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Success and challenges of Public-Private Mix DOTS initiatives in Myanmar: a process evaluation for partnership approach of non-governmental organizations

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The study was conducted in three townships in which Public-Private Mix DOTS (PPM-DOTS) was implemented by three partners - Myanmar Medical Association (MMA), Population Services International (PSI) and Japanese International Cooperation Agency (JICA). It aimed to describe the process of implementing PPM-DOTS by the partners and to elicit their opinions on PPM-DOTS in order to take necessary actions. This study was a process evaluation which included desk review, opinion survey, in-depth interviews, key informant interviews and participation and observation of advocacy meeting and training on PPM-DOTS. Initiations of PPM-DOTS by each partner were different although all coordinated with National Tuberculosis Programme (NTP). More than half (54.3%) of general practitioners (GPs) had moderate level and 34.3% had very high recognition and acceptance of the need for partnership. For development of clarity and realism of purpose for partnership, 54.3% had high score. Most GPs convinced that their previous practices were not in line with NTP guidelines. Majority pointed out that proper advocacy for PPM-DOTS was crucial for success of future activities. Most respondents were aware many GPs needed to be involved, especially, GPs who were very good general practitioners known as "GP Kings". Almost all respondents highlighted that if there are fewer burdens for paperwork, more GPs would get involved in PPM-DOTS. Majority mentioned existing good personal relationship as success factor for PPM-DOTS. They also expressed trust building could be obtained by sharing information through regular contacts among each other. Based on the research findings, coordination mechanism among the partners in two pilot townships is initiated.

INTRODUCTION

There are many circumstances that are favorable for the initiation of Public-Private Mix Directly Observed Treatment Short course Strategy (PPM-DOTS) in Myanmar: political and economic changes, the introduction of an open market economy, increased demand by the general public for quality services, limited resources in the public sector, an increased proportion of public staff working also in the private sector, the increased involvement of non-governmental organizations (NGOs) in health care services, urbanization and diversity of health care providers in peri-urban and slum areas, and sub-standard practices in private sector. Most TB patients (73.3%) at public tuberculosis (TB) centre first sought care at general practitioners' (GPs) clinics [1]. Many patients (38.8%) shopped around more than two GP clinics before seeking care at public sector [1]. However, the current practices of GPs were not in line with National Tuberculosis Programme (NTP) guidelines [2, 3]. The rate of multi-drug resistant TB (MDR-TB) was significantly higher in patients sought care at GP clinics first before seeking care at public sector [4]. All these circumstances

were interrelated leading to the introduction of the public-private partnership. The incorporation of the private sector into the public sector to deliver DOTS in different ways could meet the community needs, shorten the diagnostic delay and prevent emergence of MDR-TB.

PPM-DOTS focusing on involvement of private GPs in TB control in Myanmar has been established since 2003. Currently, there are three NGOs involved in PPM-DOTS: Population Services International (PSI), Myanmar Medical Association (MMA) and Japanese International Co-operation Agency (JICA).

The MMA and JICA mainly aim for Scheme I for all GPs which stipulates that GPs refer chest symptomatic patients to the public sector and that they provide health education messages to TB patients. Scheme II includes all components of Scheme I and stipulates GPs provide Directly Observed Treatment (DOT) to their patients. The PSI implements Scheme III of PPM-DOTS which includes the provisions of all items specified in Scheme II and mandates GPs to run their clinics as NTP approved centres, i.e. diagnose and categorize TB patients, keep records and report TB cases to the NTP.

Although there are few success stories of PPM-DOTS in Myanmar [5], there is no study which searches for explanation of success and challenges. A process evaluation focuses on the internal dynamics and actual operations of a programme that attempts to understand its strengths and weaknesses [6].

In contrast to outcome evaluation which assesses impact of programme, process evaluation verifies what the programme is and how it is implemented. It also aims to provide managers feedback on the quality of implementation and increase utilization of research findings. For future planning and effective implementation of PPM-DOTS, it is necessary to assess the process of activities by different partners and to utilize lessons learnt from pilot projects in scaling up of PPM-DOTS in Myanmar.

Objectives

- To describe the process of implementing PPM-DOTS in Myanmar by MMA, JICA and PSI in collaboration with NTP
- To elicit lessons learnt and opinions of key partners on PPM-DOTS in order to take necessary actions
- To enhance utilization of research findings for more effective expansion of PPM-DOTS

MATERIALS AND METHODS

Study design

It was a process evaluation including both qualitative and quantitative methods.

