Georgia TB Coalition

Advocacy Strategy for establishing patient-centered TB care model through strengthening TB outpatient services in Georgia

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- Payment mechanisms within the state program encourage long hospital stay for both drug susceptible and drug resistant TB and do not incentivize good performance for achieving better treatment outcomes.
- TB related stigma among public and health care workers is high that hinders integration of TB services into the primary care and general health settings.

Overall goal

Aim of the strategy is to improve access to and quality of TB services through strengthening outpatient TB services and establishing a patient-centered TB care model. Eventually this should lead to improving TB treatment outcomes and reducing the spread of the disease. It is anticipated that this strategy will contribute towards the following outcomes (a) TB treatment outcomes improved; (b) the proportion of MDR TB cases reduced; (c) allocative efficiency within the TB programs improved (d) TB related stigma among health care workers and public will reduced (c) Attitude towards outpatient TB care positively changed and demand for ambulatory services increased.

This aim will be achieved through the following four objectives.

Objective 1: High level advocacy at national level conducted to sensitize decision makers of the importance of a patient-centered TB care to ensure sustainable and adequate funding for the National TB Program.

Objective 2: Programmatic advocacy aimed at health care providers implemented to encourage facility owners to support capacity building in TB and MDR TB case management

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1 Introduction

1.1 The value of the advocacy strategy

Access to TB services and the way of TB service delivery in any country are highly influenced by the policies, regulations and practice standards which are enacted and operational. Positive changes in the policies and laws can be achieved through brining up gaps and weaknesses to the attention of high level decision makers. Potential solutions which are evidence based, feasible and acceptable for beneficiaries and society should be also offered to facilitate the change. This process aimed at addressing challenges through supporting policy decisions for improving responsiveness, effectiveness and efficiency of the system is often referred to as advocacy.

The value of advocacy is well recognized by the National TB Program in Georgia. The National TB Strategy for 2016-2020 emphasizes the need for expanding TB related advocacy at all levels. Advocacy efforts in Georgia have been mainly focused at addressing TB related stigma and maintaining access to basic diagnostic, treatment services and drugs. Advocacy focused at transitioning from hospital based to outpatient TB care model has been minimal if not none. For the last decade, in the context of the overall hospital sector reform Georgia has managed to significantly reduce the TB in-patient capacity. However, the need for currently functional 466 beds can be explained not only by medical but also by social reasons, unfavorable family circumstances for taking care of patients diagnosed with TB and weaknesses of community based service delivery.

A further optimization of hospital capacity is certainly possible if a scope of involvement of primary care providers and other community based organizations in TB care gradually increases. Well planned advocacy interventions will allow for gaining support of high-level decision makers, thus influencing policy and programmatic decision making on TB program funding and improving quality of TB service delivery and patient care.

1.2 Basic concepts and approaches underpinning the advocacy strategy

The following concepts and approaches form a basis for this advocacy strategy.

For the purposes of the strategy **advocacy** is defined as a process which aims to educate and influence decision makers in order to generate and promote changes in policy and practice in favor **of people-centered TB care,** in particular through **strengthening ambulatory TB services.**[1]

As a key focus for this advocacy is to strengthen TB care delivery at outpatient level, the benefits of ambulatory versus inpatient TB care are outlined below:

Outpatient or ambulatory care refers to the treatment and care of patients outside of hospitals. In the context of tuberculosis (TB) and multidrug and extensively drug-resistant TB (M/XDR–TB), it should be seen as part of a comprehensive continuum of care. While directly observed treatment (DOT) remains a cornerstone of TB care, effective ambulatory care models should embody a holistic patient-centered approach to supporting treatment adherence in the context of each patient's individual needs, taking into account social and economic vulnerabilities. [2]

Despite the availability of a wide network of primary care and outpatient TB services, the initial hospitalization of patients with TB is still common practice in Georgia. The average length of stay is 10 days for smear negative and extra pulmonary cases, 25 days for smear positive cases and 75 days for MDR-TB.[1] A vast majority of these cases could effectively be managed at outpatient level giving significant financial savings through avoiding unnecessary use of expensive hospital infrastructure and resources. From public health view point inpatient treatment is not an effective mean of preventing the further spread of TB, because most transmission occurs before diagnosis and hospitalization. The risk of someone with TB infecting other people drops significantly after the first two to 14 days of effective treatment. In addition, inpatient TB treatment in hospitals with poor airborne infection control measures can contribute to further spread.[2]

The potential role primary care services in TB detection and follow-up care cannot be undermined. Primary care providers are expected to take continuing responsibility for providing the patient's comprehensive care by identifying and addressing medical, social, psychological and spiritual needs. A patient-centered TB care model can hardly be implemented without active engagement of primary care physicians and nurses in TB service delivery. While hospitalization requires patients to be separated from their families and communities, outpatient TB care allows for bringing the entire continuum of care closer to affected individuals. Although the effectiveness and cost-effectiveness of outpatient TB care model seem obvious, a limited capacity of PHC services may prevent integration of TB preventive, diagnostic and treatment services into primary care package. PHC capacity building for early TB detection, timely referral, treatment initiation and long term care should be an integral part of any health care reform aimed at patient-centered care delivery.

