

A PUBLIC-PRIVATE PARTNERSHIP TO CONTROL TUBERCULOSIS IN AN URBAN SETTING, KAMPALA UGANDA.

A Stepwise Approach and Results from the Slum Partnerships to Actively Respond to Tuberculosis in Kampala District (SPARK-TB), October 2011- June 2014



International Union Against
Tuberculosis and Lung Disease
Health solutions for the poor





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List of Acronyms

- AFB Acid-Fast Bacillus
- BMUs Basic Management Units
- CNR Case Notification Rate
- DHT District Health Team
- DTLS District Tuberculosis & Leprosy Supervisor
- EQA External Quality Assurance
- GoU Government of Uganda
- HIV Human Immunodeficiency Virus
- KAP Knowledge, Attitude and Practices
- KCCA Kampala City Council Authority
- M & E Monitoring and Evaluation
- MDG Millennium Development Goal
- MDR Multi Drug Resistance
- MoH Ministry of Health
- MoU Memorandum of Understanding
- NGO Non-Government Organization
- NMS National Medical Stores
- NTLP National Tuberculosis and Leprosy Program
- NTRL National Tuberculosis Reference Laboratory
- PPM Public Private Mix
- PPP Public-Private-Partnership
- SPARK-TB Slum Partnerships to Actively Respond to Tuberculosis in Kampala
- TB Tuberculosis
- VHT Village Health Team
- WHO World Health Organization
- ZN Ziehl -Neelsen

Message from The Union's Scientific Director



Although globally the incidence of tuberculosis (TB) has declined since 1990, only seven out of the 22 high burden TB countries have met both Millennium Development Goal 6 (MDG-6) related to TB and the Stop TB Partnership's targets of reducing TB prevalence and deaths by 50% compared to the 1990 levels. Even the seven countries that have achieved these targets still struggle to ensure that every person with TB can access quality diagnostic and treatment services in their communities.

This situation required us to take a hard look at how widely and how well the TB interventions outlined in the Stop TB Strategy (2006-2015) are being implemented. If the world is to realise the ambitious post-2015 goals for TB control, we need to find new ways of reaching people with quality diagnostic and treatment services.

The International Union Against TB and Lung Disease (The Union) is an organization that brings innovation, expertise and solutions to address health challenges in low- and middle-income countries. The Slum Partnership to Respond to Tuberculosis in Kampala (SPARK-TB) described in this document is one such innovation that was developed and implemented in the urban slums of Kampala, which are home to 60% of the population in Kampala City. We designed the project to find and treat those with TB who had not previously been diagnosed in Kampala. We achieved this goal through a public-private partnership for TB control that 1) built the capacity of private health care providers to diagnose and treat TB and 2) enabled patients seeking care in the private sector to receive free-of-charge anti-TB medicines provided by the public sector.

In this document, The Union shares the lessons learnt in the process of implementing SPARK-TB with national and local governments and partners supporting TB control in resource-limited settings. We hope that others will use the lessons we learned to establish public-private-partnerships for TB control in urban settings within resource-limited countries, most especially in sub-Saharan Africa.

A handwritten signature in black ink that reads "Paula I. Fujiwara, MD, MPH".

Paula I. Fujiwara, MD, MPH

Scientific Director

Message from The Union Uganda Country Director



In the last ten years, Uganda has made great strides in implementing TB-HIV collaborative services and strengthening laboratory capacity countrywide to detect TB cases. Since 2006, the number of laboratories in Uganda offering advanced smear microscopy for diagnosing TB has increased from 303 sites to 1,091 sites as of 2013. With this additional capacity for diagnosing TB, we now need to increase the numbers of people who receive access to it. Engaging private-sector health facilities in this effort is vital.

The private health sector has grown rapidly alongside an increase in the urban population from 3.0 million in 2002 to 6.4 million in 2013. In Uganda today, fifty-two percent of the urban population seek medical care from the private health providers, who have limited capacity to diagnose and care for TB patients.

The Slum Partnerships to Respond to Tuberculosis in Kampala (SPARK-TB) was a Wave 2 TB REACH project aimed at increasing access to quality TB diagnosis and care for the urban poor residing in the slums of Kampala, the capital city of Uganda. The goal was achieved by building capacity of the private health providers to detect and treat TB and engaging community resource persons to participate in TB care and prevention by identifying and referring people with TB symptoms, and providing support to TB patients on treatment.

In this document, we share with you the steps that were taken to implement a successful Public-Private Mix (PPM) model for TB control in the urban slums of Kampala. In addition, we present the results and lessons learnt from the process. We hope that the steps and lessons learnt will guide the Uganda National TB and Leprosy Programme, the District Local Governments and the partners supporting TB control in Uganda to scale up PPM in other urban settings.

