PATH's engagement in TB Control Programming

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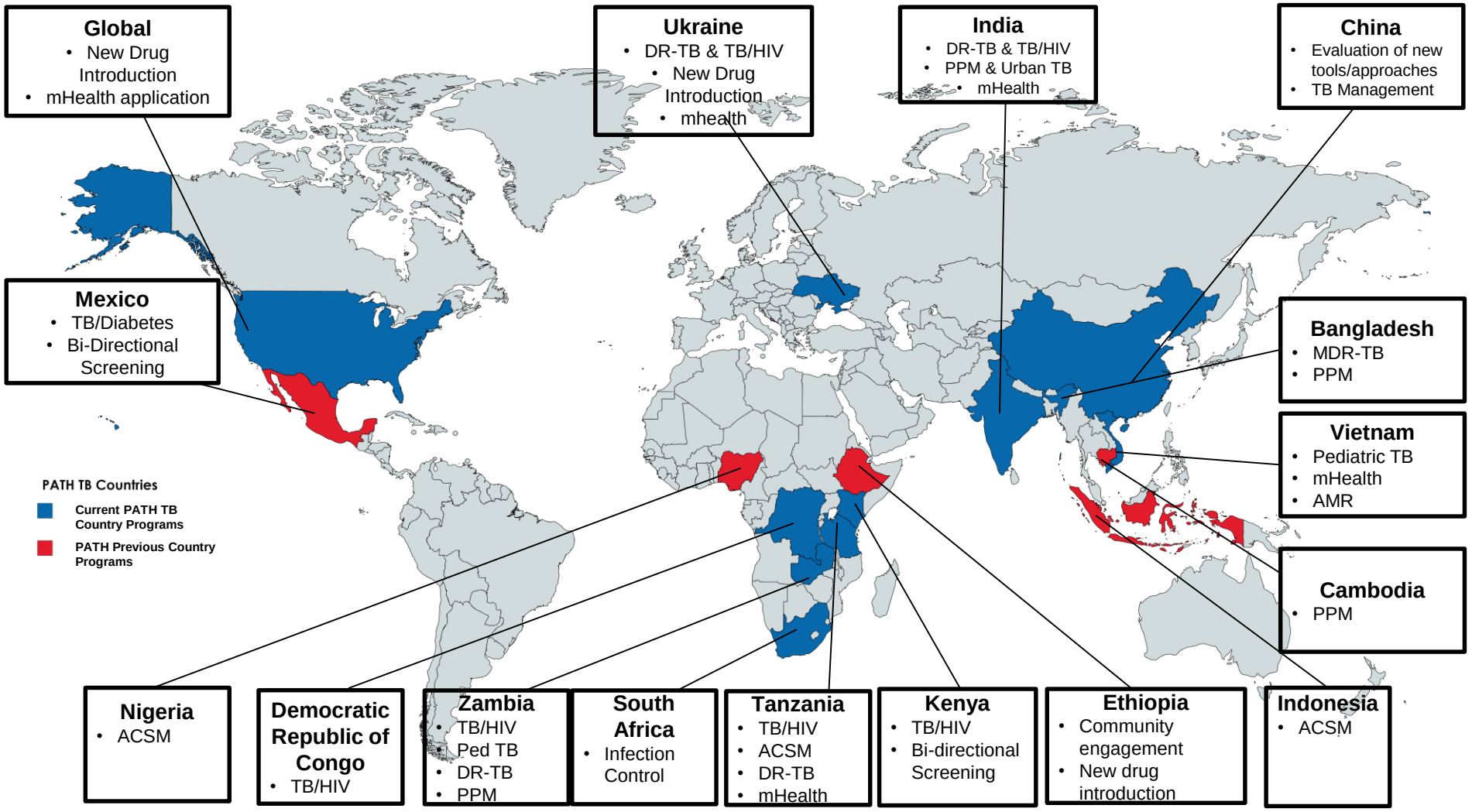
PATH is a global team of innovators working to eliminate health inequities so people, communities, and economies can thrive.

