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Integrating TB/HIV Services in Private Clinics in Ethiopia

BACKGROUND

Ethiopia has a national case detection rate of 27%, and is ranked seventh in tuberculosis (TB) prevalence among high-burden countries (*Global Tuberculosis Control Report*, World Health Organization [WHO] 2008). In addition, the growth of the HIV/AIDS epidemic in Ethiopia has contributed to a significant rise in TB cases. The Federal Ministry of Health (FMOH) has been working on multiple fronts to reduce morbidity and mortality from TB. Current efforts to control TB are aimed at achieving two global targets set by WHO in 2006: detecting 70% of the estimated smear-positive TB cases and curing 85% of the diagnosed smear-positive cases. Until August 2006, provision of Directly Observed Therapy-Short Course (DOTS) for TB treatment was limited to public sector health facilities.

However, the FMOH had a strong interest in expanding DOTS services in line with WHO's global recommendation to involve the private sector in the delivery of TB services (*Engaging All Health Care Providers in TB Control*, WHO, 2006).

Engaging the private sector in TB case detection and treatment is logical in the Ethiopian context. According to the *Health and Health-related Indicators 1999* (Ethiopian calendar) (FMOH, 2006/7), the private sector is a key provider of health services in the country; there are 2,253 private health facilities compared with 759 public sector health facilities (hospitals and health centers). According to the *PPM-DOTS Implementation Guidelines* (FMOH, August 2006), 55% of general practitioners, 65% of specialists, and 79% of laboratory technicians are employed by the private sector. By expanding TB care to the private sector, access to care will be increased, particularly for clients who are reluctant to visit public health facilities due to fear of stigma, long waits, or perception of unsatisfactory quality of care. Service provision at private facilities will likely reduce the patient load at crowded public facilities and expand access to care for migrant populations who do not have local identity cards necessary to access care at public facilities. Private sector health facilities, already providing prevention, diagnosis, and treatment services for

EQC is conducted routinely at private clinics supported by PSP-E

PSP-Ethiopia

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The PSP-Ethiopia is a five-year task order (September 2004 to September 2009) funded by the United States Agency for International Development (USAID) through the President's Emergency Plan for AIDS Relief (PEPFAR). PSP-Ethiopia works to increase access to high-quality TB and HIV services and prevention programs by building sustainable partnerships between the public and the private sector. Abt Associates leads a team of international partners that includes IntraHealth International (IHI), Population Services International (PSI) and Banyan Global in implementing PSP-E. Abt Associates also works closely with many Ethiopian partner organizations to implement PSP-E program activities. For more information on PSP-E: http://psp-one.com/section/taskorders/psp_ethiopia
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Program Summary

other infectious diseases, can be provided with support to expand their services to TB diagnosis and treatment.

The Private Sector Program-Ethiopia (PSP-E), funded by the United States Agency for International Development (USAID) through the President's Emergency Plan for AIDS Relief (PEPFAR), began activities to increase the capacity of private sector organizations to deliver HIV/AIDS and TB prevention and treatment services in April 2006. Abt Associates Inc., the lead partner of PSP-E, works with Population Services International, IntraHealth International, and Banyan Global to support the implementation of DOTS at 90 private sector clinics in Addis Ababa, Amhara, and Oromia regions.

TECHNICAL STRATEGY

PSP-E has used the following key strategies to guide the development and implementation of the Public-Private Mix (PPM)-DOTS activities:

- **Close collaboration with FMOH and RHB, and partnership with local stakeholders:** The FMOH played the leading role in the conceptualization of PPM-DOTS, with PSP-E supporting key activities in line with the FMOH's vision. The project's driving partners in program implementation are the Regional Health Bureaus (RHBs) of Addis Ababa, Amhara, and Oromia. The RHBs are involved in all steps of program planning, implementation, and monitoring. This begins with the assessment of clinics, site selection, signing of memoranda of understanding with private clinics, training, data monitoring, external quality control (EQC) of laboratory services, and supportive supervision. A high level of government commitment is critical for program success and sustainability.
- **Adapting tools to use with private sector:** Private sector health clinics did not provide DOTS services prior to 2006. To build private sector capacity to deliver these services, PSP-E adapted or developed tools tailored to the unique needs of the private sector. PSP-E developed a standardized questionnaire to assess private clinics for their readiness and willingness to implement TB services. The three existing training curricula used for public sector health care workers were integrated to reduce the duration of these trainings while maintaining content and quality to facilitate participation of private sector health care workers. In addition, PSP-E developed a supportive supervision tool to be used quarterly to assess and monitor performance of PPM-DOTS clinics, set plans for corrective action, and monitor progress over time.
- **Piloting and evaluating activity in a limited number of facilities:** Following the development of a national policy to expand the delivery of TB-DOTS services to the private sector, the FMOH and PSP-E agreed to pilot the service in 20 health facilities in Addis Ababa and Oromia regions. The two regions were selected due to the number of private health clinics and the proximity of selected facilities, which facilitated close monitoring of programmatic activities by PSP-E and the FMOH. The purpose of the pilot was to: assess the potential opportunities for expanding access to DOTS coverage in the private sector; assess the willingness and ability of the private sector to deliver TB services; and understand operational issues such as logistics, reporting, supervision, and quality related to delivering TB care. After one year of implementation at the pilot sites, PSP-E and the two RHBs conducted a summative evaluation to assess program performance, to identify areas for improvement, and to identify recommendations for scale-up.
- **Addressing evaluation findings in scale-up:** PSP-E reviewed the findings from the summative evaluation both internally and with the FMOH, RHB, and clinic staff. PSP-E designed activities to address the challenges and weaknesses identified through the summative evaluation; they were implemented at the initial pilot sites and at the additional sites identified for geographic expansion and scale-up.