A handwritten signature in blue ink, appearing to be 'AN'.

Anna Nakanwagi-Mukwaya, MBChB, MPH

Country Director.

Introduction

The number of undetected cases of tuberculosis (TB) in the urban slums of TB high burden countries constitute a significant proportion of the 3,000,000 million TB cases that are missed globally every year.

The undetected TB cases in these communities will not be reached unless the capacity of the private health sector that is in closest proximity to this population is built to find, diagnose and treat TB.

The engagement of the private health sector in the fight against TB, needs continuous support from national and sub-national TB control programs to continue the momentum.

Global burden of TB disease

Tuberculosis is a major global public health problem. In 2012, there were an estimated 8.6 million incident cases and 1.3 million deaths globally. Most of the estimated cases occurred in Asia (58%) and in the African region (27%). Although the number of TB deaths remains high, progress has been made in reducing the TB mortality rate by 45% since 1990. TB incidence rates have also fallen in most parts of the world. The Human Immunodeficiency Virus (HIV) epidemic fuels the TB epidemic, especially in sub-Saharan Africa.¹

About Uganda

Uganda has a total population estimated at 37 million in 2013, a high growth rate of 3.2% per annum with 60% of its population, under 18 years of age.

It is a low income country with a per capita income of USD 506, with 25% of the population below the poverty line.²



Burden of TB disease in Uganda

Tuberculosis remains a major public health problem in Uganda which is one of the 22 TB high burden countries. Although the incidence and prevalence of TB reduced over the years to 179 and 175 cases per 100,000 population, respectively in 2012, the National TB and Leprosy Programme (NTLP) still lags behind in detecting all the expected cases. In 2012, the national TB case notification rate was 130 cases per 100,000 population.³

HIV continues to fuel the TB epidemic with 50% of TB patients co-infected with HIV.⁴

Multi drug Resistant (MDR) TB is further complicating the situation with 12% of previously treated and 1.3 % new TB patients confirmed with MDR TB.⁵

¹World Health Organization, Global TB Report, 2013

²Uganda Bureau of Statistics, the Statistical Abstract, 2013

³World Health Organization, Global TB Report, 2013

⁴World Health Organization, Global TB Report, 2013

⁵Ministry of Health, National Drug Resistance Survey, 2011

Kampala, the Capital City of Uganda

Kampala is home to 1.5-2.0 million people and accounts for 25% of the national urban population in the country.⁶

Due to the large rural to urban migration in search of jobs, over 50% of the population in Kampala are poor and live in its slums, which are characterised with overcrowding, poor housing and poor sanitation.

Although Kampala city accounts for 20% of the national TB notification, it still has many undetected TB cases, most especially in the congested slum areas where access to TB services is limited.

A map of Kampala showing the distribution of slums (in red)



Source: Kampala City Council, Planning Unit,

Beautiful Kampala



The other face of Kampala City

Access to health services in Kampala City

The average distance to health facilities in Kampala is 1.5 km for private health facilities (clinics) compared with 3.7, 5.5, and 6.4 km to a government health unit, a non-governmental organization (NGO) hospital, and a government hospital, respectively.⁷

Out of 1370 health facilities in Kampala, 26 (1.8%) are owned by Government, 71 (5%) by NGOs and 1273 (93%) are private.⁸

When people get symptoms of disease, 52% first seek medical attention from private clinics, 17% from pharmacy/drug shops, 12% from health centers and 15% from hospitals.⁹

TB Services in the Private Health Sector in Kampala

A situational analysis conducted in Kampala in 2009 showed that private health facilities had limited ability to diagnose and treat TB. Only 5% of 1,003 private facilities assessed, provided TB treatment services routinely.¹⁰

The majority (95%) of private health facilities did not have adequate knowledge and skills to diagnose and treat TB, had no access to NTLF guidelines and tools and did not receive support from the NTLF and Kampala City Council, the local authority responsible for delivering health services in the city.

Between October 2011 and April 2014, The International Union Against TB and Lung Disease (The Union), with support from TB REACH built the capacity of 70 additional private slum health facilities in Kampala to diagnose and treat TB, increasing from six before the start of the project to 76 private facilities notifying TB cases to the NTLF by end of 2013.

About The Union

The International Union Against Tuberculosis and Lung Disease (The Union) is an international (NGO) that brings innovation, expertise, solutions and support to address health challenges in low- and middle-income populations.

The core values of The Union are **quality** of its technical work, **independence** with an emphasis on critical evaluation, **solidarity** with countries with high burden of disease, and overriding **accountability** in all aspects of its work.