Photos: PATH/Aaron Joel Santos, PATH/Gabe Bienczycki, PATH/Gabe Bienczycki

PATH's current (blue) and past (red) TB presence



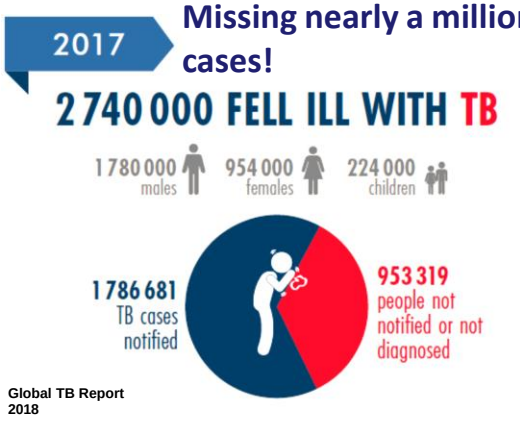
Our vision for TB elimination

Enable countries to meet the End TB Strategy goals by finding missing cases, reducing the inequity in treatment outcomes, and boosting LTBI detection and prevention.

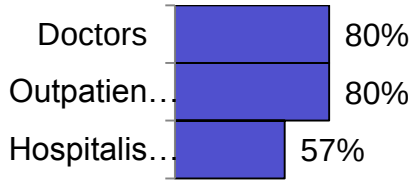
Key strategies include:

- **re-defining service delivery** utilizing existing tools and technologies
- **building public private partnerships** to address LTBI detection and TPT, case finding, diagnosis, and treatment especially in urban centers and for DR-TB
- **accelerating integration** of TB within HIV, diabetes, and malnutrition interventions and leverage joint funding to grow regional and technical expertise in these areas
- **introducing innovative diagnostic and treatment measures** in TB control programs
- improving quality of patient management, data collection and analysis through **strengthened ICT and digital platforms** for strategic decision-making and program targeting
- **ensuring a gendered-approach** and focus on populations that are at greater overall vulnerability to poor TB and health outcomes

Introduction: Why Private Sector Engagement



Share of Private Sector in Indian Healthcare [1]



India has the one of the largest private healthcare sectors in the world.

- 72% of healthcare expenditure is out of pocket[1]
- Mean costs incurred by patients with pulmonary tuberculosis - **$562.66** ; (~193% of the estimated monthly income of a manual laborer)[2]

National Sample Survey, 2015

Statement 3.5 : Percentage distribution of spells of ailment treated during last 15 day by level of care separately for each gender

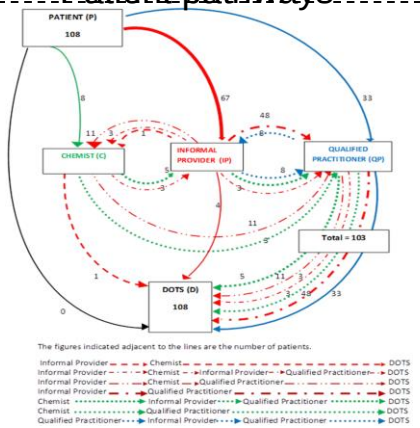
level of care	percentage of spells of ailment treated					
	rural			urban		
	male	female	persons	male	female	persons
(1)	(2)	(3)	(4)	(5)	(6)	(7)
HSC, PHC & others*	10.6	12.3	11.5	3.5	4.2	3.9
public hospital	15.9	17.5	6.8	17.4	17.3	17.3
private doctor/clinic	52.7	48.9	0.7	48.9	50.8	50.0
private hospital	20.8	21.3	21.0	30.2	27.7	28.8
all	100	100	100	100	100	100

* includes ANM, ASHA, AWW, dispensary, CHC, MMU

Statement 3.7a: Percentage distribution of hospitalised cases by public and private hospital for each quintile class of [illegible]

quintile class of UMPCE	percentage of hospitalised cases in					
	rural			urban		
	public hospital	private hospital	all	public hospital	private hospital	all
(1)	(2)	(3)	(4)	(5)	(6)	(7)
1	57.5	42.5	100	48.0	52.0	100
2	52.9	47.1	100	43.5	56.5	100
3	47.1	52.9	100	32.7	67.3	100
4	42.8	[illegible]	100	28.3	[illegible]	100
5	28.9	71.1	100	18.7	81.3	100
all	41.9	58.1	100	32.0	68.0	100