KEY ACTIVITIES

- **Policy development:** PSP-E facilitated the policy process with the FMOH to extend the provision of DOTS services to the private sector by convening a consensus-building meeting that included all partners working on TB in Ethiopia in April 2006. Following this meeting, a technical working group was formed to guide the development of national guidelines for PPM-DOTS and plan the piloting of services. The national PPM-DOTS guidelines were finalized in August 2006. The guidelines were officially launched in March 2007 with a national meeting convened by the State Minister of Health to formally endorse the guidelines and call upon the regions to dramatically expand the number of PPM-DOTS sites. To support the activities at both the policy and implementation level, PSP-E employed a focal person to assist the National TB Control Program with developing national PPM-DOTS guidelines, assessing private sector health facilities, organizing training for selected private providers, initiating TB service provision, conducting quality assurance activities, evaluating the pilot phase, and designing the scale-up strategy.

- **Site assessments:** PSP-E developed a standardized site assessment tool to collect information on infrastructure, human resources, training requirements, laboratory availability, equipment, and the willingness of the facility to commit to implementing PPM-DOTS services. PSP-E and the FMOH jointly assessed 25 private clinics in Addis Ababa and Oromia (medium and higher levels) and selected 20 facilities (11 in Addis Ababa and 9 in Oromia) for the pilot phase based on selection criteria developed by the PPM-DOTS technical working group. During the scale-up and expansion phase, the RHB, zonal, and local health officials and PSP-E staff assessed 179 facilities in Addis Ababa (33), Amhara (58), and Oromia (88). Based on these assessments, 20 pilot sites and 74 expansion/scale-up sites were selected for implementation of PPM-DOTS activities. The information from the site assessments was also used to prepare each selected clinic for service delivery.
- **Training:** Following site selection, PSP-E conducted six-day integrated trainings for clinical staff in TB/HIV, DOTS, and provider-initiated HIV counseling and testing (PIHCT). Laboratory technicians were trained in acid-fast bacilli (AFB) and HIV rapid testing. PSP-E conducts additional trainings as needed (full and refresher) to address the issue of staff turnover.
- **Drugs and logistics:** PSP-E and the RHBs provide formats and registers to all selected sites and link the private clinics to the local health offices for TB drugs, laboratory reagents, and supplies. PSP-E provides additional equipment and supplies to private clinics as needed to initiate services (e.g., face masks, weight scale, slide boxes, safety boxes for sharps disposal, and medical tray to carry sputum cups).
- **Launching services:** PSP-E and the RHBs jointly organize TB launch events at the regional level for all private facilities initiating TB services to formally recognize the service. Each private clinic and the respective RHB signed a memorandum of understanding at these launch events to formally define the roles and responsibilities of each party.
- **Advocacy workshops:** PSP-E organized a series of advocacy workshops in each region to bring together representatives from public and private clinics, the local health office, zonal health departments, and RHB. The purpose of this workshop is to create awareness about the services provided by both public and private facilities, foster a dialogue between facilities, and establish linkages for referrals.
- **Quality assurance:** Quality assurance and improvement is built into program implementation through routine supportive supervision and EQC of laboratory activities. The Regional Laboratories provide blind rechecking of AFB slides to monitor quality of laboratory results and provide timely feedback to private clinics and PSP-E. EQC was previously not practiced in the private sector due to limited resources of the Regional Laboratories to provide this service. PSP-E provided slide boxes to each facility and, each quarter, laboratory staff collect the slides and conduct blind re-checking with feedback provided at the site level.

