Role of Private Sector and NGOs in Tuberculosis Control

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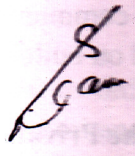
Preface

Tuberculosis is a serious public health problem in the SAARC Region with 38% Global TB burden. Directly Observed Treatment Short course (DOTS) is under implementation by National TB Control Programme in all Member Countries. About 50% of TB patients first contact private health sector for diagnosis and treatment. 10th Meeting of the Governing Board of SAARC TB Centre advised the Centre to work on this issue.

An special session on Role of Private Sector and NGOs in TB Control were organized during the SAARC Trainers Training Programme jointly organized by SAARC TB Centre and National TB Institute at Bangalore in India. The issues were discussed at length and various presentations were made on the subject. The participants included Private Practitioners, TB Programme Managers, Teachers and Researchers working on Public-Private Sector for TB Control.

This document is prepared based on the discussion held in the session and the documents currently available on the subject. We hope this document will help strengthening the partnership with Private Practitioners and NGOs in effective implementation of DOTS for control of Tuberculosis. I want to sincerely thank Dr. P. Jagota, Director, NTI, Bangalore; Dr. P. Kumar, Dy. Director, SAARC TB Centre; Faculty of NTI Bangalore; Facilitators and participants attended the special session for bringing out this useful document.



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Introduction:

The SAARC Region accounts for nearly 38% of the world's tuberculosis cases with three million new cases and nearly 700,000 deaths occurring annually. Tuberculosis is the commonest cause of death from infectious disease among adults in the Region; 75% of the mortality and morbidity due to the disease occur in the age groups 14-45 years. The advent of HIV and the emergence of drug resistance underlines the urgency with which responses have to be made. DOTS strategy for TB control has been adopted by all the national TB control programmes in Member countries in the Region, all of which are making good progress. Treatment success rates in areas under DOTS are nearly 80%. However, this very effective strategy is available currently only to 45% of the population of the Region and case detection rates remain low at an average 30%.

Expanding and enhancing DOTS services throughout the Region is therefore a priority. In order to have mortality from the disease in the next ten years, universal coverage and the global targets of 85% treatment success and at least 70% case detection of all new cases must be achieved by 2005. This can only be possible by diversifying ownership and by involving multiple sectors within and outside the government health sector to increase access to and utilization of health care services. It is equally essential to ensure that quality services are delivered and to increase awareness among communities. Lacunae must be addressed through operational research.

The Region has a rapidly expanding private health care sector which is already playing a major role. This sector also commands considerable resources and credibility among communities. Long term sustainability of national control programmes will depend on building on the strengths of the private sector.

How the Private Medical Sector can help in Disease Control

The Role of the Private Sector

Private medical practitioners are major health care providers in much of the developing world. It is estimated that in the SAARC Region, 60-70% of all patients with tuberculosis prefer to use the private sector. The potential of private medical practitioners in contributing to the control of communicable diseases, particularly in early diagnosis and treatment is therefore considerable.

What is also recognized with concern, however is that the treatment provided by the private sector often does not conform to standardized regimens and may not be in accordance with national policy. In addition, private medical practitioners do not adhere to the disease reporting systems of governments. In view of this regular dialogue with the private medical sector with a view to achieving effective involvement in disease control programmes remains a major priority in the developing world, particularly in the SAARC Region.

Priority issues are therefore expansion of quality services, improvement of case finding through enhanced communication for increased awareness; partnership building; better supervision, and the creation of a demand for good public health services.

A SAARC Workshop on Formulation of Guidelines for Co-ordination in Government and Private Sector/NGOs Initiatives of Tuberculosis Control along with the Meeting of the Tuberculosis Experts for Compilation of TB Control Training Manuals for SAARC Member Countries was held on 18th-23rd June 1997, Kathmandu. The details of the workshop are as under:

Introduction:

The SAARC Workshop on Formulation of Guidelines of Coordination in Government and Private Sector/NGOs Initiatives of Tuberculosis Control and Meeting of the Tuberculosis Experts for Compilation of TB Control Training Manuals for SAARC Member Countries were held in Kathmandu on 18th – 23rd June 1997. Delegates from India, Maldives, Nepal and Pakistan participated in the Workshop and Meeting.

The purpose of the Workshop was to formulate guidelines for the co-ordination between government and private/NGO sectors in the field of TB control and of the Tuberculosis experts meeting was to compile TB control training manuals for the region.

Workshop and Meeting were inaugurated by Mr. Khem Raj Regmi, the Secretary, Ministry of Health, His Majesty's Government of Nepal. Ms. K. C. Namgyel, the Director represented the SAARC Secretariat.

Objectives:

The objectives of the workshop and meeting were:

i) To formulate clear-cut guidelines for coordination in Government and Private/ NGO sectors initiatives in TB control.

ii) To compile the training manuals of TB control for member countries.

Programme of the Meeting:

The meeting began with presentation of country papers on coordination in government and private/NGO sectors initiatives of TB control in Member Countries.

Highlights of Discussions:

The National TB Control Programme Managers and representatives of leading NGOs and Medical Associations of the SAARC Countries had an opportunity to meet in Kathmandu on 18th- 23rd June 1997 for workshop and meeting on current status of co-ordination between government and private/NGO sectors initiatives of TB Control and to formulate clear-cut guidelines on this issue for future implementation as well as to compile TB control training manuals for the use of Member Countries.

The detailed presentation and discussions on various aspects on these issues were held some of the observations of discussions are as under:

i) Tuberculosis is a serious public health problem in all the member countries. Due to its close association of HIV/AIDS there is a possibility of sharp rise in TB cases in coming years.

ii) National TB Control Programmes are functioning in all the member countries.

iii) Nearly half of TB patients are being treated by private sector therefore, there is a urgent need of partnership in the field of TB control between Government and private/NGO sectors.

iv) Different models of coordination for TB control between both the sectors are working in the region to have an effective coordination to achieve the ultimate goal of TB control. Therefore there is strong need of uniform guidelines for partnership between these sectors.

v) Directly Observed Treatment Short-curse (DOTS) is being implemented in all the member countries to achieve high cure rate under National TB Control Programmes. To achieve high cure rate the partnership with private/NGO sector become more important.

vi) Training is basic need of the success of any programme, therefore, appropriate and adequate training materials for the TB control workers in the region is the need of the time.

Out Come of Meeting:

The workshop and Meeting were successful in formulation for guidelines for cooperation in government and private/NGO sectors initiatives for Tuberculosis control and compilation of training manuals of TB control for the Member Countries. The Recommendations have been made for approval of the Governing Board of SAARC Tuberculosis Centre and for further implementation by Member Countries.

Recommendations:

The Group realizing the fact that the SAARC countries account for 40% of the global Tuberculosis burden and taking into consideration the availability of manpower resources came to the conclusion that governmental efforts alone can not succeed in achieving the goal of Tuberculosis load of SAARC Countries at one point or the other is attended to by private for profit sector or by other NGOs. It was with this background, that the group unanimously appreciated the urgent need of involvement of the private for profit sectors and other NGOs which also enjoy the trust of the community. The group also felt that the private and Governmental sectors should have working partnership built on mutual trust and respectability. The group debated on all relevant aspects including every aspect of the existing Tuberculosis Control Programme, formulation of technical and operational guidelines, co-ordination, defining initiatives of Tuberculosis control in the private sector, identification of their training areas and requirements leading to formulation of training modules and manuals required for the purpose.

The group decided to take a holistic view of the existing scenario keeping in view the requirements of the SAARC countries made the following recommendations:

Guidelines for Coordination between Government/Private Sector:

While discussing the ways and means of involvement of private for profit sector and other NGOs following guidelines have been recommended for the purpose.

1. Advocacy aimed at private for profit and other NGOs emphasizing the importance of their role in complementing and supplementing governmental efforts in control of Tuberculosis.
2. Building up mutual trust and respect among the collaborations and jointly ensure promotion of the TB control programme without affecting the interest of either sector.
3. Publicizing the endorsement of the governmental policies and programmes formulated to control Tuberculosis.
4. Identification and acceptance of the areas of collaboration amongst the partners.
5. National level organizations shall be involve in formulation broad policy guidelines and planning frameworks while the methodology for actual implementation shall be decided by implementation levels of both sectors.
6. The private for profit and other NGOs shall have requisite infrastructure/system to undertake identified activities.
7. The private for profit and other NGOs shall extend full cooperation to the governmental agencies in evaluating and monitoring the activities being undertaken by them.
8. The governmental sector shall provide to the private sector a profile of Tuberculosis control programme activities in their respective areas.

Incentives to Involve Private for Profit and Other NGOs:

a) Representation to private sector at policy formulation, planning, programming and implementation levels.
b) Provision of training and exposure at national and international levels in all programme activities.
c) Provision of inputs to private sector for training of their members.
d) Technical assistance in the care of TB patients.
e) Provision of high quality diagnostic and curative services free of cost at designated centres.

Initiatives of Private Sector in Tuberculosis Control Programm:

Private physicians and other NGOs can play an important role in control of Tuberculosis in the community by:

i. Advocating the use of sputum microscopy as the primary tool of diagnosis for pulmonary Tuberculosis and monitoring of its treatment.
ii. Ensuring that each and every person with productive cough of three weeks or more has three sputum samples examined in a designated laboratory.
iii. Referring patients to identified sites for diagnosis and or treatment.
iv. Referring contacts of sputum positive TB cases to the designated centres for screening.
v. Adopting the recommended regimens of treatment.
vi. Propagating the message that DOTS is the standard of care and is the only means of ensuring "Cure".
vii. Undertaking IEC activities on all aspects of Tuberculosis with special emphasis on completion of treatment.
viii. Educating the community that TB patients are not rejected by their families and others.

Identified Training Manuals & Modules:

The group observed that the techniques of diagnosis and treatment of Tuberculosis have revolutionized in the SAARC countries during the last few years. Unfortunately new tools and techniques being adopted have not been adequately documented and made available to health care providers. Taking the realistic situation into consideration, the group felt the need for the effective and meaningful training. In addition to developing training manuals training modules with practical exercises also need to be developed for the various categories of health care providers. The group had a number of buzz and brain storming sessions on this critical aspect and recommended that formulation of following manuals and modules of different categories of personnel engaged in TB control activities.

A. Technical guidelines for Tuberculosis control indication the magnitude problem, diagnosis, treatment, proper recording/reporting requirements and programme evaluation.
B. Operational guidelines depicting various operational aspects for each category of health care worker.

C. Peripheral level health worker manual indication his/her job requirements as well as the methodology for its implementation.

D. Peripheral level health workers training module containing actual training requirements, methodology of the activity implementation and tools and techniques of imparting training.

E. A guide for community health volunteers highlighting important general aspects of TB as well as all activities related inputs.

F. A guide for private practitioners and other NGOs containing general aspects of Tuberculosis their role in its control with emphasis on practice of adopted treatment regimens including the actions in case of possible side effects of drugs as well as diagnosis and management of HIV-TB co-infection.

G. Manual for laboratory technicians containing all aspects of his/her job responsibilities as guidelines for safe disposal of contaminated materials and maintenance of records.

H. Module for laboratory technicians containing actual training activities and methodology supplemented with practical exercises to evaluate the training imparted.

I. Comprehensive training manuals for the Medical officers involved in Tuberculosis control programme covering all aspects of programme activities including supervision, monitoring and evaluation of services. It should also contain guidelines on education, coordination, motivation, facilitation and guidance required for subordinate workers.

J. Comprehensive training modules for the medical officer covering all aspects listed above with practical exercises including evaluation of training.

The group concluded its discussions with a recommendation that SAARC TB Centre should act as the nodal agency for exchange of training manuals/modules developed by Member Countries amongst them.

List of the Participants and Observers:

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10. Dr. D. S. Bam, Director and

11. Dr. P. Kumar, Dy. Director,
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This was followed by a systematic approach to determining the involvement of the private sector in TB control was initiated in 1998. An assessment of existing private-public partnerships was carried out. Following this, it was proposed that a working group would define guidelines for strategies for effective public-private partnerships, identify sites for pilot project, disseminate the experiences emanating from these and then develop evidence-based policy guidelines that could be applied by national programmes globally. During the first phase, private practitioners, researchers and Programme staff in 23 countries were interviewed. The assessment found several promising initiatives either proposed or already under way that are attempting to build locally specific public private mix models of service delivery. The assessment identified the following issues.

1. Barriers within National Tuberculosis Control Programmes

In most situation, the NTP appeared unprepared or even reluctant to involve the private sectors. This ideological opposition appeared largely to stem from a lack of information about the private sector and prejudices regarding private for profit practitioners. Preoccupation with DOTS implementation within national programmes, weak regulatory mechanisms and absence of precedents to follow were other major barriers. Where Private Public Partnership collaborative projects were in place, Programme staff hand doubts about replicability.

2. Barriers within the Private Sector

The major issues here were a lack of information about the practices of national control programmes, technical doubts regarding strategies used especially with reference to DOTS, limitations to performing public health tasks and a view that public health functions were not remunerative. The past poor performance of national control programmes has led to a bias against government run health services. Being largely unorganized, the private practitioners also find developing liaisons with the public sector health services challenging.

GPs and TB Case Management

Strengths:	Apparent weaknesses of constraints:
● Located close to patients	● Reluctant to do sputum examinations
● Patients seek services despite cost	● Can not trace defaulters
● Could improve treatment adherence	● Records maintenance is poor
● Enjoy the confidence of patients	● Do not use recommended drug regimens

However, there are opportunities to increase and speed up case findings, improve treatment outcomes through enhanced patient acceptance, share the service deliver load with front line health staff and build a degree of long term sustainability in disease control. Innovative partnerships with private practitioners could assist NTPs in meeting the goals by or before the year 2005. Options available to NTPs range from an exclusively public delivery system through parallel and independent public and private systems to a coordinated public private mix. It is important that these private public partnerships are set up in areas where the DOTS Programme within the national health services is in place and working well.

Communicable diseases dominate the disease burden in poor countries. Many of these countries have large and growing private health sectors. Available evidence suggests that all segments of the population seek care from private health care providers who play a major role in care for infectious diseases. However, existing control efforts rarely reflect the reality of widespread private provision. Most disease control programmes are designed to deliver exclusively through government channels. There have been growing calls for approaches to service delivery that take into account the public-private mix (PPM) in different context. But there are few working examples

of public private collaboration for care delivery in communicable disease control. In some countries. Private practitioners (PP) have contributed significantly to childhood vaccination programmes.