Patient pathways



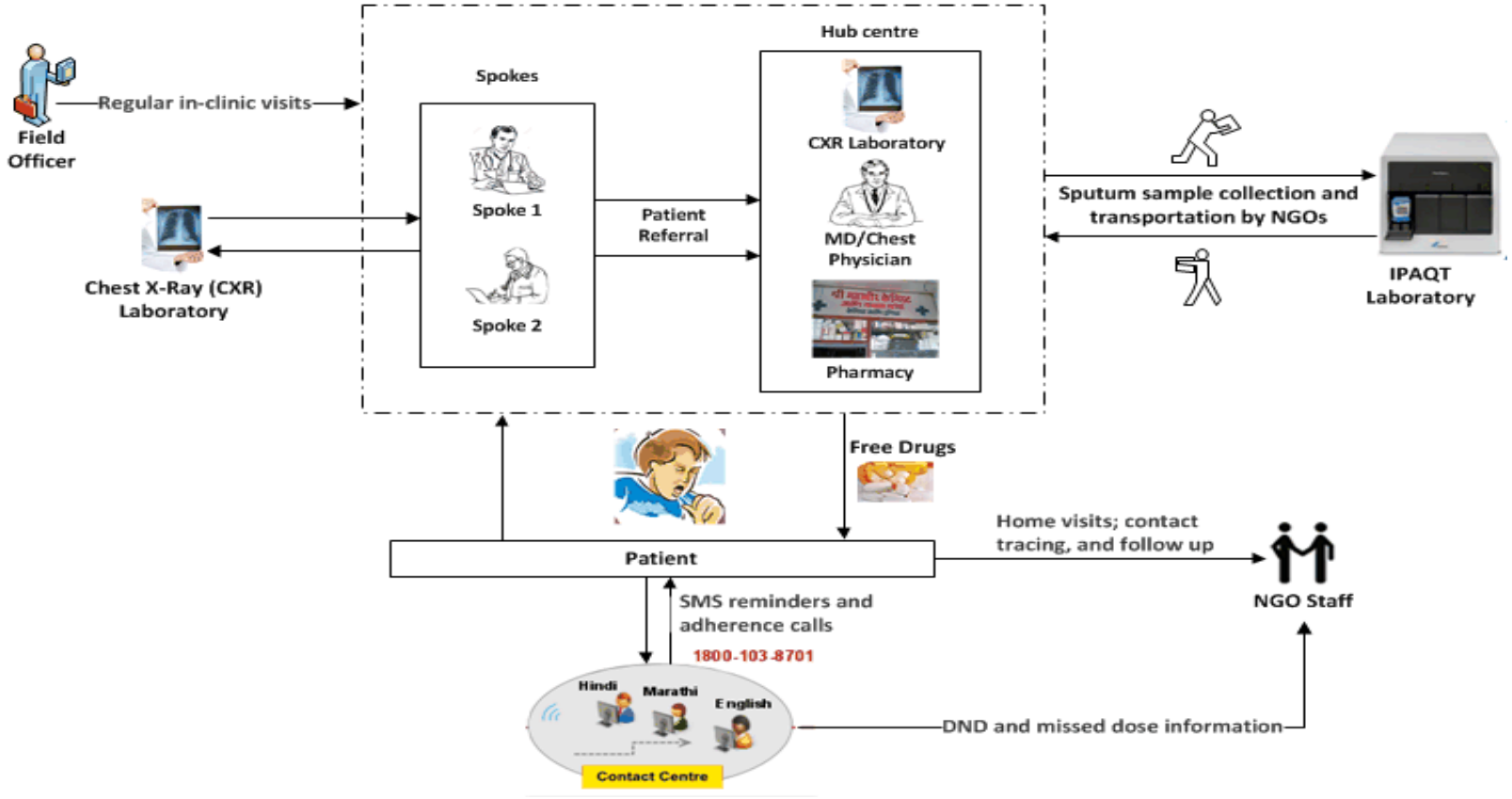
SOURCE: 1. 60th NSS-2005, Venkat Raman et al; 2. John, K.R (CMC Vellore, 2009); 3. Kapoor SK et al. PLoS ONE 2012

