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Cured TB patient with doctor who treated him at Yirgalem TIC 10.
Photo credit: Jennifer Gardella

TECHNICAL BRIEF

OVERCOMING CHALLENGES IN PRIVATE-SECTOR ENGAGEMENT FOR TB CONTROL IN ETHIOPIA: EXPERIENCE FROM THE USAID ELIMINATE TB PROJECT

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August 2023

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BACKGROUND

Ethiopia has made remarkable progress over the last decades to reduce the burden of tuberculosis (TB). All the major TB indicators—incidence, prevalence, and mortality—have decreased by more than half since 1990 (1). However, the gains have been uneven—nearly a quarter of TB cases go undetected each year, resulting in continued spread of the disease throughout the country, often among the poorest and most vulnerable communities. In 2015, the World Health Organization (WHO) launched the End TB Strategy, which comprises three pillars with ten components. The second pillar is bold policies and supportive systems, and one of its components is engagement of communities, civil society organizations, and public and private care providers (2).

Private providers include pharmacies, primary and specialty clinics and centers, hospitals, for-profit and not-for-profit facilities, workplaces, and government facilities outside of the Federal Ministry of Health (3). They account for approximately 20% of facility visits nationally and 35% among the growing urban population (3). Engaging all care providers is a core strategy to expand services and end the TB epidemic. Considering the persistent TB case-detection gap in the country and the potential of private providers to deliver services, including TB diagnosis, treatment, and prevention, the national guidance recommends scaling up engagement of private providers at all levels.

Funded by USAID, the Public–Private Mix (PPM) for TB Prevention and Control in Ethiopia began in 2006. It was later followed by two subsequent private health-sector projects. Some of the achievements of PPM TB in the past decade include developing an implementation guide, expanding private facilities in all regions, capturing the PPM directly observed treatment (DOT) contribution to national health information system, strengthening the capacity of health care providers from private facilities, including PPM sites in the national Integrated Pharmaceutical Logistic System standard operating procedure, integrating PPM sites into the national laboratory network for external quality assessment (EQA), and implementing a sample transport system for GeneXpert services. Every year, a budget is assigned to expand PPM TB services in regions for new site assessments, capacity strengthening, and review meetings.

The USAID Eliminate TB Project, a five-year USAID-funded project led by Management Sciences for Health, provides technical and financial support to the National TB Program (NTP). It actively engages in TB, TB/HIV, and multidrug-resistant TB (MDR-TB) programming and implementation from the national to community levels, including the Oromia, Amhara, Sidama, South West Ethiopia Peoples, Central Ethiopia, Southern Ethiopia,³ and Tigray Regions.

PROBLEM STATEMENT

Four specific problems have been identified regarding the PPM TB program. First, the contribution of PPM to national TB case notification is stagnant and low. In 2016, Ethiopia designed a five-year national action plan (as part of the National Strategic Plan) to increase PPM health care providers' contributions to TB case notification to 26% (4). Although an increasing number of private facilities are engaged in the PPM TB program, their contribution to national TB notification is only 15–17%.

Second, district (woreda) support to the PPM TB program is inadequate. In October 2021, the USAID Eliminate TB Project conducted a rapid assessment to investigate challenges and gaps in implementing PPM TB in 199 private facilities (table I).

³ The Sidama, South West Ethiopia Peoples, Central Ethiopia, Southern Ethiopia regions formerly comprised the Southern Nations, Nationalities, and Peoples Region (SNNPR).

