

Increasing access to HIV treatment through a community-supported public private partnership in Myanmar **A case study**



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About the International HIV/AIDS Alliance

This case study is one in a series of case studies produced by the International HIV AIDS Alliance. This series brings together best practices from our global community-based programming to define and guide good practice in a range of technical areas including: Human rights and GIPA, Research, evaluation and documentation, HIV prevention, Sexual and reproductive health and rights and HIV integration, HIV and tuberculosis, HIV programming for children and, HIV and drug use.

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Zero: 'One of the outreach workers at my organisation is motivating others to work towards this goal' © Arkar 2014 / International HIV/AIDS Alliance / PhotoVoice

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Introduction and context

There has been a rapid increase in the number of people living with HIV in Myanmar over the last decade, the majority of who are eligible for treatment. Alongside this increase has been an effort by the ministry of health to rapidly scale up provision of treatment in-order to reduce HIV-related illnesses and deaths¹. By the end of 2013, a total of 147 sites were providing ART across almost all of the states and regions of the country, compared to 57 sites in 2008. As a result, coverage of ART is rising. At the end of 2014, 85,626 people were accessing ART at these sites, which represents significant progress.

HIV situation in Myanmar

Number of people with HIV (2014)	210,000
Number on ART (by end 2014)	85,626
HIV prevalence (adult population 15 years and over)	0.54%
Prevalence among female sex workers	6.3%
Prevalence among men who have sex with men	6.6%
HIV prevalence among people who inject drugs	23.1% ³

However, Myanmar has an ambitious national strategic goal of providing ART to 106,058 people by the end of 2016². The health system in Myanmar is already stretched, and to achieve this goal, innovation in ART delivery will be required in-order to ensure that ART is provided close to communities, without compromising quality.

Need for public private partnerships

In most contexts globally, rapid scale up of ART provision has not always been matched with a similarly rapid increase in trained healthcare providers. This often leads to overloaded clinicians who have to provide clinical care to a large number of people living with HIV, which ultimately reduces quality of care. This situation is frequently compounded by the long distance that patients have to travel to obtain ART in some areas, which further impacts on adherence and retention in care, and ultimately, leads to sub-optimal viral suppression and mortality outcomes.

In Myanmar, there has been significant commitment from the government to decentralise ART provision. Decentralisation is aimed at ensuring that ART is provided in locations that are as close as possible to people living with HIV and their communities. One way of achieving that goal is shifting ART services from tertiary to primary health care facilities. This is an approach that is being increasingly utilised.

Another complementary option is the provision of ART from other health system infrastructures that already exist in the community, such as private sector general practitioners. Alliance Myanmar has explored this option, which could bring ART close to communities, while at the same time alleviating the burden that faces public health facilities. In this regard, Alliance Myanmar has been operating a partnership with private sector general practitioners since 2009, in order to increase coverage of HIV treatment.



Purpose of this case study

This case study describes the model and outcomes of the public private partnership (PPP) that has been implemented by the Alliance since 2009 in Yangon, Myanmar. This information and evidence is essential to support and guide possible expansion and replication of this model in efforts to decentralise ART delivery in other contexts, whilst easing the burden on public health facilities. It highlights the collaborative role of the partners; high impact strategies that have contributed to the success of the model; lessons learnt, best practice and patient outcomes; and concludes with recommendations regarding how this model may be improved.

Questions addressed in this case study

How does the GP public private partnership model work in practice, and who are the main actors?

How is the partnership contributing to the wider scale up of ART provision in Myanmar?

What programmatic approaches and strategies have been at the centre of this programme?

What are the main patient outcomes in this model?

What are the lessons learnt, challenges and best practices experienced within this model?

What recommendations and next steps can be made to improve and sustain this programme?

Methodology

To compile this case study, a retrospective review of routinely collected health records of people living with HIV, together with an analysis of previous programmatic reports was conducted. We also included qualitative quotes from a focus group discussion conducted in 2012 among clients in the program to illustrate the impact that the treatment has had on their personal lives.

Organisation of the Public Private Partnership

The general practitioners: The partnership is formed primarily between Alliance Myanmar and 16 General Practitioners. Under this partnership, the Alliance developed terms of reference and contracted the GPs to provide HIV testing and clinical follow up services for HIV positive patients. The general practitioners conduct HIV testing, assessment and WHO staging, diagnosis and treatment of OI; and other aspects of clinical management of sexually transmitted infections and Tuberculosis. The general practitioners then prescribe and initiate antiretroviral therapy (ART) according to the national guidelines.

