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Involving Private Medical Practitioners in TB and STI Control

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CONTENTS

	<i>Page</i>
1. INTRODUCTION.....	1
2. AN OVERVIEW OF STI/HIV AND TB IN THE REGION.....	1
2.1 STI/HIV.....	1
2.2 Tuberculosis.....	3
3. HOW THE PRIVATE MEDICAL SECTOR CAN HELP IN DISEASE CONTROL.....	4
3.1 The Role of the Private Sector	4
4. EXPERIENCES IN PUBLIC-PRIVATE PARTNERSHIPS.....	7
4.1 Nepal.....	7
4.2 India	8
4.3 Sri Lanka.....	13
4.4 Thailand.....	13
5. PERCEPTIONS OF AND EXPECTATIONS FROM THE PRIVATE SECTOR.....	14
6. ROLE OF MEDICAL ASSOCIATIONS: A FEW EXAMPLES.....	16
6.1 India.....	16
6.2 Indonesia	16
6.3 Sri Lanka.....	17
7. ENHANCING THE ROLE OF PRIVATE SECTOR IN HIV/STI AND TB CONTROL.....	19
Strategies and Approaches	19

	<i>Page</i>
8. CONCLUSIONS AND RECOMMENDATIONS.....	20
8.1 Conclusions.....	20
8.2 Recommendations.....	21

Annexes

1. List of Participants.....	24
2. Programme.....	29

1. INTRODUCTION

The role of private medical practitioners particularly in the management of sexually transmitted infections and in the treatment of tuberculosis cannot be underestimated, particularly in this Region. This is especially true since studies have shown that 50-70% of such patients are cared for by the private sector.

Recognizing this, the WHO Regional office for South-East Asia, in collaboration with Siriraj Hospital, Mahidol University, Bangkok, organized an informal consultation from 20 to 22 February 2001 involving private medical practitioners, representatives of medical associations, medical schools and officials from national STI/HIV/AIDS and TB programmes from Member Countries.

The objectives of this consultation were:

- (1) To review the status of TB and HIV/STI in the South-East Asia Region, including patterns of accessing health care;
- (2) To identify the next stages/steps required to involve private practitioners in TB and STI control, and
- (3) To identify specific issues to be addressed at country level to effect changes in health delivery.

2. AN OVERVIEW OF STI/HIV AND TB IN THE REGION

2.1 STI/HIV

HIV/AIDS is a major public health and developmental problem in the Region. Of the 50 million HIV infections worldwide since AIDS was first reported in 1981, 18 million have already died. Unlike in the developed world where the epidemic has stabilized and deaths related to HIV/AIDS are falling due to behaviour change and availability of anti-retroviral therapy, the epidemic in

South-East Asia Region is constantly evolving. The transmission pattern is determined by the risk behaviour and vulnerability of various populations as determined by their gender, social and economic status. HIV was first reported in the Region in 1984 and rapid transmission was first seen in Thailand during 1988-1989 when the prevalence rate of HIV increased to 40% among injecting drug users. Similar increases were subsequently seen in Manipur in India, Myanmar and Southern China.

South and South-East Asia presently account for 5.8 million infections of the 36 million cases worldwide, which is second only to Africa, where, in some areas, one fifth of the population is presently infected. Nearly 95% of HIV infections as well as reported AIDS cases in the Region are from Thailand, India and Myanmar where the epidemic is in an advanced stage, although it must be taken into account that reporting is much more complete in Thailand than other countries. Effective prevention and control has resulted in a decline in HIV prevalence particularly in Thailand. Besides India, Myanmar and Thailand, two other countries are significant in this context; Indonesia and Nepal currently have low rates of HIV in the general population, but have reported small outbreaks and pockets of high incidence among high risk populations especially intravenous drug users (IDUs). Reports from the rest of the Region presently indicate low prevalence; DPR Korea is yet to report any HIV or AIDS. The implications of HIV/AIDS in the Region are the increased burden on already over-stretched health services and major economic losses, both of which will reverse earlier gains in life expectancy and quality of life in the Region. The impact of HIV on tuberculosis is an added concern; in areas where HIV incidence is high, as shown from Chiang Rai in Thailand, rates of tuberculosis nearly doubled.