Good understanding of the principles of a patient-centered care model is crucial in this discussion. A patient-centered care approach makes the patient a key focus for all health interventions which should be designed in respect of patients' beliefs, values, needs and rights. A patient centeredness at a minimum assumes that any individual has universal access to high quality services. A patient is a partner and not a passive recipient of services. Thus a patient should be well informed about health issues and possible solutions and participate actively in shared decision making. Clinical care process should be planned and implemented in agreement between a provider and a patient. Both parties should realize that this is a shared responsibility and mutual commitment is required to achieve desirable outcomes. Patient-centered care is based on integrated service delivery model to comprehensively address all medical, social and psychological needs of patients and their families. Community support is important for patients to overcome disease related challenges. Therefore partnerships with community volunteers and civil society organizations are highly encouraged. Implementation of patient-centered care

1. National Health Statistics, NCDC 2014

model should be monitored and documented. Early results should be analyzed with active involvement of patients groups and vulnerable communities. The model should be refined in collaboration with all key stakeholders.

1.3 Alignment of TB advocacy strategy with national TB and global TB and health strategies

This strategy presents an advocacy framework for strengthening TB outpatient care model in Georgia. It includes priority objectives, specific activities, expected outcomes and a monitoring and evaluation framework.
The strategy is in line with the following global and national strategies which call for establishing a patient-centered TB care model and shifting the paradigm towards outpatient care delivery for improving access to and quality of TB services:

1. Global End TB Strategy which aims to end the global TB epidemic, with targets to reduce TB deaths by 95% and to cut new cases by 90% between 2015 and 2035, and to ensure that no family is burdened with catastrophic expenses due to TB. These ambitious goals should be achieved through organizing the TB control efforts around three pillars: integrated, patient-centered care and prevention; bold policies and supportive systems; and intensified research and innovation.[3]

2. National TB Strategy for Georgia for 2016-2020 which prioritizes the implementation of a predominantly outpatient TB case management (from day one) through building community based patient support systems for good treatment adherence and introducing adequate financing mechanisms to discourage unnecessary hospitalization.[4]

3. "Health 2020" European health policy framework which aims to support action across government and society to: "significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centered health systems that are universal, equitable, sustainable and of high quality".[5]

2 Key challenges of the National TB Program in Georgia to be addressed by the advocacy strategy

2.1 Georgia TB Profile

Tuberculosis and especially drug resistant TB are critical public health threats in Georgia. TB incidence and prevalence in Georgia have shown a decline in recent years but remain high. According to the WHO, the latest estimated TB incidence was 106 per 100,000 population (for 2014), which is the fourth highest level among 53 countries of the WHO European Region. The estimated 2014 mortality rate was 6.6 per 100,000 population (excluding TB/HIV cases).[6]

In 2015, 38.8% of previously treated culture positive TB patients and 11.6% of new culture positive patients were estimated to have multidrug resistant TB, which is slightly lower than in 2014. The steadily high rate of MDR-TB identified in new TB patients is a warning sign that MDR-TB is intensively spreading in the community. Georgia must have a substantial "reservoir" of MDR-TB patients serving as sources of infection for these patients who were never treated for TB in the past, indicating that specific interventions are needed to identify and cure the MDR-TB patients in this reservoir, and stop the spread of MDR-TB to others.

While the treatment success rate for new bacteriologically confirmed DS pulmonary TB cases has reached 82.6% (2014 cohort), the MDR TB treatment success rate gradually decreased as the numbers of patients lost-to-follow up has grown. In 2009, the treatment success rate was 55%, in 2011 - 50% and for 2013 cohort decreased to 41% while rates of lost-to-follow up increased from 27% (2009) to 34% in 2013 with slight reduction to 32% in 2015.

2.2 Organization and financing of TB services

National TB Program in Georgia is implemented by multiple partners including the Ministry of Labor, Health and Social Affairs (MOLHSA), the National Centre for Disease Control and Public Health (NCDCPH), the National Centre for Tuberculosis and Lung Diseases (NCTBLD), and the Ministry of Corrections and Legal Advice (MCLA).

