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TB ARC
Accelerated Response and Care

ENGAGING ALL CARE PROVIDERS FOR TUBERCULOSIS CONTROL: PUBLIC-PRIVATE MIX

CALL FOR PROPOSALS

INTRODUCTION

Tuberculosis Accelerated Response and Care (TB ARC) is a five-year USAID funded activity implemented by a consortium led by Centre for Health Solutions – Kenya (CHS) to support TB control activities across Kenya's 47 counties.

Through TB ARC, CHS works in close collaboration with the Ministry of Health's National Tuberculosis Leprosy and Lung Disease Unit (NTLD-Unit) to reduce the burden of all forms of TB in Kenya. The collaboration brings together CHS, PATH, Safaricom and Tangazo Letu, and aims to improve access to and utilisation of TB services, enabling implementation of evidence-informed activities that support early identification and management of TB cases and supporting activities of the NTLD-Unit.

CHS invites proposals from local organisations to engage all care providers through the implementation of the Public Private Mix (PPM) by way of sub awards. Implementation of this component contributes to the achievement of the National TB Strategic Plan and Intermediate Result Area 3 for the TB ARC activity, i.e. technical assistance for the local adaptation and scale-up of globally proven interventions.

CHS will grant two awards to address the **formal private sector** and the **non-formal private sector** to ensure focus on both providers.

In line with the definition of 'local organisation' applicants must meet all of the following criteria:

- Be organised under the laws of the recipient country (Laws of Kenya)
- Have its principal place of business in Kenya
- Be majority owned by individuals who are citizens or lawful permanent residents of Kenya or be managed by a governing body, majority of whom are citizens or lawful permanent residents of Kenya
- Not to be controlled by a foreign entity or by an individual or individuals who are not citizens or permanent residents of Kenya

Applications will be evaluated using a selection criterion that includes the technical merits of the application, cost effectiveness, as well as past performance of interested applicants in similar activities.

Thereafter, a pre-award assessment will be conducted to determine the capacity of shortlisted entities to adequately perform and achieve the intended activities. CHS will use appropriate subaward mechanisms to engage eligible and qualifying local organisations.

PART 1: TECHNICAL PROPOSAL

BACKGROUND

Private providers in developing countries have been identified as first points of care for a number of patients[1]. According to the draft report of the Kenya Household Health Expenditure and Utilisation Survey, 2013, though the public sector remains the main provider of outpatient service with 58% of all visits, private clinics and pharmacies accounted for 23% of all outpatient clinics. People in urban areas and of rich wealth quintile are more likely to consult formal private health providers. Informal providers in developing countries comprise a significant component in health systems. They are important points of care pre and post-diagnosis for the poor, as they are convenient, affordable and culturally sensitive. However, these informal providers are in most cases unregistered, unregulated, poorly trained or not trained and hence not updated on country guidelines[2].

In Kenya, there was an observed 9.48% decline of TB cases in 2013 as compared to 2012. The total number of cases was 89,760 from 99,159 in 2012. Public institutions contributed 77.9% of the total cases as compared to 88.7% in 2013 of all notified cases, while private sector contributed 21.3% and prisons 1% [3]. The cases being notified from the private sector have been on the increase over the years with total number of cases notified rising from 7,160 in 2010 to 11,000 in 2012. The treatment success rate for new smear positive patients rose from 83% in 2010 to 88% in 2012[4].

According to Kenya's 2014 World TB Day theme, **Reaching Our Unreached; Test, Treat and Cure All TB**, about 20,000 patients are undiagnosed for TB and untreated in Kenya. The non-state or private health care sector collectively provides about 50% of all health care to Kenyans. This range includes formal and informal health providers where a potential number of TB clients could be seeking care. Kenya has been implementing the 4th component of the STOP TB strategy: Engaging All Care Providers; the initiative has been more in the urban formal sector. TB ARC plans to support this component targeting both the formal (private hospitals/clinics, chemists) and informal sectors (herbalists, traditional healers) to bridge the gap to the unreached and ensure appropriate treatment. In the emergence of Multi Drug Resistant (MDR) TB, capacity needs to be built within the private sector to appropriately manage MDR TB patients.