Study areas

One township for each partner regardless of implementing schemes was selected. Three townships - Pyae, Pyin Oo Lwin and North Okkalapa Townships - were selected after discussing with three NGOs for PPM-DOTS and NTP.

Data collection

Desk review

All available documents on PPM-DOTS including policy guidelines, NTP annual reports, WHO review mission reports, conference proceeding or presentations and meeting minutes were reviewed and analyzed.

Opinion survey

It was conducted with all GPs (n=35) involved in PPM-DOTS with MMA, JICA and PSI by using pre-tested self-administered structured questionnaire including 10 questions. It was based on two principles of partnership: recognize and accept the need for partnership, and develop clarity and reasons of purpose for partnership [7]. The responses were measured in 4 point Likert scale -- strongly agree, agree, disagree and strongly disagree.

In-depth interviews (IDIs)

They were conducted with 13 GPs.

Key informant interviews (KII)

A total of 8 KIIs were conducted with public staff, Township Medical Officers (TMOs), Township TB Coordinators (TCs), Franchising Officer (FO) and Out Reach Workers (ORWs) from study areas to find out their perceptions towards partnership and collaboration.

Observation

Investigators participated and observed key activities on PPM-DOTS by different partners such as advocacy meetings, trainings and evaluation meetings.

Data analysis

Quantitative data from the opinion survey were cleaned and entered in SPSS version 11. Descriptive analysis was carried out by calculating frequencies and percentages. The scoring was given for responses to questions related to two principles of partnership. For the principle A (recognize and accept the need for partnership) and principle B (develop clarity and realism of purpose for partnership), scores were given as 16-20=high, 11-15=medium, 6-11= low and 5=very low. For aggregated score, it was given as 31-40=high, 21-30=medium, 11-20 = low and 10=very low, respectively [7].

Qualitative data were organized with the assistance of ATLAS ti version 5.0 software to conduct code retrieval, create cross link between different transcripts and net-working among relevant code family. Systematic contrasting and comparing among cases was carried out by sorting out similarities and differences.

Ethical consideration

Researchers followed the principles and guidelines of ethical consideration for privacy and confidentiality. This study obtained ethical approval from Ethical Review Committee of Department of Medical Research (Lower Myanmar).

RESULTS

Initiation of PPM-DOTS

Initiation of PPM-DOTS included how each partner conducted advocacy meetings, trainings and organizing GPs. The approach to initiate PPM-DOTS by each partner was slightly different although all coordinated with NTP. The PSI organized GPs through existing franchising network, MMA and JICA conducted advocacy meeting at township and organized GPs through existing continuing medical education (CME).

Advocacy meeting and training

For PSI, GPs were trained in batches, via a three-day training course for Scheme III. Once trained, the GPs received branded DOTS signboards to identify their clinics as sites for free TB treatment and diagnosis. The NTP provided TB drugs free of charge and PSI repacked in branded boxes and distributed to the Sun Quality Health (SQH) doctors. The JICA conducted advocacy meeting first before the training, TC went to GP clinics and invited the GPs for advocacy meeting. The MMA conducted advocacy meeting together with training of GPs. Personnel from NTP provided technical support and guidance for the training. The MMA implemented all schemes according to GP's preferences. Findings from KII and field observation showed only selected GPs were invited for advocacy meeting. Thus, not all the GPs in the township were informed about PPM-DOTS.

How GPs involved in PPM-DOTS

For PSI, SQH-GPs involved in PPM-DOTS through existing franchising network. Most GPs who involve in reproductive health, malaria and sexually transmitted infection projects were invited to attend training on DOTS. For JICA and MMA, GPs involve in PPM-DOTS through existing Continue Medical Education (CME) programme. GPs who attended regular CME were invited to attend PPM-DOTS training. At that time, they were not well informed about PPM-DOTS activities and their responsibilities.

Majority of respondents pointed out that initiation and advocacy for PPM-DOTS was crucial for success of future activities. It was also essential to desensitize public staff, physicians and GPs for essence of partnership, sharing information and credits among each other.

Understanding the concepts of PPM- DOTS

Some GPs perceived that the reason for initiation of PPM-DOTS might be due to the unsatisfactory case detection rate by public sector. Almost all GPs stated most patients seek their health care in private clinics and only by means of PPM, TB patients in the private clinic can be detected and be able to provide the appropriate treatment.

