected and vulnerable populations can help in prioritizing areas for PPM implementation. Information on the utilization of different provider groups for PPM can be used to focus PPM interventions and set priorities when targeting specific provider groups.*

3. Lists and maps of different categories of health care institution and provider.
4. Existing resources for TB management in the non-NTP sector, and management practices.
5. Knowledge about non-NTP providers' needs from partnerships, and their will to participate.
6. Public health tasks undertaken by non-NTP organizations, and their potential for involvement.

***ACTION POINTS:** These outputs can help to define the task mix (See Annex 1) for different providers, address the needs of non-NTP providers from a partnership, and devise appropriate incentives and enablers.*

7. Regions/TB reporting units with essential requirements in place for implementing PPM.

8. Evidence for additional resources needed to enable PPM implementation.

*ACTION POINTS: PPM can be implemented in regions or TB reporting units that have all the essential requirements in place. Evidence of additional needs can be used in delegating human and financial resources towards preparing all sections of the NTP for PPM implementation.*

9. Knowledge of existing laws and regulations that can have an effect on PPM for TB care and control

*ACTION POINTS: This information can be used strategically, and any policies and regulations that may help implement PPM should be promoted.*

A proper situation assessment would help directly in beginning to create national resources for PPM and in developing PPM operational guidelines based on consensus among key stakeholders. The logical next steps would then be local implementation first at selected sites and then scale-up in phases. Lessons from initial implementation should be incorporated into subsequent scale-up of PPM.

## **6. WAY FORWARD**

The NSA tool has already been used to conduct situation assessments in 12 countries from the African and Eastern Mediterranean region, Annex 3 presents summaries of two of the assessments. It is important to note that this tool is only a guide for conducting a national situation assessment and that it needs to be adapted and tailored to the specific country context . The NSA is the cornerstone of PPM implementation in the country and information collected during the assessment should be carefully processed and analysed. Based on this, clear conclusions must be drawn for the current and potential role of PPM for TB care and control in the country. Practical recommendations should then be made on the next steps to be taken and the roles of the various stakeholders in taking PPM implementation forward.

## Annex 1. Summary of areas of enquiry, sources of information and outputs of the NSA

	Areas of enquiry	Sources of information	Outputs of NSA
<b>Epidemiology of TB</b>	<p>Notification of TB: geographical variation and time trends</p> <p>Prevalence and distribution of TB/HIV coinfection</p> <p>Prevalence and distribution of MDR TB</p>	NTP reports, WHO and World Bank reports, independent research papers	Lists of regions/districts/TB reporting units categorized by extent of epidemic and prevalence of TB/HIV coinfection and MDR TB
<b>Utilization of health services by people seeking care</b>	<p>Poverty mapping</p> <p>Populations with poor access to health care</p> <p>Populations especially vulnerable to TB (high HIV prevalence, slum dwellers, industrial workers)</p>	Reports of the government, the national HIV/AIDS programme, WHO and World Bank, independent research papers	List of regions/districts/TB reporting units with vulnerable populations
	<p>General pattern of health care utilization in private and public sectors</p> <p>Health care utilization for TB in private and public sectors</p> <p>Delays in diagnosis and treatment for TB</p> <p>Costs associated with seeking care for TB</p> <p>Proportion of health expenditure that is out-of-pocket</p> <p>Stigma related to TB and HIV impeding access to health care</p>	Reports of the government, WHO and the World Bank, independent research papers	Data on clients' usage of different provider types, delays in care and costs to patients
<b>Composition and characteristics of the non-NTP sector</b>	<p>Different categories of health care institutions and providers in the non-NTP sector</p>	Discussions with consultative committee and programme staff	Lists and distribution maps of private health care providers by region/district/TB reporting unit
	<p>Numbers of private health care institutions in the different categories</p> <p>Number of health staff in private sector</p> <ul style="list-style-type: none"> <li>• physicians/nurses/paramedical/counsellors/care workers</li> </ul>	Professional association membership lists, medical registration records, directories of services	
	<p>Distribution of private institutions</p> <ul style="list-style-type: none"> <li>• rural/urban</li> <li>• located in areas difficult to access</li> </ul>	Reports of the government, WHO and the World Bank, independent research papers	