Among infectious diseases, tuberculosis (TB) is the single largest killer of young people and adults in the world. In recent years, many National Tuberculosis Programmes (NTPs) have adopted the DOTS (Directly Observed Treatment, Short-course) strategy. DOTS programmes have performed relatively well with an average treatment success rate of 78% among new infectious cases enrolled in 1997. While case detection has been increasing steadily, in 1998 DOTS and non-DOTS Programmes taken together notified only 40% of new infectious cases. Anecdotal evidence and the few surveys done to date indicate that a substantial proportion of the remaining cases is seeking care in the private health sector. Many of the notified cases have come to NTPs after seeking care from one or more private providers.

Seeking a better understanding of the extent and nature of private involvement in TB care, the World Health Organization initiated a global situation assessment in 1999. Twenty three countries in the 6 WHO regions were visited as part of the assessment, including 10 of the 22 high burden countries identified as priorities for global TB Control. The assessment focused on private from profit practitioners. Particular attention was also given to ongoing and proposed PPM approaches in TB care.

The assessment confirmed earlier findings of both a substantial TB caseload and unsatisfactory management practices in the private health sector. The consequences include high morbidity and mortality, a heavy socio-economic burden and the serious risk of drug resistance. If private providers continue as alternative sources of poor quality TB care, DOTS programmes face the prospects of low case finding and a dilution of the epidemiological impact of strengthened TB Control efforts in the public sector. But the private health sector can also be viewed as a valuable resource, close to and often trusted by communities. There are opportunities to increase and speed up case finding, improve treatment outcomes through enhanced patient acceptance, share the service delivery load on frontline health staff and build a degree of long term sustainability in the TB control efforts. Options available to NTPs range from an exclusively public delivery system through parallel and

independent public and private systems to a coordinated public- private mix. In practice, most NTPs have ignored the private health sector and opted to deliver services through government channels. The wisdom of such an approach is questionable, particularly in many high-burden countries with large private health sectors. In these countries, there is a compelling case for collaboration with private practitioners in the delivery of TB care.

The assessment found several promising initiatives either proposed or already under way that are attempting to build locally specific public-private mix models of service delivery. Local NTP staff and concerned private individuals have initiated many of these efforts at collaboration. In general, while the assessment found structural and attitudinal barriers to collaboration, there was also evidence of pragmatism and a willingness to collaborate on both sides in most settings.

Innovative forms of partnerships with private practitioners can assist NTPs in meeting the goals for the year 2005 set out in the Amsterdam Declaration. Currently, most NTPs lack a coherent strategy towards the private health sector. Existing policy frameworks will have to be revised and expanded to incorporate policies on private involvement in TB care. More information and debate is needed to develop and finalize WHOs guidelines to NTPs on this issue. However, to strengthen and expand ongoing DOTS implementation, the assessment already suggests some of the elements that would from the basis for these guidelines.

- Action-oriented communication with and information gathering on the private health sector at all levels should be encouraged.
- Collaboration with the private health sector is recommended. Local NTP staff should enjoy a degree of autonomy in capitalising on opportunities to improve care in partnership with private agencies.
- Existing public private mix projects should be evaluated and scaled up. New models of public-private partnership should be tired out in diverse settings.
- Public funding should be available for provision of TB care by private providers.
- Medical curricula should be appropriately modified to influence young medical graduates.
- TB care could be a starting point for a wider involvement of private providers in control of major communicable diseases.

SAARC TB Centre, in collaboration with international and national partner agencies, is well placed to co-ordinate and stimulate research on suitable public-private mix models. It has already begun to link ongoing initiatives under a common framework, the objective is to support a research project that systematically pilots existing and new public-private mix models of TB care. Additional sites and researchers and being identified. Continued funding and technical support are crucial. The pilots should yield robust models with the potential to improve TB care to the larger number of cases who approach private practitioners. The pilots and the resulting models can also pave the way for broader collaboration with the private health sectors in communicable disease control.

Communicable diseases continue to dominate the disease burden in resource poor countries today. In most of these countries health care provision by the private health sector to all segments of population is rapidly growing. And yet, there is little collaboration between the public and the private sectors in delivery of care for control of communicable diseases. Although much has been written and discussed about Public-Private Mix (PPM) in health care, documented examples of successful collaboration on the ground are few and far between. This applies particularly to communicable diseases including malaria, tuberculosis (TB), diarrhoea, acute respiratory infections (ARIs), sexually transmitted infections (STIs) and others. Attempts to forge partnerships between public and private sectors in health care provision for any of the above health problems, if successful, could have valuable lessons for other disease control programmes. Such attempts could pave the way for public- private collaboration for communicable disease control in general.

TB is the largest single infectious cause of death among young people and adults in the world. Accounting for nearly two million deaths a year. About a tired of the world's population harbors the infection; this large pool of infected people means that TB will continue to be a major problem in the foreseeable future. While they belong to all socio- economic strata, the vast majority of TB patients are poor. Available evidence suggests that private providers play a major role in TB care. This report analyses the potential for public- private collaboration in TB control efforts and recommends a strategy for action.

Historical Background

Organised efforts to control TB led to the design and launch of National Tuberculosis Programmes (NTPs) in high burden countries over half a century ago. The focus was on the use of government machinery to implement public health initiatives. The private health sector was usually excluded from such initiatives. It was perceived that for health problems of major public health significance, curative medical care centred on individuals formed only a small part of the overall disease control measures. Further, the government was considered better placed to offer all promotive, preventive and curative components of health care. Finally, the private health sector did non yet have a significant presence in most of the countries with a high TB burden.

Barring a few exceptions, the performance of the NTPs was not satisfactory. By the mid- 1980s, outbreaks of TB in countries and places supposedly rid of the disease helped focus renewed attention on the global burden of TB. The TB epidemic was declared a global emergency by the World Health Organisation in 1993. In recent year, there has been an increasing acceptance of the WHO recommended Directly Observed Treatment, Short-course (DOTS) strategy. By the end of 1998, 119 countries had adopted DOTS as their strategy for TB control, including all of he 22 high-burden countries. Forty three percent of the global population lived in areas where they could access DOTS services. However the number of new smear-positive TB cases detected by DOTS Programmes was about 21% of the estimated global incidence. Even among the populations with access to DOTS, many TB patients continue to seek alternative sources of care. The average treatment success rate among infectious patients treated by DOTS programmes was 78% in 1997. The DOTS strategy emphasizes case finding among symptomatic individuals self-referring to health services, with a focus on detection of the most infectious cases through sputum smear microscopy. Standardized short-course regimens are used for treatment with direct observation of drug intake in the initial phase. Other key elements of DOTS include regular drug supply, and a standardized recording and reporting system. Political commitment.

NTPs and the Private Health Sector

There is now enough evidence to suggest that in most countries the private health sector play a major role in TB care. WHOs report on Global Tuberculosis

Control for the year 2000 noted that, although case finding by DOTS programmes was increasing, the increase was small. Also, in part it was due to transferring cases to DOTS programmes that would have been notified anyway. The report went on to add that the reach the global target of 70% case detection, most countries would have to find innovative methods to find and treat case not notified. The design and implementation of DOTS programmes do not take into consideration the existing reality of a large pool of cases outside the public sector. Thus most NTPs appear to have no explicit strategy to address private health sector involvement; the implicit strategy is one of denial of tolerance of the private sector.

One major reason for the continued neglect of the private sector is that there persists formidable ideological opposition to leaving TB care to market forces. There are other major reasons that could explain why the private sector has been ignored by NTPs. The information on the extent and the role of the private sector in TB care tends to be very sparse. Sensible interventions involving the private sector cannot be designed in the absence of such information. Furthermore, there are perceived to be significant structural barries to the inclusion of the private sector in public health interventions. The private health sector in developing countries tends to be a relatively amorphous, unorganized and dynamic entity comprising various provider types of different sizes and characteristics. In contrast, government health services are structure well suited to the specialized nature of the typical DOTS Programme. Yet another factor is the socio-economic profile of the typical TB patients. TB patients belong to the poorer sections of society; it is assumed poverty of the target group is a strong argument for government funding, not necessarily for government provision of care. However it has bee pointed out that in poor countries with walk institutional bases, public provision of essential health care might still be the best available option. Alternatives such as support and incentives to PPs or subsidies to insurance schemes require substantial administrative capacity and there are few precedents in poor countries. Finally, the implementation of DOTS has usually meant a radical overhaul of the existing NTPs. It has been argued that the NTP managers should invest their limited time and energy in building up a strong DOTS Programme within the public sector. In some countries, NTP managers might be implicitly seeking to elbow out the private sector from the TB care market by running a superior TB control programme.

DOTS programmes in many countries are now coming face to face with the reality of large private health sectors. In general, the private health sector has grown considerably in the last few decades. It plays a major role in ambulatory care, particularly in urban areas. Asian countries account for over half of the global burden of tuberculosis. Most of these countries e.g. India, Indonesia, Bangladesh, Pakistan, the Philippines, Thailand etc. also have large and growing private health sectors. The few available studies of the health seeking behavior of TB symptomatic individuals and patients have shown that many first approach the private health sector. Be remaining aloof from the private health sector, NTPs could be hampered in their case detection efforts. Poor management practices in the private health sector such as improper diagnosis and treatment, and absence of follow-up could dilute the epidemiological impact of DOTS Programmes. Such practices could also contribute to a growing incidence of the hard to treat multi-drug resistant TB. Besides, the health policy environment within which DOTS programmes operate is gradually shifting. While their remains broad acceptance of the need for government funding of major public health activities and government leadership in regulation, there are calls for better use of private providers who are currently supplying services of public health importance. The evidence of market failure in delivery is not as compelling as that in the financing of health interventions with large externalities. Partnership with the private sector could offer some promise of higher case finding rates, improved patient acceptance of DOTS and a degree of long term sustainability.

A Global Assessment: Methods and Scope

In light of the potential threats and opportunities posed by the private health sector to TB control, WHO plans to stimulate action research to investigate various options available to NTPS. The objective is to prepare operational guidelines that will assist NTPs in formulating suitable policies to address private sector involvement in TB care. There research should yield valuable lessons for broadening public-private collaboration in infectious disease control in general. The global assessment is the first step in that direction.

The knowledge about the current and potential role of private practitioners (PPs) in TB control is uneven with most of the information coming from a few descriptive and intervention studies including initial work started by WHO in India.

To increase the knowledge base, WHO undertook a global situational assessment in 1999-2000. Selected countries in all of the six WHO regions were visited as part of the assessment effort. The selection criteria included the size of the TB burden, the perceived degree of involvement of the private sector in TB care available information on ongoing efforts to evolve a suitable public private mix, and the availability of interested researchers willing to collaborate in the rupture research efforts. Among the countries visited were 10 of the 22 that have been identified as high burden countries by WHO in its Global Tuberculosis Control report of 2000. A list of countries and sites visited is available in Appendix 1. The assessment is based largely upon documented literature and in-depth on site discussions with NTP managers, private physicians and researchers and national public and private institutions engaged in tuberculosis and health services research. In all, 144 discussions were held in 23 countries including 48 with NTP managers and their associates, 51 with private physicians, 30 with researchers in public health and 15 with WHO staff based at regional and country offices. Moreover, at 7 sites, group discussions were arranged jointly with NTP staff and private practitioners. Of these, 2 discussions included members of the local chest physicians associations.

The private health sector involved in TB care includes private practitioners, non-qualified providers including traditional healers, practitioners qualified in non-allopathic forms of medicine, private pharmacists, non-governmental organizations (NGOs) and pharmaceutical companies. The assessment focused on qualified private for-profit practitioners, in solo or group practices. In the rest of this report , the term PPs will refer to This group, Where appropriate the role of other types of private providers will be considered. In some countries, physicians work in the public sector but also have private practices in the afternoon and the evenings. Such physicians will also be considered PPs when they are managing patients in their private practice.

Due to logistical and time convenience, the assessment focused on urban areas. Also the PPs tend to congregate in urban areas. Many of the high-burden countries have a large number of TB patients among the urban poor. These countries are also urbanizing rapidly. Since TB patients as well as practitioners in rural areas share many common characteristics with their urban counterparts, the findings of the assessment and the strategy proposed will have relevance for a large number of TB patients. The assessment has also focused on the delivery of TB care. Issues of

regulations and medical education are examined to the extent that they impact on the private sector role in delivery. The appropriate public-private mix in financing of TB care is outside the scope of this report and will be touched upon only briefly. Finally a special effort was made to identify and assess ongoing efforts to address the role of the private health sector in TB care.

Section II of this report is a summary of the findings of the situational assessment. We describe the major characteristics of the private health sector role in TB care and highlight some of the country based efforts to address the issue. Based on the findings, we argue the case for addressing private sector involvement in TB care in Section III. Next, in section IV we present a framework for addressing TB care in the private sector. The spectrum of strategic options available to the NTPs is highlighted. The options range from provision of TB care exclusively through the public sector on the one hand to active inclusion of the private health sector on the other. The options are considered in some detail and working examples are cited where available. We identify key factors that NTPs should consider when choosing an appropriate strategy. On the basis of available evidence and trends, we argue that inclusion of the private health sector in the delivery of TB care is one of the most promising options from NTPs in many of the high-burden TB countries. We conclude in Section V with the outline of an emerging framework to guide NTP policies towards the private health sector. We comment upon the respective roles of WHO and NTPs in developing and finalizing the policy framework. In particular, we emphasize and agenda for operational research that spurs the development and piloting of robust public private mix delivery models we suited to local conditions. The pilots and the resulting models will provide useful lessons in public-private collaboration not just for TB control but also for infectious disease control in general.

Findings of the Global Situational Assessment

The Role of the Private Health Sector

Size of the private Health Sector

The private health sector varies considerably between and within countries in its size, composition, level of Organization, types of services delivery and socio-economic groups served. There are few statistics on the private sector share of service delivery in poor countries. However, there is some information on health expenditures

that suggests a large and growing private health sector in most poor countries. Shows that private expenditure on health accounts for a major portion of total expenditure in almost all of the high burden countries. Further, virtually all of this private expenditure is out-pocket, suggesting considerable utilization of PPs and private pharmacies on a fee for service basis.

Table 1 - Private Health Expenditure s in the 22 high-burden countries.