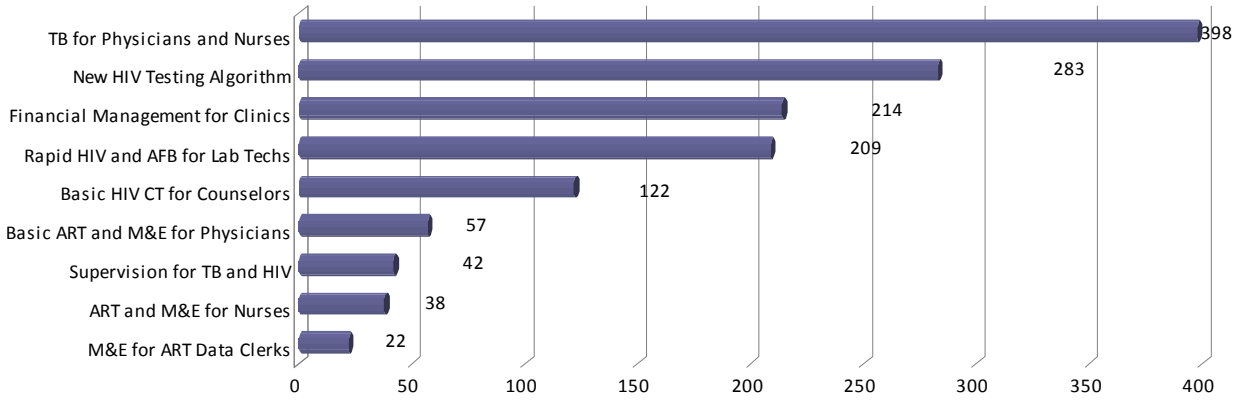
  PSP-E and the woreda health office (WoHO) conduct joint supportive supervision visits using an action-oriented supportive supervision system to quickly identify implementation issues and define clear follow-up actions agreed to by the private clinic, WoHO, and PSP-E to resolve the identified issues.
- **Monitoring and evaluation:** The private clinics report through the existing MOH monitoring and evaluation system. PSP-E and the FMOH provide formats and registers to the private health clinics. The clinics compile the data each quarter and submit a report to the local health office, which then submits the data to the zonal health department and the RHB. PSP-E staff provide onsite technical support to the private clinics in data recording and reporting as needed.

ACHIEVEMENTS AS OF DECEMBER 2008

Following are some of the key achievements:

- **Policy formulation:** The national PPM-DOTS implementation guideline was developed and officially launched in March 2007. This guideline allow private health facilities to provide TB services.
- **Scale-up and geographic expansion:** PSP-E supported the scale-up of PPM-DOTS services to a total of 90 private health facilities in Addis Ababa, Amhara, and Oromia regions.
- **Training and capacity building:** The following figure breaks down by type of training the 1,385 private service providers that PSP-E has trained since 2006. In addition to the formal trainings PSP-E organized quarterly clinical seminars (for 110 physicians) to discuss complicated clinical issues, review the latest developments in TB and TB/HIV collaboration, and discuss challenges faced in achieving and maintaining international standards for TB care and treatment.

NUMBER OF PRIVATE AND WORKPLACE HEALTH PROVIDERS TRAINED BY TYPE OF TRAINING PACKAGE (PSP-ETHIOPIA OCTOBER 2006 - DECEMBER 2008)



- **Capacity building in financial and human resource management:** PSP-E designed a training program for private clinic owners to use financial information to make sound business decisions so that they can operate on a sustainable and profitable scale. PSP-E also supports training courses for private clinic bookkeepers and accountants to ensure that staff members responsible for bookkeeping and accounting have the tools needed to create effective financial reports. PSP-E has trained a total of 109 clinic managers and 105 bookkeepers and accountants in these areas.
- **Service delivery:** A total of 4,727 TB patients received treatment from the 90 PPM-DOTS sites supported by PSP-E. In Addis Ababa alone, the 11 PPM-DOTS sites contributed to 15.2% of the cases detected and treated in the region. The treatment outcomes for the period from July 2007 to June 2008 are shown in the table below:

Indicator	Percentage
Smear-positive proportion among pulmonary TB cases	31.8%
Cure rate	70.3%
Treatment success rate	76.8%
Treatment failure rate	0.0%
Defaulter rate	4.5%
Death rate	6.5%
Transfer out rate	12.3%

- **Laboratory quality:** The EQC results showed a 2.1% discordant rate (12 false positives and 14 false negatives out of 1,231 slides examined) between the results obtained by the private clinics and the verification tests conducted by the regional laboratory. The 1.99% false negative rate is lower than the national acceptance rate of 5% and the false positive rate of 2.26% is slightly higher than the nationally accepted rate of 2%.

LESSONS LEARNED

- The summative assessment conducted at the end of the first year of the program yielded important results that were used to improve the quality of the program at the 20 pilot sites as well as lessons to apply to the additional 70 private clinics.
- A high level of government commitment is critical for program success and sustainability. The high level of involvement of the FMOH during program initiation had unintended side effects in the sense that it delayed establishing the critical links between PPM-DOTS clinics and the woreda, zone, and RHB offices. However, the federal leadership in setting the course of this new initiative has been key to driving the program forward.

  Subsequently, the full participation and engagement of the government at the regional, zonal, and woreda levels was important for the ongoing program implementation and scale-up. This ensures local ownership and commitment to the program.
- Ongoing capacity building and frequent contact with sites is required to identify and address staff attrition at private clinics. TB treatment is an intensive long-term service, and human resource issues and training needs must be quickly identified and addressed at the facility level to ensure that services are not disrupted.
- PPM-DOTS sites have a high potential for improving national case detection and, as many stakeholders pointed out, the public sector is overwhelmed with the current patient load. There is potential to increase the private sector's contribution to case detection through strengthening of referral networks, promotion of the services at the current clinics, and expansion of services to additional sites. As mentioned earlier, there are 2,253 private health facilities and 759 public health facilities in Ethiopia. Engaging the private sector will ultimately help reduce the current burden on public health facilities.