TB services are delivered by specialized outpatient and in-patient clinics. There are 69 TB service points staffed by a TB specialist and a nurse in each district of Georgia. In Tbilisi, outpatient TB care is still being provided by a network of TB dispensaries and a number of DOT spots at primary care facilities. In 2015 standalone TB dispensaries were merged with the National Center for Tuberculosis and Lung Diseases and currently they operate under one management umbrella. TB service points can offer a full range of diagnostic services to confirm the diagnosis and provide care follow-up and clinical monitoring. TB specific diagnostic tests are conducted at NCDCPH public health laboratories and the National Reference Laboratory in Tbilisi. A well functional sputum transportation system via Georgian Post allows for timely transfer of the sputum samples from district level facilities to labs.

Primary care providers (PCPs) are responsible for early recognition and timely referral of TB suspects to specialized services. If TB is confirmed, then primary care physicians and nurses with support and supervision of the rayon TB teams are expected to provide DOT in the community. Despite the availability of a wide network of PCPs across the country, patients often bypass primary care services and go directly to hospitals. Furthermore, PCPs consider TB service delivery beyond their competencies and are often reluctant to actively collaborate with NTP staff.

In addition to outpatient TB service points which are part of district level general hospitals (private and public), there are six specialized TB hospitals in Tbilisi, Batumi, Zugdidi, Abastumani and Poti. The total bed capacity amounts to 466 beds (out of which 170 beds are for

M/XDR TB cases). A vast majority (70%) of new smear-positive TB cases and almost all (90%) of MDR TB care are still hospitalized. Average length of stay is 25 for regular and 60 days for MDR TB cases. The average length of stay is lower as compared to many other countries in the region. However, out of government expenditures on TB control, the highest share (63.1% in 2014) is spent on inpatient curative care compared with outpatient care.

District level public health centers have been increasingly involved in contact tracing since late 2012. TB specialists are obliged to report the confirmed TB case to the public health service within 24 hours. Then public health personnel are responsible for visiting patients' households and referring eligible contacts to TB services for a diagnostic workup.

Georgia has universal access to TB services and drugs through state and Global Fund supported programs. The total budget for TB services in 2015 was at a level of 17 USD million of which 33% was funded domestically. The average expenditure per notified TB patient in 2014 was estimated at a level of US$ 2.000, - which is moderate, compared to other countries in the region. The expenditure per treated MDR-TB patient comes to roughly US$ 15.000, -. The WHO Tuberculosis financial profile calculates a financial gap of USD11 million, which would correspond with roughly 25% of total TB expenditure. The expenditure on inpatient care is almost double compared to the outpatient care (2014). External funding support to TB has been substantial and contributed to strengthening the TB program. Main international partners include GFATM, USAID, WHO and MSF. The level of external funding in 2014 amounted to US$ 6,1 million. Most was used for procurement of TB medicines, laboratory consumables and social support to patients.

Total expenditures on TB control is showing increase, which is mainly due to increased government TB spending. This is also manifested by gradual increase in government per capita TB spending as well as government spending per TB case. However, the share of international donor funding still remains high (40%), which is calling for improved financial sustainability planning in light of decreasing international donor funding in Georgia and globally. Based on the Global Fund allocation information for Georgia for 2014-2016 allocation period, namely the amount of additional TB funding (5,395,442 US$), it is expected that from 2016 onward, the external donor support for TB control will be reduced approximately twice.

Cash incentives scheme is operational since 2014 that provides cash payment and transportation fee to MDR and regular TB patients which comply with the treatment regimen well.

Compared with 70% share of out-of-pocket payments from total health spending in the country, 5% share of out-of-pocket expenditures on TB prevention and care is considerably low.**Error! Bookmark not defined.**

However, in light of the aforementioned anticipated reductions in the external donor funding, there is a risk that this share may increase. It is recommended to continue close monitoring of TB expenditures in the future so that to avoid respective increase in financial burden on TB affected individuals and households.

2.3 PHC readiness for integrated TB service delivery

By definition PHC is the first level of contact for individuals, the family and community with the organized health system. It is an essential part of the state health care system based on methods that are practical, scientifically sound and socially acceptable. PHC should be accessible to all members of the community at a cost the country and community can afford.

PHC brings health care as close as possible to where people live and work, and constitutes the first component of a continuing health care process. A primary care service package should include at least: health education; promotion of healthy life style; adequate supply of safe water and basic sanitation; maternal and child care, including family planning; immunization against major infectious diseases, prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries and provision of essential drugs. PHC providers are best placed in the system to recognize TB presumptive cases, organize timely referral and facilitate smooth progression of individuals with the disease across the continuum of care. TB control targets can hardly be achieved without integration of TB prevention, diagnostic and treatment services into the PHC system.