The Union has provided technical assistance to the Uganda NTP since 2002 and opened a country office in Kampala in 2007. The country office supported the implementation of a 3 year USAID funded project that improved TB/HIV collaborative services in 12 of the country's administrative districts between 2007-2010. This was followed by the Slum Partnerships to Actively Respond to Tuberculosis in Kampala (SPARK-TB), a TB REACH project designed to improve access to TB services for the urban poor.

⁷ Uganda Bureau of Statistics, the national household survey, 2009/10

⁸ Ministry of Health, Health Facility Inventory, 2010

⁹ Uganda Bureau of Statistics, the national household survey, 2009/10

¹⁰ Ministry of Health, Draft Report, Situational Analysis of Private Health Providers' Service provision in Tuberculosis Care and Management under the PPM DOTS Programme, Kampala District, August 2009

About TB REACH

TB REACH is a Stop TB partnership initiative funded by the Canadian Government and UNITAID, that supports Governments and civil society organizations to implement innovative intervention that result in detecting undetected TB cases.

Because more than one-third of the nine million people around the world that become ill with tuberculosis do not gain access to accurate diagnosis or effective treatment, TB REACH was established to focus on reaching people with limited or no access to TB services. Many of the unreached people suffering from TB live in poverty-stricken areas and have very limited access to health services. The main objective of TB REACH is to increase case detection of TB, detect the disease as early as possible, and ensure timely and complete treatment while maintaining high TB cure rates.¹¹



Slums are some of the places with undetected TB Cases

¹¹ www.stoptb.org

About SPARK-TB

SPARK-TB was implemented in Kampala City between October 2011 and April 2014.

Through SPARK-TB, The Union supported the Ministry of Health (NTLP) and Kampala City Council Authority (KCCA) to partner with the Private health facilities located in the slums of Kampala, to improve access to quality TB diagnosis and treatment services for the urban poor. The ultimate goal was to find and treat the undetected TB patients within the slums of Kampala city. The specific objectives were to:

- 1. build capacity of selected private health facilities to improve access and quality of TB diagnosis and treatment.*
- 2. improve supervision of treatment and adherence to treatment for patients diagnosed/referred within the private health facilities.*
- 3. improve communication on TB in the communities served by the selected private facilities*
- 4. support the NTLP and KCCA to build a public-private partnership with the selected private health facilities supported under SPARK-TB.*

While the public and private health sectors played various roles in SPARK-TB, The Union provided technical assistance in initiating this public-private-partnership for TB control; training, mentoring and supervision of the private health providers; setting up mechanisms for delivery of anti-TB medicines to the private sector; setting up a mechanism for reporting from the private sector to the public sector and establishing linkages between the private health facilities and the community health workers.

In this document, The Union shares the lessons learnt in the process of implementing SPARK-TB with national and local governments and partners supporting TB control in resource limited settings.

