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Public-Private Partnerships for TB Control

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1. INTRODUCTION

During the past decade, all over the world, attention has been drawn to the significant role that private health providers play in the delivery of health care services. In the South-East Asia Region, it has long been recognized that the private health sector provides a considerable proportion of services for communicable diseases, including tuberculosis, which continue to form the largest burden of disease in the Region. They have been shown to be often the first and only point of contact for over 60% of patients with tuberculosis in this Region. Their role is particularly important since detection and cure remain the major interventions for reducing disease transmission.

Recognizing the importance of collaboration between the private health provider and the National TB control Programmes, WHO initiated operational research projects on public-private partnerships in the SEA Region in 1995. A compilation of the experiences and lessons learnt from these and other public-private partnership initiatives from 23 countries in the six WHO regions, together with a baseline situation assessment, was undertaken between 1999 and 2000. The assessment found several initiatives that had achieved considerable success. Though several attitudinal and structural barriers existed, there was, overall, pragmatism and willingness to collaborate. A consultation on "Private Practitioners' Involvement in Control of Communicable Diseases with a focus on Tuberculosis" followed in August 2000 and a preliminary policy framework and recommendations for evolving broad guidelines emerged.

In February 2001, a regional consultation on involving private medical practitioners in TB and STI control was organized at Bangkok for private health providers, representatives of medical associations, programme managers and policy-makers to specifically address these issues in the SEA Region. The key future steps identified were:

Adoption of a national policy to actively involve private health providers in national disease control programmes and representation of private health providers on national level committees.

- Development of specific guidelines and mechanisms at country level for public-private collaboration, including modalities for monitoring.
- Promotion of private health sector involvement in national control programmes by medical associations and professional societies.
- Building of capacity and provision of necessary assistance to the private sector for its effective participation.
- Documentation, dissemination of successful models of public-private partnerships for replication and adoption for implementation on a wide scale.

The Regional Consultation on Public-Private partnerships for TB Control at Chennai was arranged to provide a forum for Member States to follow through with these recommendations. The consultation, held from 7-9 August 2001, was attended by policy-makers, prominent representatives from among private health providers, representatives from national medical associations and TB programme staff from Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand.

The objectives of the consultation were:

- (1) To review the TB control strategies and share information and learn from experiments and experiences on public-private partnerships for TB control in the Region;
- (2) To discuss adaptation to local contexts of successful strategies used in pilot public-private partnership projects;
- (3) To recommend strategies to promote implementation, expansion and replication of successful public-private partnerships; and
- (4) To develop a monitoring system for public-private partnership projects.

Dr M.D. Gupta, Director, National Institute of Epidemiology, Indian Council of Medical Research, as the local organizer of the consultation, welcomed the participants. After the preliminary introductions, Mr Deepak Gupta, Joint Secretary, Ministry of Health and Family Welfare, Government of India, was nominated Chairperson, and Dr (Ms) Anowara Khatun, National TB Programme Manager, Bangladesh, as Co-Chairperson and Dr (Ms) Nalini Krishnan, India was nominated Rapporteur for the meeting.

2. RATIONALE FOR PARTNERSHIPS FOR TB CONTROL AND THE ROLE OF THE PRIVATE MEDICAL SECTOR

With the resurgence of TB in the advanced countries and increasing case-loads in Asia and Africa, global attention was focused on TB. In 1993, WHO declared TB "a Global Emergency". The DOTS strategy for TB control, which had evolved in the preceding decades, was widely promoted and adopted throughout the world; it is currently being practiced in 127 countries around the world. Yet, the global situation with respect to TB continues to be alarming. Over 8.4 million new cases (and 1.8 million deaths) were recorded in 2000. The reasons are not far to seek - only 23% of the patients received treatment under DOTS and the HIV epidemic has caused the TB epidemic to grow both in Africa and Asia. In the South-East Asia Region, 3 million new cases and nearly three-fourths of a million deaths are registered every year.

At the meeting at Amsterdam in March 2000 between Ministers of Health, Finance and Planning, 20 of the 22 high burden countries committed themselves to achieving the global targets for TB control by 2005. They called for assistance to develop national plans, a new initiative to increase access to drugs, research to develop new drugs, diagnostics and vaccines and a Global Fund for TB. Global partners through the Stop TB secretariat responded rapidly to this call. A global partnership to stop TB has been formed, a global TB drug facility established, a global plan for DOTS expansion developed, mechanisms to accelerate research to develop new tools and help mobilize resources for TB through multi- and bilateral funding identified. Within the SEA Region, priority is being accorded to three key areas - building national capacities, ensuring regular drug supplies and forging and sustaining partnerships in order to rapidly and effectively expand DOTS to achieve universal access and programme targets by 2005.

Developing partnerships with health providers outside the government health system, and especially with private health providers, is critical to progress with DOTS in the SEA Region. Besides the large case-loads, diagnostic and treatment practices within the private sector differ considerably from the practices of national programmes. The consequences of these are dilution of the epidemiological impact of the DOTS strategy in terms of mortality and disease burden, higher risks for the development of MDR-TB, and higher out-of-pocket expenses incurred for often ineffectual outcomes.

The case for addressing the private health sector

The **strengths** within the private sector offer many opportunities to NTPs to rapidly improve local access and acceptability through the personalized private sector practices of more convenient timings and locations, shorter waiting periods, closer identity with the communities they serve and greater trust enjoyed. Co-opting the private health sector to deliver DOTS would therefore afford opportunities to rapidly enhance case-finding and treatment outcomes while according a sense of joint ownership and accountability for TB control. This sharing of the “service load” would, in addition, ensure long-term sustainability. There is therefore, a strong case for addressing the private health sector despite the many perceived barriers.