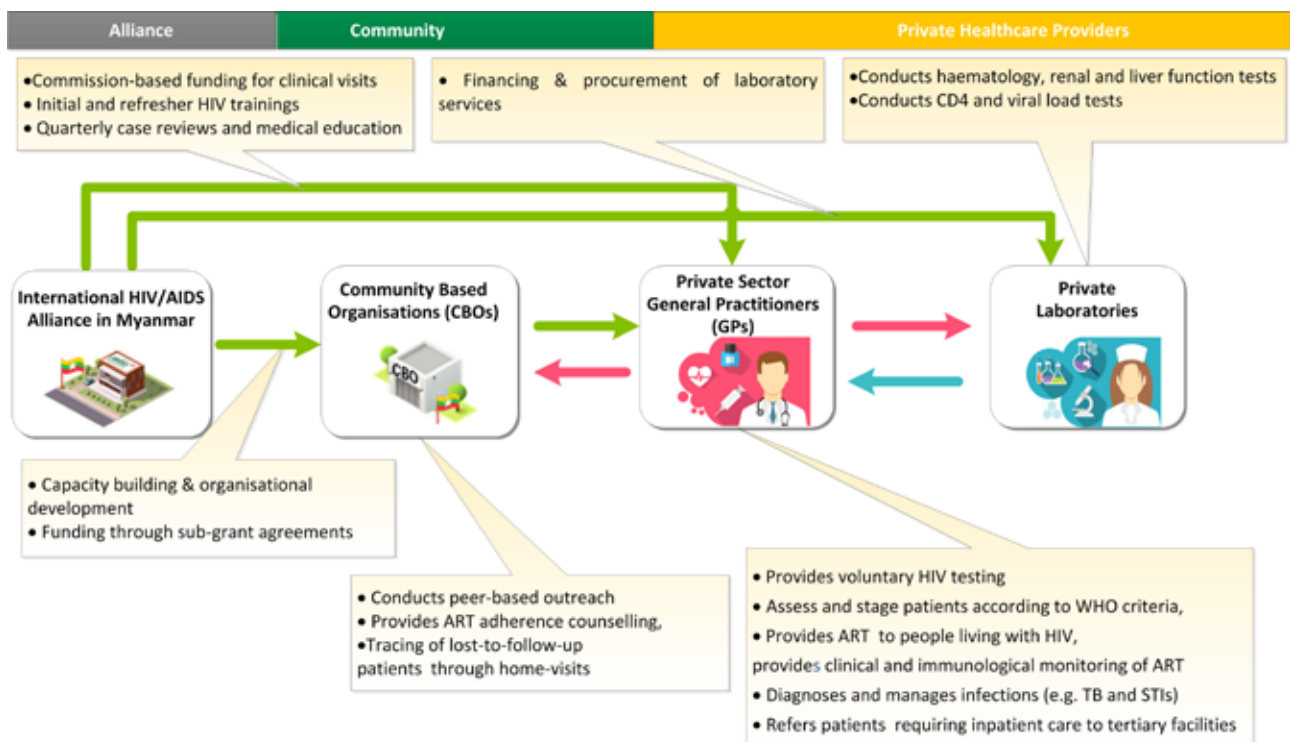
General practitioners then monitor patients immunologically, via CD4 count, as well as clinically. When patients are not progressing well, or showing signs of failing treatment, the general practitioners discuss the

case with Alliance staff and request a viral load (HIV-RNA) test from private laboratories. Based on results, they switch patients from first to second line drugs. When patients develop OIs requiring inpatient care, general practitioners refer them to public government facilities. The Alliance supports the general practitioners by providing them with commission-based funding, technical assistance and quality assurance; and by collecting, monitoring and reporting data related to patient outcomes.

Community-based organisations: In addition, the Alliance supports treatment literacy, adherence support, support with disclosure, home-based care, and tracing of lost-to-follow-up patients through community-based activities. These activities are implemented through outreach workers who are deployed from a network of community-based organisations (CBOs) and key population (KP) networks in Yangon. Provision of these community-based follow up services strengthens the continuum of care - from testing to long-term retention on ART – for people living with HIV. At the same time, CBOs are able to link those that test negative to an on-going package of HIV prevention. Engagement with CBOs complements clinical care that is provided by private sector general practitioners.