Primary care in Georgia is delivered by a wide network of family physicians, district internists, pediatricians and general practice nurses. The post-graduate training of family medicine in Georgia that follows the educational agenda of the European Academy of Teachers in General Practice and Family Medicine (EURACT) affirms that general practitioners and FPs are primarily responsible for the provision of comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness.

Primary care providers, which function at a village level, can successfully assume the role for DOT delivery. Recently implemented capacity building efforts resulted in better case detection and increased participation of primary care providers in DOT provision. Overall share of TB patients who receive DOT at PHC level has been steadily increasing from 13% in 2012 to 20% in 2015.[7] During the same period, the referral rate of TB presumptive cases has increased from 2% to 16% indicating the positive change in PHC providers' competencies in TB detection and long-term care. Although technically ready, PHC providers are not always able to fully apply their knowledge and skills in TB care as there are many systemic barriers which hider effective TB service delivery. Low financial motivation and lack of incentives for good performance, inadequate physical infrastructure and deficient infection control measures at outpatient facilities, lack of transportation and communication means, weak linkages with TB specialized services, no cooperation model with CSOs all are factors which prevent PHC providers to deliver quality services to TB affected individuals and communities. Substantial efforts will be required to address the systemic challenges to integrating TB services into primary care and fully use capacity and potential of primary care providers for achieving TB control targets in the country.

2.4 Social acceptability of outpatient TB care model

TB related stigma in Georgia among health care workers, public and TB patients is substantial. This prevents patients to timely seek medical care for TB diagnosis and treatment. Health care providers in general health care settings often fail to treat patients with TB with dignity, compassion and respect and offer needed services for TB or concomitant conditions. The established belief is that one with TB presumptive signs and symptoms should go directly to TB clinics. Neither population nor primary care providers perceive themselves as someone who can confidently deal with TB. A strong dominance of specialized TB network also plays a role in forming stereotypic vision about TB hospitals as the best and only place where persons with TB, particularly at an early stage of the disease, can get adequate care. Intensive information campaigns on advantages of outpatient TB service model should be implemented to make it attractive and socially acceptable.

Key challenges of the National TB Program in Georgia to be addressed by the advocacy strategy

- MDR TB burden remains high with 41% treatment success rate in 2013 cohort
- Hospital services are still highly utilized
- Lack of resources for high quality and patient-focused TB care delivery by outpatient TB service providers (DOT is facility based; outreach services not supported; innovative approaches to DOT e.g. video DOT not yet established; service providers reimbursement level extremely low; deficient infectious control measures at general health facilities)
- Payment mechanisms within the state program encourage long hospital stay for both drug susceptible and drug resistant TB and do not incentivize good performance for achieving better treatment outcomes.
- TB related stigma among public and health care workers is high that hinders integration of TB services into the primary care and general health settings.

3 The guiding principles for the TB advocacy Strategy

The following principles form a general framework and will guide the implementation of the TB advocacy strategy presented herein.

1. **Consider TB as a global public health challenge that requires a systemic, multidimensional and comprehensive response**

TB in Georgia is recognized as a major public health threat which has devastating societal, economic and financial consequences for patients, their families and respective communities. The increasingly high burden of MDR TB in Georgia poses a significant threat and burden not only to the national but also the European system of public health. For the last few years, it has been well documented that tens of Georgian citizens with the most dangerous forms of TB left

the country to seek medical assistance in France and other Western European countries. Article 356 of the EU Georgia Association Agreement issued in June 2014 stipulates the commitment of Georgia to strengthen "epidemiological surveillance and control of communicable diseases, such as for example HIV/AIDS, viral hepatitis, tuberculosis as well as antimicrobial resistance, as well as increased preparedness for public health threats and emergencies."
Taking into account the strong association of TB with social and economic determinants of health, strengthening social support systems and reducing poverty are critical preconditions towards sustainable development goals.

2. **Consider the reforms aimed at integrating core TB response functions into the overall health care landscape**

The Governmental policy on health is aimed at full elimination of financial access barriers to high-quality health services for the entire country population. The Government of Georgia launched the Universal Health Care Program (UHCP) early 2014. This significantly improved access to health services for Georgian citizens. Compared to the year 2010, in 2014 the share of the population covered by UHCP has increased from 30% to almost 100%.

