# Internship Report

# on

# Public Private Mix approach in Tuberculosis Control Programme, BRAC


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## Contents

Brief profile of the organization – BRAC: .......... 3

My Assignment at BRAC: TB Control Programme .......... 3

BRAC TB Control Programme profile .......... 4

Achievements: .......... 4

My Responsibilities and Leanings under this Programme .......... 6

Coordination .......... 6

Capacity building .......... 6

Operational .......... 6

Learning from the Programme: .......... 7

Understanding Public-Private Mix .......... 7

The PPM approach for TB control .......... 7

Roles of divers PPM partners in TB .......... 8

Self evaluation .......... 10

Constraints .......... 10

Recommendation .......... 11

Conclusion .......... 12

**Brief profile of the organization – BRAC:**

Known formerly as the Bangladesh Rehabilitation Assistance Committee and then as the Bangladesh Rural Advancement Committee and now Building Resources Across Communities, BRAC was initiated in 1972 by Sir Fazlé Hasan Abed at Shallah Upazila in the district of Sunamganj as a small-scale relief and rehabilitation project to help returning war refugees after the Bangladesh Liberation War of 1971

Now BRAC, an international development organization based in Bangladesh, is the largest non-governmental development organization in the world, in terms of number of employees as of September 2016. Established by Sir Fazle Hasan Abed in 1972 after the independence of Bangladesh, BRAC is present in all 64 districts of Bangladesh as well as other countries in Asia, Africa, and the Americas.

BRAC employs over 100,000 people, roughly 70 percent of whom are women, reaching more than 126 million people. The organization is 70-80% self-funded through a number of social enterprises that include a dairy and food project, a chain of retail handicraft stores called Aarong, Seed and Agro, Chicken etc. BRAC has operations in 14 countries of the world.

BRAC started providing public healthcare in 1972 with an initial focus on curative care through paramedics and a self-financing health insurance scheme. The programme went on to offer integrated health care services.

## My Assignment at BRAC: TB Control Programme

BRAC TB Control Programme started in 1984 as a pilot project in Manikganj sadar upazila (sub-district) and was extended to 10 other upazilas in 1992 in order to test the potential of scaling it up. Following the successful outcome in the pilot and the 10 scaled up sub-districts, BRAC was the first NGO to sign an MoU with the Government of Bangladesh in April 1994 to expand the Directly Observed Treatment Short Course DOTS services nationwide. By 1998: DOTS expands to rural areas & by 2002-2003: DOTS started in urban areas. BRAC's approach for TB diagnosis and treatment focuses on community level education and engagement. BRAC conducts

orientation with different stakeholders of the community to engage them in efforts to identify patients, ensure treatment adherence, and reduce social stigma.

## BRAC TB Control Programme profile

- Population covered :93 million
- District Covered : 42
- Upazila Covered : 297
- City corporation Covered : 5
- Peripheral Laboratories : 406
- EQA Center : 26
- DOTS Corners at Medical College Hospitals /Institutes: : 31
- Prisons covered : 41
- Port Hospital covered :2
- EPZ covered :3
- Work Places covered : 776

## Achievements:

- Detection of cases ≥ 70% (Achieved-2006)
- Treat successfully ≥ 85% (Achieved-2003)
- Reach MDG related Targets of Halving TB Mortality and Prevalence by 2015: in Track
- Achieve universal access to high quality care for all people with TB : special emphasis for Hard to Reach Area & Vulnerable group
- DOTS coverage: 100%
- Programme available throughout the country at all Upazila Health Complexes, all Chest Disease Clinics & Hospitals, urban health centers, medical college hospitals, and defense hospitals, EPZ, BGMEA and prisons.

**Case Notification:**

Case notification has been increased throughout last 8 years while new smear positive is almost consistent amounting about 70,000. But new smear negative case notification has increased at a higher rate. Extra pulmonary case notification has also increased but not similar to new smear negative.