Private diagnostic laboratories: The Alliance finances and coordinates logistical services such as supply of patients’ test results to the general practitioners, including CD4 count and viral load tests. These laboratory services are outsourced to private laboratories, and the Alliance pays for these services as shown in the figure below:

Figure 1 PPP Model



Programmatic approach and interventions

The introduction of a new and innovative model of ART delivery required the development of new tools and standard operating procedures, as well as the extension of the monitoring system to capture data in GPs' clinical records. In this partnership, standard operating procedures and referral protocols were tailor-made for 1) general practitioners and 2) peer educators/outreach workers.

Training: An initial training package on antiretroviral therapy, reflecting the national guidelines, is provided to all general practitioners, and regular updates are provided when these guidelines are updated. In addition, quarterly case review workshops are conducted in which real cases are reviewed to improve the quality and outcomes of patient management.

Programme management tools introduced with this model included a new health information system that captures individual patient registers that are maintained by general practitioners. The information recorded includes client demographics, baseline immunological and haematological data, monthly follow up data, as well as relevant data related to sexually transmitted infections (STI), Tuberculosis (TB) and other opportunistic infections. In addition, training and educational materials to enable CBO-based outreach workers to provide ART adherence support have been developed. This is particularly relevant because lack of adequate adherence counseling and support can result in poor adherence and retention outcomes.

Standard operating procedures were devised to create a streamlined pathway through which patients access HIV testing, pre-ART care, ART, ART adherence, and psychosocial support. Following outreach and identification of people at risk of HIV, outreach workers conduct pre-test counselling as part of HIV education and behaviour communication. These outreach workers then refer individuals to general practitioners, where they are tested for HIV and, if positive, their blood sample is drawn and sent to a laboratory for CD4 count assessment. Post-test counselling is provided by the general practitioners, and clients are linked back to CBOs for continued HIV prevention services, or provision of psychosocial services including treatment literacy, adherence support and support with disclosure. Depending on eligibility for ART, and based on the national guidelines, HIV-positive clients are either followed up in pre-ART care or commenced on ART following ART adherence counselling. Clients then have either monthly or quarterly appointments with the GPs, depending on their health or adherence status.

Referrals for clinical and psychosocial support: Patients are followed up clinically and assessed for opportunistic infections regularly. For example patients are referred to TB detection and treatment services when they develop TB symptoms (such as persistent coughs, night sweats and weight loss). Patients

“We have been given drug recording cards [diary] where we have to tick every time after taking the drugs. This helps us to see if we have missed any dose.”

Female patient from Ratana Metta Organization, CBO



A general practitioner discussing treatment options with a client.
© International HIV/AIDS Alliance

who are having difficulties with adherence are referred by the GPs to CBOs who provide support, for example adherence support, drug diaries, as well as transport allowances to enable them to attend future appointments.

Data and clinical quality assurance strategies: Regular data collection takes place in order to monitor and report on patient outcomes. These data are double checked and verified to ensure that they are reliable, accurate, consistent, and complete. Trends in service delivery and outcomes are used to aid decision making and program implementation. During quarterly workshops, general practitioners and the programme team review programme trends, and identify any constraints related to service delivery. These constraints are addressed in collaboration with CBOs, laboratories and other stakeholders including ministry of health.

“My condition improved dramatically, CD4 count increased from a low of 15 to 37 and then to 239 and much higher. I was able to work again and take care of my family.”