Perceived barriers to public-private collaboration for TB control

Within NTP	Within the Private Sector
<ul style="list-style-type: none"> • Ideological opposition • Lack of information on the private sector • Preoccupation with strengthening and expanding NTP • Prejudices about private for profit care • Lack of resources for coordination and supervision, weak regulatory mechanisms • Absence of precedents, doubts on replicability 	<ul style="list-style-type: none"> • Inadequate training and lack of information • Technical doubts about NTP guidelines and quality of care within NTP • Public health viewed as being a low priority with little remuneration • Competition for patients • Infrastructural limitations • Largely unorganized; liaison and interaction challenging

3. NATIONAL POLICIES AND SUPPORT SYSTEMS

Bangladesh

Bangladesh, with a population of 130 million, has made considerable progress with DOTS since 1994. TB services have been accorded high priority under of the Fourth Population and Health Project and are included in the Essential

Services Package (ESP). Ninety-five percent of the country has been covered; 60% through government health facilities at national, district and upzila levels and 40% through NGOs with whom the government has signed memoranda of understanding. As a result, DOTS centres are now available to 80% of the population within 30 minutes' walking distance. Under the ongoing Health and Population Sector Programme, there are plans to expand the services of NTP to the four large metropolises of Dhaka, Chittagong, Khulna and Rajshahi by 2003 through collaboration between the city corporation, Ministry of Health & Family Welfare, and the private sector. Training, drugs and laboratory consumables will be supplied and assistance with recording reporting and supervision will be undertaken in an integrated fashion on similar lines, as has been done in the past.

In Chittagong, a city of 3.5 million, a plan of action for TB control was developed in 1999. A TB coordination committee comprising the Mayor, Divisional Director of Health, district civil surgeon, Chief Health Officer of the City corporation, city TB supervisors, NTP staff and NGOs was established. A partnership with NGOs and the business sector was also established. Through this mechanism, an improved network of 6 microscopy and 42 DOTS centres has been established and regular supervision and monthly/quarterly coordination ensured. A preliminary analysis has revealed better case-finding among women - a female:male ratio of 0.8:1 as compared to the national average of 0.4:1 and improved treatment outcomes among new smear cases detected.

India

India has achieved a twenty-fold expansion of RNTCP within the past three years with excellent treatment success rates; through continued expansion, it is expected that 80% of the country would have access to DOTS by mid-2004. Several steps have been undertaken to effectively involve private health providers in recent years. Meetings have been arranged with private practitioners at the state level in several states. District TB societies comprising RNTCP staff, private practitioners and NGOs have been formed. Draft national guidelines for the involvement of practising physicians in RNTCP have been developed and seven participatory schemes designed. Each scheme designates a role for the district Tuberculosis Coordinator, outlines the specific criteria for eligibility of individual private providers, including practitioners of alternative systems of medicine, the necessary approval/registration procedures and the assistance that will be provided by RNTCP for the implementation of each scheme.

These schemes are briefly outlined below:

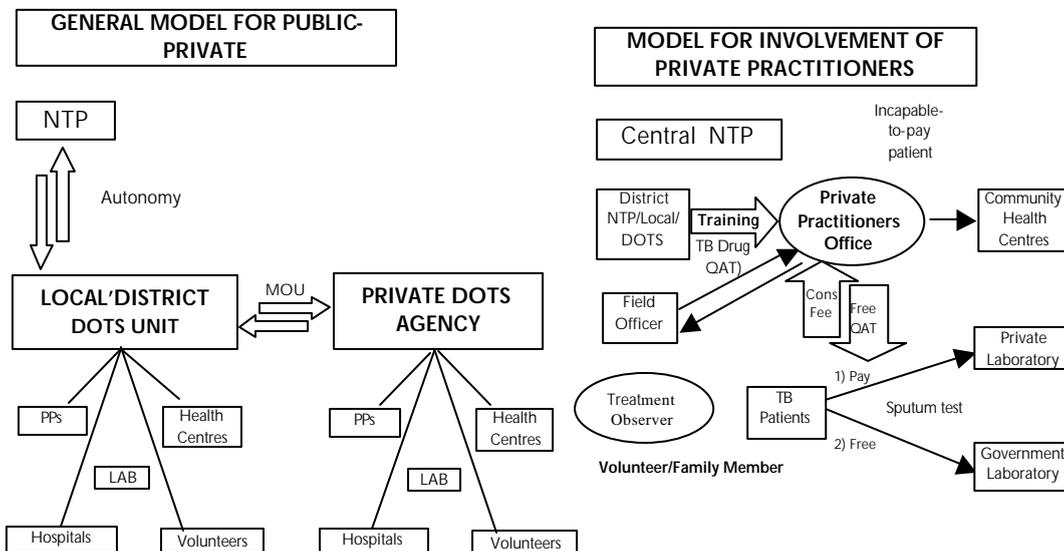
Scheme 1	PP will participate in referral only
Scheme 2	PP will provide DOT
Scheme 3A	Private facility approved by NTP for microscopy (the centre will utilize own resources and may charge fees but will be supervised by NTP)
Scheme 3B	Private facility approved by NTP for microscopy and treatment (the centre will utilize own resources and may charge fees but will be supervised by NTP)
Scheme 4A	Private facility designated a microscopy centre by NTP (smear microscopy free of cost, laboratory materials provided by NTP)
Scheme 4B	Private facility designated a microscopy and treatment centre the NTP (diagnosis and treatment provided free of cost; supplies from NTP)
Scheme 5	Private facility which will undertake, in addition, systematic monitoring and evaluation

Provision has been made for adequate financial assistance to each treatment unit and designated microscopy centre with additional funding being made available for in-patient management and for the payment of a small incentive to individual lay DOT providers for each patient cured.