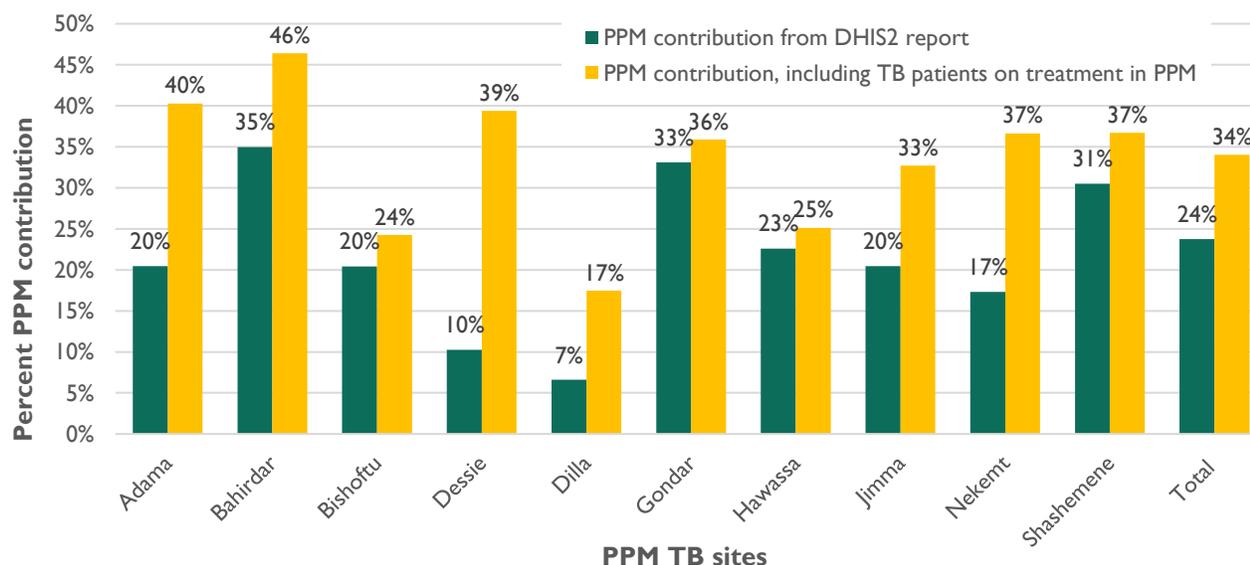
Table I. Summary of rapid assessment of PPM TB health facilities (N = 199) in selected regions, October 2021

Region	Sites in region	Provides only diagnosis	Provides DOT	No recording materials		No trained provider	No anti-TB medicines	Did not participate in EQA (last 6 months)	No access to sample transport	Not included in database
				No TB registers	No referral pads					
Amhara	48	14	34	6	13	24	12	20	18	15
Oromia	102	41	61	16	65	45	19	39	63	40
SNNPR	36	24	12	1	22	8	7	27	29	25
Sidama	13	7	6	2	6	8	4	8	7	6
Total	199	86	113	25	106	85	42	94	117	86
Percentage		43%	57%	22%	53%	43%	37%	47%	59%	43%