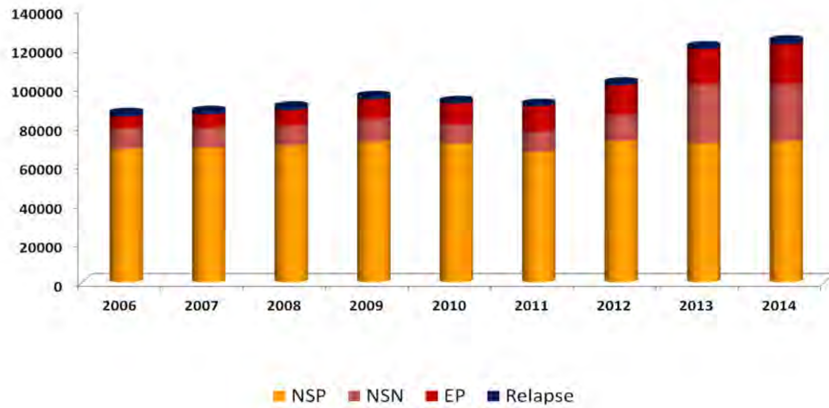



Figure 1: TB Patient Case Notification 2006-2014; source Annual Report 2014

The role of PPM has contributed to these changes. As laboratory diagnostic centers of Gov. and NGOs are working for case notification through smearing which has been run since 2002. As the service remains same in structure, the smear positive case trend is consistent. Development over the years resulted PPM which has led to ensure the smear negative case detection through X-ray, biopsy and other clinical symptoms at hospital facilities by graduate and non graduate private medical practitioners. Thus, smear negative case notification and extra pulmonary case notification has shown increasing trend.

**Treatment Success Rate** –Treatment Success Rate has been increased throughout last 9 years from 92% to 95%. The role of PPM has contributed to these changes. This success is due to decentralizing sputum smear

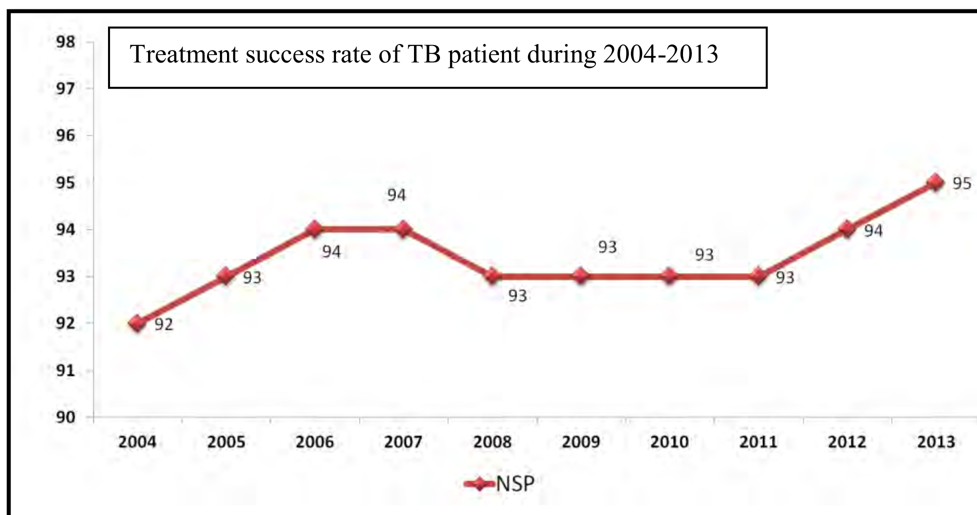



Figure 2: Annual report 2013, Tuberculosis Control Programme, Bangladesh

microscopy and treatment delivery services to peripheral health facilities, utilizing the existing primary health care network following PPM concept engaging health care providers at all levels such as community health workers of BRAC called Shasthya Shebika, graduate and non graduate private medical practitioners, village doctors etc.