A large number of private providers, including NGOs, have been involved in providing DOTS services in the various states in India. Public-private partnership projects in Pune (Maharashtra), Sitapur (Uttar Pradesh), Patna (Bihar), Hyderabad (Andhra Pradesh), Chennai (Tamil Nadu) and in the capital Delhi, including three pilot projects initiated by the Delhi Medical Association (a branch of the Indian Medical Association), have made good progress. A number of initiatives to involve the corporate sector, such as the sugar industry, coal mines, large corporate employers, the railways and the Employees' State Insurance, are simultaneously being undertaken. The focus is on initially achieving a comprehensive involvement of all sectors in the provision of DOTS in one treatment unit (population 0.5 million) in each RNTCP district as DOTS is expanded throughout the country. A comparative analysis of TUs using this approach with the conventional DOTS TUs will follow.

Indonesia

TB is a major public health problem in Indonesia; the country is ranked third among the countries with the highest burden of TB in the world today. Since the adoption of the DOTS strategy in 1995, the country has made good progress due to the high level of political commitment accorded to the programme under the national movement for integrated TB control, "GERDUNAS TB". Initiatives to involve the private sector are being actively pursued through the Indonesian Medical Association (IMA) which has been an active member of GERDUNAS TB since its formation in March 1999. This has proved strategic since IMA has branches in over 80% of the districts in the country and 90% of the private practitioners are members of the Association. A preliminary situation assessment among private health providers has been undertaken in three provinces in the country through the Indonesian Medical Association (IMA). In October 2000, a memorandum of understanding was signed between MOH and IMA to develop guidelines for the involvement of private providers. This was followed by the setting up of pilot projects involving individual private practitioners. In July 2001, a national seminar was jointly arranged by MOH and IMA together with the Indonesian Hospitals Association to develop models for collaboration with private hospitals. The models developed for public-private partnerships are shown below:



Targets set for public-private partnerships are: by 2004, 90% of the hospitals and at least 50% of the private practitioners will be actively involved in implementing DOTS in collaboration with NTP in Indonesia.

Myanmar

Myanmar has extended the DOTS strategy to 85% of the country's population in 259 out of the country's 324 townships with good treatment outcomes and steadily improving case detection rates. Intra and intersectoral collaboration within the country has been developed with the involvement of other ministries such as Labour, Railways and Industry, the police force, religious leaders and several local NGOs and international donor/partner agencies.

The Myanmar Medical Association (MMA), with 72 branches and a membership of 7000, has been actively associated with NTP in Myanmar, mainly in the areas of advocacy and continuing medical education. In coordination with NTP, the Myanmar Medical Association holds regular meetings at all state capitals and divisions to advocate with its members to actively collaborate with NTP. Guidelines for general practitioners have been published and distributed. These recommend early referral of TB suspects, adherence to NTP practices, guidelines for the provision of DOT, default retrieval, contact tracing, and procedures for reporting to NTP. Constraints within NTP in developing public-private collaboration have been frequent transfers of TB medical officers, with consequent difficulties in sustaining their interest, weaknesses in supervision and training, especially refresher training, and a lack of incentives within the government sector. Within the private sector, constraints are similar to those faced in the Region as a whole.

However, the results of a public-private partnership pilot project set up in the township of Shwepyithar are encouraging, having developed a high level of cooperation between NTP and general practitioners (GPs), resulting in excellent treatment outcomes.

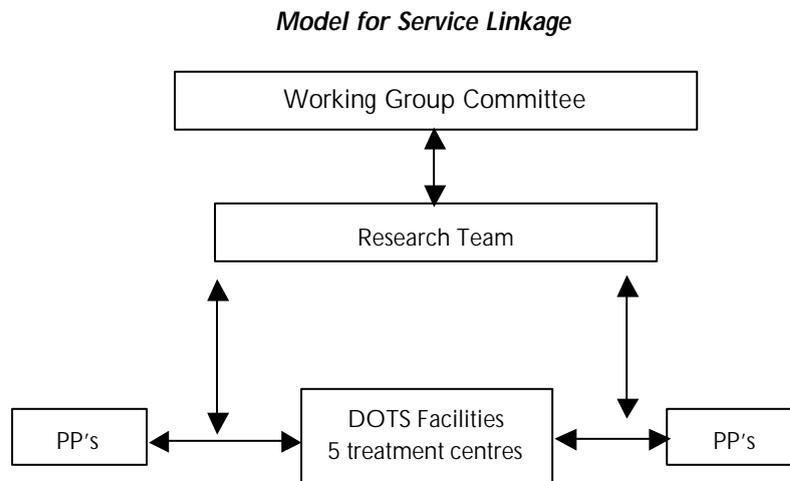
It is expected that initial successes such as this will lead to gradual replication of PPPs in the country.

Nepal

The National TB Control Programme in Nepal has ensured that the DOTS strategy is now available to 85% of the country's population in the 75 districts

in the country. Evidence has shown that case detection in the public sector is around 50%. However, nearly 70% of anti-tubercular drug inputs are accounted for by the private sector. Establishing private-public collaboration was therefore considered especially important in urban areas in view of rapid population growth, high burden of disease, weaker public health services and freely available over-the-counter anti-tubercular drugs in the setting of a rapidly expanding private sector.

