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Stop TB Symposium: Working with the Whole Health System
Part 4 – Engaging All Health Care Providers
October 16, 2008

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LIND VIANZON, M.D.: So, in behalf of the team, I personally thank the organizers for giving me the opportunity to chair this afternoon's session. It's entitled, "Engaging All Health Care Providers." So, may I also introduce to you being the National TB Program Manager of the Philippines and to show that we have high support for the National TB Program, I'd like for me to recognize us all our Assistant Secretary of Health from the Department of Health of the Philippines, a staunch supporter of the National TB Program, a true partner when it comes to public-private mix DOTS.

Ladies and gentlemen, please give a warm round of applause to our Assistant Secretary of Health, Elmer Punzalan. [Applause] Thank you very much, Sir, for your support.

Okay, so, at this point in time, perhaps we can start the session. May I call on the first speaker who's really a renowned person when it comes to the field of TB control known as the team leader right now of the Innovative Approaches and Health System Strengthening, WHO Stop TB Department. Friends, let us all welcome, the famous Mukund Uplekar for his public part, private partnership. [Applause]

MUKUND UPLEKAR, M.D.: Thank you very much, Lind. Well, in this Stop TB Symposium on Working with the Whole Health System, I'm going to argue that it is possible to

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completely ignore some parts of the health system and yet achieved progress.

I'm then going to counter-argue that this may be a convenient approach that it's clearly inadequate and I'm going to then present to you with some evidence that, at least so far when it comes to the supply side, which is the major part of the any health system, it is indeed possible to work with all parts of the health system, and I'll conclude saying that you cannot claim to be adopting the health system's approach and ignore some healthcare providers.

Let's go back in time a little. You are pretty familiar with this structure, a typical structure of a TB program in a high prevalence country. You are also familiar with this package, the famous DOTS package.

What did the DOTS package do to the TB programs? DOTS transformed TB programs. The DOTS package converted the health systems from the ones that were not able to tell how many patients they handle and how do the health systems which could then detect 50, 60, 70-percent of the cases, cure 80, 85-percent of them and report them not just nationally but also internationally to WHO. And how did DOTS achieve that?

The government commitment ensured that there was leadership and there are resources, financial as well as human. There was no ambiguity about the technology to be used or the products, the treatment regimens to be used. And context-specific approaches to service delivery were established in

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countries and most important, continuous monitoring and evaluation made it sure that the essential health information was available.

Are you all familiar with this structure of the building blocks of the health systems? So, DOTS contributed to the six building blocks of the health system to achieve or to exploit the potential of the health system to the good for the TB control program.

Now, why I am ending, and the results were obvious that the countries did make a lot of progress with DOTS? Why I'm then saying that it is possible to completely ignore some parts of the health system and yet achieved progressing TB control? Because it did happen.

The TB programs operated as if in the earlier DOTS implementation, they're all planned, designed, and implemented by the public sector for the public services and through public health centers only in spite of the full knowledge that there are whole other providers outside the public health services.

And it's not just that, there are many providers even within the public sector under the Ministry of Health and outside the Ministry of Health and the results were obvious. The targets for 2000 were missed. And much has happened after, I mean that's why my second conclusion that was convenient, it was easy for the TB programs to operate only to the public sector. This approach was clearly inadequate.

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Much has happened after that. Countries have, after emphasizing, after several small demonstration projects, there are many countries with good examples which have demonstrated that all these provider groups can be successfully linked and can be productively involved in TB control and can contribute substantially to TB control.

And I'm not talking about these tiny projects where you give intensive inputs and you do proper documentation just to produce a paper. I'm talking about large-scale programs, you know, being operated in millions of, I mean, populations involving thousands of providers.

Now, we don't have time to go through, you know, to talk about each and every provider groups, but let's take the ones which are seemingly difficult to work with, traditional healers or informal providers.

Now, why I have grouped them in the same box? Because they share many characteristics, they are close to the people. They are community-based. People have faith in them. They are culturally closer. Now, these are difference that the traditional healers, well, they tend to be much more in Africa while you'll find more informal provider in Asian settings.

Traditional healers generally do not use modern medicine which informal providers do. And, so, in that sense, they could be more problematic, informal providers, because they could cause delay in diagnosis. They could misuse drugs, promote drug resistance and what not.

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Then, let's talk about private GPs. They are in hundreds. How can NTP work with hundreds of individual private practitioners? So, we'll see one of the examples of this.

We'll go to the other side, the so-called public mix and talk about public hospitals, a pain to work with, with multiple departments. And then, there is no difference really between the public and the private hospitals because the characteristics are not greatly different.

And then we have medical colleges and even greater, even major problem with the super specialists and the academician setting there.

So, let's see some of the examples and how countries have demonstrated that you can privately engage with these groups. Now, I can tell you that they can be, you know, independent presentations on each of these examples but I'm going to just launched through.

And I can also tell you that the real heroes, the people who have really implemented these programs are, or will be in this conference, and you can directly talk to them if you were interested enough.

Now, I'm never tired of showing this slide. This is really doctors in Bangladesh, the so-called informal providers. Thousands of them who could otherwise be a major liability because they have access to drugs, they have their own pharmacies. They could use anti-TB drugs, give them to the patients.

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So, doctors, who are really, otherwise, a major liability for the TB control program, have become a major resource. They continue to be treating 15-percent of about 12,000, 15,000 patients detected every year and even more important, more than half of the TB patients are supervised by these village doctors with cure rates of 90-percent or more.

Now, why can't this be adapted and applied to the African setting where there is no DOTS of traditional healers? I was in Malare, there are 75,000 traditional healers in Malare and we went to the Office of the President of the Federation of Traditional Healers Associations, they have a computerized database of all those 75,000 traditional healers.

Are TB and HIV programs working with them? No. Some projects here and there. Now, do we have to work for six, seven, eight, ten years to be able to, you know, do collaboration? Look at this experience of Pakistan. The NTP, which supported this good life project by, it is a social marketing franchising project. And look at the impressive contribution of private practitioners, and it is not gradual from second quarter of 2006 to third quarter of 2006.

And this is a scaled-up project, millions of population in the world, five major cities of Pakistan. In Karachi alone, 53-percent of all cases are contributed by private practitioners.

Let's go to the third example and, again, I would like to impress on your minds that this is not just working with

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individual provider groups. I mean, there are other providers which I'm not talking about. But their approach is comprehensive.

The idea is to engage every provider who have symptomatics and patient—seek care including NGOs, medical colleges, hospitals or what not. But you can, if you use the right approaches, and I wanted to highlight different examples where countries have successfully engaged the different provider groups, which, apparently, you know, some countries find it very difficult, almost impossible to deal with.

China probably would not have been able to achieve the 2005 target of 70-percent if they had not set up an internet-based reporting and follow-up system that upgraded between the TB dispensaries and the hospitals.

Wonderful example, again, and I can tell you that the hospitals in China have almost all the characteristics of private hospitals in another settings.

Another example of, not a leading country, India. Again, approach is the same, engage all care providers. But look at the impressive gains that they have made where a quarter of the case detected come from big medical colleges. Now, they are very few in number if you compare to other services. Hundreds of general practitioners, hundreds of NGOs, public health facilities but look at the medical college contribution you can successfully engage even with this academician, the super specialist and get them to do the job.