"The first contact of the patients is GP and all kinds of patients become intimate with us and they discuss with us in detail. They reveal their feelings frankly. So we can detect TB cases and persuade them to examine sputum etc. GPs play a key role in case detection".

(GP, 10 years GP service, implements Scheme I)

Partnership principles

More than half of GPs (54.3%) had medium level score and 34.3% of GPs had very high recognition and acceptance of the need for partnership, respectively. About 54.3% had very clear and realistic purpose of partnership (Fig.1).

Roles and responsibilities

The MMA-TC, JICA-TC and FO had different tasks, background and responsibilities according to implementing schemes and data needed for individual projects and funding agencies although all were local persons for PPM-DOTS in their respective townships. At advocacy meeting and trainings, GPs were informed about their responsibilities in general such as to refer TB suspects. Majority of GPs did not expect to take care of recording although they were aware to provide other tasks like providing health education.

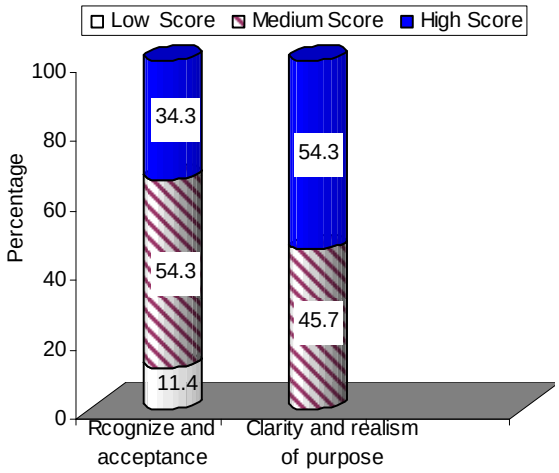

Fig.1. Opinions of GPs on partnership principles

"At first, I knew there were three schemes. Since I chose Scheme I, I need to refer TB suspects. I also explain patients to examine sputum and how to collect sputum. Then TB department examined sputum, diagnosed and provided treatment. They gave feedback to us."

(GP, 4 years GP service, implements Scheme I)

"Our responsibility is to detect TB cases and treat them. Others will be taken care by FO such as recording, reporting and defaulter tracing."

(PSI- GP)

Lessons learnt

<u>Strengths</u>

Main strength of PPM-DOTS mentioned by most respondents was benefits for TB patients. They can get treatment free at GP clinics which was more convenient for them. Increasing case detection, gaining new knowledge and better case management skill for GPs were also regarded as opportunities for GPs. Only a few expressed having risk of contracting TB and increasing workload especially paperwork as threads of PPM-DOTS.

"We are very happy to involve in PPM-DOTS especially as it has benefit for patients. That is the main strength. Weakness or risk is getting chance of TB infection. But as you know, we're exposed to

all kinds of infections. So there is no difference."

(GP, 24 years GP service, implements Scheme III)

"*Some GPs are reluctant to implement Scheme III especially whose clinics are attached to their home. They concerned of contracting TB infection to their family especially children."*

(MMA Staff-1)

Challenges

Challenges in implementing PPM-DOTS as identified by respondents were as follows:

- Burden for recording
- Frequent change of recording formats
- Reluctance of specialists to refer their cases
- Disorganizing in using anti-TB drugs/ patient kits by some GPs
- Wrong address given by some patients
- Difficulty in establishing private lab for Scheme III
- Some delay in issuing anti-TB drugs

Almost all respondents (GPs and key informants) highlighted problems in less familiarity to recording thus required to keep minimum and essential facts. Formats for records were not standardized and changed frequently. Some stated specialists did not want to refer their cases because they were afraid that medical officer would criticize their diagnosis. So specialists referred only confirmed sputum-positive cases to NTP and kept sputum-negative cases at their clinics. Although FO and ORW assisted PSI-GPs for recordings, they mentioned that few GPs were not well organized in using patient kits. Delay in issuing anti-TB drugs from NTP had been solved by providing patient kits during the study period.