A model for service linkage was developed as shown below in one municipal ward, Lalithpur, in the Kathmandu valley:



The Lalithpur municipality has a population of 200 000 and was selected since it was close to Kathmandu. One hundred private practitioners were involved in the project. Following a basic needs assessment based on interviews with private practitioners, a working group as well as local DOTS committees consisting of all stake-holders was formed. Standard case management protocols were developed and private practitioner workshops held. Service providers (microscopy centres, treatment centres and sub-centres) were identified. These included five urban DOTS treatment centres and four diagnostic centres. Health workers, volunteers and social workers were trained to implement DOTS and late patient tracing mechanisms developed with NGOs' support. Feedback meetings with private practitioners were arranged and PP clinic visits made periodically. An informal coalition against tuberculosis (CAT) involving District Health Office, non-governmental organizations, international non-governmental organizations, private practitioners, the local municipality and members from the community was also formed.

Up to 17% of new cases now being registered by NTP are from private practitioner referrals, contributing significantly to case finding. Treatment success rates in the project area rose to over 90% thereby showing that through sensitizing private practitioners and providing appropriate information, it is possible to build up local health services. Another conclusion that may be derived from this example in Nepal is that a successful NTP, by setting exemplary standards, can very rapidly achieve effective collaboration with the private sector.

Future stress will be on programme intensification, advocacy for and more active involvement of the private sector.

Thailand

DOTS was initiated in 1996 and currently covers 66% of the country's population of 60 million. A survey of the practices being followed for diagnosis and treatment of patients with tuberculosis by private practitioners in the hospitals in 19 large provinces in Thailand was conducted in 1997. The 207 questionnaires returned revealed that 30% of the private practitioners commenced treatment for TB when abnormal shadows were seen on the chest X-ray and after only one smear examination, often negative. Eighteen different regimens were being used to treat new smear-positive TB patients. Most doctors preferred to refer relapse and failure cases to public hospitals. They did not maintain separate TB registers and undertook no formal or regular evaluations of treatment outcomes.

A national policy for the involvement of private practitioners has been articulated. The policy envisages the involvement of private practitioners in the programme mainly in the area of service delivery. The following criteria have been developed to guide private sector involvement:

- Collaboration should be strictly within the DOTS framework.
- Diagnosis should be based on three specimens of sputum being examined, besides chest X-ray.
- There must be an explicit plan for treatment and case holding.
- Drug regimens should follow NTP guidelines.
- Anti-TB drugs should be provided free of charge to patients.
- Recording and reporting system of NTP should be followed; reports sent regularly to the NTP.

Introduction of mandatory notification of TB cases by the private sector is also planned. Attention is now focused on disseminating information on TB and standard guidelines on diagnosis and treatment to all private doctors. As a beginning, a model for public-private partnership has been developed focusing on service delivery and involving, initially, the hospitals enrolled in social security system. TB case management is presently not a part of the medical curriculum. The inclusion of information on national disease control programmes into medical teaching programmes is also being pursued.

4. EXAMPLES OF ONGOING PUBLIC-PRIVATE INITIATIVES IN TB CONTROL IN THE REGION

4.1 Tuberculosis Research Centre – ACT and Private Practitioners

An initiative named ACT (Advocacy for Control of TB) to involve private practitioners in Chennai, India, in TB control was launched by REACH (Resource Group for Education and Advocacy for Community Health), together with the Tuberculosis Research Centre (TRC), the Corporation of Chennai, private practitioners and patients in Chennai, India. The objectives of this project were to develop a model to induct private practitioners into RNTCP, identify modalities to link private practitioners with the public health care system, develop sustainable approaches and determine ways to upscale the model. The target groups were individual doctors in private clinics, group practice or in corporate hospitals and institutional intermediaries. Doctors willing to participate in the programme were identified through questionnaires and through their monthly association meetings. The Independent Medical Practitioners Association of India, the Tamilnadu Medical Practitioners Association and the Indian Medical Association were contacted. Doctors were sensitized and then informed about the policies and practices of RNTCP. ACT organized training workshops on the components of RNTCP and the DOTS methodology in coordination with the Tuberculosis Research Centre, Chennai. The staff of 30 private laboratories were also trained by TRC, Chennai. Eighty-three doctors joined the programme and the agreed inputs for them to participate were provided, including documents, patients case records and information for the patients and DOTS providers. Drugs were procured from the Chennai Corporation and ACT arranged for social workers and programme coordinators who were also trained by the faculty of TRC. A wide range of partners from other sectors, such as the industry, NGOs, the media and community-based clubs, were also involved.

A unique feature of the ACT project was the emergence of volunteers within the community who acted as DOTS providers.

Future plans are to develop links with corporate business and industry, develop a network with other NGOs, assist with training of doctors in other disease control programmes, such as malaria, HIV and other major health concerns, and to develop a system of quality control and monitoring.

4.2 Mahavir Trust Hospital, Hyderabad

In a joint effort between the government and the private sector, a charitable speciality trust hospital in Hyderabad, India, undertook a project to involve individual private practitioners in the DOTS programme. This project, started in 1995, currently covers a population of 500 000 in the city. Following a basic situation analysis where it was found that upto 80% of patients were seeking treatment in the private sector and that most private facilities were not following national guidelines for either diagnosis or treatment, an intervention first to sensitize private practitioners to the programme and then to develop a model for collaboration was developed with the charitable trust hospital functioning as an interface between the government and individual private practitioners. A campaign was launched to inform local physicians about DOTS and to create a mechanism for referral of TB patients with the assurance that private practitioners would continue to be the patients' primary care giver. A referral card was developed and, following initial diagnosis, counselling and treatment at the Mahavir Hospital, patients were referred back to identified private sector DOTS centre within easy walking distance of their homes. Flexible timings were also ensured.

The results of this programme have been outstanding. Nearly two-thirds of the patients registered were referred by the private practitioners in the project area and women accounted for nearly half of all smear positive cases. National goals of 75% case-findings and cure rate of more than 85% of new smear-positive patients have been achieved. This experience shows that a strategy of collaboration between the public and private sectors is feasible and cost-effective.