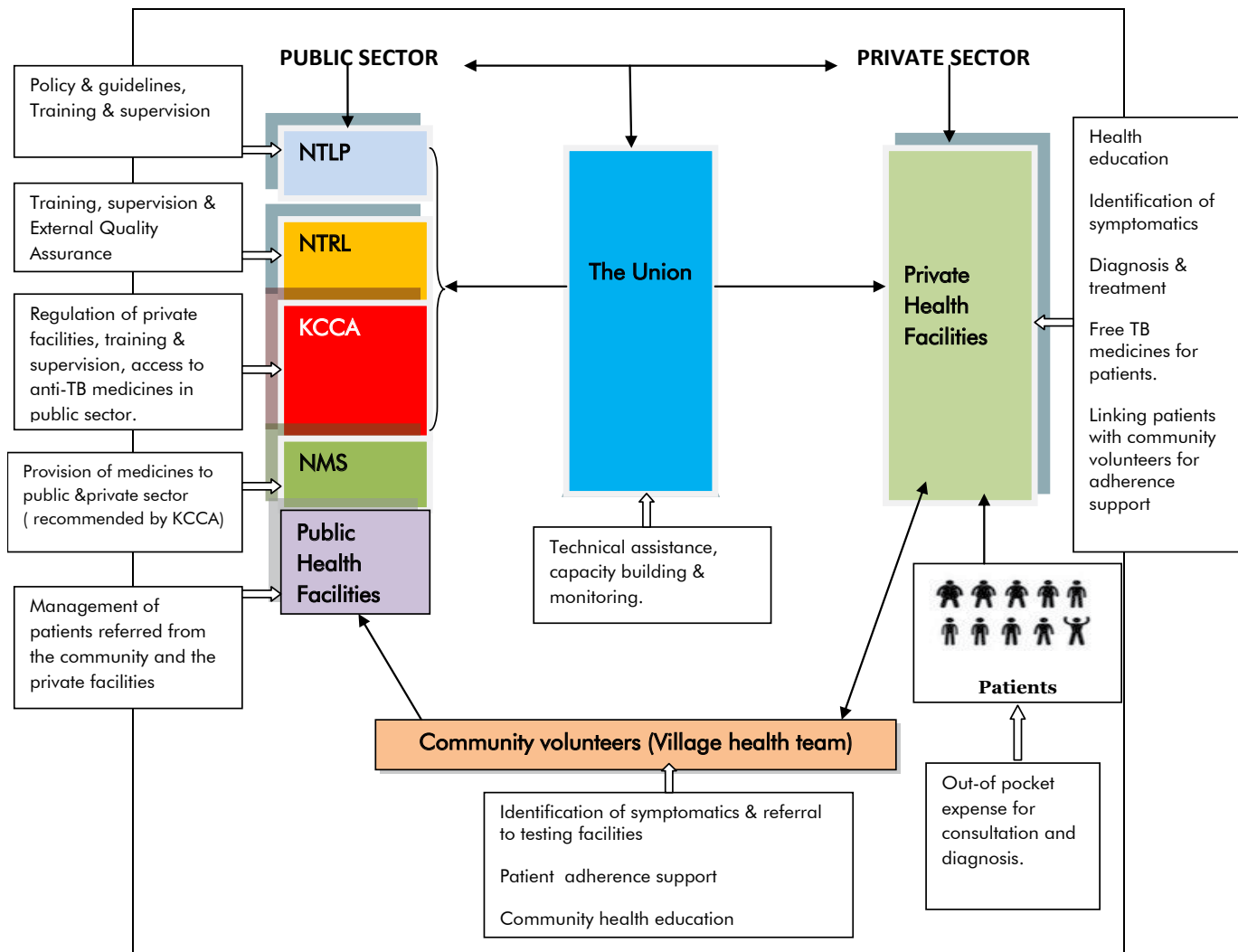
The SPARK-TB Model

SPARK-TB was a **Public-Private Partnership (PPP)** model for improving access to quality TB diagnosis and treatment for the urban poor in the slums of Kampala. The design of the model was informed by The Union's understanding of the health system in Uganda and its vast experience in working with National TB Programs in low income countries.

The Union facilitated the process that brought the public sector and the private sector to jointly invest in the provision of TB control services in the slums of Kampala. The different skills and resources housed within the public and private sectors and within the community, were combined in innovative ways to increase access to TB services for the urban poor. The Union played a major role in analysing these resources and advising the NTLP and KCCA on how these could be combined to increase access to TB services for the urban poor. The Figure below summarizes the different players in SPARK-TB and their roles.

The SPARK-TB Model

Figure 1: The SPARK-TB Model



NTLP=National Tuberculosis and Leprosy Control Program; **NTRL**= National Tuberculosis Reference Laboratory; **KCCA**=Kampala City Council Authority; **NMS**=National Medical Stores;
The Union=The International Union Against Tuberculosis and Lung Disease.

The Process of SPARK-TB implementation

Understanding the environment in which the public and private sectors operated and the social and economic complexities in urban settings were very important in the design of the interventions. The expertise and the resources available in the public and private sector and those within the community were critically analysed, organized, and utilized in the various stages of implementation of SPARK-TB. In the section below, we describe the steps that were followed in the implementation of SPARK-TB.

Step 1: Mapping and selection of Private Health Providers

A mapping exercise was done to determine the registered private facilities located in the slum areas in Kampala and the profile of services they were offering was ascertained. Selection of the private facilities that participated in SPARK-TB was based on the following criteria;

1. Presence of an annual licence for operation
2. Located in the slum area
3. Services offered during the day between 8.00am and 5.00pm, five days a week minimum
4. Facility employs qualified health staff
5. Facility with a laboratory was prioritized for selection
6. Willingness of the proprietors or managers to join the partnership

Step 2: Training the public sector on how to engage the private sector.

Although public sector workers may have adequate knowledge and skills on TB control, they may not be well versed with the skills to engage and motivate the private sector to participate in the control of TB. With the help of the

“Practical approach to build partnerships with public and private providers at decentralized level”, The Union conducted a half-day training of public officers from NTLP and KCCA on how to engage the private health workers in TB control.

Step 3: Meeting with the Directors of the Private Health Facilities

Before any engagement with the health workers at the private health facilities, it is important to get the buy in from their Directors.

The Directors of the Private Health Facilities were invited to a one hour meeting with the NTLP and KCCA health officers to understand why they should work with the public sector to control TB. The benefits of the partnership were explained together with the roles of the public and private health sectors.