The primary mode of HIV transmission in the Region remains heterosexual accounting for 85-90% of new infections; about 5% is due to transmission from mother to child and a smaller percentage occurs secondary to blood transfusion. Strategies for prevention of sexual transmission of HIV in the Region are two-pronged. Firstly, the promotion of adoption of practices of safer sex and secondly, reduction in the incidence of sexually transmitted infections (STI). The second strategy follows from the understanding that STIs facilitate the transmission of HIV and that early and effective management of STIs is a key intervention to prevent HIV transmission; viral loads in semen have been shown to drop with treatment of the underlying STIs.

The Region faces several constraints in the management of STIs; delays in seeking care are compounded by a lack of basic laboratory facilities for diagnosis. Referrals to designated facilities remain problematic. Most patients present either to a local private practitioner or at the primary health centre level. It is therefore essential that appropriate management is provided at this first point of contact with the health care system. In consonance with this, WHO has prepared flow charts for the syndromic management of STIs; a simple, inexpensive and fairly accurate tool that can be applied on a large scale by diverse health professionals. This approach is based on the identification of a consistent group of signs and symptoms and treatment for the main organisms responsible for disease. A comprehensive approach consisting of health education of patients and their partners, informing the general public, diagnosing and treating patients early, targeting vulnerable groups, syndromic management of STIs and effective follow-up form the key elements of good case management at the community level. The benefits of the syndromic approach are that complete STI management is offered at the first visit, treatment can be made more widely and rapidly made accessible, with patients being treated for possible mixed infections; issues of prevention and compliance are simultaneously addressed. Targeted interventions directed at specific groups, condom promotion and social marketing through programmes such as 100% condom in Thailand are important prevention strategies.

2.2 Tuberculosis

The South-East Asia Region accounts for nearly 38% of the world's tuberculosis cases with three million new cases and nearly 750 000 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 15-45 years. The advent of HIV and the emergence of drug resistance underlines the urgency with which responses have to be made. The WHO recommended 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 halve 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 in managing cases of STI and tuberculosis. 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.

3. HOW THE PRIVATE MEDICAL SECTOR CAN HELP IN DISEASE CONTROL

3.1 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 South-East Asia Region, 60-70% of all patients with tuberculosis and an equal number with sexually transmitted infections 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 SEA Region.

There is however, a lack of information about the contribution of the private sector in STI control in terms of the case loads and also of most commonly used practices in case management. Data available from outside the Region show that upto 48% of patients attend the private sector in South Africa and that 60% do so in Jamaica. Several strategies were adopted to involve the private sector. Guidelines and continuing medical education programmes were provided for private practitioners and in addition, in South Africa, "syndromic kits" and materials for health education were also distributed.

Inappropriate use of available drugs is another area of concern. It is well known that many patients self-medicate owing to easy access to "over-the-counter" drugs from pharmacists. Some national programmes have attempted to involve pharmacists, private practitioners and traditional healers in an attempt to promote best practices for case management and to improve access, particularly for women. The integration of STI clinics into general health services so as to avoid the stigma attached to attending specialized STI clinics is an extremely important strategy.

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.

In the area of TB, a systematic approach to determining the involvement of the private sector in TB control was initiated in 1998 by WHO. A global 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 projects, 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 situations, 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 had 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 or constraints:
<ul style="list-style-type: none">- Located close to patients- Patients seek services despite cost- Could improve treatment adherence- Enjoy the confidence of patients	<ul style="list-style-type: none">- Reluctant to do sputum examinations- Can not trace defaulters- Records maintenance is poor- Do not use recommended drug regimens