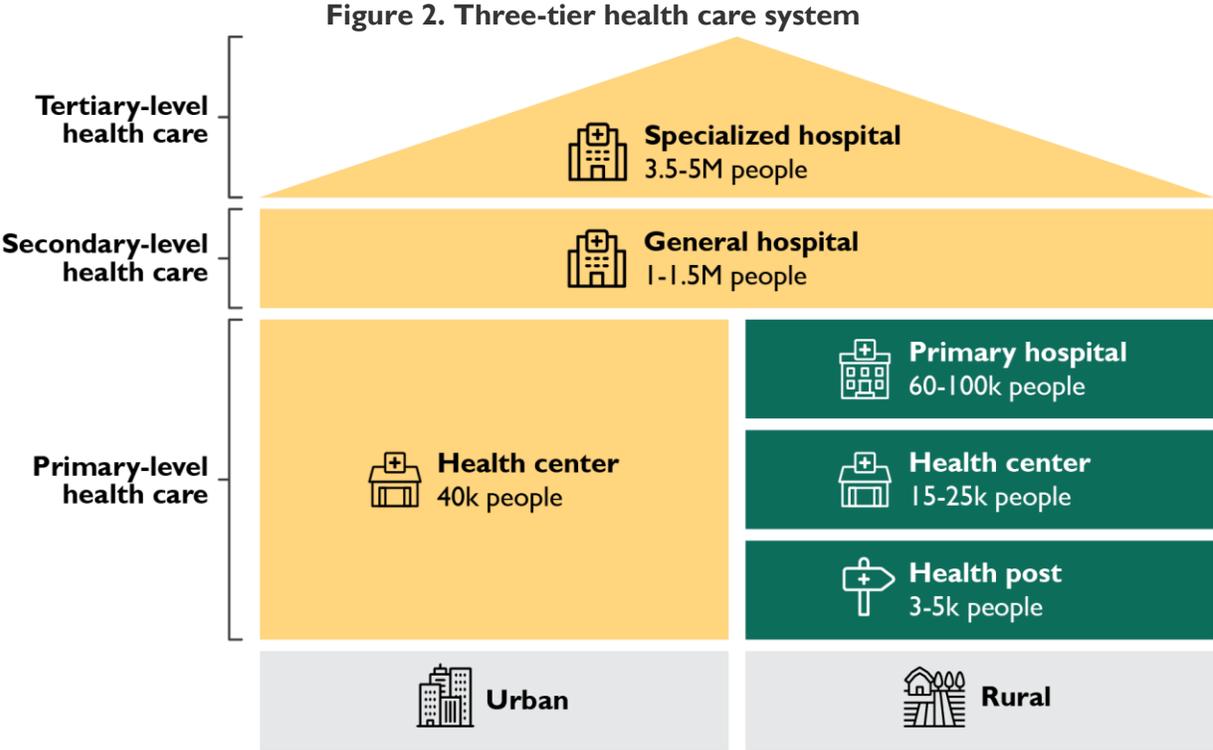
The assessment shows that 37% (42/113) of PPM facilities had no anti-TB drugs, 47% (94/199) had not participated in EQA in the last 6 months, and 59% (117/199) had no access to sample transport. Additionally, capacity strengthening activities were inadequate, as 43% (85/199) of the assessed sites had no provider trained in basic TB/HIV. According to the assessment, data quality issues were also common. The TB unit register captures patients referred from private or other non-NTP providers. This register is the source document used to measure the contribution of PPM to TB case notification. More than one-fifth of the assessed PPM facilities (22% [25/113]) had no TB registration book. PPM sites were usually not included during distribution of health management information system (database) materials.

Third, the assessment revealed that a significant number of PPM DOT facilities (43%) do not have database codes and are not reporting their own performance. Instead, they submit their report to the nearby public health facility or woreda, where their performance is added to the public facility's, which undermines the contribution of private facilities to case notification. Our assessment in towns demonstrates that the contribution of PPM facilities to TB case notification based on the database is, on average, lower by 10%, compared to the contribution based on DHIS2 registers at private health facilities (figure 1).

Figure 1. Database report versus TB patients on treatment at PPM TB sites, 2020/21 (N = 5,808)



Finally, the three-tier health care system (figure 2) does not factor in the private health sector. Private providers, both for-profit and not-for-profit, manage and represent 27% of facilities (5); the remaining 73% are public health facilities. However, because the health care system does not consider private facilities, it appeared as if health care services were only delivered by public health facilities. Because the private sector is not integrated into the tier system, there were challenges with the patient referral system and with establishing linkages with the public health system, including regulating private health facilities.



Source: National Health Sector Transformation Plan (HSTP 2020-2025)

