

SITUATIONAL ANALYSIS ON PUBLIC PRIVATE MIX: A CASE OF BHAKTAPUR DISTRICT, NEPAL

Background

The private sector is a major provider of health services both in terms of financing and service provision. It is estimated that half of the people seek care from the private sector in Nepal particularly private pharmacies and private clinics being the initial point of consultation for most TB patients. In this context, their involvement in service delivery can improve access and assure provision of high-quality and effective TB services. Public private mix (PPM) is the best approach of engaging all health care providers in TB control. A model of Public Private Mix (PPM) piloted in Lalitpur sub metropolitan city in Nepal since the year 1998, has now provided the evidence of success of PPM in urban Nepal with 90 percent treatment success rate, an increase in case notification and decrease in treatment by private practitioners by more than two thirds. It is of utmost importance to identify the relevant public and private sector stakeholders and define appropriate approach to collaborate at local level. So the situation analysis provides information on relevant stakeholders and assesses district capacity to implement PPM in TB control in Bhaktapur district.

Objective

The study aims to explore current situation of district capacity and approaches to Public Private Partnership in Tuberculosis by documenting general information of district, TB epidemiology, TB service providers at NTP and non NTP sector, involvement of private practitioners in TB service delivery, current linkage and collaboration and capacity of the district to implement PPM.

Methods and Materials

This was an exploratory study conducted in Bhaktapur district. Four in-depth interviews were conducted among district programme people, representatives from NGO and private provider. Similarly, a consultative meeting was conducted with representatives from public and

private TB service providers. In addition, semi-structured interviews were conducted with 76 private institutions out of 120. All of the nursing homes and hospitals and 15 percent medical shops were selected purposively covering entire district. Secondary data from published reports were also referred. Quantitative data were entered in the database and analyzed using SPSS whereas qualitative data were first transcribed and analyzed by using thematic analysis approach.

Findings

Bhaktapur is one of the districts of Kathmandu valley with a total population of 225,461; total households 41,253 and average household size 5.5. 53.4 percent of the total population was residing in the urban area of the district. Since 2003/04 to 2007/08 Bhaktapur district has achieved global target in case detection except for the year 2005/06 (66%). However it has declined to 52 percent recently in the year 2007/08 which is much lesser than the national target. Treatment success rate of new smear positive cases in the district has been 88 percent in 2006/2007, crossing the national target. More than three quarters (77%) of total cases in the district are concentrated in the urban area.

There are altogether 17 DOTS centers, 12 Sub Centers and 6 Diagnostic Centers in the district in the public and private sector working under the NTP guideline. There are 6 private hospitals/nursing homes and 109 private medical shops. Only six DOTS centers are functioning in whole urban Bhaktapur.

One third of the total smear positive cases were diagnosed from the private laboratories and out of total AFB slides examined 45percent were in the private laboratories. Mainly DOTS services were being provided through public health system network with very few institutions from private sectors. However the study showed that

one third (34%) of private providers are providing TB related services in the district beyond NTP network. On an average, the consultation fee in the private sector is NRs 178, sputum examination fee is NRs 80 and medicine cost (6 months) is NRs 2880 with total cost of complete TB treatment is NRs 3,258 indicating expensive TB treatment in the private sectors while it is available free of cost in the public sector.

It is realized that there is no proper collaboration between private providers and DPHO except few; only one fourth of them reported of having direct/indirect linkage with DPHO. However, DPHO in coordination with other partner organizations has already taken step to implement PPM through sensitization and orientation programmes to private providers. For those under PPM, different trainings and four monthly workshops are being held along with regular monitoring and supervision.

DPHO has shown strong commitment from its side to implement PPM and to strengthen the existing collaboration in the district. Only one third of the private service providers had received training on TB which seems to be insufficient to effectively implement PPM in the district. Study reveals the adequacy of the human resources in private sectors as well. DPHO has capability of providing training and other necessary support. More than half (58 %) of the institutions had microscope.

Almost all of the private service providers were positive towards Public Private Mix (PPM). However qualitative findings revealed very few organizations from the private sectors showing their interest in PPM and unless private sectors are not ready and agree to follow the national guidelines, the programme would not be successful. Private sectors are looking forward to be involved in various aspects/areas of TB

control: providing DOTS facility, suspect identification, diagnosis, referral of suspected/diagnosed cases and health education about TB and its services. Majority (89%) of the private providers were ready to comply with NTP's recording and reporting system.

Despite the fact that PPM can strengthen NTP to deliver more service oriented TB care, various challenges exist in its implementation. A large no. of TB cases is being managed outside the NTP networks but NTP does not have access to the information and control over the service providers. Resource constraints along with lack of effective managerial system are the hindrances to implement PPM.

Conclusions and Recommendations

Involvement of private providers in TB control has been crucial in the district since many providers are already delivering TB services beyond NTP network and this could also address the low case detection in the district. It is important that DPHO take initiation and lead in the programme implementation so as to scale up and strengthen the existing collaboration making the municipality and private sectors equally accountable. A PPM working group with defined roles and responsibility needs to be formed involving all responsible bodies and stakeholders to plan and effectively implement the activities. It is vital that resources and infrastructures in the private sectors be assessed and strengthened along with their effective mobilization. Technical capacity building, regular orientation and update about the programme and progress with regular supervision and monitoring are other vital aspects in PPM. In addition financial benefits and continuous appraisal could motivate private sectors so that they don't lose their interest in PPM and this might have significant impact in programme sustainability.