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Now, you maybe a bit bored with, you know, my showing these big numbers, but I would like to give a glimpse of how does it really work in practice on the ground and thanks to my friend, DK Mitra who works in India with GRE [ph 00:12:39].

This is a replica of an old book maintained by a health worker and this is exactly what we proposed. We say, in our guidance from WHO, that you should simply do a mapping of the providers. You try and sensitize them. You find out which ones are, you know, can be engaged.

So, look at these columns. I mean, I'll be quick, but if you see there are these, for he has apparently done the mapping and the first on the list is qualified private practitioners. It identified 66 sensitized, potentially 12 could collaborate. Then, you have RNPs. These are informal providers or quacks. So, these are, you know, informal, unqualified or maybe those who are trained in the Indian systems of medicine.

Huge numbers 220, 83 sensitized 52 potential providers and then you have, you know, the laboratories. You have private hospitals and you have other health programs also happening. And then he has, it didn't stop there, there are telephone numbers of doctors who are willing to so that they can be followed up.

And then he writes the notes that a diagnostic microscope is badly needed in whatever in that municipality and that a large number of patients are coming from outside the TB,

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et cetera which means this is how it works, you know, simply in practice.

And finally, there have been enough examples I would say and this, I would say, is one of the most leading examples in the world, the PPM in the Philippines. They have institutionalized public-private mix. Of total countries cohort, they have a wonderful accreditation system. There is a government plan, health insurance package, a generous package for private institutions and providers.

They have over 2000 and I can tell you this is a bit dated. These figures are dated because, yes, I'm sure, you know, they are higher numbers today and their contribution to case detection about 11-percent.

And they would agree that in many countries, after achieving 70-percent, there is a kind of saturation in the public sector services and the more case that you're able to get, you are most likely to get from outside the public sector services.

So, number of examples, scaled-up without doubt, they're not new projects and that's why my second conclusion that it is indeed possible to work with all parts of the health system.

So, what's the problem? Everything seems to be doing well. No, it's not that easy because although these numbers are good, impressive, these are scaled-up programs, they are long, long way to go.

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There are many issues. I will just talk about two or three. The scale-up of PPM is pretty modest and very slow. PPM is not easy, it is demanding.

A major issue is there are collaborating doctors or institutions but there are many more who are not collaborating. Now, we changed the collaborator's practices. They're to become rational and they do contribute.

What about those who are not collaborating or who are not likely to collaborate? There are no disincentives for non-collaborators and the major problem today is the continuing misuse of TB drugs. That happens and the two other major issues is PPM still is stuck with basic TB controlled DOTS and it is not applied to other components of the Stop TB Strategy. That is a major issue.

What will be the simple actions? We have to invest to enhance capacities of both the public and private sectors who work together. And the strategy here, the tendency on the part of the national TB programs, generally, is to, of course, work with the TB private providers or all providers, but, in turn, the NTPs increase the amount of work that they have to do.

The burden on the NTP of giving support, giving training, and making supervision increases. The strategy has to be such that you increase the capacity of at least the institutional providers so that they ease the burden on their NTPs and not increase the burden.

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And those who are there yesterday in the DOTS Expansion working group meeting with the professional associations must have seen the amount of, you know, the kind of enthusiasm and the capacity some of the professional associations have and all professional associations, all these can potentially have this capacity of taking on a major part of TB control.

This, I would say, is the most important and with the Beijing meeting on the MDR TB coming, I think the TB community must come together to limit access to TB drugs only to collaborating providers. This is not easy.

People have talked about it for years together that in resolutions of our rationale of medicine but the TB community and the partnership with all the high profile figures and the power it has with the collaboration of the industry because the partnership works with their industry, with the collaboration of the activist, the treatment action group, with collaboration with the people, in general, we have to take this issue forward and make sure that the politicians take actions to limit access. I'm not saying band. I'm not saying regulate. I'm saying limit the access of TB drugs to only those collaborating providers.

And lastly, I failed to understand. It has been a long journey for those who have been working in PPM to conquer this stage of, you know, countries accepting it, doing it and now, enthusiastic about it that, you know, those who work on the other parts of the other components of the Stop TB Strategy, it

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would be a great, you know, mistake of omission if they continue to operate as if this is 1995 and as if it's only the public sector which exist out there.

We have to work, whether they are simply a TB, or TB/HIV or a CSN or research, we have to work together now from the beginning with all the care providers and that's why this. And you cannot claim all these, you know, working groups working on the different components of Stop TB strategy to be adopting the health systems approach and continue to, you know, not work with the whole lot of providers which we need to work with.

So, my first light is also my last light. Again, I would reiterate that it is possible, you can continue to make progress and continue to ignore some part of the health system. And we should remember that.

But it is not correct and we have to continue to engage with all kinds of providers. I would reiterate that there is enormous amount of experience on how to work with different providers.

Among TB program managers, in the regional offices, among partners and, of course, those who are all members of the PPM sub-group. So, if you are working on any component of the Stop TB strategy, if you are uncomfortable with working with any group of these providers which you haven't worked before, don't wish them away or don't try to run the wheel. Just send an email to ppmtb@who.int and here we are to connect you to the

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right kind of people and if they are not there, we will be very happy to work with you hand in hand to be able to solve the problem you have. Thank you very much. [Applause]

LIND VIANZON, M.D.: Thank you very much, Dr. Uplekar. Indeed, that was a presentation wherein you can see that models work from north to south, from east to west. And furthermore, our next speaker will talk on the engagement of academes and associations, the report back from what has transpired yesterday during the DEWG report. So, friends, may I call on Dr. Phil Hopewell.

PHILIP HOPEWELL, M.D.: Thank you very much, Lind. I have a daunting task, first, is to get the presentation up, here we go. Okay. The task is to condense the one-half hour meeting that transpired for the whole day yesterday and that as was mentioned, focus on the engagement of professional associations in tuberculosis control.

I think this is a very appropriate topic and sits very nicely within the overall theme in this symposium working with the whole healthcare system and I think, also, nicely follows Mukund's presentation that provided a very comprehensive picture of how public-private mix activities can work.

So, what I'll try to do is summarize for you the proceedings from the meeting yesterday. Our meeting started also on the sad note, Dr. Seita presented a tribute to Dr.

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Hasan Sadiq who is a member of the public-private mix sub-group who attended our meeting in Cairo last June, stayed for the DOTS expansion working group core group meeting, left, flew home to Pakistan and was killed on a traffic accident on his way home from the airport. So, we are all shocked and saddened by his death.

The goal of the meeting was to mobilize professional associations to help foster effective collaboration between national TB programs and private healthcare providers. I've put these two terms in red to emphasize the importance of making the connection between the professional associations and national TB programs.

The objectives were to sensitize the leaders of the professional associations on TB control to the Stop TB Strategy and to the International Standards for Tuberculosis Care, one of the tools that you'll hear me refer to - serving to as a way of focusing mobilization of the private sector and professional societies.

Second, to share experiences on engaging the professional associations in TB control in diverse country settings, third, to provide a platform for exchange of ideas between national TB program managers and leaders of professional associations for implementing the international standards and finally, to discuss ways to enable professional associations to contribute to national and global efforts to control tuberculosis.

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Now, we let off with that presentation by Leopold Blanc from WHO talking about the current status and the progress that has been made and the challenges that global TB control still faces. And what I'll do with each of the presentation is to present one or two slides to kind of hit the highlights of the presentations.