Country	Pvt. Health expenditure (% of total health expenditure)	Out-of-pocket expenditure (% of total health expenditure)
India	87	84.6
China	75.1	75.1
Indonesia	63.2	47.4
Bangladesh	54	54
Pakistan	77.1	77.1
Nigeria	71.8	71.8
Philippines (the)	51.5	49.5
South Africa	53.5	46.3
Ethiopia	63.8	63.8
Vietnam	80	80
Russia	23.2	23.2
DR Congo (the)	63.4	63.4
Brazil	51.3	45.6
Tanzania	39.3	38.3
Kenya	35.9	35.9
Thailand	67	65.4
Myanmar	87.4	87.4
Afghanistan	59.4	59.4
Uganda	64.9	48.2
Peru	60.3	50.2
Zimbabwe	56.6	38.2
Combodia	90.6	90.6

In general, available surveys on health care utilization indicate that the private sector is an important source of care, even where public services are available. Private

providers are extensively used for disease of public health importance such as TB, malaria, STIs, diarrhea disease, ARIs. For instance, in India, 80% of the households prefer the private sector for minor illnesses and 75% for major ones. In urban areas in Indonesia, 39% of sick individuals where found to be consulting private providers as compared to 30% who consult public providers. PPs tend to congregate in urban areas, many rural patients still seek care in the informal sector including traditional healers.

Poor people use the private health sector almost as much as better off people. In nine of the poorest countries, an average of the 47% of visits to health providers by the poorest 20% of the people were to the private sector as compared with 59% of visits to private providers among the richest 20%. A 1987 survey in Jalgaon District, India, found that only 13% of the poorest 20% of the households utilized government facilities for care, the rest used PPs or self medicated. Studies in HO Chi Minh City (HCMC) in Vietnam have found that the socio-economic profile of individuals with TB symptoms and TB patients who approach PPs is similar to that of patients who approach the NTP.

TB Caseload in the Private Health Sector

Very little precise information is available on the size of TB caseload managed in the private sector. Reliable information on TB caseload in the private sector could be found in South Korea, the Netherlands and the Czech Republic, only 3 out of the 23 countries visited in the 6 WHO regions. Notification of TB cases from private sector is rare among most low and middle income countries. Even today, in spite of strengthened NTPs and improved information systems, about 60% of all estimated smear positives and 55% of all forms of TB are not notified globally. India for instance has the highest burden of TB and the largest private sector that manages as many as half the prevalent cases without notifying them. The accounts for almost a sixth of the World's burden of TB. A prospective crossing from private sector over the public health services. Nevertheless, it is generally assumed that a large proportion of TB cases end up with the NTP. An unknown but seemingly substantial proportion of TB cases in high burden countries such as Pakistan, Bangladesh, Indonesia and the Philippines are also managed in the private sector. Well-managed TB programmes

do not necessarily attract all the TB patients. In South Korea, in spite of good program offering free services, 47% of TB cases are diagnosed and treated by PPs-GPs and specialists.

In most countries, the Programme managers assume that only a small proportion of patients - mainly the well of - seeks care from the PPs. The basis for this assumption is that TB primary affects the poor who cannot afford to spend large sums of money for paying doctors fees and buying expensive drugs. Most of them supposedly use free services made available by the NTPs. This is thought to be particularly relevant where the costs of care in the private sector are very high while the public sector provides free services, for instance in most of the Latin American countries. Yet a recent survey in Mexican State showed that about a third of patients who died of TB were treated in the private sector. A substantial proportion of all anti-TB drugs is sold in the private sector.

WHO's year 2000 report on global TB control has noted that while the case finding by DOTS programmes in increasing, the increase is small. To reach global targets, many countries will have to introduce innovative ways to find and treat cases not yet notified. Knowledge of the actual case load and types of patients treated in the private sector is essential not just for surveillance and monitoring but also to emphasize the need to engage with the private health sector.

Private Sector Share of First Contracts

The few available studies suggest that in many low-income TB endemic countries with large private health sectors, private physicians, traditional healers and private pharmacists play a significant role in the initial stages of helath seeking by TB symptomatic individuals. This is in keeping with the private sector presence in ambulatory care and the fact that the initial symptoms of TB are virtually indistinguishable from those of other chest symptomatic individuals. Further costs is not a big concern for most patients in these early stages. In one study, in the Indian City of Pune, of households reporting chest symptomatic individuals, over 60% of the symptomatic individual first went to a private health provider. A subsequent study in Pune and Mumbai showed that 88% of the rural and 85% of the urban patients of PPs had started off with a private provider. In Indonesia, where PPs have a major share of ambulatory care in urban areas, it has been estimated that over half

the urban TB cases are being detected in the private sector. In HCMC, Vietnam, a survey or patients diagnosed with TB in the NTP found that about half had first turned to PPs or private pharmacists. A 1996 study in Blantyre in Malawi showed that more than one third of the all sputum smear positive patients had visited a traditional healer before seeking regular medical care. In Pakistan a survey in 1996 showed that about 80% of the TB patient first seeking care from PPs. In the Philippines a survey found that about 39% of the TB symptomatic individuals were self-medicating while 26% had consulted a private practitioner. While this report focuses on PPs, the role of private pharmacists is drug were sold without prescriptions. The most commonly perceived indications were thirds of patients buying medicines over the counter did so without a prescription. In HCMC, about 25% of all drugs dispensed at private pharmacies were dispensed without prescription. In Nepal, pharmacists have been found to be the first source of treatment for a large number of TB patients. They could potentially assist in reducing diagnostic delay serve as treatment supervisors.

The larger share of first contacts has important implications for TB control since PPs follow poor diagnostic practices leading to long delays in diagnosis as discussed below.

Delay in Diagnosis

Most of the disease transmission in TB takes place before the diagnosis of TB is made and treatment started. Delay in TB diagnosis therefore leads to an increase in disease transmission. Several studies have sought to establish whether the delay in diagnosis is due to a delay in seeking care or due to the inability of the provider to diagnose promptly. Commonly, the delay is in receiving a diagnosis rather than in seeking care. Even in countries where TB treatment is offered exclusively by the public sector, patients tend to be under private care for a considerable length of time before TB is suspected and patients referred to the TB services. In Sao Paulo city, where TB care largely takes place in the public sector, an analysis of the place of first diagnosis and the extent of delay in diagnosis showed that in about 20% cases the diagnosis was first made in the private sector. The mean delay in diagnosis was 12.5 weeks (VMN Galesi, personal communication). In Kenyan study, 90% of TB suspects claimed that they had attended a health care facility (private and/or public) for an average of times, yet 65% had neither a chest radiograph taken nor their sputum examined.

A study of TB patients and practitioners in private clinics in India showed median delays in diagnosis of about 3 weeks and 2 weeks respectively among urban rural patients after they sought help at private clinics. About 33% of the urban patients and 36% of the rural patients had not been diagnosed even after 4 weeks of seeking help. Another study in Vietnam showed that patients who had first turned to private pharmacy or a private physician were significantly more likely to have a long provider delay compared to people who had first turned to the NTP. The potential positive impact of private sector involvement is clearly demonstrated in a unique public-private mix project operated by a private hospital in Hyderabad City in South India. The mean delay in diagnosis after seeking help among patients reporting to the public sector DOTS Programme was half as much again as that among patients of that project (7 weeks and 5 weeks respectively.) In the same place, the comparison also showed that before the start of TB treatment, patients in the public sector, DOTS Programme had spent two and a half times more than their counterparts on the private side (USD 38 vs. USD 15).

It is important that the providers of TB care be made cognizant of the epidemiological and economic implications of shopping for treatment and delay in diagnosis. If convinced about the extent of spread of the disease as a result of delayed detection, PPs might get motivated to contributed to reducing the delay of diagnosis.

Management Practices

Very few studies in the past have examined the prescribed behavior of PPs in treating TB. Recently, however, their TB management practices have come under scrutiny world wide, in countries and settings as diverse as urban and rural India (10, 16, 32,) Pakistan (26) Philippines (36) Korea (37) Uganda (38) United Kingdom (39) Switzerland (40) Bolivia (41)and United States (42, 43). It is common among PPs, as these studies indicate, to deviate from standard TB management practices, recommended nationally and internationally. Of greater relevance from the global TB control point of view are the practices of physicians in high burden countries. Although the settings vary greatly, interestingly, the findings do not. PPs in these countries place an undue emphasis on chest radiography for diagnosis. They rarely use initial and follow-up sputum examinations. They tend to prescribe inappropriate drug regimens, often with incorrect combinations, and inaccurate dosage for the

wrong duration. There is little attention to maintaining records. Case notification is uncommon and treatment outcomes are not evaluated.

Why do PPs deviate from recommended practice? The basic medical education in most poor countries is of uneven quality and there is inadequate attention to public health education. Continuing education is usually missing. Regulations are often non-existent or archaic, and where they do exist, they are rarely conveyed to professionals or enforced. To top it all, there is a major communication void between TB programmes and PPs. The most damaging negative influence pointed out by some senior PPs was the sorry state in which TB programmes were run for a long time. They listed factors such as sputa showing negative results until you virtually start seeing the bacilli with naked eye, drug regimens devised every day and modified mid-way combining drugs available in the cupboards, and no regard either to humans or their lives.

The absence of recording and reporting and absentee retrieval mechanisms suggests that overall case holding is week. This is confirmed by the few available surveys. In South Korea, a large study of over 1000 patients found that 42% of the patients of PPs interrupted their treatment prematurely. In Mumbai, India only 2% of the PPs surveyed claimed treatment complication rates over 50%. In HCMC, a semi-private specialist lung clinic had an overall treatment success rate of about 50%. The cure rate among new smear positive cases was about 22%.

Regional and Country Variations

As with TB prevalence, there are great variations among the six WHO regions with regard to the private health sector, its characteristics, and its role in TB control. There are variations among and indeed within countries as well. Some broad observations may, however, be made. The private health sector does exist in all the regions, but the extent to which PPs play a role in providing TB care and the proportion of TB patients managed by regions. Their contribution- positive or negative - is perceived to be insignificant. The same, to some extent, may be true for low and middle-income countries of the European region. The private health sector is said to be growing rapidly in Eastern Europe and countries belonging to the former Soviet Union, but TB care provision is still restricted mostly to the public sector.

The regions with the highest burden of TB - South- east Asia (SEARO) and western pacific (WPRO) also have large private health sector with a significant role in provision of TB care. The scope of the private sector in these regions and its current and potential contribution to TB control is well appreciated. Some attempts are being made and experiments are under way to identify ways of involving PPs in TB control in these regions but organised efforts aimed at developing and implementing policies for meaningful involvement of private sector are not yet in place. The Eastern Mediterranean region has only a few countries with a high burden of TB. PPs have been on the agenda of many countries in this region, thanks to the initiatives in 1996 by the Eastern Mediterranean Regional Office (EMRO). Some of these countries have made enough progress to enable them to put in place national policies on private sector involvement.

There are great variations in the characteristics of PPs in different regions, countries, and within countries as well. There are PPs who are not linked in any way to the public sector. There are those who have private practices but devote a part of their time for a public sector service-paid or honorary. Then there are those who work mainly for the public sector but have private practices too official or unofficial, and those who are exclusively in the public sector service. In the SEARO and the WPRO regions, the first level private health care providers (i.e.GPs) often manage TBN as well while in some other regions chest physicians manage most pulmonary TB patients. Approaches to private provider involvement are likely to very according to target intervention groups.

A Regional Initiative on the Involvement of the Private Sector in TB Control

In April 1996, EMRO organised a consultation of member states in Beirut, Lebanon, on the issue of the private health sector and TB control. The consultation first reviewed the reasons for poor TB case management practices in the private health sector and then discussed the likely consequences of such practices including MDR-TB. The options available to the NTPs were identified. Participants made presentations on the status of public-private collaboration in their respective countries. The presentations were structured around two key themes-the existence of NTP guidelines that could be adopted for private sector use and the TB treatment practices in the private sector. Subsequently, the participants discussed a common protocol to guide collaboration with the private sector. Each of the five participating countries

used to common protocol to develop their own research protocols for implementation. EMROs initiative served at least two useful purposes. It focused attention at the regional level on an important but neglected issue. It also helped stimulate various research activities in the member states, all within a common framework. In Syria, the research findings helped shaped the decision to restrict anti-TB drugs to the public sector.

Involving PPs: Prevailing Perceptions

In most poor countries, there is very little interaction between the public and the private health sector. Given this communication void, it is important to understand how either side views the other particularly in terms of potential collaboration. For collaborative arrangements to have a realistic chance to succeed, the gap in perceptions has to be recognized and bridged.

The assessment found that NTP staff viewed collaboration with PPs with a mix of pragmatism and septicemia. Among the commonly expressed views, was the candid confession, Any public private mix (PPM) intervention will work, it can't be worse than now. Others were generous is judging the private health sector, for instance, Respect their clinical approach to TB; they cannot be different just their TB patients. And appreciate positive performance in the private sector. Many were realistic in their expectations, Keep expectations of the private sector reasonable, it has taken decades for TB programmes in poor countries to achieve desirable outcomes. Further, keep the time frame for designing and implementing PPM interventions adequate we ought to be patient. The need for collaboration was acknowledged, Accept leaders of the profession as part of the decision making apparatus, Reach out to them do not expect them to approach, it is not their job. Also, Be willing to provide adequate support to the private sector to carry out public health functions of TB care Encourage local action provide freedom to field staff to interact and engage with PPs.

But there was also evidence of the implicit assumption that the public sector DOTS Programme will eventually elbow out the private sector, if we improve our services, patients will automatically come to us. And some doubts, It is ambitious to discipline them (PPs) without any working controls, They are money minded and unwilling to change. We never sensed any genuine desire at the higher levels to work with private doctors for TB control. Is not the current interest likely to be short-lived?

In general, the PPs met during the assessment welcomed the idea of collaboration although they voiced a few complaints against the NTPs. The complaints included. We have never received any communication from them, Generally they (public sector staff) have disrespect for us and present themselves in a highhanded manner. There was some defensiveness, We cannot go around chasing every patient. It is a misconception that we dictate to our patients, the patients dictate our course of action. Sputum positives and sputum negatives are equal for us. It is TB in any case. But the dominant view was that collaboration was feasible, There is no discernible reason why we should oppose collaborating with the TB Programme, We propose joint care of each TB patient WHO comes to us. Finally, you all seem serious about involving private doctors. That a good sign. And we are not only happy but proud of working with the NTP.

Table 2 Major Barriers to Public- Private Collaboration in TB care

Within the NTP	Within the Private Health Sector
Ideological opposition	Inadequate training & lack of information
Lack of information on the private sector	Technical doubts NTP guidelines
Preoccupation with strengthening and expansion of the NTP	Low priority to public health functions; not remunerative
Prejudices about the profit motive & the behavior of PPs	Competition for patients, particularly among chest specialists
Limited resources for co-ordination & supervision	Infra-structural limitations to performance of public health tasks such as defaulter tracing
Weak & anachronistic regulatory mechanisms	Doubts about quality of care within NTP
Absence of precedents; little evidence on replicability	Largely unorganized; liaison and interaction challenging.