<ul style="list-style-type: none"> <li>• working with underprivileged / vulnerable populations</li> </ul>		
<p>Organized or managed health care</p> <ul style="list-style-type: none"> <li>• coverage by private insurance companies</li> <li>• lists of hospital or health care chains/franchises</li> <li>• existence of corporate employee health schemes</li> <li>• lists of NGO and faith-based care networks</li> </ul>	<p>Discussions with consultative committee and programme staff</p>	<p>Lists of organized or managed health care networks in the private and public sectors</p>
<p>Number of health care staff in non-NTP sector</p> <ul style="list-style-type: none"> <li>• physicians/nurses/paramedical/counsellors/care workers</li> </ul> <p>Distribution of public (non-NTP) facilities</p> <ul style="list-style-type: none"> <li>• rural/urban</li> <li>• located in areas difficult to access</li> <li>• located in areas with vulnerable populations</li> </ul>	<p>Reports and programme documents of the government, WHO and the World Bank</p> <p>Discussions with programme staff</p>	<p>Lists and distribution maps of public (non-NTP) health care institutions and providers by region/district/TB reporting unit</p>
<p>Non-NTP provider characteristics and needs</p> <ul style="list-style-type: none"> <li>• income from practice, source of income (salary/fee)</li> <li>• training needs</li> <li>• incentives to participate – training opportunities, financial incentives, status and recognition, assistance in patient management</li> <li>• career advancement goals, concerns, risks</li> <li>• (private providers') attitudes to the public health sector</li> </ul>	<p>Discussions with stakeholders from non-NTP sector and NTP staff, independent research studies, feedback from existing PPM (if any)</p>	<p>Knowledge about non-NTP providers' needs from a partnership</p>
<p>Existing TB diagnosis and management</p> <ul style="list-style-type: none"> <li>• whether TB patients are seen, diagnosed as TB-positive and managed for TB by different groups of providers</li> <li>• numbers of TB and TB/HIV patients treated</li> <li>• fees/charges for TB treatment</li> <li>• adherence to treatment guidelines</li> <li>• treatment success rates</li> </ul>	<p>Reports of WHO and the World Bank, independent research papers, discussions with consultative committee, independent research studies, feedback from existing PPM (if any)</p>	<p>Data on management of TB patients by different groups of non-NTP providers</p>
<p>Private sector: resources for clinical management</p>	<p>Discussions with consultative</p>	

<ul style="list-style-type: none"> <li>• anti-TB formulations available in the private market</li> <li>• private facilities employing patient supervisors and counsellors</li> </ul>	committee, feedback from existing PPM (if any)	
<p>Non-NTP public sector facilities: resources for clinical management</p> <ul style="list-style-type: none"> <li>• regular supply of anti-TB therapy</li> <li>• existence of functioning, quality-controlled microscopy services</li> <li>• capacity for DOT, patient supervision and default retrieval</li> </ul>	Discussions with consultative committee and programme staff, feedback from existing PPM (if any)	Detailed information on resources available in the non-NTP sector
<p>(Non-NTP public sector) political will to implement DOTS</p> <ul style="list-style-type: none"> <li>• whether DOTS adopted</li> <li>• health staff understanding of NTP and willingness to adopt DOTS</li> <li>• nature of involvement with NTP, if any</li> <li>• competing priorities</li> </ul>	Discussions with stakeholders from the non-NTP sector, consultative committee and programme staff, feedback from existing PPM (if any)	Knowledge about will to partner with NTP
<p>Professional associations' capacity to undertake public health tasks</p> <ul style="list-style-type: none"> <li>• existing activities: in-service training programmes, newsletters, journals</li> <li>• ability to take role in advocacy, training, monitoring and supervision of PPM</li> </ul>	Discussions with stakeholders from the non-NTP sector (professional associations, NGOs, corporations)	Information on public health tasks presently undertaken by associations, and potential for involvement
<p>NGOs and voluntary bodies with capacity to undertake public health tasks</p> <ul style="list-style-type: none"> <li>• ability to undertake role in training, monitoring and supervision of PPM</li> </ul>		Information on potential for involvement of NGOs in public health tasks
<p>Corporate social responsibility programmes</p> <ul style="list-style-type: none"> <li>• existing activities (outside the workplace) for public health</li> <li>• ability to support and advocate PPM for TB care and control</li> </ul> <p>Corporate workplace health programmes</p> <ul style="list-style-type: none"> <li>• existing health benefits and schemes for employees</li> <li>• existence of schemes for HIV or TB prevention, anti-discrimination rules</li> <li>• ability to undertake role in training, monitoring and supervision of PPM</li> </ul>	<p>Discussions with stakeholders from accreditation agencies, franchising schemes, educational councils, medical colleges, agencies involved in in-service training, funding agencies</p> <p>Discussions with consultative committee, donor organizations</p>	<p>Information on potential for involvement of corporate bodies in public health tasks</p> <p>Information on potential for involvement of public and private corporations in public health tasks</p>





	<p>Preparedness to undertake PPM</p> <ul style="list-style-type: none"> <li>• regions/districts/TB units with all essential resources for undertaking PPM (including trained staff), 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 and pilot projects, summaries of lessons learnt</li> <li>• staff attitudes towards the private sector</li> </ul>	<p>Discussions with consultative committee and programme staff, evidence and programme documentation from existing PPM (if any)</p>	<p>Evidence for training and additional resources required for PPM implementation</p>
<p><b>Policy and regulatory environment</b></p>	<p>List of official regulatory agencies for medical establishments, education, pharmacies and diagnostic laboratories</p> <p>Existing regulations or legal provisions pertaining to:</p> <ul style="list-style-type: none"> <li>• DOTS and ISTC</li> <li>• prescription of drugs, and restriction on sales of drugs or formulations over the counter</li> <li>• notification of TB cases</li> <li>• access to essential drugs and medicines</li> <li>• other relevant areas</li> </ul> <p>Means of enforcing existing regulations, if any</p>	<p>Guiding documents of regulatory agencies, discussions with stakeholders from regulatory agencies</p>	<p>Knowledge of existing laws and regulations that may facilitate PPM-DOTS or require its modification</p>