So, Leo pointed out that there were key issues from the perspective of WHO and chief among was that the case notification rate is not increasing in many settings. The good news being that treatment success rate has reached the 85-percent global target in many countries.

But that he emphasized that there was a need to accelerate efforts in TB control by continuing to increase treatment success, 85-percent is good but 90, 95—percent would be much better, aiming in reaching all TB patients.

There's the famous 40-percent that you've been hearing about today that are not being reached, to shorten diagnostic delay. By doing so would decrease the amount of injury to the lungs and transmission of mycobacterium tuberculosis to the community, thus, improving the health of individuals as well as the health of the public.

And finally, he went through a fairly complicated proposed framework by which one could identify areas in which specific actions could be undertaken to improve case detection and reduced diagnostic delays. And we'll go through that framework, I think you could probably sort it out in your minds

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however, when you think about the path that followed by a patient with a cough who comes into the healthcare system.

And Dr. Blanc also pointed out to accomplish this required extending our actions beyond national TB programs and you just saw several very nice examples of that in Mukund Uplekar's report. This happens to be one showing the additive value of incorporating private practitioners and chest clinics and hospitals even though government hospitals, they weren't participating in reporting to the National TB Program in Indonesia, in this particular instance in Jakarta. One of many examples of private and other non-NTP governmental facilities being incorporated into tuberculosis control activities in a systematic and effective way.

I then reported on our experience with examining utilization of the International Standard for Tuberculosis Care in the five pilot countries that resulted in our writing this handbook for using the International Standards for TB Care.

And as an outgrowth of that activity of examining the way countries use international standards, it became apparent that professional societies can serve as a very valuable collaborators with TB programs.

Now, this is not revolutionary news. Professional societies have for many years been involved in collaborating with TB programs but generally not on a very large scale, generally, not in a very systemic way and, generally, not

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overall contributing to tuberculosis control in a given country.

But it became apparent in examining the uses of the ISTC that professional societies can serve as often the only conduit to their private sector members to disseminate information, in this case, the international standards and other information related to international standards.

That by their endorsing the international standards and by their involvement with the tuberculosis control programs they give credibility to those programs. That the international standards provides a uniform way for both the public and the private sector to deal with patients with tuberculosis and by so doing gives credibility in the eyes of the private sector to public sector TB control programs.

By providing technical assistance to TB programs in the form of treating complicated patients, in the form of supervision of laboratories that can contribute to the diagnosis of tuberculosis, a variety of ways in which they can provide technical assistance.

They are also very good at providing training, in conducting continuing medical education programs. Importantly, they can exert peer pressure by endorsing a set of standards in a given way of doing things. It pressures the members of the organization to follow suit and to practice in the same way that the organization has officially endorsed.

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And, finally, professional organizations can be very effective as advocates for appropriate resources and policies, resources that serve to provide sufficient services for TB patients, policies that facilitate the accomplishment of the aims of tuberculosis control.

And, then, just to point it out that there is a set of tools that has been developed with the international standards for TB care, a set of training modules, the standards themselves and the handbook and importantly, the patient's charter for tuberculosis care. And that was the next presentation we had by Case Gordon and a group of patient activists.

The patient's charter for tuberculosis care was developed in tandem with the international standards and these are mutually supporting documents. The patient's charter, as you may know, presents patient's rights and importantly, patient's responsibilities. It's considered to be a very important document, recognized as being an important document in the community but it is currently very much underutilized and this was strongly attested to by the group of activists that assisted Case in his presentation.

But there are plans to make this a more widely utilized tool, plans to develop a condensed version of the handbook or condensed version of the patient's charter to develop a handbook for utilization of the charter and to translate the

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document into multiple languages so that dissemination and utilization can be more broadly undertaken.

We next heard a series of country experiences, two from professional societies, Dr. Ashokan from the Indian Medical Association and Dr. Burhan from the Indonesian Society of Respirology followed by three presentations from national TB programs directors, Dr. Sitienei from Kenya, Martin Castellanos from Mexico, and Mao Tan Eang from Cambodia.

And I'll try to summarize those very briefly, although I will not in any way be able to capture the full richness of their presentations.

Dr. Ashokan gets the prize for the most idyllic picture presented in the presentation and maybe the most idyllic title of his talk on Indian marriage. In this, he was referring to the collaboration between the Indian Medical Association and the revised national tuberculosis control program of India. What Dr. Ashokan emphasized was that the IMA strategy for being involved with public-private mix DOTS was that it was an approach based on the profession, the medical profession that financial incentives were not the best way to go and in fact, a series of non-financial incentives including accreditations, certification, and so forth were more useful.

That it was fairly labor intensive and required one-to-one peer sensitization and that the international standards of TB care proved to be a useful vehicle for focusing the

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professional society on the activities that needed to be accomplished to be systematically involved in TB control.

But I thought what was, perhaps, most interesting of Dr. Ashokan's presentation or his impressions. He termed them his musings. I've termed them his impressions for my presentation that the medical profession outside the national TB program is an asset, not a liability. All too often, it's been regarded the medical profession, particularly the private sectors, have been regarded as a liability.

That consorted action by the medical profession can result in marked DOTS expansion and substantial reduction in MDR. This part to date, I don't think is documented, but seems intuitively logical.

Professional medical societies have a strong role in uniting the profession to fight tuberculosis and, again, that's clearly demonstrated in India as well as in Indonesia that all public-private mix activities related to TB are a kind of dialogue between clinical medicine and public health and it's as much a political process as a technical one.

That there is a chasm here between clinical medicine and public health and the ISTC is the knowledge tool which serves to bridge that chasm that the medical profession itself transcends the barriers between government and private sector, hence, the profession-based approach and the high quality volunteers provide low cost force amplification. This is a

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health system strengthening activity by enlarging the workforce available to NTPs.

Dr. Burhan from Indonesia described the role of professional organizations as serving to socialize and disseminate, that is, make practitioners aware of the ISTC and to disseminate it, to have the ISTC as the topic for scientific sessions and seminars, to have meetings that have more of a hands-on approach for socialization and dissemination of the ISTC and that professional organizations, because they have access to journals, newsletters, what have you, can disseminate the ISCT in that manner.

As you can see, in Indonesia, they focus very heavily on utilization of the ISTC as the approach to involving the private sector. Her conclusions were that involvement of key professional opinion leaders and champions from the very start of the process for endorsement of, in this case, international standards, is important for buy-in and acceptance that by bringing people on board early, there was much more acceptance of this approach.

The professional society members, generally private sector professional society members relate more easily to the international standards than to national program guidelines because the ISTC presents the evidence and it's more clinical in focus.

As Dr. Ashokan said the ISTC can act as the bridge between the NTP and the private sector as represented in the

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professional societies, again, the ISTC as the bridging component that professional organizations can assist the NTP in roll out of the international standards to their members.

And, finally, she noted that this is actually an important part of this that there will be an assessment of the impact of the utilization of ISTC in hospitals in Indonesia with data being collected sort of before and after the introduction of the ISTC to get some assessment as to whether or not there has been a significant impact.

Dr. Sitienei from Kenya pointed out that there had been substantial political commitment generated by the use of the ISTC. And that the launch of the ISTC, and the patient's charter, was attended by the minister for public health and sanitation just last month. And that the ISTC, and I should say, and the patient's charter were endorsed by the minister.

One of the points that was made in this endorsement was that there are plans to use the ISTC for accreditation of health facilities.