In December 2014, the Government of Georgia adopted the Georgia Health Care Concept for 2014-2020 "Universal Health Care and Quality Assurance for protecting patients' rights" which stipulates national health priorities for 2014-2020. The concept identified TB and M/XDR TB as major public health challenges and set the following actions for adequate TB control:

- Strengthening leadership and governance for a well-coordinated multi-sectoral response to TB, HIV and hepatitis C.
- Introducing electronic health management information systems in various areas including the TB program.
- Achieving sustainable financing of priority health interventions, and from 2016, starting a gradual transition from international funding (Global Fund, GAVI, USAID) to state funding of priority programs (immunization, HIV/AIDS, TB).
- Improving prevention and management of priority infectious diseases - In order to reduce the burden of HIV/TB co-infection, HIV testing in TB patients and routine detection and treatment of latent TB among HIV infected will continue.
- Supporting intensified efforts aimed at early identification of presumptive TB cases. This will be achieved through the integration of TB services in general hospitals, strengthening of NCDCPH epidemiological services and screening and DOT programs in the penitentiary system.
- Introducing new diagnostic technologies for quick and accurate TB diagnosis
- Strengthening quality assurance and control mechanisms in TB laboratory networks.

Political commitment towards strengthening the National TB Response was translated into a new law on "Tuberculosis Control" adopted by the Government in December 2015. The law intends

to protect personal and public health through efficient control of tuberculosis, to prevent the spread of tuberculosis in Georgia, to establish the legal basis for management of TB cases and ensure adequate support to TB patients. It defines the main legal, institutional and financial principles for the organization of TB control measures in Georgia, issues related to TB control and rights and obligations of patients with TB. The law is explicit about the role and responsibilities of MoLHSA, and other public health institutions in national TB response. The law describes a comprehensive framework for TB control and outlines means and measures for effective preventive, diagnostic and treatment services. The social assistance to TB patients through cash incentives is deemed as an integral component of TB case management model. The law stipulates that the TB case management should be implemented in line with best practice recommendations and international standards, which implies the continued transition to outpatient management of TB cases. Full enactment of these new legislative provisions is planned from the year 2017.

3. Consider TB outpatient model development in the context of ongoing primary care system reform

Universal access to health services opened up new opportunities for developing an integrated model for TB service delivery. In the governmental resolution "Georgia 2020", the GoG stressed the importance of strengthening primary care and shifting more resources towards PHC services to ensure effective primary, secondary and tertiary prevention and improve efficiency of the system.[8]

For the last two decades, Georgia has made several attempts to reform its primary care system. The PHC reform has been oriented towards introducing family medicine based primary care model instead of one based on specialized outpatient services. Supported by the World Bank and the European Commission, Ministry of Labor, Health and Social Affairs invested substantial resources in the rehabilitation of physical infrastructure and retraining of up to 2000 family physicians (FPs) and 2000 general practice nurses (GPNs). Since 2009, a vast majority of rural FPs and GPNs were dis-attached from Ambulatory-Policlinic unities at a rayon level. Legally they became independent entrepreneurs and were directly sub-contracted by the MoLHSA Social Service Agency. In 2009-2012, a focus for the health reform shifted from primary to secondary care. The government announced a wide-scale privatization of health facilities aiming to improve physical infrastructure and build a new model for public-private partnership in health care delivery. With the launch of the UHCP the need for strengthening primary care services, thus improving efficiency of the system, became more than urgent. MoLHSA is currently working on elaborating national PHC strategy, which will set a new agenda for PHC development and introduce effective tools and mechanisms to strengthen the gatekeeping capacity of primary care providers.

Severe functional deficiencies of the current PHC system have been a subject for discussion at many high-level meetings for the last couple of years. PHC challenges described in various reports include weak institutional capacity for high-quality service delivery, poor physical infrastructure, low payment and lack of incentives to promote good performance, limited gatekeeping capacity to mention a few.

It should be noted that Georgia has one of the lowest number of PHC providers relative to the population when compared to CIS and EU countries. Nevertheless, the geographical access to PHC has slightly improved according to HUES study[9], i.e. the share of those accessing a PHC provider within 30 minutes has reached 78% in rural areas and 94% in urban locations in 2010. Despite good geographical access services are not fully utilized. Over the past decade Georgia reported one of the lowest outpatient service utilization in the European region 2.7 visits per person per annum (out of which PHC visits were less than 2). This is several times lower than that observed in CIS and EU countries.[2] This data indicate that primary care in Georgia has extremely limited gatekeeping role and does not necessarily serve as the entry point into the health system.

It is no longer argued that primary health care is the backbone of an effective health-care system, and can improve health, reduce growth in costs, and lower inequality.[10] A strong primary health care orientation is a critical condition for achieving universal health coverage targets particularly in resource-limited settings. Therefore, intensive efforts for strengthening PHC in Georgia is more than necessary for delivering high-quality services safely, effectively and efficiently.