The lessons learnt from both these models are that it is possible to induct private health care providers into public health programmes if an intermediary organization coordinates between the local health authority and the

community and ensures a mechanism to provide technical support and monitoring. Long-term sustainability can be ensured by maintaining motivation among private practitioners, leaving the “ownership” of their patients with them, and sustaining the links between the doctor and the government, while allowing some degree of autonomy to the doctor within the DOTS framework. Building on the strengths of the private providers then emerges as a successful and replicable proposition.

4.3 Other Examples of Public-Private Partnerships for TB Control - India

Participation of the Tea Industry in the National TB Programme, West Bengal

In Jalpaiguri district, West Bengal, India, there are 153 registered tea gardens each with a health clinic providing primary health care to all employees and their dependents. Officials from the Indian Tea Planters’ Association were invited to preliminary meetings when the revised National Tuberculosis Control Programme was introduced in this district. They were briefed on the DOTS programme, which was then introduced into their health care system in collaboration with RNTCP. All tea garden health clinics are now involved either as treatment observation centres or as screening centres for chest symptomatics. Two out of 35 microscopic centres and 210 of the 593 DOTS centres in the Jaipalguri district are in the tea gardens. Over 40% of cases registered in the district were detected at the tea garden health clinics and the district has achieved sputum conversion rates of over 90%.

Partnership with “NIDAN” an NGO in Patna , Bihar

NIDAN is an NGO supporting non-formal education and income-generation schemes for slum-dwellers in 48 slum areas in Patna. This NGO, in collaboration with RNTCP, took up the provision of DOTS services to this population of 3.5 lacs. The NGO works as an intermediary between community private practitioners, traditional healers and government health facilities in these slums mobilizing private practitioners, liaising between them and RNTCP and providing feedback on a regular basis. Thirty-five DOTS centres are now in operation and provide services at convenient timing and locations. This has resulted in improved case detection and treatment outcomes among TB patients in these slums.

Private-public collaboration for DOTS in Pimpri Chinchwad Municipal Corporation, Maharashtra

In areas where corporation dispensaries were not available, qualified independent registered practitioners were contacted through preliminary meetings and a widely circulated questionnaire to ascertain their willingness to participate in the activities of RNTCP. Of these, 23 general practitioners were involved in RNTCP in this municipality. They were encouraged to refer symptomatic patients to the government DOTS facilities. Diagnosed patients were then referred back to them for DOT with a written feedback letter. The National Programme staff acted as liaison officers and provided materials to the private practitioners. They assisted them with recording, reporting, default tracing and supervision of treatment. Initial results are very encouraging with cure rates of over 90%.

DOTS for the Bidi Rollers, Bangar

Tuberculosis was identified as a major health problem amongst bidi workers in this district. Following this, with local donations and support from individuals in the area, a group of young social workers started a clinic in a small tea shop in Bangar. Links with local government hospitals followed and DOTS services were introduced when RNTCP expanded into the area. Initial case detection and cure rates are encouraging.

5. STRATEGIES FOR ENHANCING IMPLEMENTATION OF PUBLIC-PRIVATE PARTNERSHIPS

5.1 Policy Level

Adopting a national policy for delivery of health care through public-private partnerships

Most national programmes have no coherent policy towards the private sector. National TB programmes were conceived as public health projects and DOTS services have so far been provided solely through the public health infrastructure. A policy would need to be adopted and strategies developed to allow private participation as equal partners in planning, implementing, monitoring and evaluating public-private partnerships. This would have to be done through a National Technical Advisory Body comprising policy-makers, national programme staff and representatives of the private health sector.

Policy and guidelines to decentralize services in order to develop locally appropriate models for partnerships

Public-private partnerships have to be allowed to develop at the operational level at which these are to be implemented. It is unlikely that a centrally-administered uniform model would succeed in the diverse health settings within a country. However, while specific schemes would evolve through consensus between NTP staff and private health providers at the district level or at treatment unit level, national guidelines within which these should operate must be developed.

Support for enhancing the involvement of private providers

A national policy must be adopted to allow NTPs to include private providers in TB control. Support must be extended to implement, monitor and disseminate successful experiences of public-private partnerships within countries at national and international forums, both to allow for replication of cost-effective models and to attract private investment in DOTS.

Implementation through local coordination committees

Local coordinating committees should be set up at district or TU level to rapidly and effectively operationalize public-private partnerships. These committees should comprise NTP staff at the local level, prominent practitioners and representatives of their associations, locally-active NGOs and community groups, large-scale corporate employers in the area, if any, and be attended, at least at the beginning, by senior bureaucrats, elected leaders of the state or municipal bodies and national-level NTP staff. These committees, by mutual consensus, must undertake to initiate dialogue with private providers, advocate for collaboration, facilitate planning of various activities, identify nodal agencies and oversee the design and implementation of proposed projects. These committees should meet regularly to monitor progress and disseminate useful information and experiences for the benefit of various partners.

Inclusion of non-allopathic systems of medicine in programme implementation

Practitioners of non-allopathic systems of medicine, including traditional medicine, provide a considerable proportion of health care in South-East Asia.

They identify closely with the communities they serve and enjoy a tradition of long-standing trust and confidence among their clientele. National disease control programmes could greatly extend their reach by involving these practitioners of alternative systems of medicine by inducting their services to the extent feasible within the framework of the DOTS strategy. Two strategic areas are increasing acceptability and improving access to those seeking care for tuberculosis through these practitioners, and case-finding, referral activities and enhanced case-holding through their involvement in the provision of DOT.