Female patient from MCC, CBO

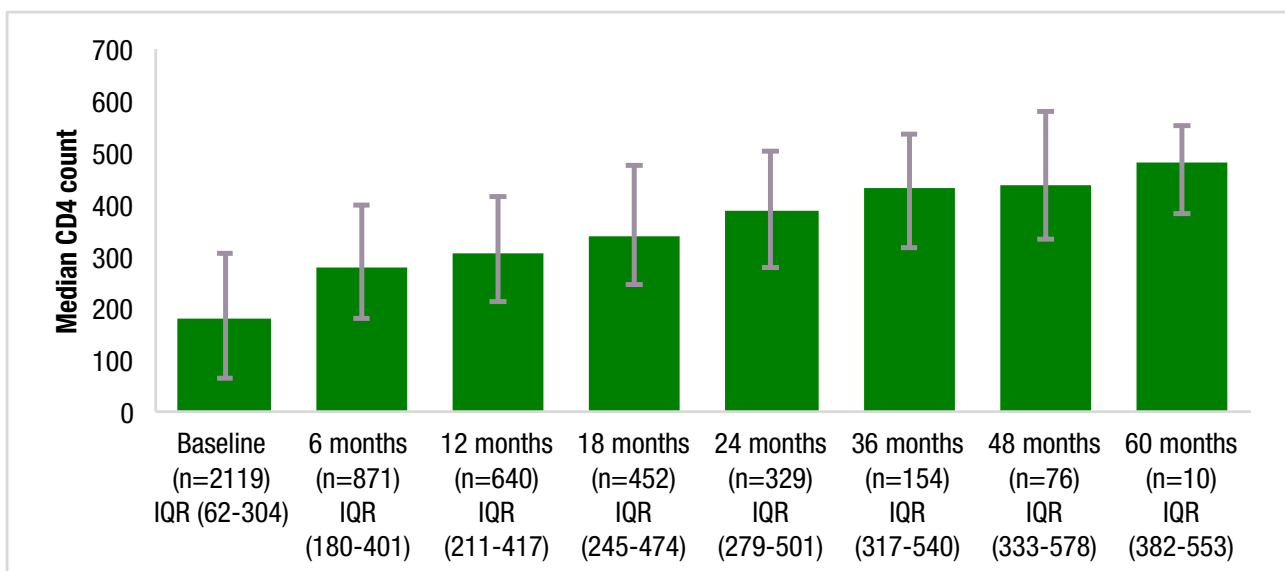
Results

Increased access to antiretroviral therapy

Between March 2009 and April 2015, a total of 2119 patients have been provided with ART. This has meant that Alliance Myanmar is the third largest provider of ART in Myanmar, contributing significantly to the national response in terms of providing ART.

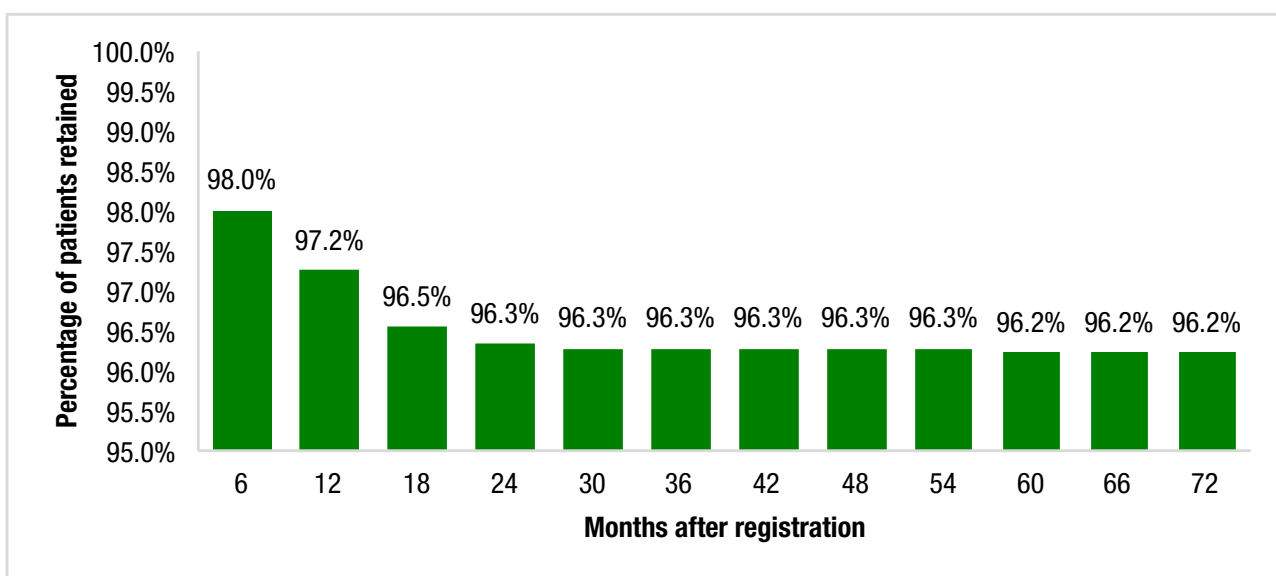
Improvement of CD4 count during treatment

Between 2009 and 2015, the programme experienced very good outcomes related to CD4 count recovery. The general health of people living with HIV in this programme was improving, their CD4 counts were rising, and they were progressively becoming less likely to fall ill with common opportunistic infections. As shown in the figure below, patient CD4 counts progressively increased over the period of follow up and retention in the programme from a baseline of 177 cells /mm³ to 482 at 60 months.