4. Create an advocacy framework that influences decision-makers from the top down and the bottom up

A combined top-down and bottom up approaches are needed to achieve the desired advocacy goals. The primary targets for top-down advocacy will be the government, multilateral and bilateral donors and other international partners. It is important to influence high-level decisions on reallocating resources within the National TB Program in favor of outpatient service delivery and making adequate investments in strengthening health systems to support this transition.

Advocacy efforts by civil society can significantly influence the success of the new model implementation. Civil society should develop a good understanding of what is meant by a patients centered TB care and how this can be achieved. Community based organizations, professional associations, patient groups and private health service providers all should be mobilized to create demand and support the implementation of the outpatient TB care model in Georgia.

5. Generate evidence to support informed decision making (with a particular focus on economic evaluations including efficiency and allocative efficiency studies)

2. http://data.euro.who.int/hfadb/, Health For All Data Base

Although brining TB diagnostic and treatment services closer to patients' residencies seems very promising for improving adherence behavior and treatment outcomes, the local evidence of effectiveness of DOT given by a PHC provider as compared to DOT by TB specialized services is limited. Neither there is evidence available on cost-effectiveness of outpatient care delivery in Georgian settings to convince policy makers and gain their support. Improving efficiency of the health system is a top priority for the GoG. Therefore, the availability of evidence-based findings on efficiency and allocative efficiency of a TB service delivery model based predominantly on outpatient services is essential to support decision making on funding priorities.

6. **Build on best practices and successful international experience on patient-centered TB care models**

A level of integration of TB services into primary and outpatient care settings varies across countries. The integrated primary care is the standard care in the developed world. Many successful specific examples illustrate the potential for integration of TB services into broad primary care package to positively impact clinical outcomes. Best practices and successful international experience on building patient centered TB care models should be regularly collected and made available to a large international community. This strategy will intend to facilitate further dissemination of these lessons learned to national stakeholders to inform policy discussions and decision making.

7. **Reach target audiences with well-tailored messages to promote day-1 ambulatory TB care**

The key messages on benefits of day-1 ambulatory TB care should be incorporated into all TB information campaigns planned within the NSP for 2016-2020. A country-wide coverage of target audiences should be achieved to develop positive attitude towards ambulatory TB care and decrease demand for hospital services.

8. **Equip CSOs with simple and reliable tools to monitor progress against the strategic objectives**

Involvement of civil society organizations in Georgia in the National TB Response has been very limited until very recently. In 2013-2015 with the USAID support 11 CSOs received needed resources and tools to implement community-based interventions aimed at improving TB awareness, reducing TB related stigma and building capacity of health care workers in patient-oriented care delivery. This program has proved that civil society organizations (CSOs) have strong motivations to serve their communities, especially vulnerable populations. CSOs are well placed to monitor TB services with respect to their reach, accessibility and quality.[11] Feedback on early implementation experience of a day-1 outpatient TB care model that CSOs can provide will be very valuable for addressing weakness and improving important aspects of service delivery. For the greater involvement

of CSOs in advocacy and resource allocation decision making, it is important to strengthen their capacity in ongoing monitoring of health policies aimed at strengthening outpatient TB care, performance and quality of health services.

4 Aim and objectives

The primary focus for this advocacy strategy is to improve access to and quality of TB services through strengthening outpatient TB services and establishing a patient-centered TB care model.

Advocacy activities will be designed to improve knowledge of decision-makers at national, regional, and district levels and media about the burden of TB disease, its impact on communities and families with TB patients, and their roles and responsibilities in TB control and prevention.

The following are priority areas for advocacy efforts:

- Ensuring sustainable financing of the National TB Program through improving efficiency of the system
- Introducing effective financing mechanisms to encourage good performance and high quality service delivery
- Supporting professional integration of TB into competencies of primary care providers
- Organizing information campaigns aimed at reducing a level of stigma
- Supporting structural and functional integration of TB service delivery into general health care setting through building outpatient health care providers capacity in TB and MDR TB management

Aim of the strategy is to improve access to and quality of TB services through strengthening outpatient TB services and establishing a patient-centered TB care model. Eventually this should lead to improving TB treatment outcomes and reducing the spread of the disease. It is anticipated that this strategy will contribute towards the following outcomes (a) TB treatment outcomes improved; (b) the proportion of MDR TB cases reduced; (c) allocative efficiency within the TB programs improved (d) TB related stigma among health care workers and public will reduced (c) Attitude towards outpatient TB care positively changed and demand for ambulatory services increased.