5.2 National Level

Development of protocols for public-private partnerships

The group felt that the seven schemes developed by the Government of India which specifies the criteria for participation and inputs, including material resources required for each level of participation, could be applied or adapted to address all categories of private providers. If necessary, an intermediate agency may be appointed to interface between private providers and NTP. Simplified recording format and referral forms for use by private providers could be developed. A system of monitoring through consensus to evaluate the volume and quality of services being delivered through these public-private partnerships must be established and some form of recognition accorded to private providers for exemplary services.

Capacity building

Participating private providers would need to be oriented to the policy and practices of NTP and imparted skills and motivation to lead his/her staff and patients to adhere to DOTS. They must be provided materials to constantly update their professional knowledge, assisted in default retrieval through NGOs, community volunteers or government staff and in the maintenance of records.

There is a need for continuing medical education through seminars, local conferences facilitated by local medical associations or branches of professional societies and through distance education in coordination with NTP. It is equally essential to improve the managerial skills of NTP staff to help them coordinate with private providers to implement these schemes.

A sense of common responsibility and mutual trust, being recognized by the government for microscopy and treatment services, recognition accorded for quality work and the generation of goodwill among patients will then continue to spur increasing commitment from private providers.

Ensuring the proficiency of all allopathic practitioners in the policies and practices followed by the NTP

Pre-service

This would involve the inclusion of teaching on the policies and practices followed by NTP in the curriculum of medical and paramedical students. In order to facilitate this, each medical school should be actively involved in the functioning of one DOTS centre which could then be used for demonstration and training. Thereafter, fresh graduates should be posted to DOTS centres during their internship. Medical councils should ensure that teaching on national disease control programmes are included in the core curriculum of various courses and accredit only those that meet this criterion.

In-service

Similarly, practising physicians should have their knowledge on national control programmes upgraded through continuing medical education including distance education. Member States should identify regional and national training institutes and strengthen their capacity to undertake this. "Core trainers" drawn from these institutes, both within and outside the government sector, must be appointed to help train private providers. Medical councils might consider the introduction of re-certification dependent on a demonstrated understanding of current national disease control programmes or on attendance at a stipulated number of CME on national programmes.

Provision of guidelines for the management of multidrug-resistant TB and other evolving challenges

It is equally essential for national programmes to monitor and disseminate up-to-date information on difficult issues such as the management of cases with multidrug-resistant tuberculosis and tuberculosis associated with other concomitant conditions even if these are not being managed within the programme. This is essential both to sustain the interest of specialist practitioners and to ensure that mismanagement is avoided in these critical areas in order to avoid adverse outcomes.

Documentation and dissemination of case studies of successful models of public-private partnership for replication

National programme staff should, in concert with local staff and members of coordinating committees and medical associations, make every effort to document ongoing PPP projects in the country and constantly provide information on progress with DOTS and with various PPP projects to all partners. This could be done through newsletters, booklets, mail networks or through web sites which most national programmes have developed. Data and experiences generated should be presented at national and regional conferences of medical associations and professional societies and to the community through the media. Resources for this could be drawn from both public funds and the private sector.

International donor/partner organizations involved in implementing and monitoring PPP projects should also assist in disseminating useful information through regional and international publications, networks and forums. They also have a role in advocating to governments adoption of policy for and wider implementation of PPPs for the delivery of health care. The corporate sector, including the pharmaceutical industry, could be encouraged to participate in successful programmes in line with the emerging concept of corporate responsibility for health concerns with major social and economic implications and in the interest of generating corporate goodwill among potential customers in the community.

5.3 Local Level

Enlisting and geographical mapping

All health facilities undertaking DOTS in the public sector and those in the private sector which intend to participate in DOTS in a given area, should be listed and geographically mapped. This could be through accessing existing databases within the state medical councils, associations. NGOs in the area could be contacted to supplement this information. Staff involved in other national programmes, such as family planning, polio, nutrition and others, could also be included in the DOTS network.

Information exchange and sensitization

The first sensitization exercise should be personalized and undertaken on a one-to one basis or in small groups with the content of the interaction being

tailored to the individual or group of practitioners being addressed. A prerequisite for this would be equipping NTP staff at district or treatment unit level with the necessary communication and social marketing skills to present the programme so as to elicit a sense of common ownership and partnership. The next very useful step would be to identify a core group of prominent practitioners or opinion-makers among private providers in the operative area and promote advocacy for DOTS through them. Information could be disseminated through newsletters and materials being regularly mailed by professional associations to their members. Web sites of these associations or unions could post information on DOTS and experiences from different parts of the world.

Implementation through local coordination committees

Local coordinating committees should be set up at district or TU level to rapidly and effectively operationalize public-private partnerships. These committees should comprise NTP staff at the local level, prominent practitioners and representatives of their associations, locally-active NGOs and community groups, large-scale corporate employers in the area, if any, and be attended, at least at the beginning, by senior bureaucrats, elected leaders of the state or municipal bodies and national-level NTP staff. These committees, by mutual consensus, must undertake to initiate dialogue with private providers, advocate for collaboration, facilitate planning of various activities, identify nodal agencies and oversee the design and implementation of the proposed projects. These committees should meet regularly to monitor progress and disseminate useful information and experiences for the benefit of various partners.

Monitoring of public-private partnerships

Areas taken up for DOTS implementation through public-private partnerships should be monitored through the systems already set up within NTP. Government staff, voluntary organizations or the private providers themselves should follow the recording, reporting and supervisory guidelines of NTP, including the system for quality assurance of sputum microscopy. NTP staff, in coordination with local coordinating committee or private providers, should directly undertake quarterly and annual reviews and monitoring. Corrective measures should be implemented through the same mechanisms. National and local branches of medical associations should be involved in the appraisal of PPPs and prominent members should undertake monitoring of PPPs in adjoining areas by mutual consent.

