Promoting the implementation of collaborative TB/HIV activities through public–private mix and partnerships

Report of a WHO consultation
27–28 February 2008
WHO headquarters, Geneva, Switzerland

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Abbreviations

ART	antiretroviral treatment
CPT	co-trimoxazole preventive therapy
DOTS	The internationally recommended strategy for TB control until 2005, and the foundation of the new Stop TB Strategy introduced in 2006
IPT	isoniazid preventive therapy
NGO	nongovernmental organization
NAC	national AIDS control programme
NTP	national TB control programme
PLHIV	people living with HIV
PPM	public–private mix
TB	tuberculosis
WHO	World Health Organization

1 Background

Tuberculosis (TB) is a leading cause of death among people living with HIV (PLHIV). Of the estimated 9.2 million new TB cases and 1.7 million deaths from TB in 2006, 709 000 cases (8%) and 200 000 deaths (12%) occurred in PLHIV. The African Region accounts for 85% of the global distribution of HIV-positive TB patients. Collaborative TB/HIV activities are essential to ensure that HIV-positive TB patients are identified and treated appropriately; and to prevent, diagnose and treat TB in PLHIV. In recent years, there has been considerable progress, particularly in the African Region, with the provision of TB/HIV interventions. In 2006, 12% of all notified TB patients were tested for HIV, compared with 0.5% in 2002. Of the TB patients who tested positive for HIV, 78% were treated with co-trimoxazole preventive therapy (CPT) and 41% started treatment with antiretroviral drugs. The expansion of access to life-saving antiretroviral drugs in HIV-prevalent and resource-constrained settings has also been instrumental in implementing collaborative TB/HIV activities. By the end of 2007, nearly 3 million PLHIV were receiving antiretroviral treatment, or ART.[1] However, scale-up of collaborative TB/HIV activities, in particular the essential interventions that are needed to reduce the burden of TB among PLHIV (intensified case finding, infection control and isoniazid preventive therapy – known as the Three I's) falls short of the targets of the Global Plan to Stop TB, 2006–2015.[2]

Patients with symptoms of TB and HIV seek and receive care from a wide variety of health-care providers outside the national TB and HIV/AIDS control programmes, depending upon availability, acceptability, costs and many other factors. These include informal village doctors, private general practitioners, public hospitals, specialized physicians, nongovernmental organizations (NGOs), medical colleges and corporate health services (*Box 1*).

Box 1. Broad categories of health-care providers engaged in implementing collaborative TB/HIV activities

Public health-care providers

- General hospitals
- Specialist hospitals and academic institutions
- Health institutions under state insurance schemes
- Health facilities under governmental corporations and ministries
- Prison health services
- Army health services

Private health-care providers

- Private hospitals and clinics
- Corporate health-care services
- Nongovernmental hospitals and clinics
- Individual private physicians, nurses, midwives, clinical officers
- Pharmacies and drug shops
- Traditional medical practitioners
- Informal, non-qualified practitioners

Engaging the private sector in the provision of ART has become increasingly important. In Malawi, for example, no private facilities were involved in the provision of ART in December 2004, but the number providing ART at subsidized rates through collaboration with the Ministry of Health of Malawi had increased to 23 by December 2005 and to 45 by December 2007. By 2008, 5407 patients who had started ART in Malawi had very good treatment outcomes, accounting for 5% of all PLHIV ever started on ART. The cumulative treatment outcomes of PLHIV started on ART in private facilities were: 72% alive and on ART at the site of registration, 7% dead, 6% lost to follow-up