This strategy will contribute towards achieving the following TB control targets for Georgia by year 2020:

1. TB mortality rate is reduced by at least 25%;

2. TB incidence rate is reduced by at least 15%;
3. The proportion of MDR-TB among new cases is under 15% and among previously treated TB cases – under 40%;
4. Universal access to diagnosis and treatment of all forms of TB, including M/XDR-TB, is ensured, so that:
    - At least 90% of estimated MDR-TB cases are diagnosed; and
    - At least 75% of all notified MDR-TB cases are successfully treated.

This aim will be achieved through the following four objectives.

Objective 1: High level advocacy at national level conducted to sensitize decision makers of the importance of a patient-centered TB care to ensure sustainable and adequate funding for the National TB Program.

Objective 2: Programmatic advocacy aimed at health care providers implemented to encourage facility owners to support capacity building in TB and MDR TB case management

Objective 3: National TB awareness campaign implemented to disseminate information about benefits of TB treatment at outpatient level

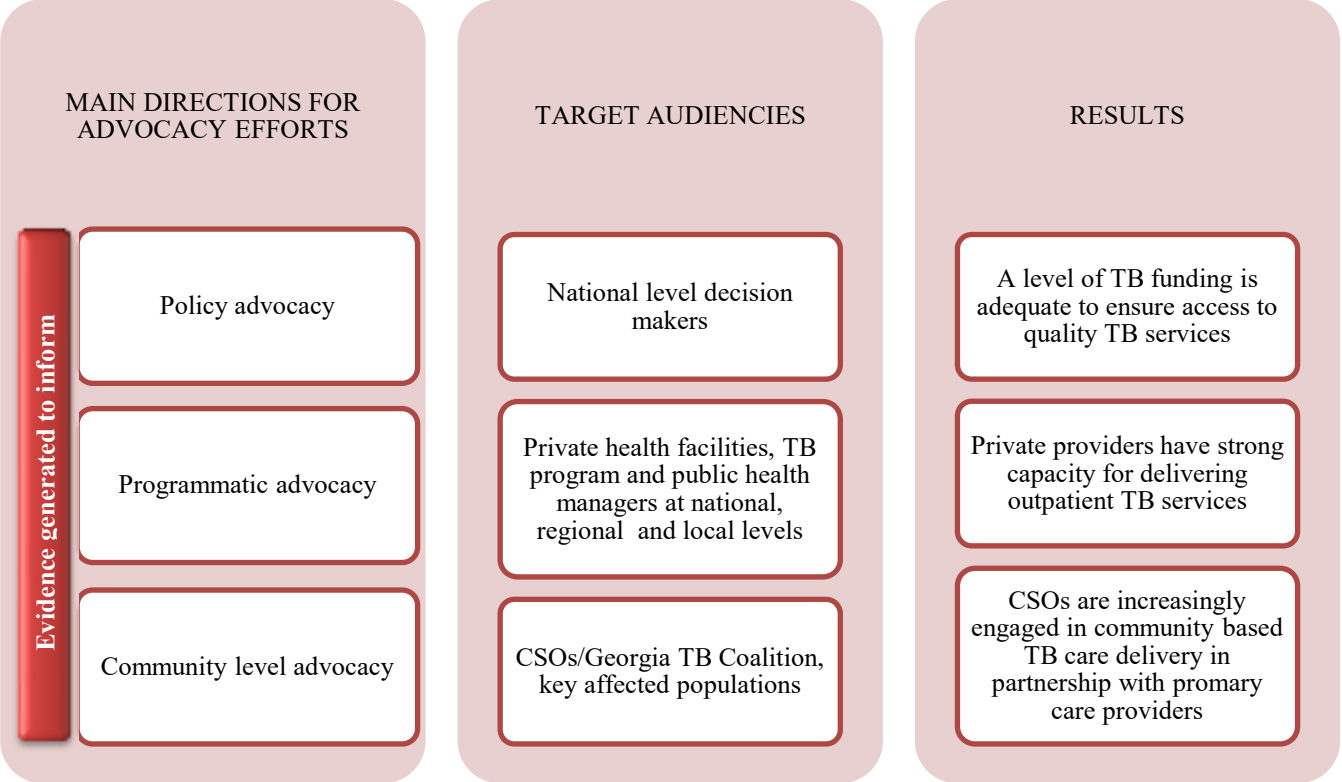
Objective 4: Evidence generated on efficiency of outpatient versus inpatient TB care models to inform policy and programmatic decisions on allocation of funds within the TB program

The strategy will target the following audiences:

- Government of Georgia
- Ministry of Labor, Health and Social Affairs
- Country Coordinating Mechanism
- Donor Agencies (Global Fund, USAID)
- Civil Society Organizations (Georgia TB Coalition)
- TB Hospital Service Providers
- Private health facilities providing TB outpatient and inpatient services
- Media

Interventions planned under each objective envision policy, programmatic and community level advocacy aimed at strengthening capacity of health and community systems for outpatient TB service delivery and mobilizing adequate funding for sustaining access to high quality services to all in need (Figure 1).