A Memorandum of Understanding (MoU) between the Public and the Private sectors was explained and was later signed by the two parties after consultation with the proprietors of the private facilities. The roles of the public and private sector were clearly described in the MoU.



NTLP and KCCA staff meeting with the Directors of Private facilities at NTRL training room

Step 4: Training of the Private health providers

The NTLP training curriculum was adapted to the International Standards for TB Care,¹² with a focus on standards for clinical diagnosis, treatment, and fostering adherence. A practical session on how to fill the NTLP patient card, registers, reporting tools was included.

The training curriculum was covered in two full days in centralised workshops. The private providers who could not be available for training for two full days were trained on four consecutive half-days.

The trained private providers were given the national TB guidelines, NTLP recording tools (suspect, laboratory and treatment registers), the Intensified Case Finding

forms and a flip chart to improve health education of patients.

The NTRL trained the private laboratory staff on AFB microscopy and External Quality Assurance (EQA).

Step 5: Branding of the Private Health Facilities

Following the training of private health providers and signing of MoUs with the NTLP and KCCA, the private facilities received a signage at their premises that read “**TB is Curable, Test here. Treat here.**” It is important for the community members to differentiate the health facilities that provide TB services.



Some of the trained Private Health Providers display their training certificate



Branding of the Private Health Facilities

Step 6: Support the Private facilities to access medicines from the Public sector

Once the private providers have been trained, they begin to identify clients with TB symptoms and make a diagnosis of TB. One of the biggest challenges in the private sector is to access quality anti-TB medicines for the patients diagnosed. Through SPARK-TB, three models were employed to support patients diagnosed in the private sector to access quality and free of charge anti-TB medicines from the Public sector. The three models are described below

- 1. Linking private facilities to nearby public facilities:** This model was employed at the beginning of the project because the private facilities had not gained the trust from the public sector to receive anti-TB medicines directly from the National Medical Stores (NMS). A patient diagnosed from the private facility was registered in the TB register at the private facility and with the support of SPARK-TB project coordinators was also registered in the nearby public facility to receive anti-TB medicines. The medicines were delivered on a two weekly or monthly basis by the project coordinators to the private facility where the patient received the medicines free of charge.
- 2. Direct supply of medicines from the National Medical Stores:** as SPARK-TB progressed, the private facilities that had adequate medicines/supply management systems in place were recommended by KCCA to NMS to receive direct supplies of anti-TB medicines, facilities that had the potential to improve, were supported by SPARK-TB to strengthen their supply management systems. By the end of the project, a total of 14 private facilities had been added on to the 39 public or NGO facilities already receiving direct supplies of medicines from NMS.
- 3. Linking private facilities to other private facilities:** 5-6 private facilities not receiving direct supply of medicines from NMS were linked to one of the 14 private facilities that were receiving direct supply of medicines from NMS. Similar to the mechanism in the first model, the diagnosed TB patient is registered in the diagnosing facility and also in the facility providing the medicines. This model was much more convenient to the private providers and the project coordinators in comparison to the first model where medicines were received from the public facilities. This is because the private facilities were much more closer to each other and the private providers were not as busy as the public providers, making the process much less time consuming.



Step 7: Linking Community Volunteers to Private Facilities

All patients diagnosed with TB and started on treatment need to be followed up and supported to complete their treatment. The follow up is best done by the members of the community who are closest to the patients. In the communities, volunteers who are referred to as Village Health Teams (VHT) were trained on the basics of TB control, identification of community members with TB symptoms and monitoring of patient adherence to treatment.

Following the training, one or two VHTs were linked to

each of the participating private health facilities, depending on the number of TB patients identified.

The role of the VHTs was to perform community follow up of patients on treatment, contact tracing, identification and referral of community members with TB symptoms and community education on basics and services for TB.



Training Village Health Teams (VHT)



A community volunteer (centre), during a home visit to support a TB patient (right) on treatment.

Step 8: Improve community education on TB

Patient delays to access health care are usually attributed to lack of adequate knowledge about the disease and where to seek services. In order to improve community knowledge on TB and awareness on availability of TB services in the private health sector, a number of interventions were implemented to educate the communities. Community education activities included:

1. Community education programs conducted by community volunteers.
2. Community Health Camps: at the health camps, community members are educated on TB, people with symptoms of TB were identified and referred to the private facilities.
3. School health talks.