About user charges, If the program provides free diagnostics and drugs for our patients, most of whom are poor, why should we charge them? Treating a patient free of charge is a good investment. Referring a patient to a place where he gets care to his satisfaction at a good investment. Referring a patient to place where he gets care to his satisfaction at modest or no cost is also rewarding. Such patients become permanent clients, as do their family members. They are walking advertisements

and the returns from them are always worth the investment. Only a short-sighted provider would insist on extracting fees from such patients. But also, with full information to patients that the same treatment is available from the NTP, if a patients is willing to pay a consultation fee to the doctor, why should there be any objections? Summarizes the attitudinal and structural barriers to effective public-private collaboration.

The Case for Addressing Private Sector Involvement

The findings of the assessment have confirmed the strong case for addressing the private sector involvement in TB care. This sector poses both threats and opportunities to effective TB Control. If the private health sector persists and grow as an alternative and unregulated sources of care, NTP will be hampered in reaching their case detection targets. The poor case management practices in the private health sector could dilute the epidemiological impact of the DOTS programmes. Such practices, if unchecked, could contribute to the evolution and spread of MDR-TB.

The Private health sector also offers major opportunities for further TB control. The private health sector is a valuable resource, located close to and trusted by many TB patients. By involving PPs, NTPs can increase case detection. Since many patients first approach PPs, there is an opportunity to reduce diagnostic delay with a concurrent reduction in transmission. By enlisting PPs, NTPs can enhance patient access and acceptance, thereby improving treatment outcomes. There is also the potential to share service delivery with the private sector and thus moderate the workload on frontline health workers. Of course, this has to be traded off against the likely increase in tasks such as liaison, training and monitoring. Most TB patients are poor and many of them use the private health sector. There is a compelling case to address this issue is order to alleviate the health and socio-economic burden on households.

Finally, DOTS implementation has be viewed within the context of changing health systems. Health sector reforms comprise a wide range of initiatives. The common themes include a strengthening of the government role in providing information, in regulating and in financing interventions of public health importance while partnering with the private sector to achieve a balanced public-private mix in service delivery. For the long-run sustainability of the TB control effort, NTP managers will have to adopt their strategy to these trends.

Figure - Range of Interventions to Involve private Practitioners

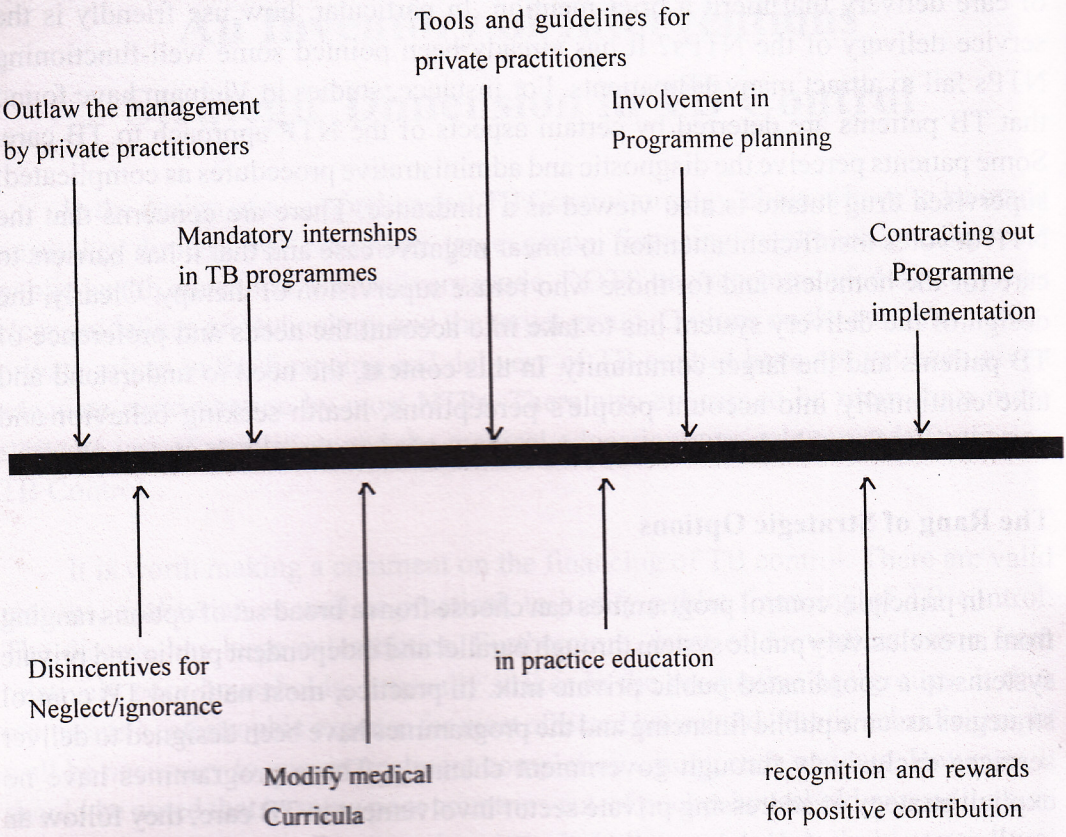


Table 3 Select Examples of NTP Efforts to Address the Role of the Private Providers

Dominican Republic	NTP manager, who has also been a private physician, has excellent rapport with private sector. In some instances, TB patients reporting to private physicians are co-managed with NTP.
Egypt	NTP provides team training to a doctor, a laboratory technician and a nurse each from Kinshasa city hospitals and polyclinics. Drugs and provided at subsidized costs. Patients are managed according to guidelines.

India	A few running and enveloping models: 1. A private non-profit hospital runs a DOTS project for patients referred by private GPs, DOT done in neighborhood centres located in private nursing homes, clinics and private and NGO dispensaries; 2. A voluntary organization acts as an interface between PPs and NTP to facilitate referrals, and DOT by PPs. 3. NTP treatment supervisors assigning diagnosed patients to their preferred private practitioner agreeing to do DOT, maintain records, and report default. 4. Local association of doctors trying out graded involvement of PPs ranging from referral to running a DOTS Programme.
Kenya	Anti-TB Association provides subsidized drugs to private hospitals and chest physicians in Nairobi who in turn follow NTP guidelines, notify cases, assist in defaulter retrieval and maintain and submit records.
Morrocco	Two successive yearly surveys show very satisfactory TB management practices of private physicians. Forty percent patients referred to NTP are from private sector. Probable reasons for good management practices of private doctors: undergraduate medical curricula provide substantial time for training in TB and all postgraduates have to work within NTP before getting license to practice.
New York City, USA	Upgrading and improving the clinical services offered by chest clinics located throughout the city. State of the art and confidential services including DOT provided free of cost to suspects and patients including treatment for latent infection to high risk individuals, social services, HIV counseling and testing. Result: a four fold increase in referrals from private sector. Obligatory for laboratories to report results of sputum smear and those of drug susceptibility testing.
Republic of Korea	NTP shares survey results with PPs of their own TB management practices and treatment outcomes of their patients. Improved performance demonstrated in a subsequent survey.
Syria	Dissatisfied by private physicians' poor response to persistent and varied approaches to involve them, the NTP manager convinces the MOH to execute a decree banning sale of anti-TB drugs in private pharmacies. Effectiveness yet to be evaluated.
The Netherlands	Involvement of PPs at all levels including representation on TB Control Policy Committee. Clarity and consensus on roles to be played by the public and private sectors in managing each patient.
The Philippines	NTP supports two projects: a university hospital and an upper class private hospital in Manila run well performing DOTS clinics.

Table 4 Framework for Addressing Private Sector Involvement in TB Control

	Public System	Parallel Systems	Collaborative System
Service Delivery	• Diagnosis and/or treatment in public sector • Private role limited to referrals • Drugs procured and delivered in the public sector	• Ignore the private sector • Compete with the private sector • Encourage private referral of poor & private treatment of rich • Drugs flow through both public and private systems	• NTP provides services to private provider & patients • Incentives to individual providers for specific tasks • Private agencies responsible for delivery of care to defined populations • Most drugs procured in bulk by NTP.
Medical Education	• TB case management in medical curriculum	• TB case management in medical curriculum • Inform private providers	• TB cases management in medical curriculum • Inform, Continuing Medical education.
Regulation	• Mandatory notification • Mandatory referral • Restricted availability of anti-TB drugs	• Mandatory notification • Legal redress for private sector consumers • Public system funded by general revenues,	• Mandatory notification • Policy framework on inclusion e.g. user fees, contracts • Forum with private sector representation
Financing	• General revenues • Social Insurance	insurance • Private system funded by user charges, insurance	• System funded by suitable mix of public funds, insurance and user charges.

In must be emphasized that the so-called exclusion of PPs from TB control can only be relative and theoretical. Wherever private heath sector exists and is used by

the people, identification of symptomatic individuals, suspicion and/or detection of TB, and notification and/ or referral to the NTP cannot be taken out of the domain of PPs.

Public System

NTPs that seek to exclude the private health sector use mechanisms such as mandating referrals and restricting availability of TB drugs. Among the countries visited, Syria has recently prohibited the sale of key TB drugs in the private sector with the objective of compelling private providers to refer TB cases to the public sector. This strategy has long been in place in Algeria, Chile and Norway. While Private providers often continue to play a role in diagnosis, treatment is delivered mostly through the public sector. Other countries such as Oman have mandated referral of TB cases to the public sector. The policy seems to have worked reasonably effectively in Oman. In general, there are major prerequisites for the success of such policies. First, government - run services should be capable of substituting for private sector provision. Specifically, the public sector should have adequate reach and capacity to take on the private sector caseload. Second, patients often prefer the private practitioners for the convenience and privacy they afford. If case finding is not to suffer, the public sector should be able to compensate for the loss of at least some of that convenience. Otherwise there is a risk that patients delay health seeking or seek care in the informal sector. Finally, and crucially, there has to exist the political will to exclude private providers and the administrative capability to enforce such legislation.

While some of the countries with an explicit strategy to minimize the private role in TB control have achieved their objective, in others such as Syria, the effectiveness of such a strategy has yet to be evaluated.

Parallel Systems:

Parallel systems were found to be in place in most countries visited. NTPs can opt for an exclusive focus on service delivery through government channels with minimum interaction with parallel private care provision. In effect, the private health sector could be ignored or tolerated. A major motivation behind such a strategy is the public sector's drive to seek a dominant role in TB diagnosis and treatment. In fact, this is an implicit assumption underlying many control programmes. The

programmes believe that the private sector will be progressively marginalized as the reach and quality of public sector TB control will be progressively marginalised as the reach and quality of public sector TB control activities improve. Morocco and Peru are examples of countries with a strong and well functioning TB Control Programme, the public sector manages most of the TB cases. In Morocco, TB care is concentrated in the public sector in the absence of any active intervention by the NTP. PPs tend to refer diagnosed cases of TB; private general practitioners are referring about 97% of the TB cases they diagnose. However, private chest physicians are more inclined to treat TB patients. The case management practices of the chest physicians are more inclined to treat TB patients. The case management practices of the chest physicians are largely appropriate. Morocco's achievements can, in bit part, be attributed to a well largely appropriate. Morocco's achievement can, in bit part, be attributed to a well-structured and effective TB component in the curriculum of medical students. A few important observations can be made on the general applicability of Morocco's use of medical education to mould future practitioner behavior. It is clearly a sensible approach the merits a close look and possibly, emulation by other developing countries. However, it is a long term strategy and will not result in tangible changes in behavior of currently practicing physicians. Crucially, to the extent that the NTP seeks to encourage referrals by PPs, the NTP has to be perceived to be performing well. Only than would most PPs refer their patients. Finally, the question of the appropriate scope and depth of instruction on TB management in the medical curriculum has to be addressed within the broader context of the long-standing debate on the public health content in clinical training.

Moroccan PPs are Groomed to Manage TB Effectively

Morocco has a strong DOTS Programme covering the entire population. The NTP has sought to understand case management practices in the private health sector through two successive studies in Casablanca and Tangiers, in 1995 and 1997. The studies found that PPs were detecting about 30% of all TB cases. General Physicians (GPs) and chest physicians refer about 20% of the symptomatic individuals to the NTP straightway. GPs use both X-ray and sputum examinations for diagnosis, 97%of the diagnosed cases are referred to the NTP. Chest physicians refer about 36% of the cases they diagnose and treat the rest themselves; the diagnostic and treatment practices are in line with NTP guidelines. Way are the PPs in Morocco more cognizant of the public health aspects of TB control than their counterparts in most developing

countries? The answer probably lines in the well structure TB component in the curriculum in Moroccan medical schools. During undergraduate training, 40 hours are devoted to instruction on tuberculosis and its management. Undergraduates are taught to remain alert to TB symptoms and the recommended diagnostic procedures. A key message is the prompt referral of confirmed case to the NTP. It is also mandatory for postgraduates in the chest specialist field to work for a specified time in the NTP. Practitioners learn to appreciate the public health aspects of TB control. The good performance of the NTP is crucial; PPs trust the program and readily refer their patients to its care.

In Peru, the success of the NTP could be attributed to many factors; two of which are of direct interest here. First, almost all physicians in Peru have both public and private practice. Since they are intimately familiar with the high quality control Programme, physicians appear to readily refer patients who come to their private practices. Second, the government health infrastructure in Peru is well perceived by the community. It is worth nothing that, at the point of delivery, TB control programmes are integrated into the general health services, Therefore, the overall perception of the government-run health services influences perceptions of the TB control Programme. In particular, perceptions of the general health services can influence choice of providers by TB symptomatic individuals in the pre-diagnostic stage. Accordingly, NTPs are likely to be hard pressed to meet case detection and treatment targets in countries where the general health services are not well perceived by the population. Such countries can be predicted to have large and fast growing private health sectors, possibly including a substantial informal component. Thus, DOTS Programme managers often face the twin challenges of a weak public health infrastructure and a large private health sector with a major role in TB care. Under such circumstance, it is not advisable for the NTP to continue to ignore the private health sector with the intention of eventually acquiring a dominant share of TB cases. The threats to TB control and the missed opportunities from the status quo have already been enumerated in the case for addressing private sector involvement in TB Control.