Potential gains of involving the private sector include:

a) Minimised provider-related delays in diagnosis of TB

[1] http://ps4h.org/

[2] What Is the Role of Informal Healthcare Providers in Developing Countries? A Systematic Review May et al. www.plosone.org

[3] Unpublished NTLD annual report 2013

[4] Draft National Strategic Plan July 2014-June 2018

b) Improved TB control activities through increased case finding, notification and treatment
c) Reduced missed opportunities for TB diagnosis, prevention, reduction in morbidity, mortality and costs associated with delayed interventions
d) Standardisation of TB treatment to enable increased treatment success and prevent development of MDR-TB
e) Increased health care worker base for TB control activities in the country
f) Expanded DOTS coverage

OVERALL OBJECTIVES

In line with its strategic plan, a related priority for the NTLD-Unit is to **scale up number and diversity of private sectors engaged in quality TB management**.

Expected Outcomes

I. Increase case notification by the private and non-state sectors by 25% by 2018, compared to 2014
II. Ensure treatment success of at least 88% of all DS TB patients managed by private providers by 2018
III. Ensure treatment success of at least 80% of MDR-TB patients managed by private providers
IV. Reduce deaths among HIV-infected TB patients managed by private providers to 5% or lower

SCOPE OF WORK

I. FORMAL PRIVATE HEALTH CARE ENGAGEMENT

Providers to be targeted in this category will include: private for profit or self financing hospitals, corporate health services, Individual private for profit health care providers (solo providers), retail pharmacies, chemists and drug shops.

Objective 1: Sustain the gains of PPM and scale up to more formal providers

i. In collaboration with the NTLD-Unit, revise, disseminate and distribute the PPM policy guidelines

ii. Baseline documentation and gap analysis: PPM in Kenya is currently being implemented in urban facilities in 14 counties. Private providers will be profiled in order to better understand available services at their practices and relative strengths that can be harnessed in TB control. The latest county-specific TB data will also be analysed including county specific gaps

iii. Sensitisation meetings/workshops: Organise NTLD-Unit led meetings with individual private institutions/providers, including decision makers as participants to share the PPM policy document. Hold targeted workshops at county level to disseminate the DOTS strategy, WHO 5Is, and PAL. CMEs to provide updates on these will be conducted quarterly through the Kenya Medical Association continuous professional development forums. Link private health specialists/consultants to monthly online TB related WEBINARS.

iv. Build capacity for MDR TB management: Identify facilities in each county and build their capacity to diagnose and treat MDR TB. Build systems for linkages and referrals to MDR TB treatment sites within the counties

v. Meetings with board of directors of private institutions: These will provide an opportunity to review national and county-level TB indicators, benefits of the PPM, costs associated with quality care and what is needed for implementation

v. Workshop for selecting improvement opportunities: Involve all identified providers at county level in establishing agreements and deliverables, selecting an oversight team, led by the NTLD-Unit representative at county level and selecting improvement indicators

vi. Collaborative agreement: develop a collaborative agreement model for signing by all partners, defining each partner's contribution to county-level TB control

vii. The monitoring plan: Provide NTLD-Unit guidelines and monitoring tools to all private providers to ensure documentation of all TB control activities. Capacity building for TIBU among private health providers

viii. Evaluating results: Working with the CTLCs, conduct quarterly review of agreed improvement opportunities, identification of new challenges, use of tools and training opportunities

ix. Recognising performance: Provide support for the documentation of successful experiences and publicity for best practices during county- and national-level TB forums

x. Support symposia, special sessions, workshops and other relevant forums at annual scientific conferences of professional associations e.g. KMA, PSK to reach individual members of these associations with TB-task-specific messages

xi. Intensify the engagement of private-sector laboratories, including:

a) Provide technical assistance on TB bacteriology to private laboratories
b) Promote linkages between the public and private health facilities
c) Ensure all engaged laboratories are networked to the national EQA system
d) Engage a pool of TB laboratory experts to support establishment of new diagnostic sites, through the PPL taskforce
e) Promote referral of TB specimens between sectors

Objective 2: Quality Assurance of PPM Activities

i. Set up peer review forums for consultants on TB issues
ii. Establish PPM centres of excellence that will be mentorship sites and offering on-job training on PPM activities
iii. Develop continuous quality improvement indicators for TB management and delivery of services among private health providers.

Objective 3: Support Coordination of PPM at National and County Levels

i. Participate and support the PPM technical working group
ii. Support the annual national PPM workshop
iii. Close collaboration with STOP TB Partnership Kenya to build multi-sectoral collaboration
iv. Support formation of county level TWGs on PPM and representation of private providers in quarterly meetings.