Approach and strategies for engaging private sector

Government is the *enabler* of the TB service, not the sole provider

- ➔ **Gazette order for mandatory notification of TB**
- ➔ **Use of Schedule H1 regulatory provisions**
- ➔ **Free diagnostics and drugs**
- ➔ **Incentives of Rs. 1000 to private providers, for notification and reporting treatment outcome**
- ➔ **Financial support for patients nutrition (monthly Rs 500)**
- ➔ **Public private support agency (PPSA)**
- ➔ **ICT support through call centre, adherence tools, NIKSHAY**

PPIA - Service delivery model



UATBC Concurrent Assessment 2016

UATBC core recommendation is to scale-up the interventions in order to optimize the benefits accrued from these approaches

Strategies used in PPIA intervention should be incorporated into existing RNTCP guidelines for engaging the private sector

Assessment report recommended to

- Expand access to free, high sensitive diagnostic tests through public or private supported by RNTCP
- Public health action
- Enable and expand ICT systems
- Reduce Out of pocket expenditure
- Build capacities of the program to manage contracts

Average recurring cost per case at full scale

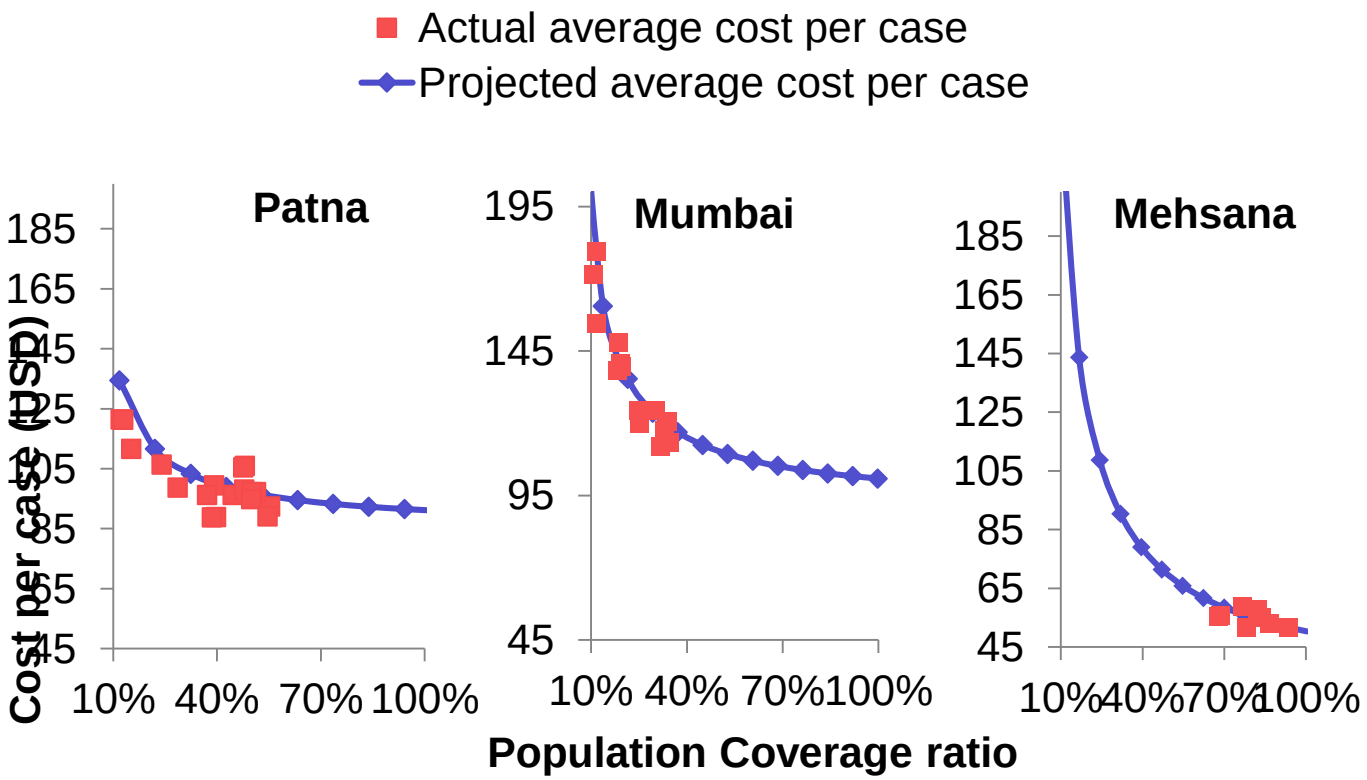
Average cost per case (US$)	Patna	Mumbai	[illegible]
Office Staff	4.67	7.11	0.10
ICT	9.64	11.75	15.32
Field Staff	12.0[illegible]	12.8[illegible]	0.00
Incentives	.26	0.00	0.89
Others	1.44	2.48	4.49
Diagnostics	20.79	32.34	0.00
Drug[illegible]	37.31	34.78	29.52
Total Cost	**91.16**	**101.35**	**50.32**