## My Responsibilities and Leanings under this Programme

I have been working in BRAC under health programme since 1998 through different health sectors in Bangladesh and abroad. Since 2009 I was engaged with Tuberculosis Control Programme. During my internship period, I was assigned to work on Public Private Mix approach in Tuberculosis Control Programme that is one of my responsibilities I have been performing from the beginning of my work in TB Control Programme. Taking in to account the responsibility during my internship period I tried my level best to involve myself with following actives:

### Coordination

In order to enhance the PPM activity effectively I took responsibility to organize as well as participate at the meetings with different stakeholders' level like journalist orientation, round table meeting with print media, stakeholder meeting with WHO and other government and non government institutions etc. Besides, I have participated at the open sharing discussuion at the quarterly performance review meetings with our partner NGOs. Moreover, I have visited to the field regularly to find the output of several PPM relevant activities we are performing in the field through BRAC as well as our 27 partner NGOs.

### Capacity building

During my participation in different mentioned forums I tried to offer myself to learn the things should be considered as well as shared my opinion and also suggested how to overcome the barriers or weakness in order to enhance the activity.

### Operational

During my field visit as well as our internal different forums I shared my experience and steps to be taken with our colleagues as well as different personnel at different level. During my field I

go throughout the review of different relevant documents and see the real scenarios on the spots based on that take the further initiatives to be taken through open discussion and providing proper guidance.

**Learning from the Programme:**

**Understanding Public-Private Mix**

Public-Private Mix is an approach which aims to link the resources of public and private health care providers to achieve national TB control targets. Public Private Mix approach helps to increase TB case detection and reduces diagnostic delays by involving all health care providers in timely referral, diagnosis, ensures proper notification of all diagnosed cases and enrollment on appropriate treatment under programme guidelines. In addition evidence shows that private providers are often the first point of contact for health services.

In Bangladesh, a large proportion of TB cases are managed by private practitioners (PPs) other than the National Tuberculosis Control Program (NTP) services. NGOs are contributing in the expansion of Public Private Mix (PPM) partnership for delivery of quality TB services under NTP.

The objective is to strengthen the linkage with graduate, non-graduate PPs and workplace in TB control, increase their involvement in referral and provision of DOT following the national guideline by private practitioners.

**The PPM approach for TB control**

Another learning under this programme is the use of PPM approach for TB control in the following ways:

1. Public with Private (for example: NTP collaborating with NGOs and private sector)
2. Public with Public (for example: NTP collaborating with Defense, Police Health Services etc.) and
3. Private with Private health care providers (for example: NGOs working with Private Practitioners)

**Roles of divers PPM partners in TB**

The PPM programs had several common characteristics. Government institutions initiate the NTP and assume responsibility for policy and guideline development and planning, as well as program financing and the provision of anti-TB drugs, facilities, and other supplies. Private health institutions or individual practitioners detect suspected cases and then either refer cases to the NTP-affiliated facilities for treatment, or notify the NTP by recording results in the laboratory register and provide TB care themselves.