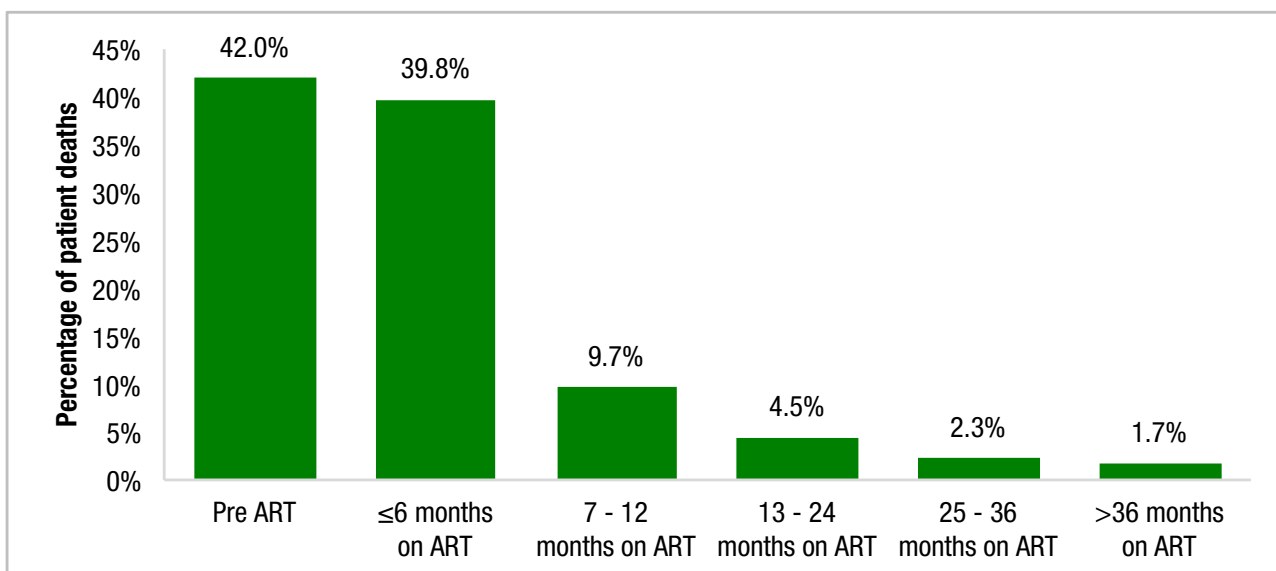
Retention in care and ART

Overall the programme had a very good retention rate of over 97% by end of the first year on treatment; and over 96% by the second year on treatment. A total of 70 (3.3 %) patients were lost to follow-up, and 90 (4.2 %) were transferred out to other health facilities for treatment. These are very good retention rates and, as shown in the figure below, high retention rates of over 96% were maintained up to the 6th year on treatment. Most loss to follow up and transfer outs occurred in the first one year of treatment.



Mortality

A total of 176 (8.3%) patients died between March 2009 and April 2015. As shown in the figure below, 42.0% of the 176 deaths occurred in the pre-ART period, and 39.8% of these deaths occurred in the first 6 months of ART. Deaths in the second, third and subsequent years on treatment were much lower.



Lessons learnt and best practices

Faced with overburdened public health systems, there is an increasing interest in the role that private providers, including public-private partnerships, can play in the delivery of ART. This case study provides useful lessons.

1. **The public private partnership model has shown good outcomes in terms of immunological (CD4 cell count) recovery and retention on ART.**

The essential lesson here is that well managed partnerships with general practitioners can achieve good outcomes. Peer-driven services from CBOs also play a critical role in helping patients achieve optimal adherence to ART and good retention in care.