Other ways in which the ISTC and the patient's charter will be used in Kenya is through development and dissemination of monthly cards for physicians in private practice each month, a different standard and message will be presented. This is, kind of, the fortune cookie approach to dissemination of the standards.

Importantly, and I don't know of any other place that's doing this, all patient drug packs supplied by private sector

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will contain the patient charter and this will be followed by the government doing the same thing in their drug packs and patients will be given the charter at registration. And as noted earlier, the ISTC will be used in an accreditation process for health facilities.

Martin Castellanos, from Mexico, pointed out that, in terms of achievements, that they have developed a Mexican version of the international standards. Local adaptation is important for making the standards most useful. And the first version of the Mexican standards for tuberculosis care was recently approved by the Ministry of Health.

They also used this to develop an instrument for evaluation of involvement of private health practitioners and they distributed the charter, again, a Mexican version of the patient's charter, distributed to tuberculosis patients in Mexico.

The next steps in Mexico are to introduce the Mexican standards for TB care to all ministry health facilities to implement several projects in states with a high TB burden as listed here. They're developing a national standards pocket guide, an abbreviated version.

They're using this to engage specialist societies and they're beginning to look at the capacity and quality of private laboratories, not something that the ISTC has proven to be or that relates to, but looking at the capacity of private

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laboratories, as well as, public laboratories conducted by the Epidemiology Institute in Mexico.

Dr. Eang in Cambodia presented a very different approach. They've involved pharmacies working through the Pharmacist Association of Cambodia to develop a PPM strategy.

They had reviewed and revised national recording and reporting forms to undertake this project. They had developed a set of standardized referral tools for pharmacist to use, developed training curricula for the pharmacist, developed a memorandum of understanding between the pharmacist association and the NTP and trained pharmacists and TB programs, had to train both the pharmacists and the TB programs in order to enable them to interact effectively.

And they have ongoing supervision, monitoring, and evaluation in place to determine exactly how useful this would prove it to be and what the problems are with it.

In terms of achievements, they have gotten strong support from the Pharmacist Association. The role of the pharmacist is to refer suspect patients, persons who were suspected of having tuberculosis to diagnostic centers and they find that these referrals are yielding a high percentage of severe positive TB cases of those being evaluated.

During this period and they're referring to a three-year period, they were almost 9,500 referrals. There was a fairly substantial drop-off. About half of the patients who were referred did not show up at a diagnostic facility but of

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those who did, a substantial percentage, something in the range of 20-percent were actually found to have severe positive tuberculosis. And these results, as Dr. Eang said, suggested that the pharmacies are really in excellent location to identify undiagnosed cases.

This set of country experiences was followed by five discussion groups. Now, really, I'll try to go through these very quickly. Again, I will not in any way be able to capture the full richness of the discussion that we had. Just to give you the overview, there were, as I said, five groups.

The first one focused on the types and contributions of health professional associations. The second group, on strengthening health professional associations to enable them to contribute to TB control, the third, what was needed by NTPs in a way of support to health professional association to enable the collaboration to be effective. The fourth group, promoting the patient charter for tuberculosis care. And, finally, the fifth group, how does the public and the private sector work together to rationalize the use of anti-TB drugs?

And this is a list of the types of health professional organizations or associations that were identified as potentially contributing to TB control and collaborating with NTPs and you can see that there is a list that is very similar to what Mukund showed you of associations that could be involved.

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The strengthened health professional associations group identified a series of steps that were needed in order to determine what kind of strengthening was necessary. First, situation analysis that may be a formal process or an informal process that identifies the problems that involvement of the private sector, involvement of the professional society would seek to solve, to work together to figure out what the structure was that was necessary, to involve or to collaborate with the professional society, to develop specific objectives for the collaboration, to develop terms of reference and finally, an MOU more formal sort of document formalizing the arrangement.

And, then, to decide what was necessary within both the NTP and the professional associations to oversee the functions that are identified. And within that would be decided what the strengthening was that was needed to enable this to actually take place.

So, the group didn't actually present what was actually needed for strengthening but rather the way to get at it because it's going to vary with the almost every situation.

What's needed from NTPs to support health professional association, they concluded that there was no global blueprint for involvement, that there was no one size that fits all much as the second group, it was emphasized that there needed to be an analysis of the situation and determination of what was needed in order to make this work, that working as a true

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partnership was key, that there'd be equal respect by all partners involved, that there would be a lot of learning by doing and a lot of feeling one's way along as this process played out.

And it wasn't something that could be undertaken and fixed very quickly, that it would take time and I think the presentations from the countries certainly documented that.

Promoting the patient's charter for tuberculosis care was generally agreed that there was a striking and inexcusable lack of awareness at all levels of the patient's charter that even where there was awareness, there was inconsistent application. They are no guidelines for its utilization and implementation. There has been a substantial short fall of resources for a variety of things related to the patient's charter including developing the handbook for its utilization and also for quality controlled translations.

That to overcome these limitations, there was a need for political commitment to ensure that the resources for implementation were available.

It was noted that the patient's charter reflects good clinical practice but, in fact, is not implemented in most countries that efforts need to be specifically directed toward empowering communities to engage and to force the issue, if you will, of implementation of the patient's charter. And that to do that would require ongoing involvement of the patient organizations and professional associations.

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Finally, the group on working together to rationalize the use of anti-TB drugs, it was noted that there was the need for country and regional specific approaches that they are needed to be better data on current situation particularly utilization of the anti-TB drugs in the private sector.

That it would important to map and involve a wide range of professional associations and other stakeholders outside of the NTP to improve rational use of drugs and that the stakeholders should be involved in the development of national TB program plans including MDR plans particularly in the 27 high priority MDR countries in preparation for the MDR meeting in China.

So, that's a very quick summary of the afternoon's discussion groups and I'll conclude with this one slide with a bunch of boxes and a bunch of arrows. I think health systems people, about every year, get together and they shuffle the boxes and they shuffle the arrows and so, it looks like there is something new coming out.

But, in fact, what's important in all of this is that they all need to improve TB care and control and the professional societies can in fact play a very important role in that outcome through their ability to disseminate and communicate with members providing technical assistance, setting standards, accrediting, and certifying, all these being activities that improve the quality of care by providing clinical care either direct DOTS services or management of

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complicated cases by strengthening laboratories in the private sector, in effect, these two activities expand the work force and increase laboratory capacity and all of these then lead to the desired outcome as improved TB care and control.

So, I hope I've given you some flavor for what went on yesterday. I think it was a very exciting meeting and it is what we think will be the first step in a set of activities that is designed to bring professional societies and national TB programs much more closely together globally. Thank you very much for your attention. [Applause]

LIND VIANZON, M.D.: Thank you very much, Dr. Phil Hopewell, for that substantial synthesis of what transpired yesterday during the DEWG's meeting.

Our third presenter is, allow me to introduce her in this sense because she is really a living legacy of the TB controlled program of the Philippines in terms of really putting concrete action to what the word public-private partnership is all about and, indeed, this is also one of her expertise when it comes to how we can really achieve cases of improving CDR in our national TB program. So, colleagues, let me call on Ms. Amelia Sarmiento to deal on the engaging of public-private partnerships. [Applause]

A. SARMIENTO: Thank you very much, Lin, for that very nice introduction. Lin is from the public sector, and I am from the private sector, so here is a partnership between the

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public and the private sector, and we have been working together for such a long time. So my presentation will be about expanding public private collaborations for TB in the Philippines.