Voluntary notifications of all cases of tuberculosis by all private health providers could be initiated: this could precede a mandatory requirement for reporting which could follow when effective DOTS services are available throughout a country.

6. CONCLUSIONS AND RECOMMENDATIONS

There is now complete consensus on the paramount need to involve private health providers in National TB Control Programmes in South-East Asia. This has emerged from irrefutable evidence of large case-loads and, in most instances, of unsatisfactory diagnostic and treatment practices. It was recognized that left unaddressed, these practices would contribute to increasing multi-drug resistance and to a dilution of the epidemiological impact of DOTS in the Region. These concerns led to the initiation of several PPP projects in diverse health settings around the world and in this Region. These local initiatives demonstrated that PPPs for DOTS could be remarkably successful and paved the way for a paradigm shift in policy from restricting DOTS services within the public health domain to the exclusion or strict regulation of the private sector, to adopting a partnership approach with the private health provider, and, more recently, to the development of broad guidelines to further PPPs in TB control.

The present consultation focused on specific steps to be undertaken in this region to promote PPs for TB control. There was universal consensus that national policy guidelines should be framed to allow the development of public-private partnerships at locally-relevant operational levels. Resources within the private sector could effectively be utilized to achieve both earlier diagnosis and better treatment outcomes through initial situation analysis, and adoption of appropriate strategies for collaboration by common consensus through state/district coordinating committees. The lessons learnt from existing PPP projects in the Region should be applied to develop new schemes or existing protocols modified for use in Member States. Both NTP staff and private providers of different disciplines of medicine need to have their interpersonal, managerial and technical skills constantly updated to effectively undertake joint implementation. Governments, medical associations, professional societies, medical schools and key training institutes, prominent private practitioners, the corporate health sector, NGOs and international UN partner and donor agencies have defined roles in furthering and monitoring this collaboration. Member States identified key future steps to be undertaken during the next five-year planning periods to promote PPPs towards the common goal of universal access to DOTS by 2005.

The following recommendations were made:

6.1 For Governments

- (1) Adopt a policy to actively involve private health providers as equal partners in implementing NTP and ensure representation of private health providers on advisory and monitoring bodies at national and local levels.
- (2) Decentralize TB control activities to allow the development of locally-relevant PPPs, including the formation of district/provincial coordinating committees to interface between private health providers and national programmes.
- (3) Support the national programme to collaborate with medical schools and national councils to make teaching of NTP policies and practices a part of the core curriculum for medical and paramedical students.
- (4) Develop appropriate guidelines for the involvement of practitioners of alternative systems of medicine and other health care providers.

6.2 For National Tuberculosis Programmes

- (1) Appoint coordinating committees to develop effective communication strategies to facilitate and sustain dialogue between NTP and private health providers at the local level.
- (2) Develop local strategies, taking into account existing models for PPP, to effectively involve the various categories of private health providers at the relevant operational levels.
- (3) Provide training and necessary resources to build the capacity of private health providers in order for them to participate effectively in NTP.
- (4) Establish joint monitoring and evaluating mechanisms for PPPs.
- (5) Extend the system of quality assurance of microscopy centres to private microscopy centres.
- (6) Accord appropriate recognition to the private health provider for DOTS services.

6.3 For National Medical Associations/Professional Bodies

- (1) Accord priority status to TB control and establish a standing committee for TB control.

- (2) Actively advocate with their membership that PPPs be undertaken in accordance with NTP policies and guidelines.
- (3) Together with NTP staff, help form coordinating committees to interface between PPs and NTP to facilitate the implementation of PPPs at relevant operational levels.
- (4) Award recognition for quality work undertaken by private providers.
- (5) Undertake to create awareness of corporate social responsibility in the private sector for priority health concerns such as tuberculosis.

6.4 For WHO

- (1) Develop a communication strategy to attract private sector participation in TB control and advocate through the Stop TB partnership for global promotion of PPPs for TB control.
- (2) Develop and disseminate training materials and best practice guidelines.
- (3) Provide assistance to strengthen identified training institutes in Member States and help develop core trainers.
- (4) Provide technical support and assistance for operational research and evaluation of PPPs.
- (5) Document and disseminate lessons learnt from PPP initiatives in the Region.
- (6) Mobilize additional resources to support the above-mentioned activities.

Annex

COUNTRY PLANS

KEY STEPS TO BE TAKEN IN THE NEXT TWO YEARS AND ASSISTANCE REQUIRED TOWARDS IMPLEMENTING PUBLIC-PRIVATE PARTNERSHIPS

BANGLADESH

- (1) Key Steps
- (2) Situation analysis of the private sector, including a survey of existing facilities, providers and current contribution to TB control.
- (3) Developing a national strategy and guidelines for private sector involvement.
- (4) Sensitization of private health providers and identification of focal points in the private health sector for advocacy and planning for PPPs.
- (5) Development of pilot projects for field trials.
- (6) Orientation and training of private providers to be involved.
- (7) Evaluation and commencement of phased expansion of successful models to other parts of the country.

Assistance required

From the government

- Ratification and financial assistance to initiate this component of NTP.
- Resources for initial pilot projects and for further expansion of DOTS through PPPs.

From WHO and other UN partner and donor agencies:

- Technical assistance for the development of policy guidelines and public-private partnership pilot projects.
- Assistance in the development of advocacy and training materials.
- Assistance with initial situation analysis and in evaluating performance of pilot projects implemented
- Assistance for further expansion of DOTS through PPPs.