2. **Training and continuous quality improvement is essential in maintaining good outcomes from a public private partnership.**

Given that HIV training is not intense during medical training in Myanmar, regular training on HIV clinical management forms a core part of ensuring that the quality of HIV services provided by the general practitioners continuously meets national guidelines. In this partnership, general practitioners were trained on: eligibility assessment, initiation, management of failure, switching to second line (among others), in line with the national HIV guidelines. The GPs were involved in regular case review conferences to support them with difficult clinical management decisions. These quality assurance strategies were essential in sustaining good outcomes.

3. **Provision of ART through private general practitioners can support decentralisation of ART, relieve over-burdened government health systems, and provide additional options for people living with HIV in terms of where they can access care.**

In this model, people living with HIV were allowed to choose their preferred general practitioner, and were able to build a long-lasting relationship with a consistent provider. In practice, clients chose private providers that practise closest to their homes, showing how important distances to health providers are to people living with HIV on ART.

4. **Existing community and private sector health system infrastructure and resources can be harnessed to increase coverage of ART without investing in new facilities.**

This model leveraged on existing community groups and community based organisations that were already providing peer-based community outreach testing, enabling them to work across the continuum of care by making referrals and providing essential adherence support. It also leveraged on existing private sector general practitioners who were already providing a wide range of primary health care services in their communities, and supported them to also provide ART. This ensured that the model built on and strengthened existing health and community systems, rather than establishing entirely new structures and clinics.

This case study exemplifies the Alliance role in increasing access to antiretroviral therapy through innovative partnerships which link communities and people living with HIV to quality HIV and health services. This vital role which the Alliance plays is expressed in our strategy. This case study also articulates how the PPP model demonstrates the Alliance Good Practice Programming Standards for HIV treatment, care and support:



Good Practice Standard G1 - Our organisation is committed to a client-centred approach to HIV testing and treatment that promotes autonomy and choice.



Good Practice Standard G4 – Our organisation supports people taking or in need of HIV treatment, including by providing treatment adherence support and treatment literacy programmes, and by advocating for HIV treatment access.

Way forward and overcoming remaining challenges

There are a number of areas that can be improved, the most important of which are:

- 1. Earlier detection and linkage to ART:** The average CD4 count for newly registered clients was just 177 cells/mm³. This is very low and shows that most people are diagnosed very late when the HIV is quite advanced. Further efforts are needed to ensure that people at risk of HIV are reached earlier with HIV testing and early linkage to care, including ART.
- 2. Preventing deaths during pre-ART and the first 6 months of ART:** In this model deaths were relatively rare. However, when deaths occurred, they were more likely to be among people in pre-ART care or during the first 6 months of treatment. This means that the programme needs to pay special attention to people living with HIV during pre-ART care and initial phases of ART. This is because these periods are particularly associated with higher risk illnesses and deaths, especially because most of the patients had low baseline CD4 count. For example, aggressive screening and management of infections and immune restoration syndrome, as well as close adherence, and nutritional support may be required during this period.

3. **Supporting access to viral load monitoring:** The achievement of good outcomes along the entire cascade of care is critical, and therefore although not available now, data regarding viral suppression will be needed in future. One way that this can be achieved is ensuring that routine viral load monitoring is available to all patients in the programme, not just those who are failing on first line treatment. This will require increased resources.
4. **Sustainability:** The ministry of health is committed to providing free ART to people living with HIV, with support from international donors, and has increasingly committed financial resources for ART. The engagement of private sector providers opens up the possibility that in the future, as the patients are stable and are able to generate income, those who are better off financially might be able to contribute partially to the cost of HIV care and thus make it more sustainable. In addition, close collaboration with public facilities makes it possible for patients to be transferred between private and public sector. However, for the time being, this model still needs to be supported by international donors, for example the Global Fund.

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Counsellors from CBOs performing a role play during refresher training.
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About the International HIV/AIDS Alliance

We are an innovative alliance of nationally based, independent, civil society organisations united by our vision of a world without AIDS.

We are committed to joint action, working with communities through local, national and global action on HIV, health and human rights.

Our actions are guided by our values: the lives of all human beings are of equal value, and everyone has the right to access the HIV information and services they need for a healthy life.

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About International HIV/AIDS Alliance in Myanmar

Alliance Myanmar has a vision of a world without AIDS. It empowers communities to play an effective role in the national HIV response in Myanmar and works through innovative mechanism to increase access to HIV prevention, treatment and care.

Established by the International HIV/AIDS Alliance in 2004, Alliance Myanmar is currently transitioning to an independent local organisation.

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