First, I will be telling you about the rationality for engaging the private sector in the Philippines, then I will be telling you about how PPMD started as a national strategy in the Philippines, the process on how we engaged the private sector, what has been achieved so far, how do we sustain PPMD, or how do we monitor PPMD sustainability, and what will be the future direction of PPMD in the Philippines?

In 1997, a survey was conducted in the Philippines. One of the questions asked was, if you had symptoms of TB, where would you usually go? A significant number of respondents said that they prefer the services of a private physician, 36.2-percent of them responded that they have confidence in the services provided by a private MD.

Several pilot projects on engaging the private sector was developed. There were models in the hospital models, there were coalition models, and models in the public sector to see whether it's really possible to engage the private sector and to address this behavior of TB symptomatics.

In 2004, PPMD became a national strategy in the Philippines. The first thing we did was to develop a guideline for the implementation of public, private, mixed, DOTs in the Philippines. The department of health issued a circular for

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the adoption of the operational guidelines for PPMD in the Philippines under the national TB control program.

The objectives of the PPMD is to increase case detection and to synchronize management of TB among all healthcare providers. Second, we would like to insure compliance to the national tuberculosis program policies for case finding, case holding, recording, and reporting by all healthcare providers.

The first thing that we really did was to look up the structure of the private sector and the public sector in the Philippines. So we have here, on the right side, the Philippine Coalition Against Tuberculosis. It is the umbrella organization of organizations working for TB control in the Philippines. We have as members, professional societies, non-government organizations, and corporate groups.

On the left side, we have the Department of Health, who is the main organization accountable for TB control in the Philippines. So, as we see here, we have here in the left side the Department of Health, and we have here on the right side, the Philippine Coalition Against Tuberculosis, representing the private sector. What we did was to create a committee for the implementation of private public mix in the Philippines. So we have a national coordination committee, and we also have a regional coordinating committee.

The roles of the committees representing both the public and the private sector is for policy formulation,

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proving technical assistance, and looking into the implementation of the public private mix DOTs strategy in the Philippines. At the national level, we have the national coordinating committee chaired by the department of health, co-chaired by the Philippine Coalition Against Tuberculosis.

At the regional level, we also have regional coordinating committees chaired by the director of the Center for Health Development in the region, and co-chaired by the chair of the local coalition. It is at the lowest level where we have all the engagement happening.

This is the installation process in engaging the private sector. As I have said earlier, the engagement happens at the lower level, so it is where we're going to establish a public private mixed DOTs facility. In the beginning, what we did was to conduct a central planning workshop where we invited the DOTs providers who would like to participate in the public private mixed DOTs strategy.

What we do in the central planning is build the capacity to engage the private sector at the lower level, this is at the local level. So during the central planning workshop, what we do is identify, map out the stakeholders. When they go back to the local area, what they will do is to try to generate commitment from the various stakeholders, including private referring physicians. This is done during the advocacy symposium. Then they will have meetings for trying to figure out what will be the content of the memorandum of understanding

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between the stakeholders and the PPMD unit in terms of the role identified during the planning process.

Between the referring physicians, the private individual referring physicians, we have a letter of agreement that they agree to refer their patients to the public private mixed DOTs facility, and there will be alarms of the public private mixed DOTs unit. Later on, there will be continuous monitoring of the engagement, and there will be continuous relational sustainability between the unit and the stakeholders, as well as the individual private physicians.

What has been achieved so far? This is the map of the Philippines, showing the location of the initial seven public private mixed DOTs that we installed under round two of the Global Fund Project. It covered a population of 2.5 million, representing about 3-percent of the Philippine population at that time.

In 2005, we installed additional 21 PPMD units and there are now 28 operational PPMD units, and this covered a population of six million. In 2006, additional 22 PPMD units were installed under round two of the Global Fund Project, making a total of 70 operational PPMD units covering a population of 13 million of the total population of the Philippines.

Again, we were able to successfully get support from the Global Fund. We have the round five Global Fund Project, and in this project, we installed additional 47 units of PPMD

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in the private sector, and also in the public sector, and in 2007, we have a total of 117 units operational covering a population of 30 million, representing 34-percent of the total population of the Philippines.

And this year, we installed additional 52 private public mixed DOTs facilities, and now we have a total of 169 units in place, 70 under the round two project, and 99 under round 5 of the Global Fund Project.

There were also other PPMD units that were self installed, and installed under various initiatives. So, in 2008, we now have a total of 17 coordinating structures, the red ones, one national coordinating committee, 16 regional coordinating committees, and we have 220 public private mixed DOTs facilities where the private sector, particularly the private referring physicians, can refer their patients for case finding or treatment.

The coverage now is 36 million of the total population of the Philippines, and this represents 40-percent of our total population.

What has been achieved so far? This is the PPMD contribution to CDR in the areas covered. In 2004, we have seven units operating, the contribution in the areas covered is 7-percent. This increased to 11-percent in 2005. In 2006, this was again 11-percent, and, in 2007, this further increased into 40-percent in the areas covered. This is the CDI contribution among the estimated cased in the areas covered.

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Nationally, the PPMD strategy in the Philippines contributed 0.2-percent in the CDR for 2004, 0.8-percent in 2005, 2-percent in 2006, and, in 2007, we detected 5,615 new smear positive cases from the private sector, and this represent 5-percent of the total estimated cases in the Philippines.

This is the trend in case detection. The blue line is the detection rate in the public sector, and if you will notice, starting in 2004, hardly is there any increase in the detection of cases in the public sector. But because of the public private mixed strategy that we were able to place in place — there was a continuous increase in case detection in the Philippines.

And, in 2007, of the 76-percent total case detection rate of the MTP, 5-percent of that was due to the private public mixed DOTs strategy in the Philippines.

We have also observed excellent treatment outcomes in our public private mixed DOTs strategy. In 2006, we discovered a total of 247 smear positive cases from the private sector. The cure rate was 89-percent, and the treatment completed is 2-percent, for a success rate of 91-percent. In 2005, there were 893 smear positive cases discovered from the private sector, and the cure rate was 87-percent, treatment completed was 4-percent, for a success rate of 91-percent. In 2006, a total of 623 new smear positive cases were detected from the private

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sector, for a cure rate of 87-percent, treatment completed was 4-percent, and the total success rate was 91-percent.

One very important thing in PPMD is to sustain the initiative and the gains that we have done. In 2002, what we did was to identify the domains of sustainability. And we were able to identify four domains, technological viability, economic viability, political viability, sociocultural viability.

We would like to achieve sustainability and equity in our PPMD strategy. When we talk about technological viability, it means continually providing quality DOT services beyond the support of the Global Fund. For economic viability, we have to ensure that we have adequate funds source to sustain our PPMD initiatives. For political viability, this is measured by the support given by the local government to the PPMD initiative, as well as the private sector. And for sociocultural viability, we talk of universal access to quality DOT services, a patient, friendly staff, and public private partnership. How do we achieve sustainability?

For technological viability we have continuous capacity building, we have the DOT certification and accreditation, we have monitoring and evaluation, we have very good logistics management to ensure that we have continuous supply of anti-TB drugs in our public private mixed DOTs facility, and we have sustained human resource developments and we have reward system.