Health Camp



Community education



Health Camp



School Talks

Step 9: Monitoring of service delivery

In order to monitor service delivery at both the facility and community level, a monitoring system was established that relied on different sources of data, as explained below:

1. Improving data availability and quality at the private facilities

- A system for monitoring TB services at the private facilities was put in place by introducing standard NTLT TB registers at all facilities. The health workers were trained on how to fill the registers and how to analyze the information in them. Through regular support supervision, the private providers were supported to improve recording of data in the registers.
- Data quality assessments were conducted quarterly to evaluate the level of completeness and accuracy of information entered in the registers.
- Data on TB from the private facilities were collected by the district TB focal persons with support from the SPARK-TB project coordinators and integrated into the district quarterly report to the NTLT.

2. Improving data availability and quality at the community level

- A system of monitoring the contribution of community volunteers to TB control was put in place by introducing a Suspect Register and a Patient Follow-up Register at the community level. The community volunteers were trained on how to fill the registers and were supervised regularly to improve their work and the quality of data entered in the registers.

3. Improving quality of AFB Smear Microscopy

- AFB smear microscopy is the first diagnostic tool available for the patients identified in the private health facilities.

To improve the quality of smear microscopy, the laboratory staff, from the private facilities were trained on AFB microscopy and External Quality Assurance (EQA).

- EQA for AFB smear microscopy was conducted quarterly by the NTRL to ascertain the quality of work done in the private laboratories. EQA was followed with focused support supervision to the laboratories with errors.

4. Regular face to face meetings with the private providers and community volunteers

Regular feedback from the private and public sectors is important to address as quickly as possible any challenges that may arise and to strengthen the relationship between the public and private sectors.

Quarterly review meetings were held for the public sector health officers, the private health providers and community volunteers to share progress in TB control, best practices and to discuss solutions to challenges encountered in the provision of TB services at the private health facilities and in the community.



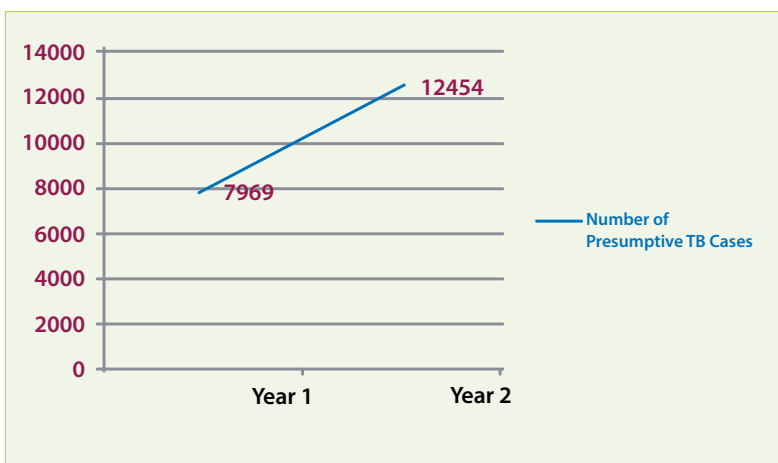
The NTLT Program Manager, Dr. Frank Mugabe talking to the private providers in a quarterly meeting to review performance.

Results

1. Private facilities and the community increased identification and referral of Presumptive TB Cases

The progressive improvement in the capacity of private health providers and the Village Health Teams (VHTs) to identify people with TB symptoms coupled with an improvement in the knowledge and health seeking practices of community members, contributed to identification of more people with TB symptoms from the community, as demonstrated in the Figure 2 below. The presumptive TB cases were referred and tested in private facilities.

Figure 2: Presumptive TB Cases identified in Year 1 & 2

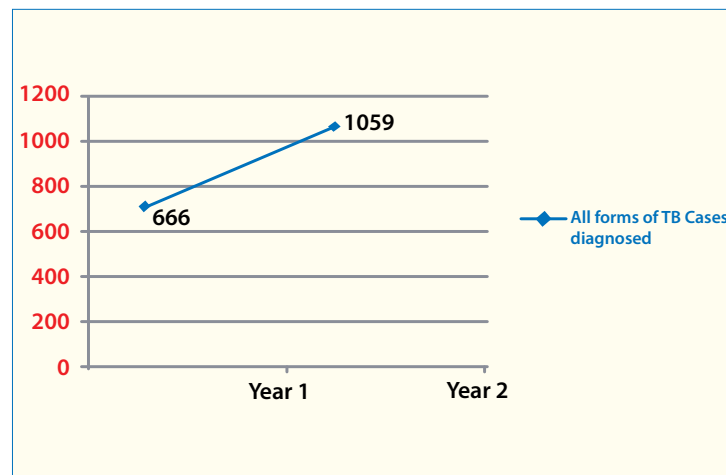


70 private facilities are now able to identify people with TB symptoms and provide TB diagnostic services or refer to a diagnostic facility. Before the project, there were only 06 private facilities providing TB services in Kampala.