Programmatic cost

Commodity cost

Recall: Cost per case in public sector is $110

Costs go down with volumes/coverage



NATIONAL STRATEGIC PLAN (NSP) TO ELIMINATE TB IN INDIA (2017-25)

Accelerating towards a TB free India

Joint Effort for Elimination of Tuberculosis

Aim:

Intensive engagement with the private sector to achieve universal access to quality diagnosis and treatment for TB and help the nation in achieving it's NSP targets of TB elimination (28 / 4.8 / 18)

Objective:

1. Develop an insight into private sector by conducting mapping & prioritization of private sector healthcare providers
2. Facilitate nationwide access to RNTCP approved affordable TB diagnostics for patients seeking care in the private sector through public and private lab network for increased notifications and quality diagnosis
3. Facilitate nationwide access to early, appropriate and free treatment initiation, public health actions and adherence support systems for patients seeking care in the private sector

The services will be delivered through establishment of Patient Provider Support Agency (PPSA) and Technical Support in PPSA lite districts

PPSA

- **49 cities** with >800,000 population across 15 states
- Coverage includes urban and rural peripheral areas around the PPSA geographies
- Activities in PPSA districts :
  - Mapping of private practitioners and identification of TB champions
  - Continuous engagement of private sector providers through in clinic visits and CMEs
  - Linkages to government provided CB NAAT testing and FDC's for all patients seeking care in the private sector
  - TB adherence support
  - TB notifications from engaged providers

PPSA lite

- **406 cities** with population ranging between 200,000 to 800,000 in 22 states
- City Officers in PPSA lite districts/cities will support –
  - Mapping of private practitioners and identification of TB champions
  - Facilitate private sector provider engagement through CMEs
  - Capacity building of RNTCP staff to undertake private sector engagement
  - Provide program monitoring support and facilitate reviews

