



Public-Private Partnership Model to Provide Humanitarian Services in Developing Countries

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The US Department of Defense has several regional military headquarters whose mission is to partner with allies in the region for mutual security. In this role, each headquarters' staff is reaching out to allied countries and their military forces through health programs, which are often perceived as unthreatening to the host nation. Some of these partnership activities involve direct provision of health care by US military medical personnel, but the trend is away from that unsustainable, Cold War era model. Increasingly, facilitation of health programs to build capacity can be done by nongovernmental organizations (NGOs) as the model. Nongovernmental organizations often remain in a country continuously for many years, developing host nation capacity in ways that a short-term military mission could not. Interventions by NGOs that are intermittent, but long-term, can also encourage the host nation to take ownership and sustain the health service capacity on their own.

We describe a public-private partnership (PPP) model for a variety of humanitarian services in Guyana and in India by medical professionals in uniform, retired military officers, and US federal employees. Public-private partnerships can be formal, with specific memoranda of agreement delineation of duties and deliverables, or they can take a less structured form that suits all parties. In Guyana, the work was specific, based on the local needs for renal replacement therapy (RRT), corneal transplantation, and a rural village-based public health effort, the Sanitation and Health, Education in Village communities through improved Awareness and Knowledge of Prevention/Management of Diseases and Health Promotion (SEVAK) program. These services were provided to bring the best available medical expertise from the US to a

developing country at no cost to patients, in partnership with a philanthropist from the US, local governments, and health care personnel in Guyana and in India. Such a PPP does not rely on direct funding by any US governmental agency and may be a model that could be replicated in other countries. Our work continues to undergo modifications as we learn from our 7 years of experience.

As the US military continues its efforts in global health engagement, there will be opportunities to facilitate or implement PPPs to enhance mutual security. Out of the activities of PPPs and partnerships with NGOs may be some best practices that can be adapted to the needs of the health and security challenges of developing countries.

RENAL REPLACEMENT THERAPY PROGRAM IN GUYANA, SOUTH AMERICA

Our work has been possible because of an intricate partnership between private and public sectors. The initial idea and funding for the project came from a Guyanese philanthropist, living in the US, who saw a dire need for RRT and corneal transplantation in his country of origin (Guyana) and sought to help those in despair. In a developing country like Guyana, very few patients could afford the cost of RRT and related services. The transplant team, led by Dr Jindal, consists of other transplant surgeons, nephrologists, operating room nurses, dialysis nurses, and an anesthesiologist. Team members are from the US, and the exact participants for each visit depend on availability. Trips are scheduled a few months apart, to allow the recipients to stabilize before a new operation is performed.

Since its commencement in 2008, our PPP has carried out 26 living kidney transplants (and an additional 3 by the local surgeon independent of the US team) and numerous peritoneal dialysis catheter placements and vascular access procedures for hemodialysis. This service was not available in the country before the US team arrived. Host-nation providers have participated in the surgery and care of these patients, learning new skills and gaining confidence to work independently. We also biopsy the native kidneys, and the biopsy results are read by US pathologists, ex gratis. We have delivered lectures and held press conferences to make local doctors and patients aware of the program, and helped change the government's health policy.^{1,2} Our work has also led to

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Abbreviations and Acronyms

ESRD	= end-stage renal disease
HD	= hemodialysis
IDC	= Independent Duty Corpsman
NGO	= nongovernmental organization
PD	= peritoneal dialysis
PPP	= public-private partnership
RRT	= renal replacement therapy
SEVAK	= Sanitation and Health, Education in Village communities through improved Awareness and Knowledge of Prevention/Management of Diseases and Health Promotion

a number of professional journal publications, which may assist physicians in other developing countries to develop a renal replacement program.^{3,4}

A local urologist, anesthesiologist, internist, and operating room nurse are now well trained to manage dialysis and transplant patients, so the visiting team is smaller, and over the next few years, our role will mainly be support via tele-medicine. Creating a capacity solely within the host nation is the ultimate goal of the program.

We have faced several ethical dilemmas in our work in Guyana.⁵ We screened 450 patients with chronic kidney disease, 70 of whom were suitable for kidney transplantation. There were 5 patients whose evaluations raised possible ethical dilemmas: 1 was nonadherence to dialysis and he was turned down because the team felt that he would not be able to comply with postoperative follow-up. Two patients of Guyanese origin living abroad wished to have the transplant performed in Guyana, and they were accepted for transplantation after consultation with the government because they were considered ex-patriot Guyanese; a minor who wished to donate to her mother was refused because she was not competent to provide informed consent, and another subject who was considering commercialization of the transplant process was turned down.

Lessons learned from efforts in Guyana can inform Department of Defense planners and medical leaders about best practices in this field. Further, the regional US military headquarters for Latin America can benefit from positive publicity brought to our nation, and from the access and influence it provides. Several national newspapers in Guyana have reported positively on the outcomes of the kidney transplant program.^{6,7}

CORNEAL TRANSPLANT PROGRAM IN GUYANA, SOUTH AMERICA

In the developing world, restoration of sight can be a powerful tool for creating positive publicity and restoring the ability of a recipient to contribute to local economic

activity. The third author (Dr Waller) was part of an Air Force team that performed such surgery in Nicaragua in the late 1990s, when the US did not have a military-to-military relationship. The cornea transplant surgery was featured on national TV and in the Managua newspapers,⁸ and helped open the door to a better military and diplomatic relationship with the host country. That short-term mission was not designed, however, to bring independent corneal transplant capability to Nicaragua, as the work in Guyana is focused on achieving.

Inception of a successful, sustainable, corneal transplant program in a developing country like Guyana takes substantial long-term efforts and involves partnership with government agencies, sponsorship to help with incurring costs and building surgical capacity, establishment of an infrastructure for an eye bank, identification of appropriate patients, and reliable follow-up.

Eye banks in the US must be certified by the Eye Bank Association of America (EBAA) and the Food and Drug Administration (FDA). Eye banks in Latin America and the Caribbean basin should be certified by the Pan American Association of Eye Banks (APABO). The certification requirements include adequate space and equipment; 24-hour telephone service; certified technicians; a medical director who is an ophthalmologist with expertise in cornea transplantation; and acceptance by the national association of ophthalmology and ministry of health in the host country. The medical director is responsible for ensuring application of medical standards, education of health care personnel, release and distribution of corneal tissue for transplant, and oversight of the waiting list. A separate administrative director is responsible for public awareness and quality control, and interaction with accreditation agencies (APABO), host nation ministry of health, and the national association of ophthalmology. An eye bank will also require at least 1 certified technician. The role of the eye bank technician involves consent of family, medical history review, physical examination of donor, ability to evaluate the eye and determine appropriateness of tissue for transplantation, ability to retrieve tissue by following standard operating procedures (SOPs) of the eye bank, and responsibility for obtaining serologic testing of the donor. The technician must ensure that there are no specific contraindications for donation, such as positive HIV status, hepatitis status, and injectable drug abuser profile, or active infection of the eye. The medical director oversees all these tasks by the technician, and ensures an equitable system for transplant waiting list with priority to younger patients and those with bilateral blindness.

An independent eye bank must establish medical standards (to protect the recipient and the technician), uniform evaluation procedures, recipient and donor data

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