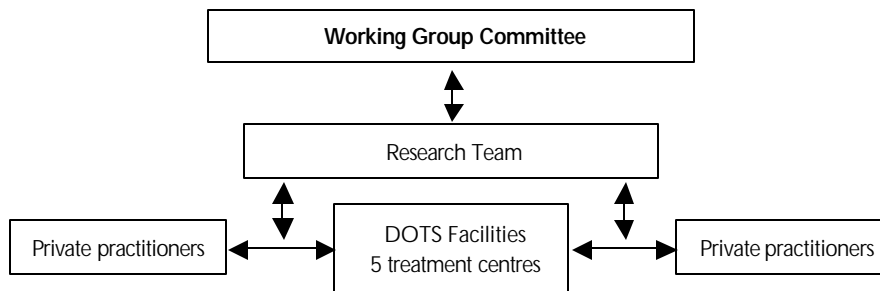
However, there are opportunities to increase and speed up case finding, improve treatment outcomes through enhanced patient acceptance, share the service delivery load with front line health staff and build a degree of long-term sustainability in disease control. Innovative partnerships with private 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.

4. EXPERIENCES IN PUBLIC-PRIVATE PARTNERSHIPS

4.1 Nepal

The national TB control programme in Nepal extended the DOTS strategy to 75% of the country by end 2000. With cure rates well over 85% it was appropriate to focus on the private sector before 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 a 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 group as well as local DOTS committees consisting of all stakeholders were formed. Standard case management protocols were developed and private practitioner workshops held. Service providers (microscopy centres, treatment centres and sub-centres) were identified. These included five urban DOTS treatment centres and four

diagnostic centres. Health workers, volunteers and social workers were trained to implement DOTS and late patient tracing mechanisms developed with 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 large urban areas in the Region with rapid population growth, migration, higher burden of disease, poor health infrastructure, and the free availability of over-the-counter 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.

4.2 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 patients 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 specialty 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 programme, 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 a mechanism for referral of TB patients with the assurance that the private practitioner would continue to be the patient's primary care-giver. A referral card was developed, and following initial diagnosis, counselling and treatment of TB patients at the Mahavir Hospital, patients were referred back to identified DOTS centres within easy walking distance of their homes. Flexible timings were also ensured. The results of this programme have been outstanding. Nearly two-thirds of the patients 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.

(2) 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 launched by REACH (Resource Group for Education and Advocacy for Community Health) together with the Tuberculosis Research Centre (TRC), the Corporation of Chennai, private practitioners and patients.

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 individual doctors in private clinics, group practice, or in corporate hospitals and institutional intermediaries. Doctors willing to participate in the programme were identified through questionnaires and 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 Chennai Corporation and ACT contributed social workers and programme coordinators, while 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 Lab Technicians' Training	Tuberculosis Research Centre (TRC)
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.

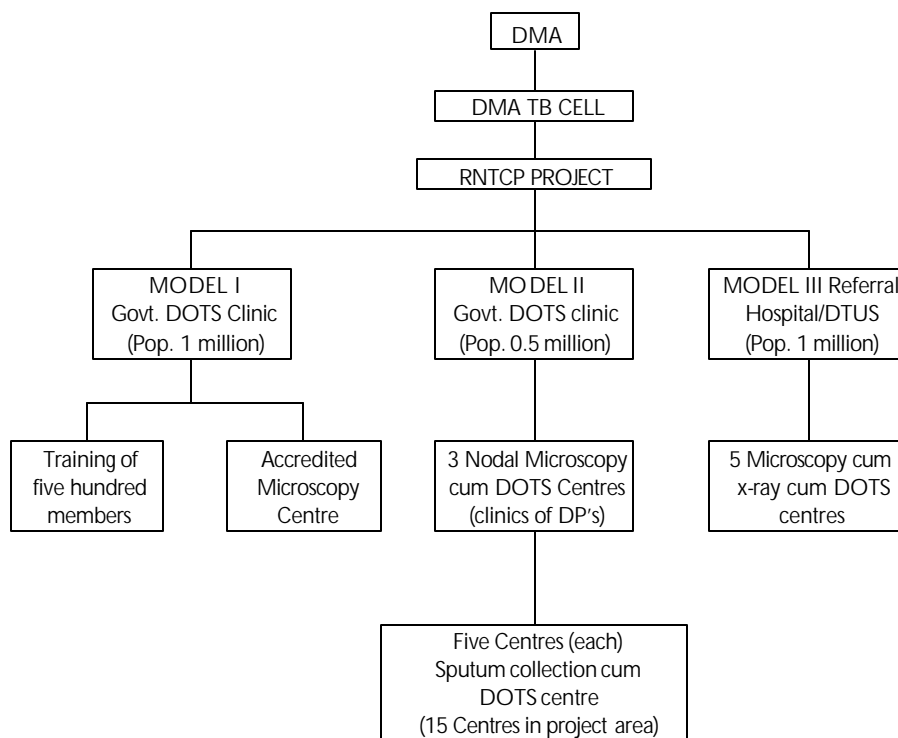
A unique feature of the ACT project was the emergence of volunteers within the community who acted as DOTS providers. The lessons learnt from this programme are that it is possible to induct private health care providers into public health programmes if an intermediary organization will coordinate

