Terms of Reference (TOR)
Public Private Mix Technical Assistant
CRF/0152/2019

A. Background

With increasing number of patients seeking care from the private sector, engagement with the private sector through Public Private Mix (PPM) approaches has become an essential mechanism for increasing TB case finding, early diagnosis and treatment and ensuring treatment adherence for further prevention of drug resistant TB. Unprecedented growth of the urban population, including the urban poor, has increased the concentration of at–risk populations in the Kathmandu Valley and several terai district towns. The urban population is now 44% (2016) and projected to grow further accompanied by increase in the number of populations at-risk population. The private sector goes hand in hand with urbanization and has already grown quickly in the last two decades. From 1995 to 2008, the proportion of private hospitals grew from 23% of all hospitals to 78%. In 2011, 83% of registered medical practitioners present in Nepal were in the private sector[1]. Various studies have shown that 60-80% of patients (all ailments), when ill, directly approach a pharmacy (still > 46% in the poorest quintile), and 80% of pharmacies have presumptive TB patients. Such pharmacies provide drugs based on symptoms including antibiotics, cough suppressants, anti-pyretics etc. Expenditure on health care through private providers is estimated to be 67 % (49 percent from the for-profit private sector and 18 percent from NGOs) compared to 31% through public sources. Private providers, particularly pharmacies, appear to be the biggest provider of health care.

Specifically, for TB, >25% of presumptive TB cases approach private laboratories, most of which have AFB-smear microscopy available and ~20% Sm +ve TB patients are detected in private laboratories in urban areas. Nepal NTP successfully piloted a PPM model in Lalitpur a decade back (with engagement of private practitioners, private pharmacies, local NGO, community volunteers and Municipality), by which 15.8% of TB cases were referred from private practitioners to DOTs center, with a treatment success rate of 90% and less than 1% treatment discontinuation[2]. The similar PPM approach was then implemented in Kathmandu. With the PPM scale up, now it has been implemented in 30 urban sites (out of 130) within the country. However, implementation has been minimal and case detection is falling.

Scale-up failed because of lack of strong PPM leadership at central and district level; inadequate distribution of PPM activities to each city; and inadequate capacity at central, regional and district levels to engage private providers in TB control. There was weak or no monitoring of private providers' TB services in the district, resulting in ad hoc implementation of PPM approach without

[1] Annual report, Department of Health Services (2013/14), Nepal

[2] Newell JN, Pande SB, Baral SC, Bam DS, Malla P: Control of tuberculosis in an urban setting in Nepal: public-private partnership. Bull World Health Organ. 2004, 82: 92-98

considering the local context, and lack of cost reimbursement for services provided by partners at diagnostic centres and DOTS clinics.

The NTP's detailed recording and reporting system in the private/NGO sector poses a challenge for PPM expansion. Involving the private sector on a purely voluntary basis (no direct or indirect cost incentive) has put potentially catastrophic costs on patients who are subjected to additional (and unnecessary) laboratory tests for which they need to pay - apart from free sputum smear microscopy. Only when patients can no longer afford care in the private sector are they referred, which limits the benefits of PPM. Although the contribution of PPM in TB care and control in Nepal appears to be significant, especially in the urban areas, TB cases managed by the private sector are yet to be documented properly and reported to NTP. In the absence of a formalized TB care mechanism between the private and the public sector, the contribution of the former is unrecognised. The lack of a central PPM unit and limited staff has created a gap in ownership. TB patients in the private sector go unrecognised and the private sector is thought to be the largest source of diagnosed but un-notified patients. Notification of these cases is therefore a priority. Encouraging private practitioners to diagnose and find the missing people with TB can be done at the same time.

Out of 20 medical colleges, there are 18 privately run medical colleges, and the private sector produces almost 90% of all the medical doctors (MBBS) and staff nurses in the country and provides 40% of the hospital beds. Involvement of these medical colleges is varied, and referral/notification of TB patients varies but is largely undocumented making it difficult to assess their contribution. There is no formal mechanism to educate the future doctors in National TB Control guidelines.

While the International Standards for Tuberculosis Care (ISTC) and the Patients' Charter have been adopted by the NTP, utilisation of these documents is limited, especially in designing and conducting NTP interventions to support decentralization to community/village development committees (for referrals) and involvement of private and other public providers (practitioners, hospitals, medical colleges, medical associations, NGOs, etc.). The NTP should map existing partners, define their roles, determine optimal role-sharing, and agree on their involvement in implementing proposed NTP activities under the PPM framework. A detailed operational guideline for PPM, based on WHO guidance and in-country experience is vital.

NTP has undertaken initiatives to engage the private sector, NGOs and other non-public care providers over the past several years, the potential and reach of these providers still remains largely untapped. There is significant scope to build linkages with unengaged care providers across the country and strengthen collaboration with care providers already working with the NTP. In addition, mechanisms to regulate the private sector and promote rational drug use need to be put in place and enforced.

B. Objectives of assignment

The overall objective of this TA is to support National TB Program (NTP) to plan and develop implement strategies of PPM approach as per Joint Monitoring Mission's recommendations.

C. Scope of work (SOW)

The scope of the assignment will be as follows:

- Provide technical support to access existing Public Private Mix (PPM) interventions and identify current program's issues, gaps and way forward and suggest best practices which are effective in other countries.
- Provide technical support in designing/updating PPM interventions which will be implemented through SRs
- Provide technical support to develop protocol to conduct assessment and mapping of private sectors
- Support national team to establish and functionalize national and provincial PPM working committee
- Provide technical support to implement JMM recommendations

D. Expected Outputs

The consultant will be responsible to provide the following documents:

Develop PPM models and operational work plan with outputs, timelines, roles and responsibilities

E. Level of effort (LOE), Venue, scheduling and process

The consultant(s) will prepare a detailed work plan. This work plan will describe how and when the assignment will be carried out, in line with the objectives and the SOW. The level of effort of consultant is currently assessed to be of 21 days. The assignment will be started from January 2020.

F. Reporting

The consultant will report to Deputy Chief of Party, Save the Children.

G. Logistical support

The logistic arrangements including transportation cost will be managed as per Save the Children's policy.

H. Qualifications & Contract details for consultants

The consultant will have the following professional qualifications, skill and experience:

- Medical or health-related university degree;
- At least 10 years working experience in TB control at national and international level; with at least 5years working experience in PPM including designing and implementation of PPM models
- Past or current experience of work in developing countries
- Previous experience of country missions for WHO or other global health organizations;
- Proven proficiency in the field of PPM in tuberculosis
- Documentation skills and good communication skills

I. Evaluation Criteria

1. Academic Qualification
2. Past relevant work experience
3. Understanding of the task (Proposed Methodology, Approach)
4. Proposed work plan
5. Budget

J. Proposal Submission Guideline/Required Documents

Proposal Submission Deadline- 31st March 2020.

- Required Documents-
    - Filled out Consultancy Proposal Form (enclosed with this ToR)
    - CV(s) of the proposed consultant(s) with full date of birth in dd/mm/yyyy format.
    - For Individuals (Foreign Nationals): Copies of passport

      If an individual is a full-time staff member of another organization, a no objection/consent letter signed by the organization head must be submitted along with the proposal. This is not applicable for proposals sent through a firm.

Proposals should be submitted via email to eoiconsultant.nepal@savethechildren.org

K. Budget

To be proposed including taxes (Note: 15% T.D.S will be deducted from the proposed total cost as per Nepal Government Tax rule.)

L. Payment modality

As per organization rule