2. TB cases diagnosed in the Private Health Facilities increased

The number of TB cases diagnosed in the private health facilities increased in the two years of implementation of SPARK-TB, from 666 all forms in year 1 to 1059 all forms in year 2. Out of the total 1725 TB cases identified, 1267 (73%) were smear positive.

Figure 3: All forms of TB Cases diagnosed in Private facilities

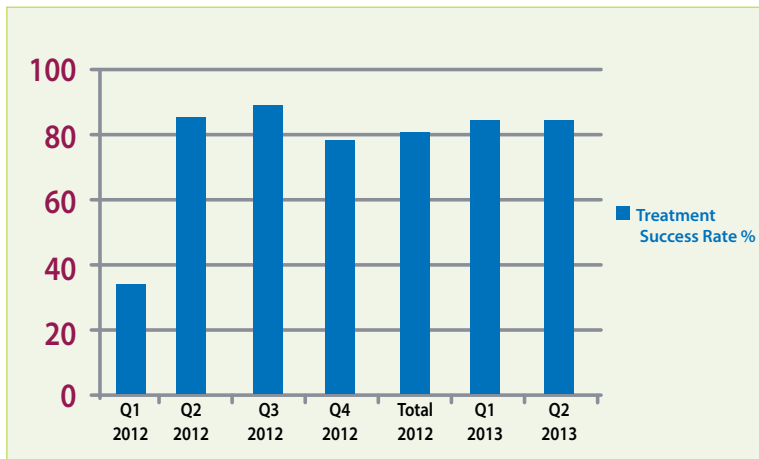


In 2012, 12% of the total smear positive/bacteriologically confirmed TB cases notified by Kampala district to NTL, were from the SPARK-TB supported private facilities, which are only 7% of over 1000 private facilities in Kampala.

3. Treatment outcomes for TB patients treated in the Private health facilities improved

Among the 484 new smear positive TB patients that started treatment in the private health facilities in 2012, 267 (55%) completed treatment and were declared cured, 119 (25%) completed treatment but did not get a sputum smear examined at end of treatment, 1 person failed treatment, 31(6.4%) died, 37 (7.6%) were lost to follow up and 29(6%) were transferred out. By the end of SPARK-TB, the treatment success rate for new smear positive TB patients diagnosed and treated in the private health facilities was 80%.

Figure 4: Treatment Success Rate for TB patients treated in the Private Health Facilities



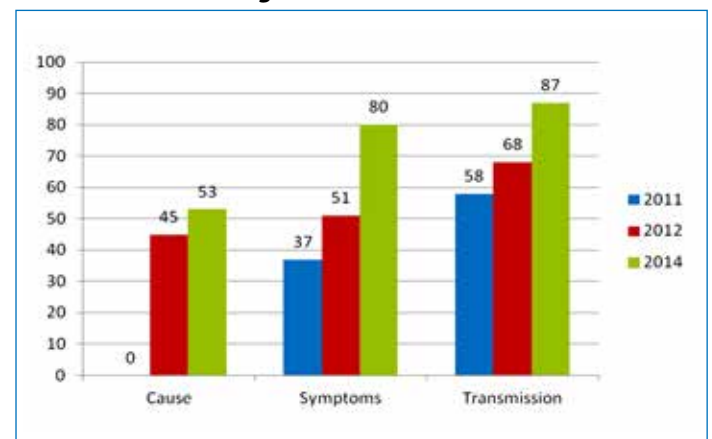
4. There was a 33% increase in the number of Basic Management Units (BMUs) notifying TB cases in Kampala to the National TB Program, from 39 before SPARK-TB to 52 BMUs currently.

Of the 52 BMUs, 13 are Private facilities brought on board by SPARK-TB. All the 70 private facilities supported by SPARK-TB report through the 13 private BMUs.

5. Community Knowledge on TB improved.

Knowledge on TB increased from the baseline which was measured in 2011 and the end of project KAP survey which was done in 2014. Figure 5 shows the change in knowledge on three parameters; cause, symptoms and transmission of TB.

Figure 5: Percentage of Community Members with Correct Knowledge on TB



6. Xpert MTB/RIF testing was introduced to private sector clients

To improve access to Xpert MTB/RIF for the clients seen in the private sector, the Ministry of Health NTLP and NTRL accepted to have sputum samples of presumptive TB cases identified in the private sector to be tested in public facilities with Xpert MTB/RIF machines. In addition, the NTLP/NTRL provided a four module Xpert MTB/RIF machine and cartridges to one of the private facilities, which is currently testing samples from other private facilities. The patients are not charged for the Xpert MTB/RIF test.



A Laboratory technician operating an Xpert MTB/RIF machine in Alive Medical Centre, Kampala.