Independent and parallel private delivery of TB care would be acceptable in situations where PPs follow standard case management procedures and achieve satisfactory treatment outcomes for all their patients. However, we could only find

examples of satisfactory performance by the private health sector in countries where the NTPs collaborate with PPs. For instance, in the Netherlands, the Programme staffs who perform the essential public health functions supports private management of TB cases. These include counseling and support for needy patients and absentee retrieval.

Public-Private Collaboration

The various ways in which NTPs in the countries visited have sought to collaborate with the private health sector, albeit on a modest scale, are described above in this section. Such efforts can range from a passive dissemination of case management guidelines to active involvement of PPs in DOTS programmes.

Education and information can be used to improve case management practices. Continuing medical education (CME) sessions and dissemination of NTP guidelines in user-friendly formats could conceivably boost the specificity and sensitivity of the overall diagnostic process. It could reduce the portion of diagnostic delay attributable to provider misjudgment. It could also reduce non-specific treatment and avert unnecessary laboratory examinations. Further, it could induce wider use of recommended prescriptions and could promote record keeping. But it has its limitations in improvement of case holding which is one of the key challenges in TB treatment. Nevertheless, the process of informing and educating PPs is important in itself. It can act as a spur to public-private dialogue. One of the main findings of the assessment was a communication void between the NTP and the private health sector. A dialogue at the national, provincial and district levels between the NTP and private players is a prerequisite to any sustainable collaboration.

Promotion of combined drug formulations merits special mention. By itself, it does not solve the problem of irregular treatment. But it can reduce the incidence of mono-therapy and slow the evolution of MDR-TB. It also simplifies treatment logistics for providers and patients.

For countries with large proportion of population covered by public insurance schemes, like for example Sough Korea or many of the Latin American countries, such schemes may provide a mechanism to ensure compliance and collaboration of private providers. Having provided detailed guidelines on TB case management to

PPs, TB experts at the Korean Institute of Tuberculosis have suggested that the Institute could screen their claims for appropriateness before a reimbursement is made by the insurance Organization. The Government of the Philippines is exploring the idea of using TB as a test case for their PHILHEALTH schemes under which health care expenditure incurred on public and private TB management and assessing claims for adherence to guidelines are likely to be the mechanisms employed.

Public-Private Mix Models in Service Delivery

Some of the promising initiatives either proposed or already under way are attempting to build a suitable public private mix in the delivery of TB care (Table 3). Key service delivery tasks in the DOTS package are shared among the NTP, PPs and possibly, other local players such as NGOs with the potential to participate. The basic premise is that each of the partners in the collaboration has relative strengths and tasks are shared accordingly. For instance, PPs are located close to and trusted by the community. Since they usually have a major share of the first contacts, they offer an opportunity to increase case finding. They could look after clinical aspects and also serve as DOT providers.

Division of responsibility for delivery of TB care is already observed notably in some of the developed countries. In the Netherlands, PPs provide clinical care while public health nurses take care of motivation, education, absentee retrieval and social support for patients. The main elements of the successful public private partnership include decentralization, transparency, mutual respect, continuing dialogue and private provider involvement at all levels of policy making. The institutional mechanisms underpinning this collaboration are not necessarily resource intensive, these can be adopted for application in poor countries.

Efforts are under way to involve PPs in TB control in many sites around the world. Public private mix schemes with varying degrees of private providers involvement have been proposed or are being tried out. The models vary by site but there are important common elements. First the essential features of the DOTS package are preserved. The NTP guidelines are adhered to; accredited sputum microscopy laboratories are used and standard treatment regimens prescribed. All the key DOTS tasks are still carried out; only they are now shared with private agencies or individuals. Second, although NTP staff have initiated the efforts are some places

by private agencies or researchers and in other in all the sites there has been intensive dialogue betw3een the local NTP staff and the private players. The local NTP staff are aware, and usually supportive of the efforts. Third, all the sites are focused on delivery of care; the appropriate public-private mix in financing is not the research issue being addressed. Most PPM models depend to some degree upon public financing, mostly in key such as supply of drugs and supports by NTP staff. Finally, all the models envisage a DOTS agency or a centre that liases with PPs and undertakes some or all of the responsibility for the public health aspects of service delivery. In some case the DOTS agency is the local NTP unit itself; in others it is a locally based private agency such as a charitable hospital or a private clinic. In either case the integrity of the recording and reporting system is maintained. There is one TB register for a divined population or a geographical area, regardless of the public or private service providing care.

Emerging Public private Mix Prototypes

A variety of public private mix delivery models are being tried out or have been proposed in sites in India, the Philippines, Vetanam, Indonesia etc. The PPm models are site-specific but in all cases, there is a singly DOTS agency that is responsible for the delivery of TB care to a defined area or population. In particular, this DOTS agency looks after the public health elements in provision of TB care such as ensuring quality microscopy, regular drug supply, patient support services, absentee retrieval, and recording and reporting including maintenance of one TB register. The emerging PPM models can be grouped in to two sites. In one et of models, the DOTS agency is the conventional DOTS unit within the NTP. Working examples include the local NTP units in Jamnagar and Ahmedabad in India. The local NTP staff lies with private practitioners and the practitioners can be involve in a variety of tasks. The second set comprises model where the DOTS agency is private, not a formal part of the NTP. Such efforts include those in Manila, The Philippines and Hyderabad, Inda. A private, often non profit, institution such as a charitable hospital can assume the role of the DOTS agency. It is responsible for delivering TB care to a defined area or a population. The functions of the local NTP changes the focus is now on identifying a promising candidate for the role of the DOTS agency, negotiating a Memorandum of Understanding (MoU) and monitoring performance. The NTP will usually provide drugs and a stipulated amount of cash to cover start-up and recurrent costs. A major motivating factor for a private DOTS agency is that some local private institutions might be better placed to interact with private practitioners and perform key public health tasks.

One advantage of using NTP units as the DOTS agencies is that it would facilitate speedy replication of successful PPM pilots. Another is that the overall responsibility of utilizing public funds and delivering TB care rests within the public sector. NTP staff can devise and administer simple incentives, financial or otherwise, to private4 providers for the performance of one or more tasks. Complex contractual arrangements are not required. For instance, in China, village doctors have been paid a mall sum, Yuan 5 for reach new infectious case referred. Further, a sum of Yuan 50 is paid for supervision of therapy of a sputum smear positive case conditionals upon completion of treatment. There are existing budgetary provisions in many NTPs for financial incentives to health workers for detection and cure of new sputum smear positive cases. The assessment found that NTP managers in India and Vietnam were not averse, in principle to offering similar incentives to private providers who carried out the desired tasks.

On the other hand, most PPM models require sustained interaction with numerous individual Ps—a task that could prove time-consuming and difficult for NTP staff given that most have no prior experience of public private collaboration. Some areas, particularly in cities, might have strong private institutions that are better placed to liase with individual practitioners. These institutions are potential candidates for DOTS agencies, which could undertake to implement the PPM DOTS model for a defined population or a geographical area. There are a few working examples of such agencies.

In one of the ongoing projects in manila, the Philippines, the DOTS agency is a large and modern private hospital, Makati Medical Centre. The centre provides the working space for the physician, the two public health nurses in the pilot and one support staff for absentee tracing and retrieval. The Tropical Disease Foundation, a research Organization based in the Centre, provides diagnostic services. The NTP supplies the TB drugs while the local government assists in mobilizing the community. {Tupasi, Personal communication}. Another interesting private sector DOTS project is operational in Manila. A pharmaceutical company has launched it. The project targets well off patients of PPs averse to treatment at NTP clinics. An entire course of anti-TB drugs is made available to the patient at a discount of 30% on the retail price [Romulo, Personal communication]. The effectiveness of the scheme remains to be analyzed. One area where pharmaceutical companies can play an important

role is in provider education. Drug companies representatives have widespread reach among PPs and could help to positively influence case management practices.

Another example of a private DOTS agency is the Mahavir pilot in Hyderabad, India (see Box 4). This pilot which covers a population of 500,000 has successfully met case detection and cure rate targets.

PPM models in which the local NTP unit servies as the DOTS agency have an existing institutional base to facilitate replication. However, replication of PPM models based on private DOITS agencies could ba a challenge. There are at least there major concerns. First, how best to identify and enlist private suitable institutions. Second, and importantly, robust yet simple contractual arrangements between the NTP and the DOTS agency would have to be devised. The government would typically provide resources such as drugs, consumables, stationery and possibly funds. In return, the DOTS agency would be responsible for meeting TB Control targets in the specified population. In effect with public funding and private provision, specific process and outcome indicators have to be agreed to and monitored carefully. Thirdly, there may be problems of sustainability.

The Mahavir Public-Private Mix Pilot - A Success Story

In collaboration with the government and PPs, Mahavir Trust Hospital, a non-profit specialty hospital, runs a public- private mix project in Hyuderabad City in India. The project area has a population of 500,000. Slum-dwellers comprise about 75% of the population; this population is a at a higher risk of TB. At the onset of the Mahavir project, Dr. Murthy who is the Medical Advisor for the project initiated contact with local PPs. They were informed about the DOTS strategy and their participation was solicited with the assurance the they would remain the primary care givers for their patients. PPs refer TB suspects to Mahavir Hospital. Diagnosis and initial treatment is done at the hospital. A detailed counseling session is held where the patient is informed of the importance of regular and complete treatment. The patient has the option of receiving free drugs under DOT at Mahavir or one of the other 26 DOT centres in the areas. No patient has to walk for more than 0.5 km to receive DOT. The Dot centres, located in private nursing homes and clinics, open at 7.30 am and are very conv4einient for patients who have to work. About two-

thirds of the TB patients are referred by participating practitioners. The main role of the PPs is to refer symptomatic individuals; a few also serve as DOT observers. Mahavir has achieved the case detection target of 70% and a cure rate of more than 85% among new infectious patients. Further, almost half of all the new smear positive patients are women compared to a third in other DOTS areas. Dr. Murthy believes that the model is replicable in other parts of urban India. He points out that private centres already exist and that patients already use them. He feels that a strategy of public-private collaboration is feasible, replicable and in the best interests of patients, providers and the government.

Other examples of private DOTS agencies are some large NGOs is Bangladesh. Six NGOs run large DOTS projects delivering TB care to defined populations. They together cover 35%of the areas under DOTS in the country. The collaboration between the government and NGOs is based on Memoranda of Understanding (MoUs). Collaboration with NGOs is intrinsic to the TB control Programme. The performance of one of these NGOs, the Bangladesh Rural Advancement Committee (BRAC), has been evaluated. Its Programme has been described as successful with a cure rate of 85% and a dropout rate of just 3.1%. An accompanying survey found that TB prevalence in BRAC areas was only half of that in the comparison area covered by government run service. BRAC itself has a strong rural presence and does not link with private practitioners. However, its success in implementing DOTS does suggest that well established NGOs with grass- roots presence could be prime candidates for DOTS agencies.

Choosing the Appropriate Strategy

Table 5 is a summary of current NTP strategies on the public-private mix in delivery of TB care with select examples and an assessment of experience to date. It appears that the TB control Programme can choose from one of the three strategic options. It can opt to build a public delivery system excluding the private sector. It could also 'ignore[the private sector and focus on delivery through government run services. In effect, there would be two parallel and independent delivery systems. The third option would be to engage the private sector players. Education and information would be one form of collaboration. More active forms already under investigation would involve PPs in one or more aspects of service delivery. It is worth commenting yet again that most NTPs either ignore the private health sector

in providing care or assume that they will eventually attract most of the TB cases through superior quality and coverage.

The optimal public-private mix in delivery of TB care will have to be derived from a careful analysis of, supply and demand-side, factors. The mix will vary across and possibly within countries. The strategy has to take into account users' perception of the quality, accessibility and affordability of different groups of providers. Further,the strategy on the private sector has to be a multi-faceted one with coherent choices on delivery, financing, regulation and education.

In choosing a strategy, NTPs have to consider at least two sets of factors. One set includes factors such as relative capacities and potential of the public and private health sectors in detecting and treating TB cases. The second set of factors relates to the trends in the broader health system.

Regarding the potential of the two sectors in TB control, the relevant question for the NTP is,'Can the TB control Programme realistically hope to achieve its case detection and case finding targets working mainly through the public sector?' If not, some from of inclusion of the private health sector might be the sensible strategy. A related question is whether the Programme can do so within the next 5-10 years. Since the private health sectors are growing rapidly in many countries, some form of collaboration could become inevitable in the near future. Many of of the high burden countries have large and growing private health sectors. Even though these countries are strengthening their DOTS programmes, the overall public health infrastructure is not strong. PPs have a major share of the TB caseload, particularly in the initial stages of help seeking by patients. There is a compelling case for collaboration with

Table 5 Current NTP Strategies on the Public Private Mix in Delivery of TB care

Strategy & Interventions	Select Examples	Experience
Public System (exclude private providers)		
Restrict anti-TB drug sales	Chile	Successful
	Oman	Successful
	Syria	To be evaluated

Mandate referrals		
Parallel Systems (independent public and private delivery systems)		
Ignore	Many NTPs	Unsatisfactory
Compete and attract TB cases	Morocco, Peru	Successful
Collaborative systems (include private providers)		
Educate, Inform providers	Many NTPs	To be evalusted (long term aim)
Collaborate in delivery		
1. Public health support services to PPs	Netherlands	Successful
	Jamnagar, India	To be evaluated
2. Incentives to individual providers for performance of specific tasks	China	Successful
3. Private agencies responsible for delivery of care to defined populations	Chennai, India	Successful
	Hyderabad, India	Successful
	Bangladesh	Promising
	Manila, Philippines	Promising
	Haiti	To be evaluated

PPs in order to increase case detection and reduce diagnostic delay. The other opportunities afforded by collaboration have already been mentioned.

Local NTP staff and private individuals in various sites in India, Indonesia, Philippines and Vietnam have arrive more or less independently at similar conclusions; they have sought to include PPs in DOTS programmes. Even where the DOTS programmes are not yet performing satisfactorily, it might not be advisable to continue to ignore PPs. Plans to strengthen the NTP should include efforts to collaborate with PPs. In particular, local DOTS units should be granted greater autonomy to explore innovative public-private mechanisms. This is in keeping with the trend towards decentralization within the health systems in many countries.

NTP managers also have to be cognizant of changes in the overall health system context. The existing reality of widespread private provision of health care is being acknowledge. Government are being urged to focus on what they do best inform, regulate, make policies and ensure financing for essential interventions. Within the public sector, there are calls for closer co-ordination among disease control programmes and a more patient centred approach. Sustainability of programs is under closer scrutiny. In keeping with these trends, TB control programmes should be giving due consideration to the appropriate public private mix in provision of TB care.