Although many GPs were reluctant and complained for recording and implementing Scheme III, one PSI-GP shared her experience as a good example to make it simple:

"Many people asked me how I could manage so many cases. I can take care twice of existing patients, I would say. Patients find their kits by themselves. I've shown them how to do that at first time. Patient' kit has number (Fig.2) *and so he/she can find it and put it on this (showing a desk). Then I come out from examination room and give drugs and mark tick on treatment card. I only need to record treatment card. Others are taken care by FO. "*

(PSI- GP)

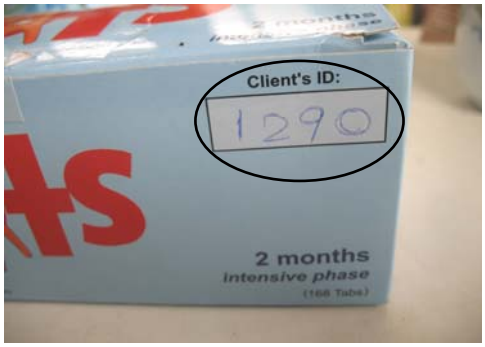

Fig. 2. TB patient kits showing patient's ID

Success

Indicators for success

Success indicators for PPM-DOTS as expressed by respondents were as follows:

- Increased number of cases/case load
- Improved case holding
- Decreased number of defaulters
- Increased number of TB cases detected
- Increased number of cure patients
- Increased number of GPs attended advocacy meetings and trainings

Contributing factors towards success

Almost all respondents pointed out good personal relationship as one of the key factors for success. Most GPs and key informants expressed understanding and trust building could be obtained by sharing information and regular contacts among each other. They pointed out that all should bear in their mind that they were working for TB patients and not for their personal

benefits or credits. Existing CME was a good way to organize GPs. Some GPs highlighted that uninterrupted supply of anti-TB drugs, enthusiasm and interest of TCs were also crucial for success and sustainability of PPM-DOTS activities.

"For success of PPM-DOTS, uninterrupted drug supply is essential. Understanding among each other and coordination are also important. We all should aware that we're working together for TB patients. It's not for our individual benefits. If we all convinced that, we can negotiate, understand, forgive even though there are some misunderstandings, conflicts or problems."

(GP, 15 years GP service, implemented Scheme II)

Suggestions

<u>How to organize GPs</u>

Proper advocacy and training played a key role to organize more GPs. Majority of respondents stated that GPs would be interested if they could learn recent treatment guidelines. Some also suggested meeting GPs in person by going from one clinic to another instead of sending invitation letters to them.

"I think it's better to go from one GP clinic to another and explain them well. It's more effective than just sending invitation letters to clinics. If we cannot persuade them once, we better try twice, thrice ect."

(GP, 30 years GP service, implemented Scheme III)

"Most GPs would come if they are invited..... and if there is no pressure for them. Pressure means... you know, if they think they are forced to do or something like that. GPs are independent people and so organizing GPs is different and delicate. Invitation letter should include agenda. GPs will come if they think they can learn something."

(GP, 12 years GP service, implemented Scheme III)

Some respondents pointed out that PPM should be targeted to the GPs who are permanently residing in local area and have many patients known as "GP Kings".

If I have to do this (organizing GPs for PPM-DOTS), I will make a list of "GP Kings" in this township, first. Then I will go to them and discuss in person for their contribution. There should be recognition or acknowledgement or incentives for them as well. If they do not come to us, we will have to go and meet them. I think it will work.

(GP, 12 years GP service, implements Scheme I)

<u>Keep recording minimum and simple</u>

Almost all key informants and GPs highlighted there should be fewer burdens of paperwork. They all convinced that if there were less paperwork, more GPs will involve.

"GPs did not expect to do such paperwork when they start involve in PPM-DOTS. We haven't told about that much. Now it becomes huge burden for GPs. So, if you ask me, I would say to reduce paperwork."

(MMA Staff-1)

"I want the PPM project to reduce paperwork and recording and keep them simple and minimum. Now, it becomes more and more data needed. If it happens like that, I'm afraid most GP would run away. GPs want to be independent and not to take care about data or records. They are only interested in clinical issue and treating patients. If there is more paperwork, PPM will not be successful and sustainable. Please consider this point seriously to expand PPM-DOTS for the whole country. Kindly include this fact in the report."

(NTP Staff-2)

<u>Enablers</u>

Almost all respondents pointed out that PPM-DOTS signboards of GPs' clinics should be striking so that general public would notice and impressed. Majority of key informants mentioned that appreciation

of individual GPs was also important since they did not have any financial incentives for involving PPM-DOTS. On the other hand, a few highlighted that it was essential to ensure incentives as motivating or enabling factors but not creating problems among implementing GPs and partners. Some emphasized that enablers or incentives for GPs and for patients provided by different partners should be similar.