INDIA

Key Steps

- (1) Guidelines to state and district TB control societies to be suitably amended.
- (2) Targets for private sector participation to be articulated at state and district levels.
- (3) Teaching on DOTS to be included in the curriculum of medical and paramedical students.
- (4) Appointment of focal points - "Ambassadors" for RNTCP - private sector collaboration at national and state levels and STOP TB committees at the local level.
- (5) Appropriate mechanisms and materials for training of private health providers of allopathic and Indian systems of medicine and of NTP staff to be developed for their involvement in PPPs for DOTS.
- (6) Involvement of national professional associations and councils for advocacy, orientation and training, and regulation of private sector practice in the context of TB control.
- (7) Dissemination of information on tuberculosis and progress within RNTCP to private providers.
- (8) Introduction of legislation for control of OTC sale of anti-TB drugs.
- (9) Operational research to develop cost-effective PPPs.
- (10) Development of evaluatory and monitoring mechanisms for ongoing PPP projects.
- (11) Periodic reviews, dissemination of results and phased expansion of successful models to other parts of the country.

Assistance required

From the government:

- Assistance with dissemination of information and advocacy at all levels for PPPs for TB control.
- Assistance for the development of PPP projects at state and district levels.
- Resources for initial pilot projects and for further expansion of DOTS through PPPs.
- Commitment to introduce teaching on DOTS in medical schools.
- Consider introduction of regulation of private sector practice with regard to TB control and OTC sale of anti-TB drugs.

From WHO and other UN partner and donor agencies:

- Effective advocacy at international and national levels to promote PPPs for TB control.
- Provision of forums at global and regional levels, sharing of information and furthering PPPs for TB control.
- Assistance in monitoring and evaluating performance of DOTS implementation through PPPs.
- Resources for operational research in the area of PPPs.

INDONESIA

Key Steps

- (1) Development of formal cooperation between the Ministry of Health and the Indonesian Medical Association (IMA) through a memorandum of understanding.
- (2) Situation analysis of the private sector, including current contribution to TB control and mapping of existing private health facilities/providers.
- (3) Sensitization of private health providers and formation of local STOP TB Committees.
- (4) Orientation and training of private providers to be involved.
- (5) Implementation of PPP projects, development of additional models for PPPs and piloting of these.
- (6) Evaluation and expansion of successful models to other parts of the country.

Assistance required

From the government:

- Ratification and financial assistance to initiate DOTS through PPPs.

From WHO and other UN partner and donor agencies:

- Technical and financial assistance for:
 - situation analysis,
 - sensitization, advocacy and training,
 - implementing public-private partnership pilot projects,
 - evaluating performance of pilot projects implemented, and
 - further expansion of DOTS through PPPs.

MYANMAR

Key Steps

- (1) Adoption of a national policy for private sector involvement in TB control.
- (2) Situation analysis and survey of current private sector involvement.
- (3) Establishment of a focal point within the Myanmar Medical Association (MMA) for PPPs for TB control.
- (4) Development of consensus between NTP and PP section of MMA for private sector involvement.
- (5) Development of pilot projects.
- (6) Advocacy and training activities.
- (7) Monitoring and phased expansion of PPP projects.

Assistance required

From the government:

- Ratification of national policy and guidelines for private sector involvement in NTP.
- Resources for situation analysis, advocacy, training, implementation of initial pilot projects and for further expansion of DOTS through PPPs.
- from WHO and other UN partner and donor agencies:
- Technical assistance for the development of policy guidelines and public-private partnership pilot projects.
- Assistance in the development of advocacy and training materials.
- Assistance with initial situation analysis and in evaluating performance of pilot projects implemented.
- Assistance for further expansion of DOTS through PPPs.

NEPAL

Key Steps

- (1) Development of national guidelines for collaboration with the private sector within the DOTS framework.
- (2) Appropriate modifications to be introduced into the medical curriculum to teach DOTS to medical and paramedical students.

- (3) Situation analysis of the private sector, including a survey of existing facilities, current contribution to TB control and identification of potential private sector partners.
- (4) Action-oriented communication and formation of working groups - DOTS committees and coalitions against TB with private providers at all levels.
- (5) Sensitization of private health providers; development of training materials for all levels of PPs for standard case management.
- (6) Training of present NTP workers, including volunteers, in initiating and implementing DOTS through PPPs.
- (7) Development of new models of PPP and piloting of these in diverse settings.
- (8) Evaluation of existing PPP projects through regular reviews and expansion of those found successful to other parts of the country.

Assistance required

From the government:

- Resources - financial and human - and assistance in logistics to implement initial pilot projects and to further expand DOTS through PPPs.

From WHO and other UN partner and donor agencies:

- Technical and financial assistance for:
- initial situation analysis,
- advocacy and training,
- evaluation of the performance of pilot projects implemented,
- further development of public-private partnership pilot projects, and
- assistance for further expansion of DOTS through PPPs.

THAILAND

Key Steps

- (1) Development of a national strategy and guidelines for the involvement of private practitioners.
- (2) Consultation between NTP and focal points among private practitioners to form consensus on strategies to be adopted.

- (3) Situation analysis of the private sector, including current contribution to TB control and geographical mapping of potential private sector facilities and collaboration with the private sector within the DOTS framework.
- (4) Selection of additional pilot areas in addition to private hospitals already targeted.
- (5) Development of additional models for PPPs within the DOTS framework through schemes tailored to PP's availability and overall feasibility.
- (6) Capacity building within the private sector through advocacy, orientation and training.
- (7) Development of appropriate monitoring mechanisms.
- (8) Piloting and evaluation of initial projects, followed by replication of effective models.

Assistance required

From the government:

- Resources and technical assistance to initiate, implement and evaluate DOTS through PPPs.

From WHO and other UN partner and donor agencies:

- Technical assistance for:
- advocacy and training,
- further development of public-private partnership pilot projects, and
- evaluation of the performance of pilot projects implemented.

Financial assistance for developing, implementing and evaluating projects through private sector partnerships should also be forthcoming from the private providers as well.