STRATEGIC APPROACH

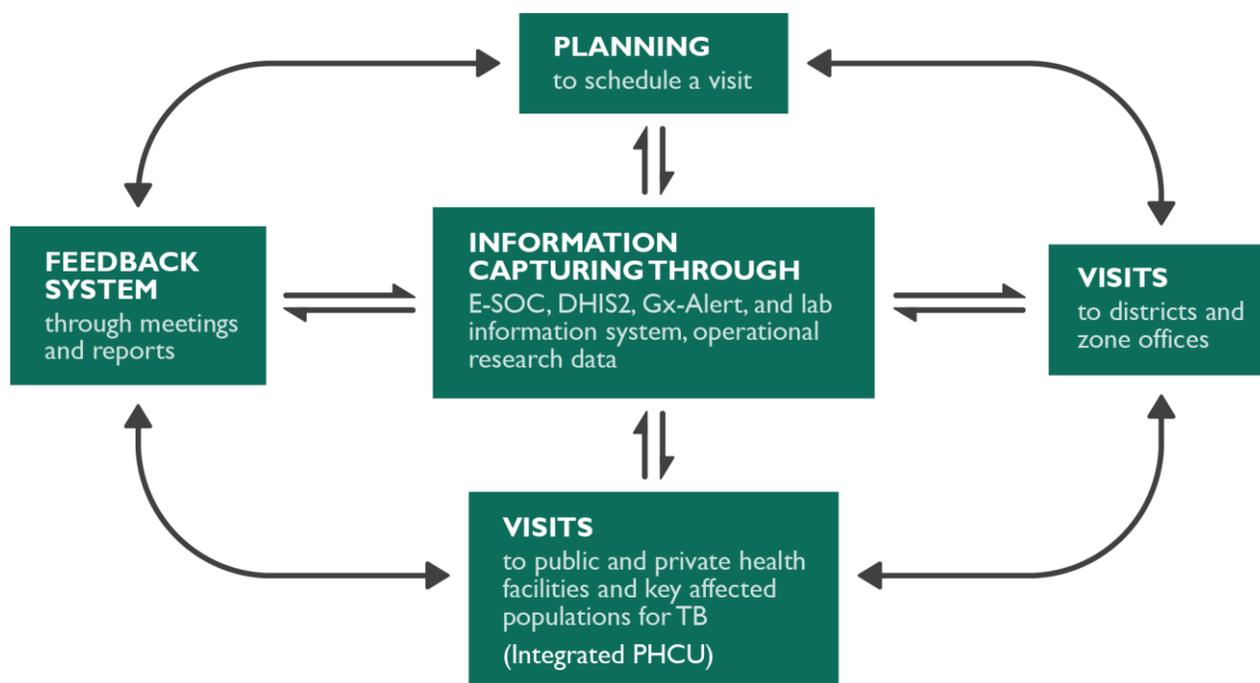
One of the strategies proposed by the USAID Eliminate TB Project to address the problems and issues is to fully engage private and other nongovernmental health facilities in TB care by integrating them into the primary health care unit (PHCU). The PHCU is the smallest division in the Ethiopian health tier system and is the unit most accessible to the general population. The health system includes primary hospitals and health centers with five satellite health posts, administratively managed by woredas, town health offices, or zonal health departments.

By functionally incorporating PPM TB facilities into the PHCU, the project planned to improve access to molecular rapid diagnostic tests, like GeneXpert; include PPM facilities in the national drugs and supplies system to get access to anti-TB drugs, HIV test kits, and TB lab reagents; improve EQA of PPM TB lab services; and improve sample transport systems. By establishing similar standardized TB diagnosis and treatment services in PPM and public health facilities, the project aimed to ensure access to patient-centered care so that patients can choose where to get diagnosis and treatment services.

Since 2020, the USAID Eliminate TB Project has been working to integrate PPM sites into routine project activities, such as site support, training, inclusion in a supply system, EQA, and sample transport. All facilities

within the PHCU model are overseen by a single team that includes the zonal TB focal person, woreda TB focal person, and a health extension worker supervisor. Such visits are conducted until all facilities, including PPM sites, within the PHCU have been visited during the quarter. This is called the “one visit, one team, one PHCU” approach (figure 3). Visits to woreda health offices and all facilities for supportive supervision or mentorship are done using a standardized tool, e.g., electronic Standard of Care (e-SoC). A team consisting of zonal and woreda TB focal persons visits all public and PPM facilities, laboratories, and post offices within the woreda and at least one satellite health post in a single visit.

Figure 3. Cycle of the “one visit, one team, one PHCU” approach integrating PPM TB service



RESULTS AND ACHIEVEMENTS

The national PPM contribution has improved from 17% to 20% since project baseline. This has been significantly demonstrated in some big towns; in Adama, it increased from 20.2% to 56.4% and in Bahir Dar, from 19.9% to 43.9% during July–September 2021 and October–December 2021, respectively (table 2).