"If budget permits, there should be better or grand arrangement for gathering of GPs - may be once or twice a year at the famous restaurant to exchange their experiences. And prominent or better quality signboard for MMA PPM-DOTS should be provided…Now it is not so impressive."

(Public Staff-3)

Sustainability

Regular drug supply, regular meetings, monitoring and supervision, recognition or acknowledgement of GPs for their contributions and motivation in kind of informal meeting were suggested by most of the respondents for sustainability of PPM-DOTS. One public staff suggested to send timely reminder to GPs who do not refer TB suspects and to acknowledge GPs who has detected many cases:

"For GPs, there should be regular reminder or acknowledgement about their referral. So they would become aware and interested in PPM DOTS. If such letters come from higher level, or divisional level, it's better."

(Public Staff)

DISCUSSION

Initiation and advocacy for PPM-DOTS was crucial for success of future activities. It was also essential to desensitize public staff, physicians and GPs for essence of partnership, sharing information and credits among each other. At the beginning of PPM-DOTS, GPs were not well informed about its activities and their responsibilities. The study conducted in 2003 found that 67.4% of GPs have heard about PPM [8]. In our study, most GPs had concept of PPM and positive aspects towards PPM-DOTS in terms of gaining new knowledge and convincing their previous managements were not in line with NTP guidelines.

More than half of GPs (54.3%) have moderate level and 34.3% had very high recognition and acceptance of the need for partnership, respectively. Acceptances of GPs for basic principles of partnership were good. The most concern for GPs as well as key factor for success of PPM-DOTS was found as less paperwork. Recording format was not standardized though all partners followed NTP guidelines. Most respondents suggested keeping recording minimum and simple which was similar to findings from previous studies [3, 8].

The study in two peri-urban townships in Yangon showed that lack of trust between public and private sector as barrier for partnership [8]. In our study, there was certain level of trust and understanding between public and private sector. However, most respondents also expressed weak coordination among PPM partners at the township level and limited awareness of each other's activities. This finding was similar to the findings from previous study that township level coordination was essential for successful partnership [8]. Trust building among all partners, public staff and GPs should be enhanced further by sharing information and regular contacts.

Conclusion

Good personal relationships among each other, fewer burden for paperwork, regular CME programme, regular drug supply, regular contacts and coordination among partners were main factors for successful and sustainable PPM-DOTS based on the research findings, coordination mechanism among the partners in two pilot townships has been initiated. The MMA aims to engage all GPs in PPM-DOTS by inviting all GPs for advocacy and to develop new signboard for MMA PPM-DOTS and to

keep paperwork and recording simple and minimum.

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REFERENCES

1. Mon Mon, Saw Saw *et al*. Knowledge of the disease and treatment seeking of TB patients in Yangon, Myanmar. *Myanmar Health Research Congress Program and Abstracts*, 2004; 8.
2. Saw Saw, Mon Mon *et al*. Existing practices of general practitioners on diagnosis and treatment of TB in Yangon. *Myanmar Health Sciences Research Journal* 2002; 14 (1-3): 12-16.
3. Saw Saw, Win Maung *et al.* Management of TB by public and private health care providers at the township level: situation assessment. *Myanmar Health Research Congress Programme and Abstracts*, 2008; 53.
4. Wah Wah Aung, Ti Ti *et al.* Drug resistance among TB patients who sought care at private sector before seeking treatment at public health services. *Myanmar Health Sciences Research Journal* 2005; 17 (3): 164-169.
5. Maung M, Kluge H, *et al.* Private GPs contribute to TB control in Myanmar: evaluation of a PPM initiative in Mandalay Division. *International Journal of Tuberculosis and Lung Diseases* 2006; 10 (9): 982-987.
6. Patton MQ. Utilization focused evaluation: the new century text, 1997; 206.
7. Hardy B, Hudson B & Waddington E. Assessing strategic partnership: The partnership assessment tool, 2003; Office of the Deputy Prime Minister, London.
8. Saw Saw. Strategies for public-private partnership in tuberculosis control: the involvement of private practitioners in Myanmar. *PhD Thesis*, University of Melbourne, 2007.