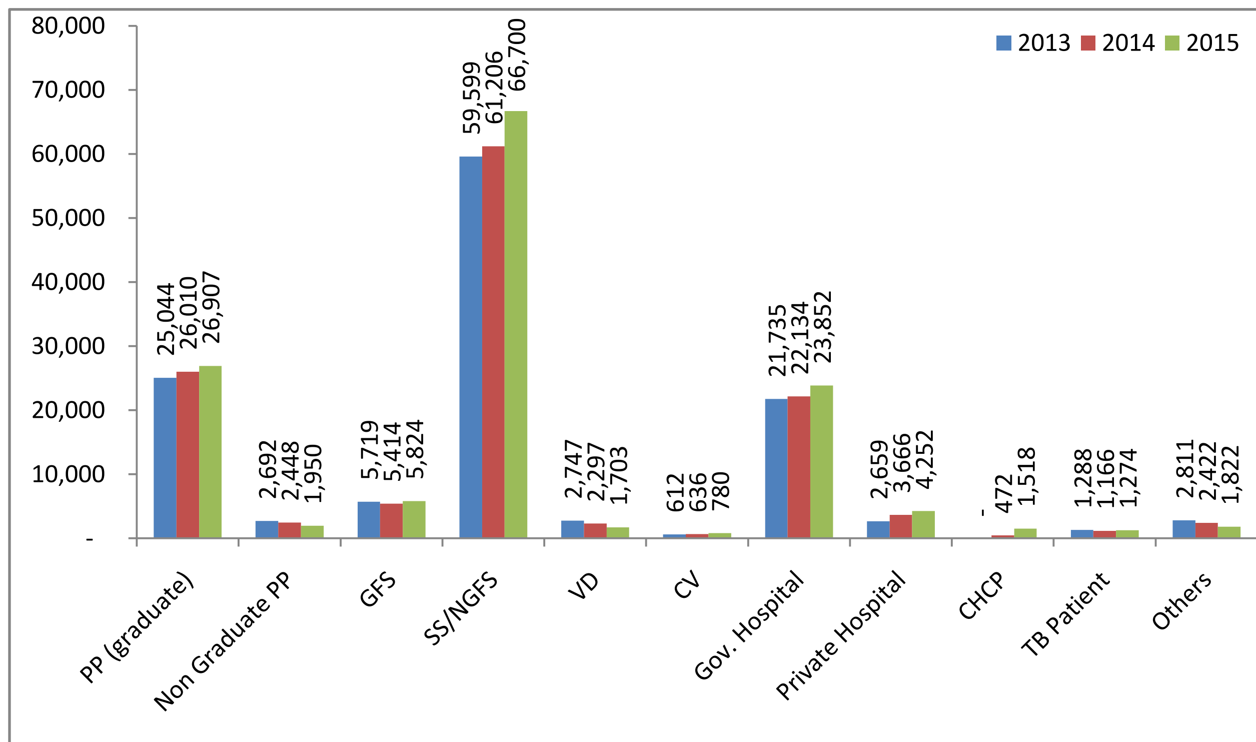
Public health institutions, such as public TB centers and public general hospitals, receive referral cases and confirm the diagnosis, and then provide further treatment or send patients back to local private providers for treatment and management. Supervision is the key element of TB control and is considered a cornerstone for sustainability of different NTP activities NGOs are often engaged in mobilizing and coordinating health partners, and sometimes in performing partial TB care work; some PPMs also involve academic institutions for staff training, patient health education, technical assistance, and outcome evaluation.

Therefore, we can tell that the relevant activities are being performed through the collaboration between institutional health care providers like City Corporations, Strong partnerships between NTP and its partners. 43 NGOs involved as partner of NTP, academic medical institutions, e.g. medical colleges, specialized institutions and universities ( Public & Private), NGO and private hospitals and clinics, government hospitals under Ministry of health e.g. : all district dospitals and all chest hospitals & clinics, government hospitals under Other Ministries e.g: combined Military Hospitals (6), Police Hospitals, Prisons , corporate sector / work Place e.g: youngone group, Bangladesh Garment Manufacturers & Exporters Association (BGMEA), export processing zones, Other Companies etc. and Individual health care providers like , specialist Medical Practitioners, graduate Private Medical Practitioners, non-graduate Private Practitioners, village Doctors, female community health volunteers (Shasthya Shebika),cured TB patients.

**Number of referred TB patients: by different corners through PPM activities in BRAC covered 42 districts during last three years:**

| Year | Referred by PP (graduate) | Referred by Non Graduate PP | Referred by GFS | Referred by SS/NGFS | Referred by Village Doctor | Referred by Community Volunteers | Referred by Gov. Hospital | Referred by Private Hospital | Referred by CHCP | Referred by TB Patient | Referred by Others |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **2013** | 25,044 | 2,692 | 5,719 | 59,599 | 2,747 | 612 | 21,735 | 2,659 | - | 1,288 | 2,811 |
| **2014** | 26,010 | 2,448 | 5,414 | 61,206 | 2,297 | 636 | 22,134 | 3,666 | 472 | 1,166 | 2,422 |
| **2015** | 26,907 | 1,950 | 5,824 | 66,700 | 1,703 | 780 | 23,852 | 4,252 | 1,518 | 1,274 | 1,822 |

The above mentioned figures shows that a significant changes are taking place in patient referring trend year by year as a result of engaging all health care providers from different sectors starting from the community level up to the Gov. hospital .