Table 2. Trend of PPM DOT contribution from facilities in Adama and Bahir Dar, July 2020–June 2022

Town	Indicator	July–Sept 2020	Oct–Dec 2020	Jan–Mar 2021	Apr–June 2021	July–Sept 2021	Oct–Dec 2021	Jan–Mar 2022	Apr–June 2022
Adama	All forms of TB	199	199	192	226	248	220	218	331
	PPM DOT contribution (%)	28.6	10.6	19.8	24.8	20.2	56.4	45	46.9
Bahir Dar	All forms of TB	190	170	169	223	221	196	215	238
	PPM DOT contribution (%)	20.5	37.6	35.5	29.6	19.9	43.9	41.9	47.1

It can be difficult to know the project’s effects all over the country and only for a short period, but because PPM TB sites have been integrated into the PHCU unit, improvements have been observed in Adama and Bahir Dar towns. The PPM TB facilities in Adama and Bahir Dar were included in the city supply chain system. They are getting TB lab reagents, anti-TB drugs, and HIV test kits. Through the national sample transport referral network operated by the postal courier system, PPM TB facilities have access to testing at GeneXpert sites. The project, together with the PHCU team, made sure that all PPM sites have database codes and report directly into the system under their own name. All PPM sites have received all recording and registration materials as per the national standard. In these cities, both public and private facilities are equally supervised during site visits. Additionally, the city health administrations have given staff at PPM sites access to orientations, training, and review meetings.

The treatment success rate (TSR) in PPM TB sites has improved from 88% to 92% and the cure rate from 63% to 86%. Also, improvement was observed in the treatment outcomes of patients followed in PPM TB sites (figures 4 and 5)—treatment outcomes of TB patients followed in PPM TB sites are comparable to patients followed in public health facilities.

Figure 4. TSR of TB patients followed in PPM sites and all facilities, July 2021–June 2022 (N = 1,065 PPM facilities)