Figure 1. TB Outpatient Care Advocacy Strategy Implementation Framework



5 Key messages

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6 Implementation plan

The strategy will be implemented through joint efforts of National TB Stakeholders including Ministry of Labor, Health and Social Affairs, National Center for Disease Control and Public Health, National Center for Tuberculosis and Lung Diseases, Georgia TB Coalition which units almost 20 local CSO, Georgia Family Medicine Association and private clinics delivering outpatient TB and primary care services. This section describes activities to be implemented at national, regional and local levels for achieving the strategic objectives outlined above.

6.1 Implementation of policy advocacy (objective 1)

- Support participation of MoLHSA and NTP leaders in high level global and regional meetings aimed at introducing patient-centered TB care model

- Conduct high-level advocacy meetings to highlight current challenges within the National TB Program and explain/illustrate how these can be solved through shifting resources towards outpatient TB care model.
- Meet the high level officials at the Ministry of Labor, Health and Social Affairs and Ministry of finance to advocate for implementation of performance based financing mechanism to incentivize outpatient providers to improve TB treatment outcomes. Elaboration of these mechanisms is envisioned within the National TB Strategy for 2016-2020 and will be supported by the Global Fund TB Project.

6.2 Implementation of programmatic advocacy (objective 2)

- Support participation of managers from TB outpatient service delivery units in national advocacy meetings
- Organize workshops for managers of private health clinics delivering TB outpatient services on TB and MDR TB case management
- Organize individual face-to-face meetings and site visits to outpatient TB clinics to observe pattern of service delivery
- Establish annual award ceremony at which the Georgia TB Coalition will identify best performing outpatient clinics and recognize their work.

6.3 Implementation at community level (objective 3)

The following activities will be implemented under objective 3.

- National TB Stakeholders secure funding for organizing advocacy training for Georgia TB coalition members for them to effectively advocate for strengthening outpatient TB service delivery model in Georgia.
- National TB Stakeholders organize at least two public awareness campaigns annually highlighting the opportunities and benefits of outpatient TB care model
- National TB Stakeholders organize at least two stigma reduction campaigns annually aimed at health care workers in general health care settings
- Georgia TB Coalition organizes social mobilization campaigns to encourage constituents to contact policymakers through letters, petitions and social media.
- Georgia TB Coalition works with media to achieve greater coverage of TB related themes with a particular emphasis on outpatient service delivery model.

6.4 Generating evidence base for effective advocacy (objective 4)

- Economic evaluation surveys will be conducted to generate evidence on efficiency of outpatient versus inpatient TB care models to inform policy and programmatic decisions

on allocation of funds within the TB program. The allocative efficiency survey of TB programs can best illustrate financial benefits that are anticipated from shifting resources towards outpatient care delivery. The survey will be conducted by the end of 2017.

- The national workshop will be organize to present the survey finding to policy makers and support decision making on resource allocation within the National TB program.

7 Logical framework

The logical framework for this strategy is presented in the attached Excel file.

References

1. TB/MDR TB Advocacy Toolkit, Advocacy Partnership 2011 retrieved from http://www.stoptb.org/assets/documents/global/awards/cfcs/TB_MDR%20Advocacy%20Tool%20Kit.pdf in June 2016
2. Ambulatory TB care A key to achieving better tuberculosis outcomes in the WHO European Region, The Regional Collaborating Committee on Tuberculosis Control and Care, Retrieved from http://stbcu.com.ua/wp-content/uploads/2014/11/1386283-Ambulatory-TB-Care.pdf in June 2016
3. Implementing the End TB Strategy: The Essentials, World Health Organization, 2015
4. National Strategic Plan for Tuberculosis Control in Georgia 2016-2020., Endorsed by the Government of Georgia in July 2016.
5. Health 2020: the European policy for health and well-being., http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being Accessed in July 2016
6. National Tuberculosis Strategy 2016-2020
7. USAID TB Prevention Project Reports produced by University Research Co. LLC
8. Georgia Healthcare System Concept (GHSC) 2014-2020: Universal Healthcare and Quality Management for the Protection of Patient Rights
9. MoLHSA 2011. Georgia health utilisation and expenditure survey: Results from two rounds of a household survey on the use of health services and expenditure on health. Final Report.
10. Starfield, B, Shi, L, and Macinko, J. Contribution of primary care to health systems and health. *Milbank Q*. 2005; **83**: 457–50
11. Stop TB Partnership, Community System strengthening and TB