Active excusing of PPs can only be virtual. The case for minimum involvement of PPs could be made in countries with strong NTPs and well functioning government health services. In such cases, the public sector could be predicted to start off with a large share of the TB caseload. Further, the public sector will have adequate capacity to treat and PPs might not be averse to referring their patients. They could do so voluntarily; the same could be achieved by mandating referrals or by restricting the availability of TB drugs. Of course, governments must have the requisite political will and enforcement capability. Even in such cases, NTps should remain cognizant of the long-term trends in the health sector. NTP managers should also be open to innovative ways of harnessing non-governmental resources to improve the TB control effort, and consequently, to engage PPs in TB control.

Collaboration with PPs for TB control can pave the way for public-private collaboration for control of communicable diseases in general. PPs are likely to show greater interest in participating in successful public-private mix projects if care is delivered for a range of diseases. While TB cases represent a small fraction of practitioners caseload, communicable diseases as a whole would account for a significant proportion of their caseload. Broad collaboration could be expected to be attractive to governments as well since the relatively fixed transactions costs of dealing with numerous private providers is spread over a larger number of diseases.

Emerging Policy Framework

The Contours of a Policy Framework

There is a clear-cut case for addressing the issue of the private sector role in TB care in many of the high burden countries. Failure to do could seriously impede

progress towards the goal of 70% case detection by the year 2005 as set out in the Amsterdam Declaration. Conversely, innovative forms of partnership with private providers could greatly assist NTPs in meeting those goals.

Most TB control Programmers do not have a well considered strategy towards the private health sector. Existing policy frameworks are focused exclusively on provision through the public sector. These frameworks need to be revised and expanded to incorporate policies on private involvement in TB care.

While more information, research and debate are needed to develop and finalize WHO policy guidelines to NTPs on the issue of private health sector involvement in TB control, the findings of the global assessment suggest some distinct elements that may be recommended as the basis for these guidelines.

1. **Action-oriented communication with and information gathering on the private health sector at all levels should be encouraged.**
   NTP managers should have a reasonable assessment of the extent and nature of private sector involvement in TB care, the threats and opportunities posed by the private health sector, and any ongoing dialogue or collaboration. Action research on various schemes of public private collaboration is encouraged.
2. **Collaboration with the private health sector within the DOTS framework.**
   The extent and details of the collaboration will vary across and within countries; those are best worked out within countries. Local Programmes staff should enjoy greater autonomy in devising site-specific public private mix delivery models. One or more elements of the NTP guidelines could be adapted to the local context e.g. innovative ways of supervising therapy and involving communities. Accountability should be maintained.
3. **Evaluation of PPM pilot projects and scaling up of those found to be successful.**
   Pilot projects should be set up to develop public private mix for TB care. These pilots should be evaluated in terms of health outcomes, cost effectiveness, equity and quality of care. Successful models should be scaled up and replicated.
4. **Availability of public funding for provision of TB care by private providers.**
   Most PPM systems will involve a degree of public funding, for instance drug supply form the NTP. In all such cases accountability will be maintained. Private funding, if available, can usefully supplement the public funds.

5. **Emphasis on the public health aspects of the control of TB and other communicable diseases in the medical curricula.**
Revised medical curricula should encourage medical students to spend sufficient time working with the NTP and other communicable disease control programmes as part of their training.

The Role of Countries

In high prevalence countries with large private health sectors, NTP managers should:

1. Support operational research on the role of the private providers in TB care. Efforts to engage with private providers have been hampered by lack of information. More precise knowledge will help determine the extent of inmpur required for effective involvement of private providers in TB control. Availability of baseline information will also help evaluate strategies on PPM for TB.
2. Solicit representation of private providers on advisory and monitoring bodies of NTP. Regardless of the extend of their current contribution, representatives of private health care providers should be involved in planning of TB control activities. Policies on private sector involvement are likely to succeed if they are developed with informed participation of private providers.
3. Initiate and maintain dialogue with private providers at all levels. Insights into expectations of private providers from NTP and the extent to which they can collaborate effectively will known only through continuous dialogue with the private sector at all levels. Their involvement at the highest national level needs to be reinforced by the NTP at the state, district and sub district levels reaching out to private providers in their areas of operation and soliciting co-operation. Working models of collaboration are likely to emerge from such interactions.
4. Decentralize TB Control activities to allow development of locally relevant PPM models. Local situations vary greatly and many elements of a robust and sustainable model of PPM will be locally specific. NTPs should be encouraged to explore various way of collaborating with the local private providers.
5. Revise national TB control frameworks to include guidelines on the involvement of private providers. The embargoing policy framework discussed earlier, coupled with results of action research will assist countries in developing policies on the role of the private health sector in TB control.

Contribution of NGOs in TB Control

The previous distinctions that separated government from non-government, and public from private are disappearing as we learn to work together, and value each other's contributions. This is seen clearly in partnerships that are developing between governmental and non governmental organizations (NGOs) to fight communicable diseases. Within the South Asia Region, NGOs are making a vital contribution to disease control that is increasingly being recognized by government as well as by international donors and development partners.

1. Introduction:

TB kills. TB destroys families and devastates communities. The current TB epidemic is a global disaster on an unprecedented scale. A third of the worlds population is infected with TB, 8 million become sick with TB every year, and more than 2 million people die. And things are getting worse, due to poor control programmes, HIV, population growth and poverty.

This situation demands urgent response from all sectors of society. Governments are increasing their efforts to fight TB, and many NGOs have also joined the battle. Some are involved through TB control programmes, but many more NGOs are indirectly active in controlling TB through socio-economic development and prevention of HIV/ AIDS.

All these are vitally important, but there are great possibilities for increasing the effectiveness of these contributions. Perhaps you are with an NGO that already works in TB control but you want to improve the effectiveness of your Programme. Or perhaps you want to become involved in this important work but are not sure what steps to take. This booklet is designed to help you and give you some ideas.

Principles of NGO involvement:

There are many ways that NGOs can be involved in TB control, but three basic principles underline the best strategy for involvement.

First Principle: Government's responsibility

Governments have the primary responsibility for maintaining and improving public health. Effective TB control demands a coordinated approach with standardized

diagnostic, treatment and information systems. The government must therefore take a lead in developing and maintaining these system. NGOs, along with the government and other regencies, become part of the national TB control Programme, and all follow the same policies.

Second Principle: NGO role is to facilitate and support community action

The nature of many NGOs has changed in recent years. Many organizations have recognized that their primary role is to facilitate and support to help build capacity of individuals, communities and governments. This is particularly important when it comes to TB Control. TB will not be controlled in 5-10 years but may take even 50 years. Few NGOs can be committed to provide services for that period of time.

Third Principle: Building on existing strength

There is no ideal model for NGO involvement in TB control. There are many alternative approaches, and the most suitable one will depend on the nature of your organization. So build on your strengths your skills and experience. If you have experience running hospitals or clinics, then you will probably want to include effective TB diagnosis and treatment services. Alternatively, if you are involved in providing community based care for people with HIV/AIDS, you will probably want to incorporate community DOTS. Different approaches are not mutually exclusive, and a combination will often be required for example advocacy, health education and community based care.

Fourth Principle: Integrating DOTS in ongoing Programme activities

Many NGOs are active in health areas. They should explore the possibility of integrating TB Control in their ongoing programmes. For example, NGOs working on HIV/AIDS can integrate DOTS as part of care activities. Particularly because TB is closely linked to HIV. People who are infected with both TB abd HIV have a very high risk of developing active TB disease- about 10% a year. In many countries of South East Asia, over 50% of people with AIDS develop active TB.

Treating people with TB and HIV prolongs their life, reduces suffering, and prevents the spread of TB to other people. If HIV increases, then the number of people with TB also rises, so preventing the spread of HIV helps to stop TB.

Organizations involved in HIV/ AIDS prevention and care may not fully aware of the close links between TB and HIV, and may not have experience in supporting people with TB. However, the close relationship between the two infection means it is important that HIV/ AIDS organizations learn about TB and find ways of integrating TB control activities into their work.

Organizations involved in prevention of spread of HIV can develop educational approaches to help increase awareness of the links between HIV and TB. However, it is important that such educational approaches do not use fear to influence people. Creating fear may have a limited effect in the short term, but in the long term can create stigma and make life even harder for people with HIV and TB.

Some NGOs provide counseling and HIV testing services. These can be linked to TB screening services. NGOs involved in care of people with HIV/ AIDS need to learn about NTP diagnostic and treatment policies.

Role of NGOs in TB Control:

4.1 Providing TB treatment services

The traditional model for NGO involvement in TB control has been service delivery through TB clinics and hospitals. Many NGOs in South East Asia and continue to make important contributions to TB care.

In a service delivery approach, the NGO is responsible for diagnosing and treating people with TB Treatment services may be specifically for TB patients, for example a TB clinic or a TB hospital. Alternatively, services may be provided as part of general health services, for example, in a hospital or health centre.

NGOs may have the facilities and resources to provide second line treatment (so called" Category IV") for people with MDR-TB. These medicines must only be given in specialized centres, because of the high risk of adverse effects from the medicines, and to ensure that patients take medicines under very close supervision. Most NTPs cannot afford to provide this treatment, which costs at least 100 times as much as a normal course of treatment.

Advantages:

NGO health services are often of high quality, and popular with patients
Service delivery through community clinics often achieves goods cure rates.

Disadvantages:

Requires long term-even permanent commitment to providing services.
General hospital often have few or no community based staff and cannot do defaulter tracing. Cure rates in general hospitals are often poor.
Service delivery is expensive because of the need to employ large numbers of staff.
Many hospitals charge fees for services, for example smear microscopy, but most NTPs have a policy of free diagnosis and treatment for TB patients.
Strong NGO health services sometimes have an adverse effect on the capacity of government health services.
Service delivery is unpopular with donors and may be difficult to sustain.

Possibilities

Suitable for NGOs that run hospitals or clinics.

4.2 Supporting Existing Health Services for TB Control

Some NGOs prefer to avoid service delivery, but want to support the development of effective government health services. They recognize that successful TB Control Programmes depend on good management, particularly for laboratory services, logistics and monitoring. These organizations help government staff carry out the management aspects of TB Control for example, needs assessment, planning, training supervision, drug supplies quality control of sputum smear examination, and reporting. This support is in the form of skills development for government staff and systems development to improve the efficiency and effectiveness of government services. NGOs can also provide support in terms of infrastructure for local TB programmes. Many NGOs have become involved in strengthening government health services at the district or community level. This approach is particularly suitable for organizations which already have this involvement, and can be a highly cost effective means of

supporting TB control. It is important to develop a close working relationship with government health services based on mutual trust and support.

Advantages.

Less costly than service delivery
Does not require long term commitment
Capacity building; enables staff of the government health service to improve the quality of their work.

Disadvantages

- Depends on the government infrastructure - if government services are weak or non-existent then may not be successful
- Difficult if government health workers are frequently transferred.
- Government health workers may not welcome the involvement of NGO workers.

Possibilities

Organizations working to strengthen district health services.

4.3 Educating community about TB treatment

Health education, information and communication (HIEC) id an important strategy in TB control. Many people with TB lack awareness of the basic symptoms of TB. Even if they do know about the symptoms, they often do not know that diagnosis and treatment is freely available through government or NGO health services or that tuberculosis can be cured.

However, education of the community about TB treatment may have a negative impact if treatment services are not widely available or are of poor quality. Provision of DOTS must go hand in hand with an education Programme.

There are many different ways of communicating messages about TB, for example, mass media (TB and radio), printed materials (poster and pamphlets), and drama (puppet shows, street theatre). One of the most important ways is by word of mouth. Health workers can play an important role in sharing information about TB during conversations with patients and people in the community.

Advantages

- Low cost

Disadvantages

- Only appropriate if treatment services are available and good cure rates have been achieved

Possibilities

Organizations working in health education.

4.4 Providing Community-based Care

People with TB live in families and communities. These communities, in villages, towns, cities, slums, and factories provide valuable social support to the members of the community. A basic principle of TB Control is provision of care as close as possible to the patient's home. This may be in the community to which the patient belongs. Community volunteers, local leaders, civil service organizations, colleagues in the work place, religious leaders, shop keepers, teachers and many other can be actively and usefully involved in helping cure TB.

Many NGOs are committed to a community based approach, in which members of the community themselves take responsibility their own needs, planning interventions, implementing activities, and monitoring and evaluating outcomes. Community based care of people with illness has become popular, as communities recognize that health services provided by institutions such as health posts and hospitals are limited in their capacity to provide adequate support within the home or local community. Relatives and neighbors already provide the majority of care; community based care is a means of facilitating this existing system and providing support to care gives.

There are two types of community based care. The first type is care by outreach workers from the health services, or from NGOs. These are often salaried health workers or social workers, and may have been recruited from within the community. The second method is by volunteers from within the community

(often as part of an NGO initiatives). Community based care workers provide social support, observation of treatment, nursing care, and education.

Community based care has grown in recent years as a result of the HIV epidemic. Many people with AIDS also have TB NGOs working in community based care for people with AIDS have discovered that they need to know as much about TB as HIV/AIDS. TB is a treatable condition, and treating and AIDS patient for TB can make a very significant contribution to their life expectancy and quality of life.

Advantages

Provides care close the patient's home
Can be integrated with other care and development activities
Responds to community needs and priorities
Encourages local involvement and ownership

Disadvantages

Requires extensive network of community level workers

Possibilities

- Organizations involved in community based care of people with HIV/AIDS
- Organizations working in community based health development

There has been a rapid growth in self-help groups and patient's organizations in the last few years, particularly for people with HIV/SIDS and other chronic illnesses. Such groups have many benefits and provide a social network for patients and their families, information and education about specific conditions, and advocate on behalf of people affected by a disease of disability. Organizations specifically for TB patients are rare. This is perhaps because:

- TB is not a chronic disease so patients will not stay long in the group
- Stigma may discourage people from identifying themselves as having TB
- Relatively few people with active TB live in the same geographic location (except in some urban areas).
- Disadvantaged groups in society often have less experience in advocating on behalf of themselves.

The potential for involving people with TB in existing self-help groups is great. These include micro-credit groups, adult literacy groups, and organizations for people affected by HIV/AIDS.

Advantages

Directly benefits those most affected by TB

Disadvantages

TB specific self-help organizations may be difficult to form and maintain

Possibilities

- Patients organizations for people with HIV
- Chest and heart associations
- Women's groups
- Income generation and micro-finance groups.