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.

(3) 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 workshops, with experts in the field and DMA TB Cell members, keeping in mind overall feasibility.

Several levels of health professionals including 700 doctors were trained 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 evaluatory 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.



(d) 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 tool 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 counselling 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.

4.3 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. It is estimated that 85% of patients with STIs seek treatment in the private sector. While tuberculosis is notifiable, STIs are not; reporting from 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 modules 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.

4.4 Thailand

There has been a remarkable fall in the levels of STIs in Thailand over the past ten years. Good STI services were introduced in the country in 1960 at

national and provincial levels and are now being extended to the district level. HIV prevalence in high risk groups has been reduced by upto 40% through the integration of STI services with primary health care; attention to providing accessible and acceptable services; ensuring constant improvements through national guidelines; effective distribution of drugs and condoms, and methodical training of staff in the syndromic approach to STI management. The 100% condom programme is an example of an outstanding public health campaign. Over 50% of the district level hospitals have been covered and greater coverage will be achieved through the involvement of the private organized and informal sectors. Public health services will be enhanced through integrating STI management into existing specialty facilities such as obstetrics and gynaecology, dermatology and urology departments and through providing updates and guidelines to hospital-based physicians. The private sector will be addressed through providing information and supplies to private clinics, hospitals and drug stores in a similar manner. Innovative approaches to training and informing the informal sector including drug vendors and traditional healers are being undertaken, as are efforts to increase community awareness to prevent self-medication.

Workshops for private doctors have been held following a needs assessment in the city of Bangkok and self-training and learning modules on the syndromic approach developed. Comprehensive guidelines on condom promotion and counselling and national protocols for STI case management have been provided.

Pharmacists and non-pharmacists have been oriented through their half-day annual and monthly meetings. User-friendly flow charts, self-learning comprehensive booklets, national treatment guidelines and education and prevention packages for clients have been distributed.

5. PERCEPTIONS OF AND EXPECTATIONS FROM THE PRIVATE SECTOR

On the National Tuberculosis Control Programme

- Regular exchange of information can improve relations between private sector and the 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 is 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 prescribe TB drugs.
- All drugs sold should be quality controlled.

6. ROLE OF MEDICAL ASSOCIATIONS: A FEW EXAMPLES

6.1 India

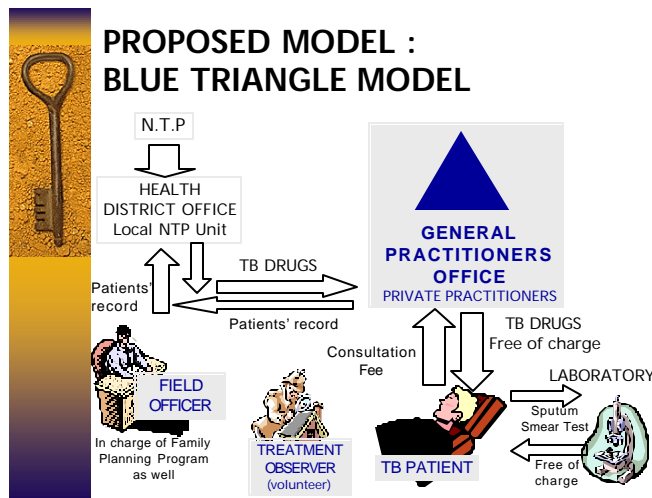
The health infrastructure in India is divided between the Government and the private sector, the former accounting for approximately 20% of available resources for health and the latter nearly 80%. The Indian Medical Association (IMA) is the largest private sector NGO in the health care sector in India and the largest voluntary body of doctors with a membership of 150 000. The IMA has 27 state branches and 1 500 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-wise projects through local IMA branches for Private Public Partnerships.