7. Fourteen Private facilities in the slums Joined the list of public and NGO facilities that receive direct supply of anti-TB medicines (free of charge) from the Government National Medical Stores.

The remaining 56 private facilities receive anti-TB medicines from the 14 private facilities. This has enabled TB patients receiving health care in the private sector to access free of charge anti-TB medicines from the Private health facilities.

8. The community network for supporting TB patients was strengthened.

A total of 56 Village Health Teams (VHT) and peer educators were equipped with the knowledge and skills to follow up TB patients in the community and support adherence to treatment. This contributed to the good treatment outcomes.

Challenges

1. High staff turnover necessitating the need to continuously train new recruits.
2. Although private providers were trained, diagnosis of smear negative TB, extrapulmonary TB and TB in children remained a big challenge for the majority of private providers. In addition, the majority of service providers in the private sector operating in the urban slums were nurses and had limited capacity to diagnose complicated TB cases.
3. Limited access to new diagnostic tools in the private sector contributing to delays in diagnosis.
4. Some community members with very low household income could not afford the cost of diagnostic services in the private sector which ranged between USD 2 to USD 8.



Lessons learnt

During the implementation of SPARK-TB, the key implementing partners reflected on what could have been done differently and for some processes, adjustments were made to better communication and service delivery and to implement activities within the shortest possible time. Throughout SPARK-TB, positive lessons were learned and are summarized in the following section. We hope that these lessons learned will benefit future PPPs for TB control and for control of other public health problems in low and middle income countries.

1. Invest in building the private sector capacity to diagnose and treat TB, including access to more sensitive tests like Xpert MTB/RIF. This helps to find and treat TB patients that would otherwise not have been found, especially in the urban slums.
2. Build the public sector capacity to initiate, implement and monitor PPP program. Because the public sector has to take leadership in initiating, sustaining and monitoring the PPP, the public sector staff need to have adequate skills on how to engage with the private providers.
3. Formalize the partnership between the public and private sector through signing of the Memorandum of Understanding (MoUs) by the two parties. This improves the private sector confidence in the public sector.
4. Maintain the business model for the private facilities. Business is the purpose for which the private facilities were established. Killing the business model will demotivate the private providers to join the partnership. The public sector should support innovative ways that help the private sector to reduce the costs for services.
5. Support the private sector to access new tools for diagnosis of TB. This shortens the pathway to diagnosis by reducing the need to refer the people that need the tests.
6. Provide regular support, feedback and updates to the private sector. This motivates the private providers and keeps them engaged.
7. Keep the directors of private health facilities regularly informed about the progress of TB activities at their facilities. This helps to quickly solve any problems that may arise.
8. Build a community network of committed and motivated resource persons to educate communities about TB and the services provided in the private sector and to follow up patients on treatment. Facilitation of the community resource persons with a monthly stipend is very important to keep them engaged.
9. Brand the participating private facilities with a signage that shows that they provide TB services. This helps the community to identify the health facilities that provide TB services. Keeping a similar signage at the public and private facilities helps the community to associate one signage with TB services.
10. When private facilities are supported to access free medicines from the public sector, they are able to provide free of charge medicines to their clients. This increases the number of community members that seek TB services from the private sector.
11. Build a network of selected private facilities that receive medicines and related supplies from the Government national medical stores and support other private facilities to access them. This puts less strain on the Government transport system for medicines.

Acknowledgement

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5. The National TB and Leprosy Control Program-Uganda
6. The National TB Reference Laboratory
7. Kampala City Council Authority
8. The Directors and staff of private clinics in the PPM network
9. Community support groups
10. The Union Staff.

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Disclaimer:

The Opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the Stop TB Partnership, DFATD and UNITAID.

The Union Uganda Staff

INTERNATIONAL UNION AGAINST
TUBERCULOSIS AND LUNG DISEASE
The Union
(Uganda) Office

Stop TB Partnership
TB REACH



Slum Partnership To Actively Respond To TB Control In Kampala/ TB REACH
2011-2014.

Mr. Mayende Joseph
Motorbike Operator

Mr. Bageya Martin
Driver

Mr. Mbogo Farouk
Motorbike Operator

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Administrative Assistant

Mr. Okatine Charles
Project Coordinator

Dr. Anna Nakanwagi-Mukwaya
Country Director/Technical Advisor

Mr. Dongo John Paul
Project Coordinator

Dr. Estella Birabwa
Project Manager

Mr. Nsonga Joseph
Project coordinator

Ms. Nakate Alice
Office Attendant

Mr. Mukaire Rashid
Finance Officer.



Dr. Stella Zawedde-Muyanja,
Project Manager

New Staff



Mr. Emmanuel Kansime,
Finance Officer