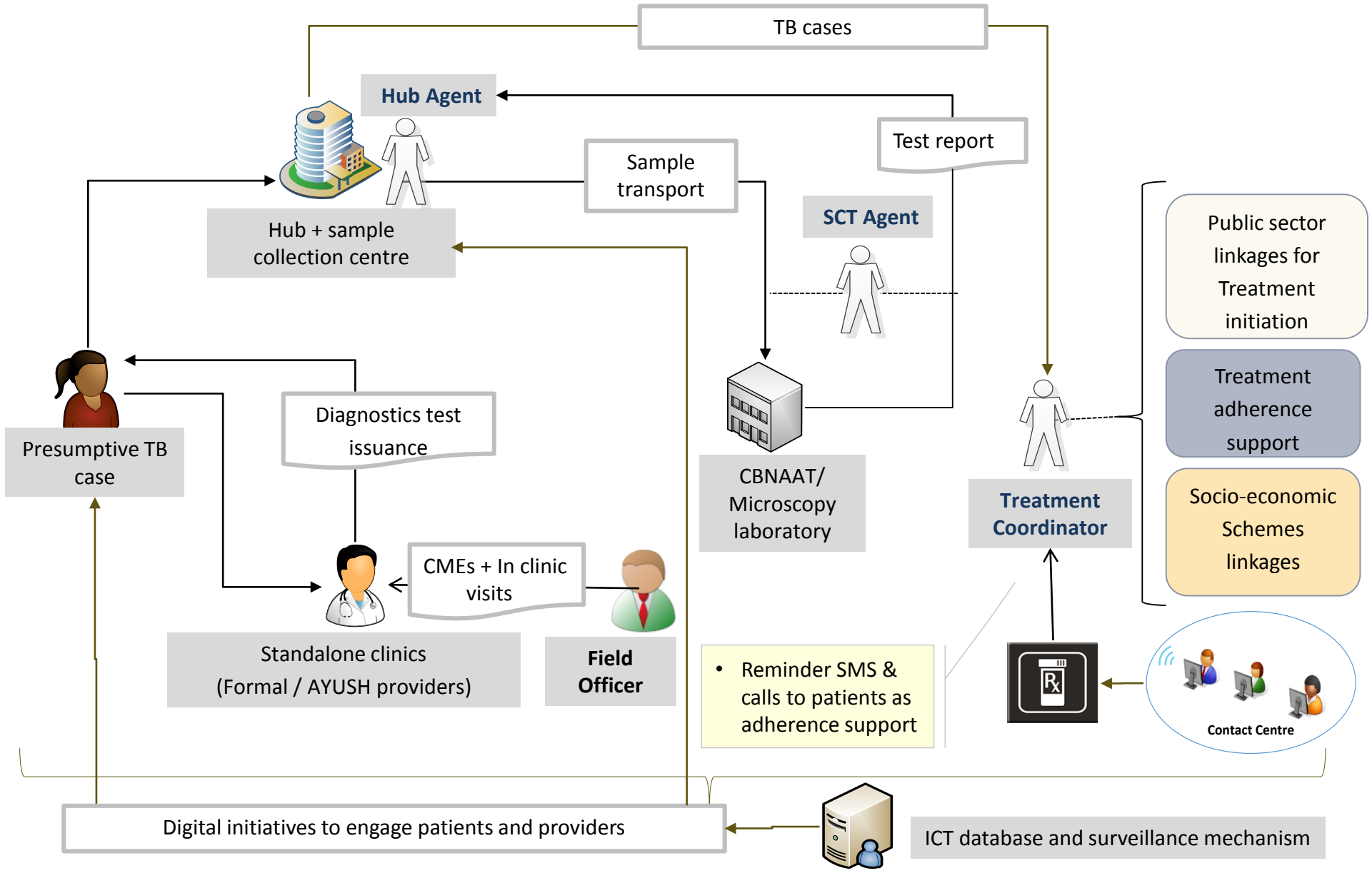
Key Activities:

- Mapping and Prioritization of private sector providers
- Ensuring nationwide access to WHO approved quality TB diagnostics to patients seeking care in the private sector
- Enabling early, appropriate and free treatment initiation, public health actions and adherence support systems

Expected Impact:

- 1.6 million notifications over 3 years
- To report successful treatment outcomes
- Setup effective and sustainable PPM strategy pan India

The PPSA operating model mirrors the Mumbai PPIA, although commodities and incentives will be sourced from the government

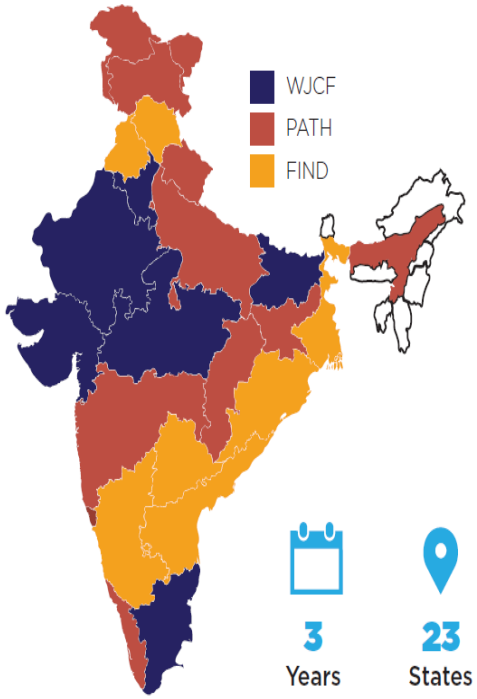


JEET Partners and coverage

William J Clinton Foundation (WJCF)