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For economic viability, we try very hard to recover the cost of planning a PPMD unit, and we have a Phil-Health outpatient package in the Philippines where for every referred TB patient who is a member of the insurance system, the Phil-Health, there is a reimbursement of approximately $100. And we are looking into the possibility of introducing user's fee. For political viability, we continue to advocate to the local government for policy support.

In terms of support for TB budget, and we've also continued to advocate to the private sector — the owners of the private hospitals, private clinics for corporate social responsibility. To achieve sociocultural viability, what we do is to have coalitions at the different levels, at the regional level, at the local level, and we go for community organizing, as well as, distribution of IEC materials and behavioral change communications materials.

How do we monitor the PPMD initiative? What we did was to have the strategic direction for each of the component for viability, and we have indicators for the viability. Example is for the technological viability, we measure viability in terms of the person takes contribution of PPMD to case detection rate. The cure rate of new smear positive cases, the person takes of compliance to DOT certification standards, and the frequency of the meetings of the TB diagnostic committee.

These indicators were agreed by the public and the private sector, representatives of the private and the public

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sector, and this is the direction that we would like to take in the next five years, to have at least a contribution of 5-percent from the initiative, and 85-percent cure rate, and 100-percent compliance to the DOT certification as standards, and at least every month, the TBDC, the TB Diagnostic Committee, would meet twice a month.

And this is our monitoring tool for sustainability. This is used every time we monitor the PPMD initiative. It is the PPMD unit that we monitor every month, and we try to determine what is the performance of the PPMD unit in terms of the certain sustainability indicators that we developed.

Last September, we had a program implementation review for the public private mixed DOTs implementation in the Philippines, and we introduced the evaluation wheel, and it has also — the components of sustainability, technological viability, political viability, sociocultural viability, and financial viability.

We introduced a scoring system for each of the sustainability elements, and then what we did was to have an overall score. For each of the sustainability elements, the highest score is 10, and for the overall score, it's 40.

So, in terms of viability, the PPMD initiative in the Philippines has high potential for sustainability as far as technological viability is concerned, and we have also a high percentage of sustainability for sociocultural viability, and

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we have moderate potential for sustainability for the financial aspect and the political aspect.

So the challenge now is to insure that we get the political support of the local government to it, as well as the local administrators of our private initiated PPMD units, and we have also to look into how it would be possible to recover the costs of public private mixed DOTs in the Philippines.

What is the future direction of PPMD? We will now have countrywide engagement of healthcare providers using the ISDC under the rolling continuation charter of the Global Fund. We have just been approved — the rolling continuation charter has been approved for round two and this is where we will do countrywide engagement of healthcare providers using the ISDC. We will also expand TB services being provided by our public private mixed DOTs facility, and this will now cover TB in children and MDR TB.

When we do the final scale up, we will now have covered 90-percent of the total population of the Philippines, and we will be installing 44 provincial coordinating committees for PPMD to manage the expansion of the PPMD initiative in the Philippines to cover 90-percent of the area. And this is PhilCAT, the Philippine Coalition against Tuberculosis, and we fight TB through unified action, together with the public sector. Thank you for your attention. [Applause].

L. VIANZON: Thank you very much, Mia, for that indeed, very unique, very innovative way, really, of addressing public

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private mix. We have had three speakers dealing on global concerns about PPMD, how professional societies can be further engaged, and we have here an example, a country example really, of how PPMD's can institutionalized in the context of system sand in the context really of a program.

So, may I invite the three speakers, Dr. Mukund Uplekar, Dr. Phil Hopewell, and Miss Amelia Sarmiento to join me here and respond to the queries or inquiries or any other things that our audience would like to clarify on. We have microphones in the aisle. Please kindly introduce yourself and we would be gladly responding to your questions. Any questions? Yes, first we have the professor from Vietnam, then Dr. Yap Brockman, and then the lady on my right. So we go from left to right, please.

DR. DUNN: Thank you. Yes, ladies and gentlemen, I am Dr. Dunn from Vietnam. I would like to have a question to Dr. Sarmiento. That means that for treatment of tuberculosis, the follow up is very important, and now my question is, if a patient is detected and treated by a private practitioners, who will do this survey? Does he has special health worker for this function, or he will refer the patient to the TB network?

SARMIENTO: In every locality where we have this private public mix DOTs facility, what we did really was to install either a private DOT facility or a public DOT facility where private referring physicians can refer patients in the DOTs facility for either for case detection or case holding.

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So, the one that really managers the observation of the daily treatment of the patient is the DOTs facility.

So, the role of the physician is only to refer patients, but we have very strong referral system where the public DOTs facility, or a private initiative DOTs facility, would give feedbacks about the progress of the patient's treatment to the private referring physicians, and this is done every two months when there is a streamline follow up.

But managing the patient is really the responsibility, still, of the DOTs facility. So, it's merely referring of patient to a DOTs facility whether it is a public initiated DOTs facility or a private DOTs facility.

DR. DUNN: I thank you for your explanation. The second question, if possible, that means in the manual of the international standard, it is recognized to have a so-called second people. From here, I prefer to use the term people. That means someone who is something like a tie between the doctor and the patient. And it is sad that we have to recruit these people from the community — from, this can be a pre-exist, family members or civil society member. And so, I would like to ask if you have any experiences to use this term people. How do you recruit these people? How will you train them, and mostly, which will be the relationship between the doctor and his patient? Thank you.

A. SARMIENTO: Okay. So the patient is really handled by the referring physician. It's still the patient, and the

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DOTs facility helps the physician insure that the patient will be able to complete the treatment. So what we really do in this public private mixed DOTs initiative, is to teach our DOTs facility – the DOTs provider, how to engage the private doctors. And we also tell them to maintain their relationship between the private doctor and the DOTs facility, and usually what they do is to have meetings between the private physician and the DOTs facility, so they have regular meetings with the private referring physicians.

But initially, what we do is to have a symposium where the DOTs facility informs the stakeholders and the private physicians about the services of the public DOTs facility or the private DOTs facility, and then we have the signing of a letter of agreement between the private referring physicians and the DOTs facility, and we really encourage the DOTs facility to give feedbacks to the private physicians.

And what we do during the process of the PPND initiative is to monitor the engagement of the private physician, so we have, what we call, an active referring physician defined as having and referred a patient, at least one patient in a quarter. So we insure that there is continuous relationship between the DOTs facility and the referring physicians and also the stakeholders.

L. VIANZON: Okay. So may we call on the next person's question, Dr. Yap Brockman?

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DR. YAP BROCKMAN: Thank you very much, and it's for me a real pleasure to talk after Professor Howomwu [misspelled? 01:21:48]. Twenty-five years ago we were in a similar situation. I'd like to compliment all speakers with their presentations, and I'd like to stress one issue that Mukund Uplekar mentioned, and that is we are taking all this effort, and I see the energy brought in the Philippines to reach out to all care providers is a beautiful example really to improve treatment of patients, but at the same time, to prevent the misuse of the first line drugs, and I think it is time now, really seriously, to think to help this initiative by perhaps some global initiative or some systematic approach, country by country, to stimulate a legal framework in which over the counter sale of drugs is being banned and in which drugs are being — TB — the whole use of drugs in the outside NTPs and certified, perhaps between parentheses — other health care providers is really brought under some control.

I think, actually, it's a very cheap measure because it doesn't ask for money. It asks for a proper legal framework, and so I think some systematic initiative is now really — it's time — we have the green light committee trying to prevent misuse of second line drugs. We have DOT to try to prevent the misuse of first line drugs, let's do something very basic, no over the counter sale of first line drugs, and similar and so on.