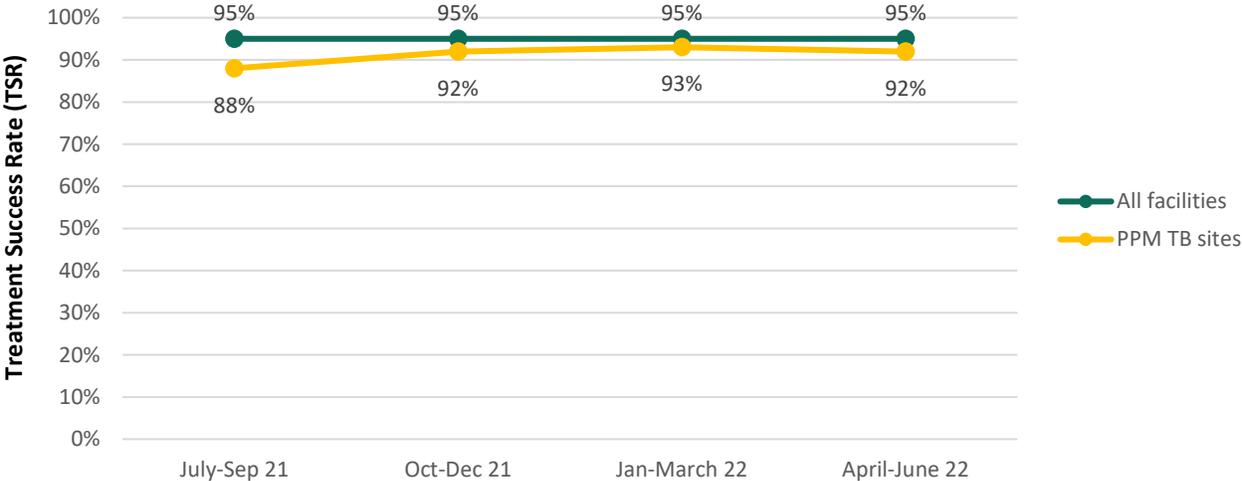
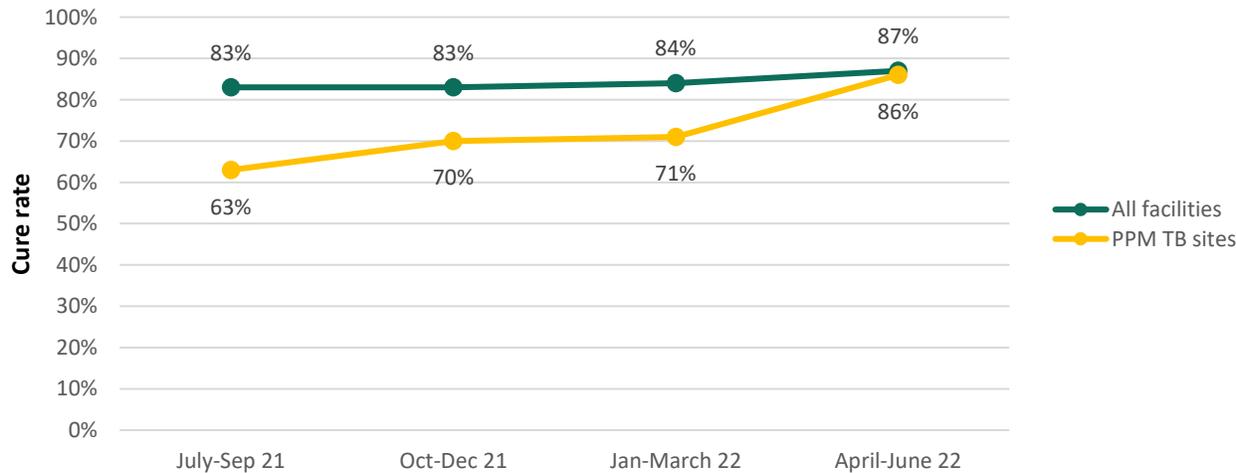


Figure 5. Cure rate of TB patients followed in PPM TB sites and all facilities, July 2021–June 2022 (N = 1,065 PPM facilities)



CHALLENGES

- Because the private sector is not integrated in the tier health system, there have been challenges with the implementation of TB control activities, such as routine and proper data capturing of their contribution, capacity strengthening, and referral linkage.
- Engagement of the private health sector in the nation's TB prevention and control efforts is suboptimal. So far, only 1,065 PPM TB facilities in the country are engaged from a total of about 12,000 potential private facilities.
- Inadequate investment in the PPM program is one of the challenges to expanding to new sites.
- There is no focal point at the regional and zonal levels to take the lead on TB PPM issues.

LESSONS LEARNED AND THE WAY FORWARD

The missing TB cases will remain invisible until PPM TB health care providers are more closely engaged to offer quality TB diagnosis and care. Engagement starts from readiness assessment and proceeds to capacity strengthening, linking PPM health facilities to the existing supply, EQA, sample transport system, site support, and inclusion in the government reporting system.

As demonstrated in Adama and Bahir Dar, operational challenges of PPM TB, such as supply shortages, interruption of EQA networks and sample transport systems, and lack of training, can be mitigated by effectively integrating PPM sites into PHCUs. The practices observed in these two cities will be replicated in the remaining project-supported regions, other regions, and zones so that PPM TB sites can find more missed TB cases and deliver quality TB prevention and control services.

The USAID Eliminate TB Project will continue to collaborate with the NTP to advocate for integration of PPM TB facilities into the PHCU model of care for the TB program.

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Acknowledgements:

We thank Rachael Church, Sara Harris, Mayssa el Khazen, Pedro G. Suarez, and Veronica Triana at Management Sciences for Health for their contributions to this technical brief.



This document is made possible by the generous support of the American people through the US Agency for International Development (USAID) cooperative agreement no. 72066320CA00009. The contents are the responsibility of Management Sciences for Health (MSH) and do not necessarily reflect the views of USAID or the United States Government.