6. Key elements of s successful NGO involvement

Collaboration

Collaboration is essential to TB control There are many existing and potential partners working in TB control. Coordination-keeping each other informed is important to avoid duplication of effort. Collaboration working together is an effective way of strengthening partnerships, reducing costs, sharing resources and skills, and maximizing the value of the contributions of different agencies. Collaboration in advocacy, education and research initiatives is of particular value.

Information

A successful Programme relies on a steady flow of information. The successful Programme will generate information that it can share with other. Equally, a good Programme needs information to ensure that it is up to date with current developments in TB control Sources of information include newsletters, journals, books conferences, meetings, training courses, and the World Wide Wed. A list of useful resources is given in the annex.

Innovation versus Standardization

Successful DOTS relies on a standardized approach to diagnosis, treatment, logistics, and reporting. Significant deviations from national standards lead to treatment chaos and seriously hinder Programme monitoring. However, innovation is necessary to maximize the potential of DOTS and to find the most effective and efficient implementation methods in different populations and health services environments. There is therefore potential tension between the need to standardize the need for innovation, whereas NTPs, emphasize the need for standardization. Fruitful innovations can be creatively fostered through close co-ordination between the NTP and NGOs involved in research, with agreement on deviations from national policy only authorized as part of a regroups research Programme.

Sustainability

Even if we were able to stop the spread of TB today, there would be new cases of TB for decades to come because people who have already been infected remain at risk of developing active TB for the rest of their lives. DOTS is the most effective control st4rategy available to us, but it will take many years before we achieve out goal of eliminating TB as a public health problem. This illustrates the need for long term commitment to sustainable TB Control Organizations should therefore avoid unsustainable activities and those that create dependence, for example additional payments to health workers that are not sanctioned by the government.

Community Participation

It is communities that are most affected by the TB epidemic, and it is comminutes that have most to gain from effective TB control measures. Involvement of the community is a key principle of TB Control, because communities are most aware of local needs and circumstances and most able to identify effective ways of delivering DOTS. Even community has strengths and these strengths can be enlisted to ensure proper DOTS implementation. Communities can identify local solutions to local problems, such as mean of organizing observation of treatment. NGOs can make an important contribution by facilitating links between government health services and local committees. Some countries have established district DOTS committees to facilitate the introduction and local supervision of DOTS. TB control can also be linked with other community development activities, such as community based care, income generation, literacy and micro credit.

Networks

Networks are groups of individuals and organizations that meet and communicate together. Most networks have formed to share information, co-ordinate activities, and advocate for action. Learning organizations are always keen to listen to other to find out what works and to share failures as well as successes. The rapid increase in the number of NGOs working in TB control, and the growth of information technology, has resulted in a profound change in the way information is shared. Many local and national TB networks have developed in recent years, such as the leprosy coordinating committee (LCC) in Bangladesh and the TB Control Network (TBCN) in Nepal.

Networks can be helpful at each level. In the community, networks of patients in self-help groups can offer mutual support to one another. At the district level groups of NGOs can coordinate activities. At the national level, networks can share information and resources and coordinate research education and advocacy activities.

There are some basic principles for successful networking. Shared ownership is important to prevent one organization dominating, or setting the agenda for the other organizations. A written constitution defining the structure, organization and ground rules of the network may help to prevent this. Rotating the chairperson and secretary and changing the venue of meetings can also help to prevent the emergence of dominate organizations or factions.

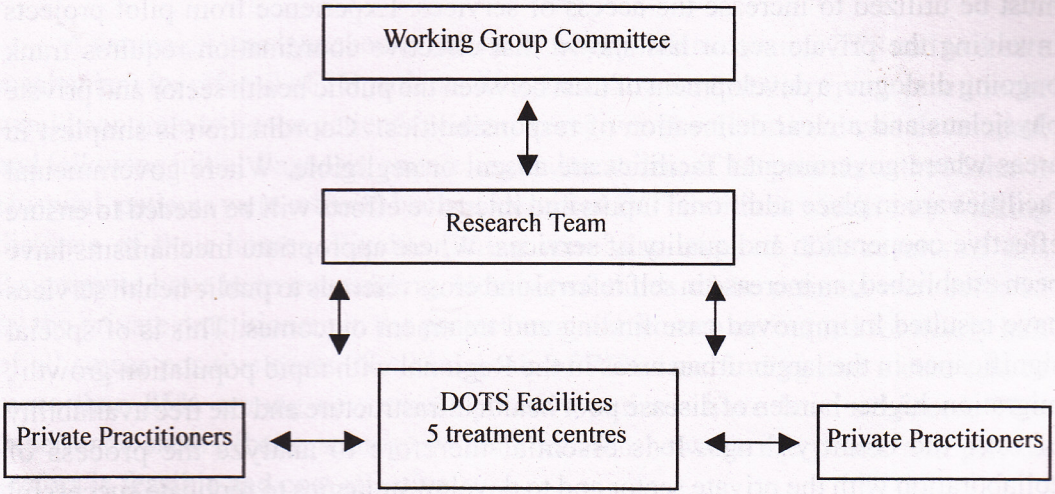
Because most networks exist to coordinate and share, decision making is usually by consensus, though voting may be needed at times. Networks also have to define their membership. This will usually be open, with few restrictions or pre-qualifications, other than interest or involvement in TB control. Prior agreement on the scope of discussions within the network will help to prevent meetings from deviating from the main purpose.

Appointment of a secretary responsible for arranging meeting, preparing and distributing the agenda, and keeping minutes of discussions, will help to increase the effectiveness of meetings.

Experiences in Public private Partnerships

Nepal

The National TB Control Programme in Nepal extended the DOTS strategy to 75% of the country by end 2000. With cure rates will over 85% it was appropriate to focus on the private sector beware the HIV epidemic and the development of multi-drug resistance became major concerns. Indirect evidence has shown that case detection in the public sector is around 50% with nearly 70% of anti-tubercular drug inputs being accounted for by the private sector. Private public collaboration was considered especially important in urban areas in view of rapid population growth, high burden of disease, weaker public health services, freely available over the counter anti-tubercular drugs and a rapidly expanding private sector. A model for service linkage was developed as shown below in one municipal ward, Lalitpur in the Kathmandu valley:



The Lalitpur Municipality has population of 200 000 and was selected since it was close to Kathmandu. 100 private practitioners were involved in this project. Following a basic needs assessment based on interviews with private practitioners, a working groups as well as local DOTS committees consisting of all stakeholders were formed. Standard case management protocols were developed and private practitioners workshops held. Services 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 trend to implement DOTS and late patient tracing mechanisms developed with NGO support. Feedback meetings with private practitioners were arranged and PP clinic visits made periodically. An informal Coalition against Tuberculosis (CAT) involving the DHO, NGOs, INGOs, PPs, the local municipality and members from the community was formed.

Upto 17% of new cases in Lalitpur now being registered by the NTP are from private practitioner referrals in contributing significantly to case-finding. Treatment success rates in the project area rose to over 90% thereby showing that by sensitizing the private practitioners and providing appropriate information, it is possible to build on the strengths of local health services. In order to develop public private service linkages consistent with the goals of national control programmes, the strengths of the private sector in terms of accessibility, flexible timings and rapport with patients must be utilized to increase the access of services. Experience from pilot projects involving the private sector has shown that effective coordination requires frank ongoing dialogue, a development of trust between the public health sector and private physicians and a clear delineation of responsibilities. Coordination is simplest in areas where governmental facilities are absent or negligible. Where governmental facilities are in place additional inputs and intensive efforts will be needed to ensure effective cooperation and quality of services. Where appropriate mechanisms have been established, an increase in self referral and cross referrals to public health services have resulted in improved case finding and treatment outcomes. This is of special significance in the larger urban areas in the Regional with rapid population growth , migration, higher burden of disease poor health infrastructure and the free availability of over the country drugs. It is essential therefore to analyze the process of collaboration with the private sector and to develop strategies to replicate successful models in order that public private collaboration be rapidly scaled up in the Region.

India

The private health sector is the first point of contact for most TB patients in India. Most TB patients first seek help from one of India's ten million private practitioners It is estimated that most of these patients spend upto 4-6 weeks before they are diagnosed and treated. TB cure rates for patient who remain with private providers are low. The introduction of Revised National Tuberculosis Control

Programme (RNTCP) in India provided a unique opportunity for Private Public Partnership.

1. Mahavir Trust Hospital, Hyderabad

In a joint effort between the Government and the private sector, a charitable specially trust hospital, Mahavir hospital in Hyderabad, India undertook a project involving 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 programmes, and then to develop a model for collaboration, was developed with the charitable trust hospital functioning as an inter phase between the government and individual private practitioners.

A campaign was launched to inform local physicians about DOTS and to create mechanism for referral of TB patients with the assurance that the private practitioner would continue to be the patient's primary caregiver. A referral card was developed, and following initial diagnosis, counseling and treatment of TB patients at the Mahavir Hospital, patients were referred back to identified DOTS centres within easy walking distance of their homes. Fixable timing were also ensured. The results of this Programme have been outstanding. Nearly two-thirds of the patients 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 finding and a cure rate of more than 85% among 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.

1. Tuberculosis Research Centre- ACT and private practitioners

An initiative named ACT (Advocacy for Control of TB in Chennai, India to involve private practitioners in TB control was a lunched 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.

The objectives of this project were to develop a model to induct private practitioners into the RNTCP, identify modalities to link private practitioners with the public health care system, identify sustainable approaches and determine ways to upscale the model. The target groups were individuals 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 at their monthly association meetings. The independent Medical Practitioners Association of India, The Tamilnadu Medical Practitioners Association and Indian Medical Association were contacted. Doctors were sensitized and then informed about the policies and practices of the RNTCPs and ACT organized training workshops in the components of the RNTCP and DOTS methodology. The staff of 30 private laboratories were also trained by TRC, Chennai. 83 doctors joined the Programme and the agreed inputs for them to participate including documents case records and information materials for the patients and DOTS providers were provided. Drugs were procured from the Chennair Corporation and ACT contributed social workers and Programme coordinators, whiled training was done by the faculty of the TRC. A wide range of partners from other sectors such as the Industry, NGOs, the media and community-based clubs were also involved.

How ACT supports private practitioners

Doctors' Training	Tuberculosis Research Centre (TRC)
Lab Technicians Training	
Diagnosis	Corporation Labs Private Labs
Referrals and for second opinion	Tuberculosis Research Centre
DOTS Providers	Community volunteers trained by ACT social workers
Drugs	Chennai Corporation
Patients referred	by ACT, from community other hospitals Private practitioners.

A unique feature of the ACT project was the emergence of volunteers within the community who acted as DOTS providers. The lessons learnt from this Programme are that it is possible to induct private health care providers into public health

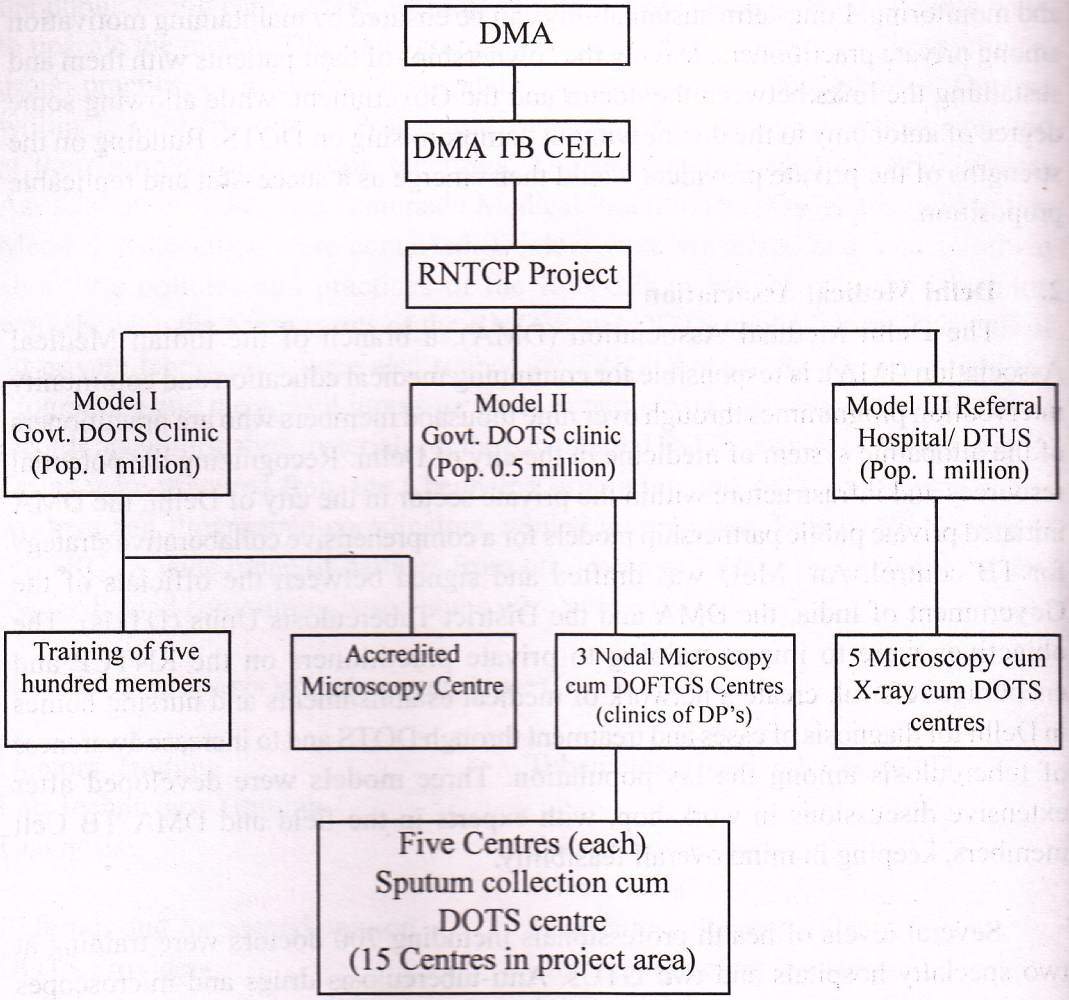
programmes if an intermediary organization will coordinate between the local health authority and the community to ensure a mechanism to provide technical support and monitoring. Long-term sustainability can be ensured by maintaining motivation among private practitioners, leaving the "ownership" of their patients with them and sustaining the links between the doctor and the Government, while allowing some degree of autonomy to the doctor without compromising on DOTS. Building on the strengths of the private providers would then emerge as a successful and replicable proposition.