**Self evaluation**

**Constraints**

Throughout the close contact during my work with different personnel engaged with PPM activities, I have observed that there are some constraints that should be taken care of in order to achieve the objectives of the approach properly:

a) Supervision and coordination by NTP of partnership initiatives-

Supervision and monitoring has been strengthened both in the rural and urban areas. Standardization has taken place through the introduction of check lists for both program management and laboratory components. The supervisory staff from the district level include Civil Surgeons, Deputy Civil Surgeons, Junior Consultants of CDCs, Medical Officers (MOs), Chief Laboratory Technologists, the laboratory technicians of Chest Disease Clinics and the Program Organizers. In addition, there are a number of national, divisional and sub-divisional officers from the Government, the World Health Organization as well as partner NGOs who also supervise TB control activities. NTP has a strong monitoring unit through that the periodically as well as regular supervision and monitoring is being done, but this initiatives could be accomplished more effectively and properly.

b) Engagement with other corporate sector's associations-

TB among garments workers is a challenging problem now. The prevailing situation in many garments presents an ideal environment for transmission of TB. So garments workers are at increased risk of Mycobacterium TB infection, but information on these risks remains scarce, especially in developing countries like Bangladesh. NTP has established partnership with the largest association like BGMEA and BKMEA and the number of population covered by them is around 707864. They are providing TB relevant services through 12 diagnostic centers to all their respective garments workers. This is very innovative and it could be speeded to others also.

c) Limited collaboration and coordination with different ministries—

   Health care services is a integrated approach. A remarkable success was done in many sectors of health in Bangladesh like family planning, immunization, maternal and child health etc. Considering the factors of success from those sectors more integration and collaboration between different ministries and institutions could be done.

d) Limited collaboration with Individual Industries /Companies-

   A large number of service holders has direct and indirect access to different industries, companies. Though PPM activities have engaged a large number of people with TB relevant services while some portion of service holders is still have easy access to have the proper services. Therefore, in order to engage more people PPM activities should be more enhanced.

e) Lack of policies and practical guidelines to address specific traits and need-

   There are specific guidelines and policies while these should be revised based on the reality.

f) Limited capacity for public health functions: poor patient retrieval, limited referral links.

**Recommendation**

I. Multiple collaboration mechanisms, such as signing contracts and establishing a multi-partner group, are recommended to ensure positive PPM performance.

II. Intensification of involvement of public basic health workers, private practitioners, village doctors and Shastho Shebikas (community health worker) will need a close follow up, in order to institutionalize this approach.

III. More emphasis should be given on monitoring and evaluation as well as recording and reporting considering it one of the major elements of TB Control programme. Proper supervision and monitoring facilitate to follow the patient once diagnosed, to monitor the

progress of treatment and also helps in cohort analysis to assess case detection and treatment outcome against set targets at different implementation levels –upazila, district and national.

## Conclusion

Bangladesh has a pluralistic health system, marked by a very effective collaboration between the GOB and a multitude of NGOs. The implementation of TB control activities should be viewed within the framework of this pluralistic health system with many stakeholders, including government and non-government organizations, who pursue women–focused, equity oriented, nationally targeted programmes such as those in family planning, immunization, oral rehydration therapy, maternal and child health, tuberculosis control, vitamin a supplementation and others.

Public–private mix (PPM), recommended by the World Health Organization (WHO) was introduced to cope with the tuberculosis (TB) epidemic worldwide. In many developing countries, PPM has played a powerful role in TB control. PPM is a promising strategy to strengthen global TB care and control, but is affected by contextual characteristics in different areas. The scaling-up of PPM should contain essential commonalities, particularly substantial financial support and continuous material input. Additionally, it is important to improve program governance and training for the health providers involved, through integrated collaborative mechanisms. Wider partnership will also help address the resource requirements for delivering effective services: human resources, financing and service infrastructure in the longer term.