CASE STUDY

Using public-private partnerships to influence healthcare policy and practice in Bangladesh

Public-Private Partnerships (PPPs) are increasingly used in health service delivery to coordinate national and international efforts in healthcare provision.

In Bangladesh, the PPP model is being used to formalise the referral process between Private Medical Practitioners (PMPs) and designated TB diagnosis centres, orientate large workforces in garment factories and tighten up processes used to administer family planning services.

Key points

1. Public-private partnerships allow PMPs to make use of free testing and prescription services offered by the National TB Control Programme (NTP)
2. They also allow the TB Centres and PMPs to trace patients and monitor whether patients complete treatment
3. Findings from our pilot study show that the PPP was responsible for a 24.5% increase in TB referrals by PMPs over 5 years[1]
4. The NTP endorsed a policy to engage the garment sector in TB control. A Memorandum of Understanding is now in place between relevant stakeholders
5. We have extended the use of PPPs to family planning services. Our initial findings show differences in approaches, incentives, and capacity across the public, NGO and private sector providers.

The TB problem in Bangladesh

Prior research[2] showed that all the sectors – private medical practitioners, the NTP, hospitals and NGOs – were working separately to tackle TB. Private medical practitioners were working within their own means, without any links to the national programme, and there were no service links between the private and public sectors for health service delivery. The same research also showed that TB case detection was low, and that PMPs didn't know they could refer patients for free testing through the NTP. Our aim was to improve the low referral rate.

Our approach

We met with the NTP to discuss engaging different service providers with the national TB programme. Together, we identified the service providers, including PMPs. Further discussions focused on how to develop links between the NTP and PMPs.

We then ran a capacity assessment exercise which involved interviewing 123 doctors, held focus groups with doctors and NGOs, and ran workshops at regional level with the NTP and PMPs. The workshops focused on:

- assessing the current practice used by organisations and individuals;
- their capacity for using an amended patient referral system; and
- the resources they needed to refer patients to TB diagnosis centres.

From this, we developed a referral system that would be appropriate to use in Bangladesh. Part of developing a referral system involved training and orienting the TB centres and the PMPs in using the amended referral system. PMPs were told that they could ask the TB Centres about their patients, and ask patients to return to their practice.

We also negotiated with PMPs to refer patients to designated TB Centres for free diagnosis and TB drugs. Crucially, we didn't change anything in the normal practice; we simply encouraged the referral process between PMPs and designated TB Centres, and designed referral forms to help administer the referral process smoothly.

Our intervention

The PPP model was used to involve PMPs in the NTP. The model asked private doctors to refer their patients to designated TB diagnosis Centres for sputum testing. If the patients tested positive for TB, they could get a prescription from their private doctor for free drugs, also available from the TB Centres, as part of the NTP. The scheme not only allowed private doctors to make use of the free testing and prescription service offered by the NTP, but also allowed the TB Centres and private doctors to trace patients and monitor whether treatment was completed.

A baseline review of patient and medical practitioners' experiences

Before our intervention:

- patients received poor treatment;
- patients often abandoned treatment after 1-2 weeks when they felt slightly better;
- patients often didn't have money to buy drugs for long-term treatment;
- private medical practitioners didn't know that they could refer patients to the NTP; and
- patients used PMPs because they wanted diagnosis to be done in private: TB has a stigma attached.

Redesigning the referral system

A new 3-part referral slip was developed and integrated into the national programme to:

- allocate a unique number to each patient;
- get a record of the patient's address and other contact details, which was missing before;
- get real-time statistics on case notification and treatment completion; and
- establish a communication loop between the PMPs and the TB Centres that allowed doctors to remain informed about their patients. The last part of the 3-part referral slip was sent to the doctor with a thank you seal.

The new forms and communication loop helped the TB Centres and PMPs with late patient tracing. They could see how far into the treatment patients were, and were also able to follow up using the unique patient number.

Scaling up the intervention

The scheme was piloted in 4 areas in Dhaka and scaled up using a phased approach. PPP is now being used in Sylhet and Chittagong divisions.

Capacity building of partners during the research and for scale-up

Part of our approach was to consider how easy scaling up would be for the NTP. The challenges to scaling up the PPP model included:

- thinking about the capacity of the NTP;
- any policy implications on a national scale; and
- encouraging the NTP to take ownership.

The close partnership with NTP, which was nurtured using a participatory approach, allowed us to plan for a gradual scale-up. We held management training, and developed materials together through piloting.

Impact on national and international policy development

Research into using the PPP model in Bangladesh has led to:

- the NTP deciding to scale up before the official end of the pilot (2008), as they could see the positive effects of the PPP model early on;
- guidelines and tools for PMPs to use in TB control now being used;
- detailed guidelines developed for PPP use in Bangladesh, specifically on how to engage PMPs in health service delivery. The research has informed and aligns with current WHO strategy which supports using the Public-Private Mix model as part of their 'engaging all providers' strategy[3]. This research also aligns with the Bangladesh government's PPP priorities.[4]

Scaling up within the garment industry

We extended the PPP model to the workplace, where there are huge numbers of workers in a high TB transmission environment. Workers face particular challenges; they are unable to attend

public healthcare facilities during working hours, compelling them to attend PMP clinics and pay for diagnosis and treatment. We approached the Bangladesh Government Manufacturer Exporters Association (BGMEA) and explained that the national TB programme was working very well, and could help identify and support TB patients in their factories.

We used innovative approaches in the workplace, for example, on-the-floor orientation and using existing audio systems to orientate large workforces at the factories.

Influencing policy and practice in the garment industry

This extended PPP model is already having an impact, for example:

- TB in the workplace is high on the agenda for WHO, informed by the PPP model in Bangladesh;
- the NTP endorsed a policy to engage the garment sector in TB control;
- a MoU was signed between the NTP and the BGMEA, showing a growing commitment of all key stakeholders to maintain the success of the TB workplace programme;
- a focal person was set up within the NTP to work with the BGMEA;
- guidelines and tools are ready to use for scale up within the garment industry; and
- our paper was the first of its kind on using PPP to challenge TB in the workplace.[5]

Poster informing clients about LARC and sources of care, saying: 'Are you interested in using family planning methods for the long-term? You have an implant - a long-acting, hassle-free method OR you have an IUD which is hormone free - an ideal long-acting method.'

Scaling up into family planning services

We are currently working in 2 urban areas in Dhaka to develop a PPP model to increase access to Long Acting Reversible Contraception (LARC) for the urban poor[6]. Our initial findings[7] show that:

- there are diverse providers of LARCs across public, NGO and PMPs;
- the service charge for clients varies between providers;
- incentives to use LARCs and to refer patients varies considerably;
- processes for follow-up and recording patient details is inconsistent across providers; and
- PMPs are not always aware of referral incentives, or have adequate knowledge of LARCs to advise clients.

- Read our Policy brief: How can a public-private partnership enhance the use of long acting contraceptive methods in Bangladesh?
- For more information about our work on PPPs, contact Dr Rumana Huque: info@arkfoundationbd.org

References

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