2. Delhi Medical Association

The Delhi Medical Association (DMA), a branch of the Indian Medical Association (IMA), is responsible for continuing medical education and community intervention programmes through over nine thousand members who are practitioners of the allopathic system of medicine in the city of Delhi. Recognizing the potential resources and infrastructure within the private sector in the city of Delhi, the DMA initiated private public partnership models for a comprehensive collaborative strategy for TB control. An MoU was drafted and signed between the officials of the Government of India, the DMA and the District Tuberculosis Units (DTUs). The objectives were to impart training to private practitioners on the RNTCP and encourage referral, create a network of medical establishments and nursing homes in Delhi for diagnosis of cases and treatment through DOTS and to increase awareness of tuberculosis among the lay population. Three models were developed after extensive discussions in workshop, with experts in the field and DMA TB Cell members, keeping in mind overall feasibility.

Several levels of health professionals including 700 doctors were training at two specialty hospitals and two DTUs. Anti-tuberculosis drugs and microscopes were provided to these centres. Regular monitoring of the designated microscopy and DOTS centres was undertaken by the project team staff in coordination with Government staff. Specific concerns and constraints were addressed during evaluator visits by high level officials of the Government of India and WHO. Lessons learnt from this project have been that a well-designed project coordinated by all stakeholders such as the Government, private practitioners, medical associations and NGOs is essential to co-recognition and accreditation is important. It is equally essential to provide regular updates and to ensure accountability for long term success. The project

is now running well and liaison with the public health services is good; outcomes are gradually improving. Efforts are underway to open more DOTS centres.



4. Delhi TB Association

Recognizing the importance of the role of the private practitioners in Delhi, which has a population of an estimated two million requiring health care for tuberculosis, the Delhi TB Association has also made attempts to involve general practitioners in the city of Delhi in the RNTCP. The strengths of the private practitioners in terms of their proximity to and of greater acceptance by their patients resulting in better adherence to treatment needed to be built on. Concomitantly their

reluctance to use microscopy as the primary tools for diagnosis, disregard for recommended treatment regimens poor documentation of outcomes and inability to trace defaulting patients needed to be addressed. In order to effectively involve them, access to information on the RNTCP, addressing doubts on technical issues, training workshops and orientation meetings with experts and Programme managers could be held through coordination with local IMA branches. However it was felt that formats for recording should be simplified and support for record keeping and default tracing provided. Reassurance that they would not lose their clients must be provided by national Programme staff. It is expected that case notifications would rise secondary to referrals from private practitioners to the public health care system and through increased awareness among their patients and families through health education about the signs and symptoms of tuberculosis and counseling regarding the need for adherence to treatment. GP clinics could be used to increase access to DOTS while private practitioners could be instrumental in creating socially supportive environments to counter the stigma attached to STI and TB.

Sri-Lanka

The country with a population of 19 million, has a well established public health infrastructure including primary health care services which are provided free of cost. However ,open economic policies have led to a vibrant and rapidly expanding private health care sector. While tuberculosis is noticeable, STIs are not; reporting form the private sector is therefore grossly inadequate. High levels of antibiotic drug resistance have also been reported owing to inappropriate use. The National STD/ AIDS Control Programme (NSACP) has adopted the syndromic management of STI at primary health care level and modified WHO models for local use. Half-day updates on STIS and HIV/AIDS have been provided and the syndromic management of STIs introduced to private practitioners. In addition, the College of venereologists of Sri-Lanka were requested to conduct updates on the management of STIs for private practitioners and UNFPA convened meetings with them to discuss improvements in reporting. Technical assistance to develop distance-learning modules was provided to the independent Medical practitioners Association (IMPA).

The national tuberculosis Programme has briefed private practitioners on DOTS and the patients are now being referred by them to the public sector. However many private practitioners continue to treat TB patients without reporting them to the national Programme.

Perceptions of and Expectations From the Private Sector

On the National Tuberculosis Control Programmer

- Regular exchange of information can improve relations between private sector and their NTP.
- Quality of care in the Government sector is low.

On public-private service linkage

- All public health programmes should try to create a service linkage.
- Systems for recording and reporting are needed to assess situation and improve case management.
- Late patient tracing systems can prevent the emergence of drug resistance.

Private practitioners do not have the time/infrastructure to do this. Hence assistance is required in this area.

On microscopy services for private patients

- Current public microscopy services are not convenient for patients.
- Quality of sputum microscopy in the private sector in questionable, as there is no quality control.
- Private laboratory staff should be trained by the national programmes.

On the use of standardized treatment cards

- Introduction of treatment cards can improve patients care.
- The doctor is too busy to fill them out and someone else should have this responsibility.

On referring patients

- They are willing to refer patients who cannot afford private care but quality of service and patient's convenience is the key.
- Current public services do not offer quality services acceptable to many private patients.
- NGOs should be the link between private and public sectors.

On the regulation of drugs

- Only licensed private practitioners should be allowed to prescribed TB drugs.
- All drugs sold should be quality controlled.

Role of Medical Associations: A few Examples

India

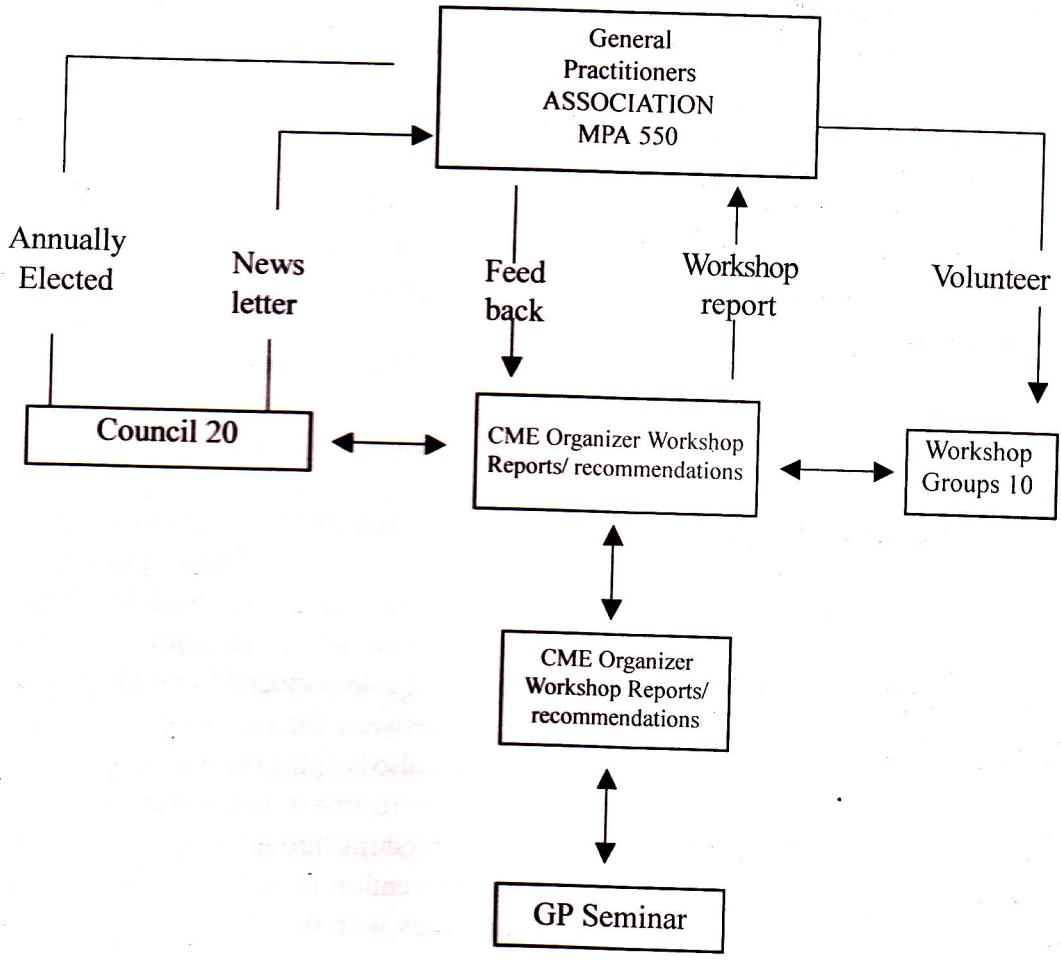
The health infrastructure in India is divided between the Government and the private sector, the formed accounting for approximately 20% of available resources for health and the latter nearly 80%. The Indian Medical Association (IMA) is the largest private sector NGO in the health care sector in India and the largest voluntary body of doctors with a membership of 150 000. The IMA has 27 state branches and 1500 local branches in the country. The Government has recognized the IMA as the principal nodal agency for implementation of various health care Programmes, such as National Malaria Eradication Programme (NMEP), National AIDS Control Programme, voluntary blood donation Programme. The IMA contributes significantly to STI and TB control efforts. The IMA has a role to play in coordinating between private practitioners and the government health system in encouraging its members to follow the policies and practices of the national programmes, facilitating accreditation of private health facilities including laboratories, arranging training, and in developing state-west project through local IMA branches for private Public Partnership.

Sri-Lanka

The Independent Medical practitioners Association (IMPA) in Sri-Lanka has a membership of approximately 800 private practitioners and family physicians throughout the country. The Association identified there main areas of work in relation to national programmes namely, continuing education, an advisory/advocacy role and policy making. The IMPA played a significant role partnership building with national control programmes, bridging the gap between the concerns of national programmes and those of private practitioners while also keeping in mind the concerns of patients regarding privacy and access to the best treatment. In the area of policy-making, the IMPA facilitated private-public partnerships through helping to define the doctor's role in primary care and disease prevention in addition to providing curative services. This was done through dialogues with the advisory committees

and clinical sub-committees. The national Programme provided free literature and drugs and monitored this collaboration, ensuring the availability of good quality drugs.

The IMPA also seeks to create a balance between the hospital based specialized services and community-based primary care. The IMPA commenced continuing medical education programmes for private practitioners in 1978. Learning materials were designed for self-study through distance learning modules. These were reinforced by field visits and sub-regional and regional seminar. Lessons were structured to ensure early diagnosis, prompt and effective treatment, referral when necessary.



These experiences in the Region show that private public partnerships can work. Successful pilot projects must be replicated. New areas have to be addressed following a needs assessment of persistent lacunae. Private-public partnerships TB control need to be implemented in the sprit of doing good and as social responsibility. These broad principles should guide the development of policy guidelines for private-public partnerships within national control programmes. SAARC has a role to promote and support private public partnerships in TB control efforts in the Region.

Enhancing the role of Private Sector in TB Control

Strategies and Approaches

1) **Areas where private practitioners could make a significant contribution**
Success for effective private-public partnership depends on mutual trust building on existing infrastructure and must remain guided by national policy. The specific areas identified in which private practitioners could make a significant contribution TB control were: advocacy; case management; counseling and health education; improving case notifications, and liaison with other stakeholders such as business, industry and NGOs for increased commitment to national control efforts and resource mobilization. The key practical strategies and approaches identified were: situational analysis and consensus-building on the roles of the various stakeholders based on their strengthens and resources; advocacy and marketing; private sector representation on national committees that frame policy, implement and evaluate TB control services; documentation and evaluation of pilot projects for replication; capacity-building for implementation and expansion of private public partnerships through orientation and dialogue with private practitioners at national and sub-national levels, and Programme monitoring to ensure accountability.

2) **Key practical strategies and approaches needed to enhance the participation of the private medical sector**
Several approaches have been used towards private sector; regulatory educational and collaborative. Several models of private-public partnerships involving private practitioners upto various levels of implementation have been developed in the Region. The following steps are required to achieve effective private-public partnerships: a multi-centric representative situational analysis

of the current involvement of private practitioners in national control programmes and consensus-building on their role is key to further collaboration. National policy must include the private sector as an equal partner from the inception in policy-making, implementation and evaluation of national health programmes, ensuring their representation at local and national advisory committees and in consensus groups. Orientation of private practitioners to the policies and practices of national programmes must be carried out through continuing medical education and accreditation programmes in collaboration with their professional associations in order to build capacity of the private sector to effectively contribute to national disease control efforts. The strengths of the private sectors must be build upon and lacunae addressed through dialogue and operational research. The potential of private sector resources and infrastructure must be fully utilized by public health services to improve service delivery and access to health.

3. **Steps needed to promote/implement private-public partnerships**

National programmes should provide learning materials, supplies and equipment, drugs and support for late patient tracing under DOTS and for record keeping to assist in private-public collaboration. Private practitioners should be assured that they will retain their clientele and the confidentiality and trust with their patients would not be eroded.

Conclusions and Recommendations

Conclusions

It was clear from the pilot projects from the various countries described at the meeting and form the presentations made by the private sector including the medical and/or private practitioners associations, the private sector involvement in public health Programme is possible and can work successfully. Although there are different models of public-private partnerships currently in operation in the Region, the feedback showed that the GPs individually or as a group, are willing to participate and to follow national policies. However, the examples of private sector participation are few and far between. What is needed is not only initiation of more pilot projects, but also documentation of experiences gained so far in order to implement these more widely in other areas. Steps are needed to enhance private sector capacity through

CME programmes and dissemination of guidelines for close collaboration between national programmes and private medical sector umbrella organizations such as medical associations. A broad framework is also needed to guide planning and implementation of public-private partnerships, although this needs to be carried out in accordance with local situations.

It is expected that as a follow-up to this consultation over the next 1-2 years, public-private collaborative activities will be implemented in most countries of the Region and steps taken to build the capacity of the private sector in correctly and appropriately diagnosing TB and managing them in accordance with established national policies and strategies.

Recommendations

For National Programmes:

1) Member countries should adopt policy to actively involve private practitioners in TB control programmes and include the private sector in national level committees.

2) Guidelines should be developed for involvement of private practitioners in strategic areas of work.

3) Skills, materials and resources should be provided, nodal agencies created to inter phase between private practitioners and national programmes and develop action plans for private-public partnership in the identified strategic areas.

4) Situation analyzed should be undertaken and operational research to promote private-public partnership and evaluate existing private public partnership projects.

5) Consensus should be developed among all stakeholders including other sectors such as education, law and finance for private-public partnership.

6) Mandatory reporting for tuberculosis form the private sector should be introduced.

For National Medical Associations:

1) TB control should be under priority projects and a position paper developed to encourage members to follow the policies and guidelines of national control programmes including compliance with reporting.

2) As member of national level committees, they should assist in developing policy on involvement of private practitioners in national TB control programmes.

3) They should conduct continuing medical education programmes, disseminate guidelines and learning materials and introduce re-certification for private practitioners.

4) Promotion, participation in and documentation of pilot projects on private public partnership should be undertaken.

5) Certification of private laboratories and treatment centres by respective government should be facilitated.