L. VIANZON: Okay. So, Dr. Uplekar, please?

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M. UPLEKAR: Yeah. Just, of course, cannot agree more, but the amazing thing is it can be done. I mean, how can Tanzania do it, how can Malawi do it, and why can't India and China or Thailand do it? So there are examples, and there has to be a more considered action. And more important, efforts by TB programs — TB programs alone will not be able to do it, so it has to have the political commitment, but even — there are many players like the that in the industry, and the people, I think all have to come together, otherwise it will come to a stage, as Mario said yesterday, that if the misuse of drugs is continued, then perhaps in a few years we will see the TB epidemic replaced by [inaudible 01:24:21] all over.

L. VIANZON: Okay. Yes, please.

DR. MICHELLE LEFEY: Yes. I am Dr. Michelle Lefey [misspelled? 01:24:27]. I am a French physician. I am by no means an expert in TB, but I was privileged to work in the Philippines for several years, starting in 1983, and I want to ask Dr. or Mrs. Sarmiento a question about cultural minorities, indigenous people, especially in so far as that — well, I make an inquiry about their conception about diseases.

Some of — many told me that they consider like this symptom like spitting blood or becoming a machinated and slowly dying, which can really be referred as TB symptoms, as coming from supernatural reasons and such that it will be entitled to have treatment by shamanism, etcetera, and so I would like to ask you if in dealing with such a patient, you have found more

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difficulty to treat them, or I can also — if I can share some of my experience with you, I had to deal with a cholera epidemic sometimes and if they accepted me to put some of the infusion, they had insisted also that they wanted to have before, the chanting, the people around, and so there was the mix of two conceptions and two system of treatments, and so I am wondering if you have some experience? Now, of course, it was a long time ago and I was in a specific place, but maybe do you have any experience of some kind of difficulty or particular case that you have to deal with like that? Thank you very much.

A. SARMIENTO: Actually, our initiative now is focused mainly in working in areas where there is a critical mass of private practitioners, because our initial intention was to engage as many private practitioners as possible, so I cannot remember exactly which of our PPMD units is doing work and is target this group, but in this next scale up where we will do the provincial engagement, this is now the time that we will address the needs of the indigenous people, and we will try to develop a strategy to engage them and to ensure that the DOT services that we provide is suited to their needs and their sociocultural correctness has been taken into consideration.

So this is now the second part of our scale up where we will be working in areas where we did not create in this initial scale up.

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DR. MICHELE LEFEY: Thank you so much. I'm so glad about that.

L. VIANZON: May I also respond to that? Being the partner of Ami from the public side, because this is actually public private partnership, yes, this indigenous population constitute, if you would recall, the global plan strategy, number two, that's addressing the high risk populations, marginalized populations in which you have to look into mechanisms in which we have to look into other considerations of how we can address them, probably going beyond a simple DOT strategy may not be the option, but looking into how cultural differences or culture variations among tribes should be taken into consideration once you try to go into addressing TB control in these special populations, and that it's already our second phase because we would like to go beyond the core population of our constituencies of the localized populations in the country.

Yes, I see the doctor here and so, yes, okay.

THOMAS CHANG: Thomas Chang, [Unclear 01:28:22] in TB Pakistan. I just want to make a comment on what Mukund had mentioned about the sale of drugs over the counter, and a question. The comment being that we do have some — in some situations in Pakistan, especially with regards to the sale of ATT drugs, where in pharmacies or very close, just opposite the district headquarter hospitals. It has come to a point that since ATT drugs are freely available from the DHQ hospitals,

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the local pharmacies no longer stock them because they say it's no longer beneficial or profitable to continue using the drugs — to sell the drugs. So I think something like that maybe should be done that we ensure the availability of quality and effective drugs in the public sector, or even the DOT's providers, so that gradually the pharmacies no longer find it profitable even to stock the drugs.

Now, my question is to Mukund. You mentioned that gradually there's an increased in the number of patients being referred from the PPM activities. Now, do you foresee the danger, that at one point of time, complacency will arise in the public sector to the point that they will just get up and say okay, let the private sector keep on doing it. I mean, and if it does happen, what will you suggest as remedial measures?

M. UPLEKAR: That's a good question. But if you see the — whatever graphs I have shown, the contribution of private sector is miniscule. Even in the Philippines, which has such a comprehensive initiative with the government supported generous benefits package, the contribution of the private is just 6 or 7-percent. So I don't foresee the private sector taking over TB control.

MALE SPEAKER: [Unclear 01:30:28].

M. UPLEKAR: Well, I'm comfortable with dichotomy, because if you look at the people, or if you look at the population, all we need to do is whatever the patients there are, they should receive good care.

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Now, who does it doesn't matter, because if you'll think from the point of view of a distinct TB program manager, he's supposed to detect as many cases as possible by different sources. So if you have that philosophy of that this is my area, I should be working as much as I can, and then it maybe in some places — one of the things which I did not mention in my presentation, that it may not be reasonable to expect national TB programs to take on and do all this, and all these successful initiatives — you know very well in Pakistan, there is no way the national TB program of Pakistan could have connected or linked with thousands of practitioners and detected whatever seven or 8,000 cases in Karachi.

It was possible only because you took help of the project and you supported that. You are not doing it, but that support is very important. Same thing in Bangladesh. It is not the NTP, it is the Damien Foundation, but this idea of not just trying to do everything ourselves, but getting things done — so, I will say that the NTP's role will change eventually if there are more and more partners to staying under the supervision, the monitoring, and then maybe it may go low on actually getting care if other providers are taking care of it. So it's a change of role other than complacency I would say.

L. VIANZON: Okay. Yes please.

ANNE FANNING: Anne Fanning [misspelled? 01:32:15], Canada, and congratulations to all describing what is really an abominable divide between public health and private medicine,

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so — and the tools and the interventions are really amazing. So, I have a question that would ask any or all of you, why aren't we starting at the preclinical level, and why aren't we engaging physicians in training, nurses in training, in the needs and the demands of the importance of their role in public health of a broader nature? There was an enormous activity by Charles Bolin [misspelled? 01:33:01], and Unisol [misspelled? 01:33:08] and Pierre Charlot [misspelled? 01:33:08]. What has happened to that? Is it moving forward?

L. VIANZON: Okay. Yes. Dr. Hopewell, please.

P. HOPEWELL: Well, this is certainly something that's a problem that's widely discussed. On the positive side, admittedly, only in one country that I know of, Saied Egwaga [misspelled? 01:33:29] described a unified approach to TB training in all of the medical schools in Tanzania. I think that's a unique situation.

There is, as you well know, Anne, substantial competition for curriculum time and medical schools — it's the same in Kenya as in Canada, and so it's very difficult to get any block of material inserted into the curriculum. I do think that there is increasing emphasis on the more general public health responsibilities of clinicians, and that young physicians coming out of medical schools now, are, in fact, more attuned to their being a public health duty that they need to fulfill, but it's far from universal, it's far from very deeply felt, and it's generally, I think not disease specific,

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but generic, and I think that those of us who are on academic faculties need to continue to try to work training on tuberculosis into the curriculum using that as the vehicle for instilling the public health responsibility for getting that element of the training across, but it's a continual struggle.