6.2 Indonesia

Although Indonesia currently has low rates for STIs and HIV except in high risk populations, there has been a gradual rise in the number of cases being reported. The national AIDS prevalence is 0.22 per 100 000 which is lower than that from areas where most cases are being reported. The predominant mode of transmission is heterosexual, with a preponderance among age-groups between 20-40 years.

Tuberculosis is the major cause of morbidity from infectious disease and the third major cause of death in the country, affecting once again, the most productive age groups.

The Indonesian Medical Association (IMA) has been actively involved with the Ministry of Health in STI and TB control. The IMA had formed a Committee for HIV/AIDS in 1994, organized training for doctors, nurses and midwives, published training manuals and developed an IEC campaign for the community. The IMA is an active member of the national movement for



integrated TB control, GERDUNAS TB. A preliminary assessment of the current perceptions of private practitioners towards TB control has been carried out and an MoU signed between the Ministry of Health and the IMA to further cooperation between private practitioners and the Government Health System. A pilot model project, the “Blue Triangle Model Project” has been set up with a view to integrating private-public partnership into the national programme in the future.

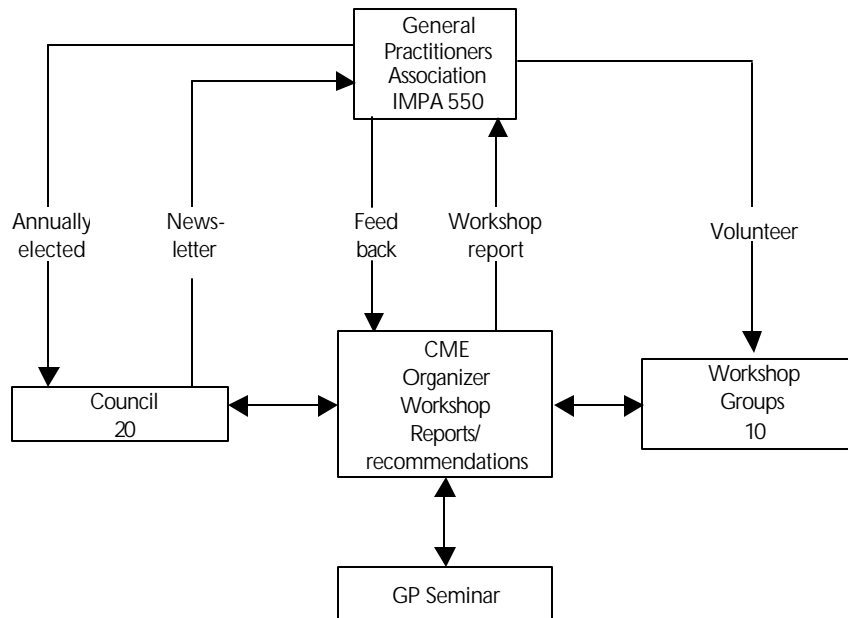
Interested private practitioners will be inducted into a programme through signing of an MoU with the provincial/district level programme staff. The NTP will provide guidelines on DOTS and train private practitioners, public laboratories will conduct sputum smear examinations, drugs will be provided free of charge and field officers from the family planning programme will coordinate the logistics for drug supplies and recording and reporting. A blue triangle sign will be posted on the clinic of the participating private practitioners as a mark of recognition.