Centre for Health , Research and innovation (CHRI)

Foundation for Innovative New Diagnostics (FIND)



Doctors to be covered
15,000

Lives to be impacted
3,500,000

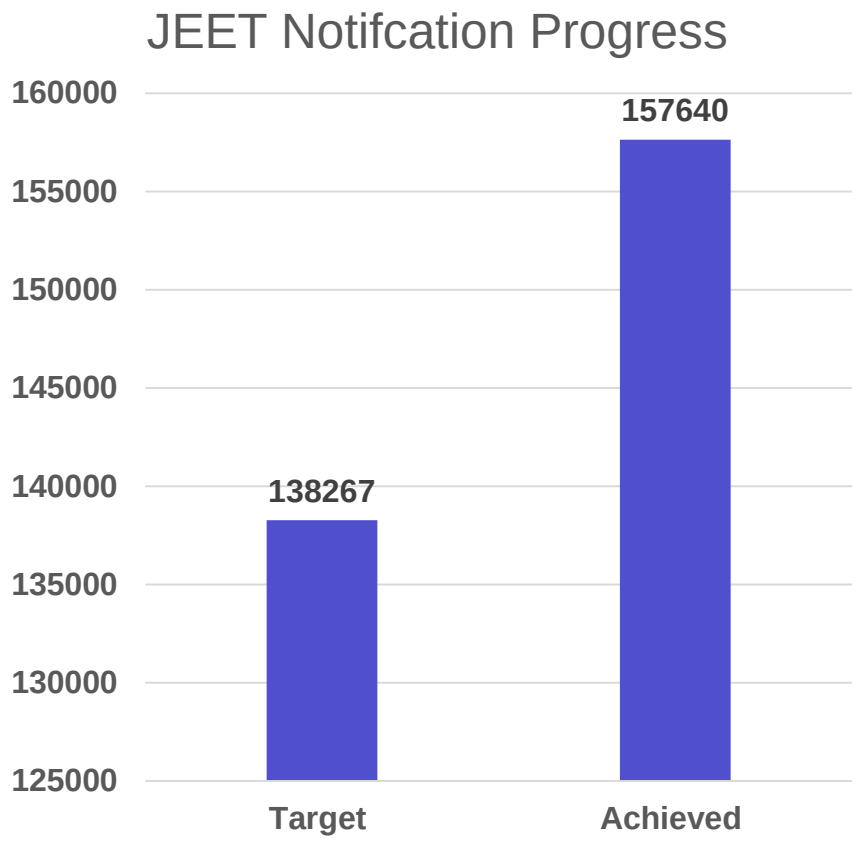
3 Years

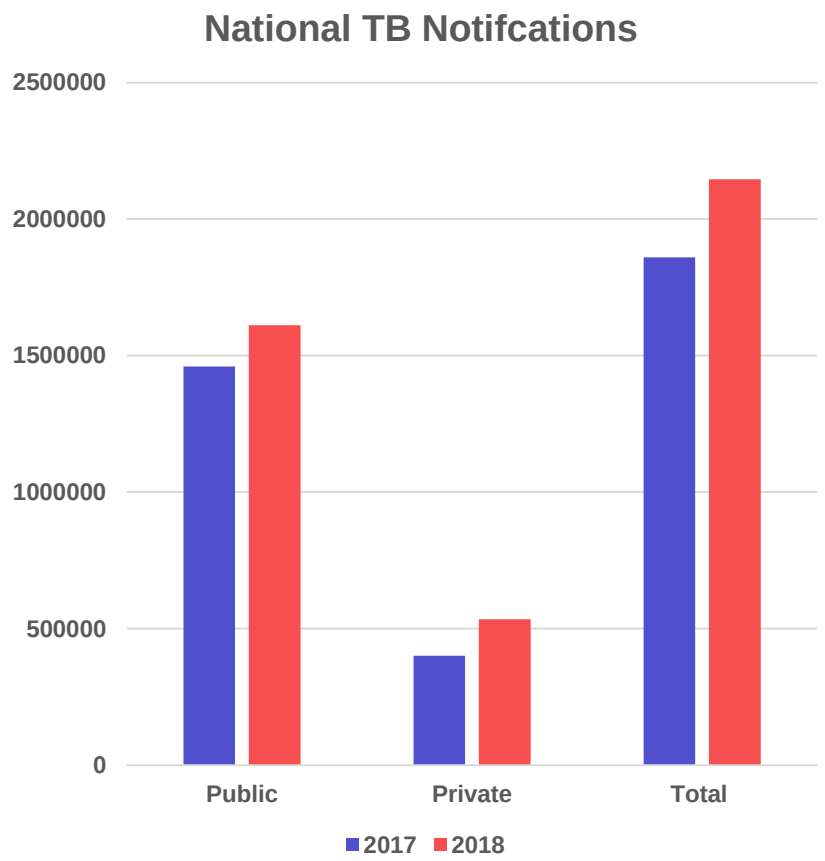
23 States

406 Cities

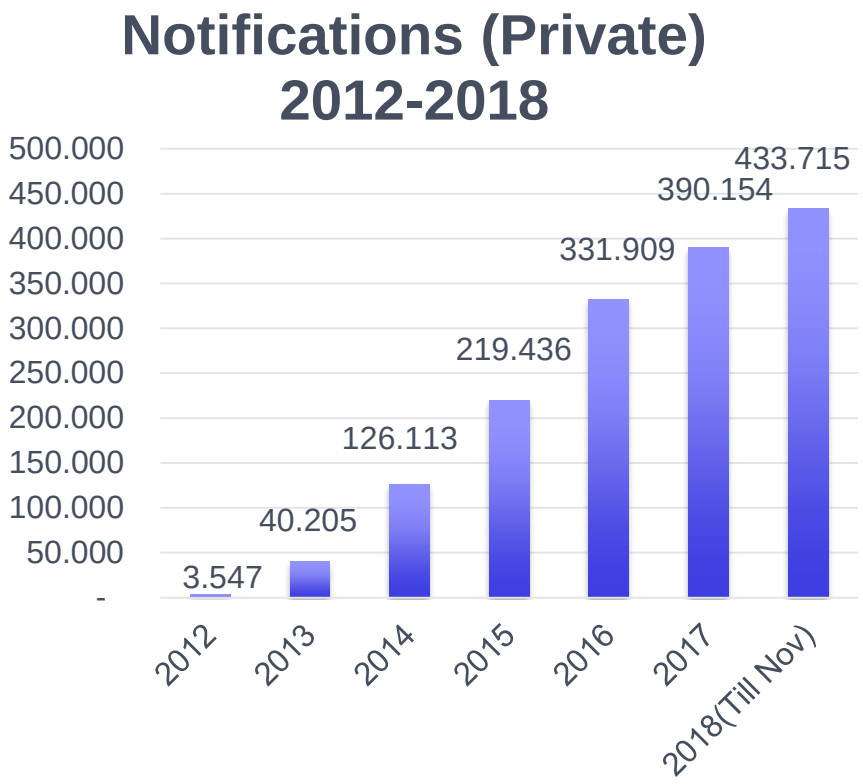
2500+ Program Staff

Progress so far





India notification progress



NSP 2017-2025	2018	2019	2020	2021
Patients notified by private sector (target)	1.5 M	1.8 M	2 M	2 M
Treatment success rate among notified DSTB (target)	-	-	90%	-
JEET private sector notification target	0.14 M	0.46 M	0.78 M	0.22M*
JEET treatment success rate target	70%	70%	70%	70%

Challenges and mitigation plan

Challenges

1. Free CB-NAAT testing for eligible presumptive TB patients & timely reporting
2. Free FDC for private sector patients
3. Timely incentive disbursals to beneficiaries
4. Local NTP acceptance
5. Non JEET geography private sector engagement
6. Adherence support in light intervention area

Mitigation Strategy

1. **Timely forecasts of commodities and remedial measures.**
2. **Manpower and working hours optimization to reduce TAT**
3. **Leverage alternate resources (LT schemes/ PPM DST schemes/ IPAQT labs)**
4. **Vouchered drugs from private pharmacy**
5. **Leveraging Contact Centre**
6. **Contracting more PPSA through domestic resources**

Thank you