L. VIANZON: Okay. So we call on the last one to question, please.

RANDAL REESE: Yeah. Randal Reese [misspelled? 01:35:23] from Denver. I was just talking with Dr. Hopewell who said that this partnership in the Philippines really led to an overall improvement in the program, yet the percentage of the cases coming from the private practitioners looks like it's still around 10-percent, so I was wondering if you could explain how this partnership actually improved the national TB program activities as well as the activities of the patients being seen in the private practitioners offices?

P. HOPEWELL: Could I give you a quick personal view of that in that I was invited to the Philippines I think sometime in the mid to late 1980s, by the Philippine College of Chest Physicians, and they told me they would like to talk about pulmonary embolism, about mechanical ventilation, about the adult respiratory distress syndrome, things that I could talk about. I said, but I'd like to talk about TB as well, because I think that — I know something about that I'm interested in that, and they said, not a problem here, we really don't need you to talk about that. So, I was — I ended up not talking

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about TB to a group of physicians who would logically be thought to be very concerned about TB. But, on the other hand, it seems to be also to me from what I recall from the origins of PhilCAT that PhilCAT actually stimulated the government to develop a much better TB control program, that there wasn't a very good – and I hope I'm not stepping on anybody's toes, but I don't think there was a very good TB control program in the Philippines prior to PhilCAT, and it's my impression that PhilCAT actually pushed the government to make a better TB control program, and continues to be very effective in partnering with the government program. Am I wrong?

FEMALE SPEAKER: Absolutely. [Laughter].

A.SARMIENTO: I think even before PhilCAT was organized in 1994, the government already was doing very well as far as the NTP program is concerned, but this is in the public sector. What PhilCAT did really was try to engage the private doctors, because at that time, before the PhilCAT was organized, they were not seeing eye to eye, so there was a different system of managing TB among the private doctors and the NTP already has their program.

So I truly believe also that before PhilCAT, there was already a good program in the government. However, what PhilCAT did was to enhance participation of the private sector. So it was PhilCAT who made sure that we had a new way the government and the private sector can discuss together what they need to do to further – to reach TB control targets.

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And together, in 2004, we were able to reach the global target of 70-percent. And to date, PhilCAT continues to support the government by trying to engage more providers, and what PhilCAT does now is mange the implementation of the public private mixed DOT strategy on behalf of the department of health for the Global Fund Project. So what we're doing now really is we are the project management unit for the department of health for the implementation of the PPND strategy under the Global Fund Project.

L. VIANZON: Let me again respond to that. I am still a medical student during that time, but historically, when I tried to review the history of the national TB program, the national TB program has already its infrastructure even during the early '80s. Infrastructure was important because this is how you delivered the services from top up to bottom. Perhaps the issue at that time was, as what Ami has mentioned, is that there seems to be a barrier in terms of how public would address or case manage a TB case versus that of a private.

And so the idea is really to make some fluidity between these two big health care providers in terms of creating an avenue where you can synchronize all your case management. So in terms of who's better or who's not, it's not the issue, but it's just really creating an atmosphere where the two can link together and try to come up with more directional ways and approaches of handling or managing TB.

So, yes, please, Dr. Henri [misspelled? 01:40:10].

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DR. PETER HENRI: Yeah. Peter Henri, [inaudible 01:40:16], I've got a question for Mukund, perhaps also for Phil. First of all, my appreciation for all three presentations, and also very excited about the positive experiences we heard over the past days, not only day.

If I relate your stories with the initial story in the beginning of today, of Katherine, where 38-percent of cases are still not diagnoses, then the question to you, in your opinion, or perhaps you have even calculated, what could be the gain if we would strengthen public private mix worldwide at the global scale, and is it possible to identify regions and/or countries where it would be very worthwhile to prioritize these actions?

M. UPLEKAR: Yes. I mean, for me the answers are simple. Yes. It should be possible to identify the regions because I mean, very clearly, if you take settings — well, cities will be the major — most cities is where you will find the private sectors — not just the private sector, but the different types of providers. The medical colleges will be mostly in cities, large hospitals are in cities, direct practitioners, both legal and illegal, are likely to be more in cities compared to the rural areas where — because, there'll be — the private sector will be more sparse.

So, it should be readily easy to target, and I do feel that if there is a combination of carrots and sticks, and not carrots alone, because we have been talking for the last five — last 10 years we have been talking about PPM, but you know, we

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have never talked about disincentives, legal frameworks, regulation, because it doesn't make sense. You don't begin with a stick. And then we are seeing that the benefits of taking a collaborative approach are very obvious. All these benefits are because of taking collaborative approach with the different providers.

We cannot do, as I said, we simply may not be able to achieve it. There may be a limit to appealing to the conscious of the private sector or different providers and expecting them to do the public health jobs. So it has to be — I mean, that's why it is not a problem in Tanzania. They don't see the problem in Malawi. The program manager has a total position of control, and I was there, and the clinical officers were really keen on — I know they get patients, they diagnose patients, they cannot treat, so they are willing to go to any length, their mental records — they were preparing quarterly reports themselves and sending it to TB program managers with the hope that they will get drugs to treat their patients.

So, I think there's a tremendous potential, and if you use the carrot and stick approach, I think that yeah, a substantial gains are possible. Again, there are limitations on doing it. Well, we are here in a symposium working with the whole health system, so there are limitations on how much we can achieve for TB only. It has to be — the vision is, for the public plan, that is, there has to be the essential public

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health responsibilities of non-public physicians or on institutions, and there has to be a package.

If you have a package that the public health providers — the private health providers should be doing this, this, these things. And if you take it as a health systems issue, then the public sector and the governments may be able to be willing to compensate them as a package. So we should be moving in that direction and I think TB could show — could be a pathfinder for that. Phil?

L. VIANZON: Okay. Thank you. And I think I'll really now call on the true last question for this session, because we have another important event to come.

DR. LEE REISHMAN: Okay. Thank you very much, Lin, and thanks to all the speakers for a great symposium. Dr. Hopewell mentioned the competition for time in medical school curriculum for DOTs. Several years ago the National Heart, Lung, and Blood, Institute addressed it by giving competitive awards to junior faculty members in medical schools, and they called it the TB academic award, and they supported a junior faculty member with the idea that the junior faculty member might become a champion for TB, and at least if he had some funding in a junior level, would be able to get some curriculum. Indeed that happened, and that even happened before the acronym DOTs was coined. A few years we had the opportunity to be involved in a program in the Philippines supported the USAID, and looking at a way to introduce the DOTs curriculum to

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medical he said, why don't we support, similarly, junior investigators in Philippine medical schools? We call them master TB educators.

We had a competitive award, and for a small amount of money, at least for the grant, over three years, we gave $20,000 to 10 medical schools; first five, and then an additional five, and I had the opportunity to visit them all at one or another time, and the DOTs curriculum stuck, different ways in different medical schools and talking to Charlie Yoo [misspelled? 01:45:58] who was here up until earlier today, said that this has really been sustained and even its replicated to more medical schools even without the money.

So just by supporting someone who's going to be the champion for something that isn't that sexy, might be a way to get this into medical schools.

L. VIANZON: Okay, so thank you for that input, Dr. Lee Reishman [misspelled? 01:46:20]. And at this point, allow me to wrap up. And thank you to all the presenters for that wonderful presentation and enlightening aspects on private partnership. So, at this point, may I call on the — [applause]. Dr. Martinez Boydoff [misspelled? 01:46:42] to give us a —

[END RECORDING]

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