6.3 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 three 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 in 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 seminars. Lessons were structured to ensure early diagnosis, prompt and effective treatment, referral when necessary,



prevention of spread to family and how to provide health education. During the late 1990s, modules for STI case management covering the epidemiology, a symptom-approach to management of various STIs and HIV, laboratory procedures for the diagnosis of various STIs, counselling, health education, harm reduction and community-based care for patients living with HIV/AIDS were developed, and widely disseminated among general practitioners. The need for accurate recording and reporting was also conveyed to practitioners.

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 in STI and TB control need to be implemented in the spirit of doing good and as a social responsibility. These broad principles should guide the development of policy guidelines for private-public partnerships within national control programmes. WHO has a role to promote and support private-public partnerships in both TB and STI control efforts in the Region.

7. ENHANCING THE ROLE OF PRIVATE SECTOR IN HIV/STI AND 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 in STI and TB control were: advocacy; case management; counselling and health education; improving case notifications, and liaising 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 strengths and resources; advocacy and marketing; private sector representation on national committees that frame policy, implement and evaluate STI and 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 multicentric 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 built 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.

8. CONCLUSIONS AND RECOMMENDATIONS

8.1 Conclusions

It was clear from the pilot projects from the various countries described at the meeting and from the presentations made by the private sector including the medical and/or private practitioner associations, that 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 STI and TB and managing them in accordance with established national policies and strategies.

8.2 Recommendations

For National Programmes:

- (1) Member countries should adopt policy to actively involve private practitioners in national STI and 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 analyses 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 from the private sector should be introduced.

For National Medical Associations:

- (1) STI and 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 members of national level committees, they should assist in developing policy on involvement of private practitioners in national STI and 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 governments should be facilitated.

For WHO:

- (1) WHO should advocate with governments for adoption of policy to involve private practitioners.
- (2) WHO should assist with preparation of guidelines for national programmes to facilitate the process of private practitioner collaboration.
- (3) Guidelines to meet evolving challenges should be updated and disseminated, technical support and assistance provided for evaluation of private-public partnership projects.
- (4) Lessons learnt from experiences should be disseminated and successful models promoted.
- (5) A broad policy framework for public-private partnerships in disease control should be prepared.

- (6) Promoting, facilitating and supporting private medical sector participation in the member countries where the sector has potential to play a significant role by (i) developing/supporting pilot demonstration projects on public-private partnerships in STI and TB control and more importantly (ii) building capacity of the private practitioners in early and correct diagnosis and effectively management of STI and TB, through continuing medical education and/or distribution of appropriate best practice guidelines.
- (7) WHO should assist in resource mobilization for TB/STI control.

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Annex 2
PROGRAMME

	09:00 to 12:30 hrs	14:00 to 17:00 hrs
20 Feb	<ul style="list-style-type: none"> • Welcome and Introductions • Overview of HIV (Jai P. Narain) • Overview of tuberculosis and the DOTS strategy (Nani Nair) • Role of private medical sector in disease control (Mukund Uplekar) • Discussion 	<ul style="list-style-type: none"> • Country experiences in Public-private partnerships: <ul style="list-style-type: none"> – Thailand (Anupong Chitwarakorn) – Nepal (Shanta B. Pande) – India (K.J.R. Murthy) – India (Nalini Krishman) – Sri Lanka (Iyanthi Abeyewickreme)
21 Feb	<ul style="list-style-type: none"> • Involvement of private practitioners in STI and TB control <ul style="list-style-type: none"> – (Sarvesh Kumar) – (S.L. Chadha) – (Patanjali Dev Nayar) • Role of Medical Association in TB and STI/AIDS control <ul style="list-style-type: none"> – (S. Malik) – (Joel Fernando) – Merdias Almatier 	<ul style="list-style-type: none"> • Group Work to discuss strategies for enhancing involvement of private practitioners in TB and STI control
22 Feb	<ul style="list-style-type: none"> • Presentations and discussion on Group Work • Follow-up actions 	<ul style="list-style-type: none"> • Closing