Objective 4: Innovation in Engagement of Formal Providers

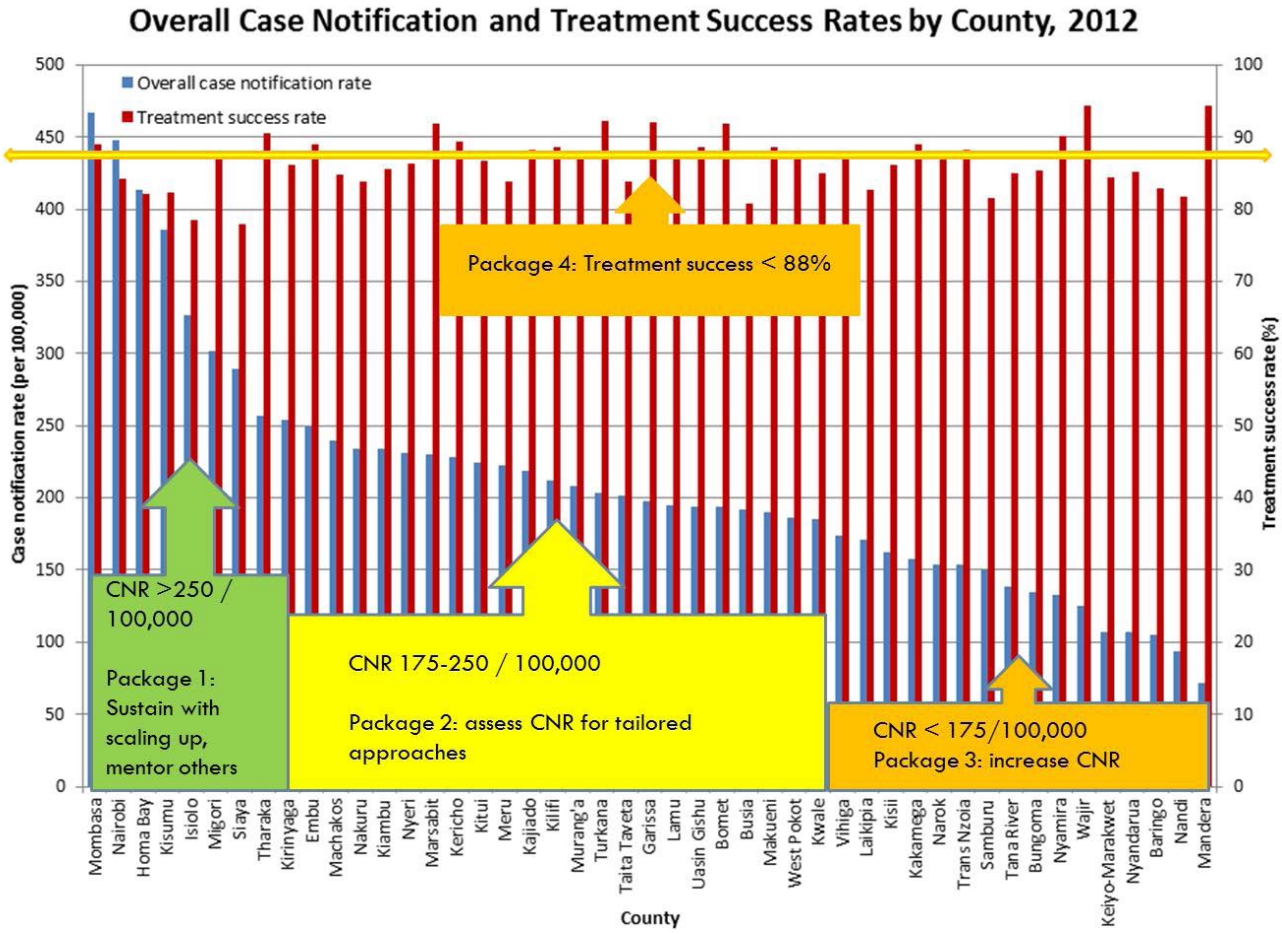
i. Franchising private clinics offering TB care
ii. Integrating with franchises e.g. PSI Tunza clinics to offer a comprehensive TB care package

II. INFORMAL PRIVATE HEALTH CARE ENGAGEMENT

Providers to be targeted in this category will include but are not limited to: herbalists, traditional healers, traditional birth attendants, village doctors, unregistered chemists, and drug sellers.

Objective 1: Identify Informal Providers

i. Map out informal providers in High Burden Counties as identified in the Epi Analysis/NSP table[5] below. Counties will be: (Mombasa, Nairobi, Homabay, Kisumu, Isiolo, Migori, Tharaka and Kirinyaga) and five (5) hard to reach counties (Mandera, Baringo, Samburu, Marsabit, West Pokot).