## Annex 2. Indicative DOTS task mix for different provider categories

Task		National TB programme	Public or private Institution	Individual private provider	Private/public laboratory	Non-physician/pharmacy
Clinical tasks	Identify TB symptoms					
	Collect sputum samples					
	Refer TB suspects					
	Notify/record cases					
	Supervise treatment					
	Do smear microscopy					
	Diagnose TB					
	Prescribe treatment					
	Inform patients about TB					
Public health tasks	Identify and supervise treatment support staff					
	Follow up on defaulters					
	Trace contacts and refer for diagnosis					
	Train care providers					
	Supervise					
	Carry out quality assurance for laboratories					
	Monitor and evaluate					
	Ensure effective drug supply and management					
	Provide stewardship, financing and regulation					

## Annex 3. Some examples of PPM national situation assessments

### AFGHANISTAN

#### 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 medical 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.

# NIGERIA

## 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 CARE PROVIDERS

- 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.

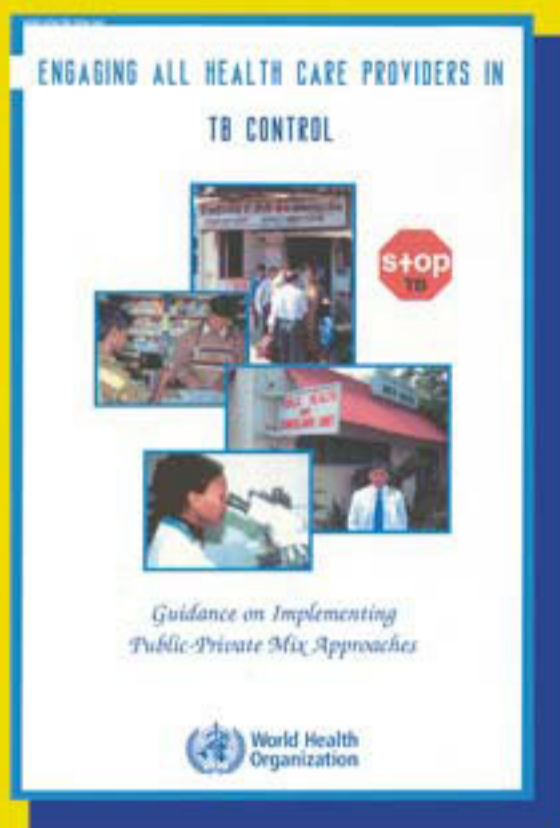
## PREPAREDNESS OF THE NTP

- 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, first-line TB drugs can be bought in private pharmacies and some drug stores without prescription from a doctor.

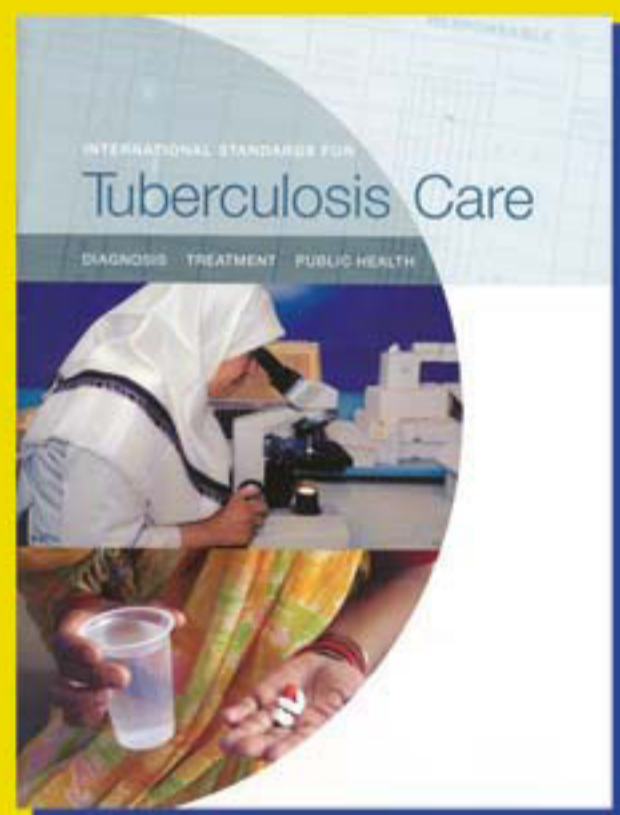
## Three useful tools for PPM planning, implementation and advocacy



*"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:**

**[www.who.int/tb/careproviders/ppm](http://www.who.int/tb/careproviders/ppm)**

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