[5] Table from the draft National TB strategic plan July 2014-June 2018

Objective 2: Streamline TB Engagement among Informal Providers

i. In collaboration with the NTLD-Unit, develop a package and model of engagement for informal health care providers

ii. Assess and classify clinics for support based on ability to be registered as TB treatment centres to administer DOTS or history taking, sputum sample collection and referral to other centres for TB treatment

iii. Create a linkage system between informal and formal public facilities for referral of presumptive TB patients

iv. In collaboration with the NTLD-Unit, APHIA*Plus* partners and organisations working at the community level, engage informal providers including drug outlets through training and support to carry out TB screening and referral of TB suspects to health facilities for diagnosis

v. Sensitisation sessions to allow discussion and sharing of accurate information on TB control as well as the role of non-formal practitioners

vi. Provision of IEC materials such as algorithms and job aides to facilitate intensive case finding and management

vii. Quarterly supportive supervision by CTLCs to provide support to health care workers in these settings

viii. Provision of tools to facilitate case notification and reporting of TB activities

ix. Support accreditation of non-formal providers by the Kenya Medical and Dentists Practitioners Board to recognise exemplary performance.

Objective 3: Scale Up Innovative Models

i. Telemedicine model to support informal providers under the World Health Partners

ii. Operation ASHA model: establish TB treatment centres in existing community locations, implement DOTs and medicine pick up. (A cure rate of 91% was achieved in South Delhi.[6])

[6] http://healthmarketinnovations.org

PART 2: BUDGET PROPOSAL

AWARD TYPE

The award will be a cooperative agreement with substantial involvement. Successful applicants will be engaged using an appropriate sub award mechanism.

PROJECT START DATE

The indicative project start date is January 2015.

APPROXIMATE TOTAL PROJECT FUNDING AND PERIOD

Subject to the availability of funds, CHS intends to provide approximately **Kshs 31,785,600** in total funding to be allocated over a one year and five months period for each category as shown below:

a) Formal private health providers: **Kshs 22,249,920**

b) Non-formal private health providers: **Kshs 9,535,680**

Funding for accepted applicant(s) shall be provided on an incremental basis subject to the availability of funds and performance. CHS reserves the right to change the funding amounts, cycle, and terms of the agreement as a result of availability of funding and USAID requirements. Should such changes occur, sub-awardees will be notified appropriately.

Budget Categories

Applicants should include a brief breakdown of allowable direct costs under the following categories: personnel, fringe, travel, consultants, equipment, supplies, and other direct costs. All the items included in the budget must be separately justified in form of a budget narrative. Applicants must submit a budget application using the CHS budget format and guidelines provided. **Refer to the provided budget guidelines for more guidance.**

The budget proposal should be organised as follows:

- A summary budget
- A detailed/itemised budget
- A budget narrative explaining costs to be incurred, and
- Other administrative documents as required

Indirect Costs

Indirect costs are not allowed and all project activities should be budgeted for as direct costs using the budget guidelines provided.

Cost Share or Matching

In order to promote sustainability, it is necessary for the applicant to commit not less than 10% of the total project costs as cost share/match.

Currency

Applicants must use the Kenya Shilling currency (Kshs) to cost all activities in their budgets.

PART 3: APPLICATION PROCEDURE

This call for proposals invites **separate** applications from entities that will work with:

i) Formal, private health care providers (FP)
ii) Non-formal, private health care providers (N-FP)

Applicants are required to clearly indicate which category their application responds to. Proposals must be driven by the aforementioned scope of work and objectives and clearly demonstrate institutional capacity, competencies and motivation to carry out the proposed activities.

Validity of the call: Interested applicants can submit their complete proposals until **4.30PM (EAT)** on **November 28, 2014** when the call closes. Proposals received after this time and date will not be considered for review. The proposals should be addressed to:

The Chief Executive Officer
Centre for Health Solutions – Kenya,
P. O. Box 23248 – 00100,
Nairobi

and submitted via email with the subject: **ENGAGING ALL CARE PROVIDERS FP/PPM 2014** for formal, private providers, and **ENGAGING ALL CARE PROVIDERS N-FP/PPM 2014** for non-formal private providers, to **calls@chskenya.org**.

No information on the outcome of individual applications will be given before the end of the selection process. The outcome of the selection will be communicated to successful applicants in **December 2014**.