Improving access to effective treatment

Facilitating responsible access to a subsidized ACT through the private sector

Rationale and Concept

MoH Uganda / MMV collaboration
Malaria endemicity in Uganda

- Malaria infection prevalence (age <10) traditionally used to describe malaria endemicity (*Matseler and Van Theil, 1959*)
- ~90-95% of Ugandan population live in stable malaria (meso, hyper or holo-endemic)
- ~5-10% (about 15 districts) live in unstable or hypo endemic areas
Malaria transmission intensity - Recent data

Talisuna et al, 2002, Okello et al, 2006

- **ARUA**: AEIR=397, Obs PR=80.5, Prd PR=87.6
- **JINJA**: AEIR=562, PR=90.6, Prd PR=91.2
- **TOROROR OJINJAJINJA**: AEIR=1586, ObsPR=70.31, prdPR=100
- **KABAROLE MUBENDE**: AEIR=7, Obs PR=67.8, Prd PR=45.6
- **MUBENDE**: AEIR=6, Obs PR=67.8, Prd PR=45.6
- **RUKUNGIRI**: AEIR=4, Obs PR=57.3, Prd PR=40.3
- **TALISUNA**: AEIR=6, ObsPR=14.9, Pred PR=42.9
Has the pattern of malaria transmission intensity changed significantly from the 1960 levels? - Probably NOT

**Transmission intensity**
- Intensely malarious
- Moderately malarious
- Malaria near water
- Malaria free

Source: Pringle (1962)

Apac and Tororo remain intensely malarious

Arua still moderate to intense transmission

South Western Uganda remains low-medium transmission belt generally and prone to epidemics
Transmission intensity - Challenges for prevention and control

• Large differences in transmission intensity between different areas of Uganda
  – One size does not fit all-Need to adjust interventions
Malaria burden: morbidity

- Presumptive cases increased from 2,708,118 in 1991 to over 12,000,000 cases in 2005

Source: HMIS
Malaria burden: morbidity

- Cases per 1000 population have increased from 169 in 1991 to over 400 in 2004

Source: HMIS
Malaria burden: morbidity

- Proportion due to malaria at OPD has increased from ~20% in 1988 to over 50% in 2003

Source: HMIS
Possible reasons for the trends

- Abolition of user fees in 2001 leading to increased OPD attendance
  - Increased OPD contacts per person/year

Source: HMIS
Possible reasons...

- Improved quality and completeness of surveillance reporting

Source: Surveillance reports
Possible reasons...

• Inadequate coverage with cost effective prevention methods

Source: Health sector Annual report, 2005
Possible reasons...

- Increasing resistance to CQ and SP

Source: NMCP
Some progress in malaria control

• Successful change of first line treatment to artemisinin combination therapy (ACT)
• AL treatments available at health facilities through pull system
• Successful HBMF strategy (non ACTs)
  – ACT within HBMF being scaled up
  – But only caters to under 5s
  – Issues of sustainability
  – Attrition due to lack of incentives
• 16-30 % ITN coverage
• 20-40 % coverage with IPT2
Important ACT distribution gap remains

• ACTs unavailable through the informal private sector
  – Prescription only status
  – Too expensive

• Private sector key provider of treatment
  – 60-80% of Ugandans seek fever / malaria treatment through informal sector
    • Convenience, distance, lower costs
  – Effective anti malarials must be close to patients home to ensure access within 24 / 48 hour window
  – Back-up source of ACTs vital in event of stock-outs in public sector

• Today Chloroquine /SP remain the standard treatment in private sector!
Treatment actions for febrile children...where are we?

Health centres + HBMF = only 53 %

First Treatment Action

Mugaga et al, 2007, Rakai Uganda
### Caregivers perceived treatment failure by first treatment action, Rakai Uganda, 2006

<table>
<thead>
<tr>
<th>Action</th>
<th>Not recovered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health centre (Govt. or NGO)</td>
<td>15 %</td>
</tr>
<tr>
<td>HBMF</td>
<td>23 %</td>
</tr>
<tr>
<td>Private clinic</td>
<td>38 %</td>
</tr>
<tr>
<td>Drug shops</td>
<td>55 %</td>
</tr>
<tr>
<td>Use herbs</td>
<td>56 %</td>
</tr>
</tbody>
</table>

Partly due to differential quality of care and ineffective medicines

Mugaga, et al., 2007
Intervention has to be pro-poor.
First step in defining engagement with Private Sector: MOH / MMV Stakeholder Consultative Meeting
February 2007

Active participation from all stakeholders

Led by Ministry of Health
- National Malaria Control Programme
- Pharmacy department
- National Drug Authority
- National Medical Stores

WHO
MMV
AFFORD / MSH
PSI, Malaria Consortium, other NGOs

MU-IPH

Press
Key areas of agreement
MOH / MMV Stakeholder Consultative Meeting

- Urgent need to provide a highly subsidized ACT through the private sector (including unlicensed drug outlets)
  - Should complement public and formal private sector distribution
  - Explore alternative outlets for under-served rural areas
  - Use existing networks / structures
- Target all age groups (go beyond under 5s)
- Align National Drug Authority policies with proposed intervention
- Strong monitoring and evaluation component
- Should address issues of sustainability in design
- Details to be worked out by Task Force
Structure to move the agenda forward

- **Task Force Secretariat**: Prepares working documents and follows-up implementation
- **Task Force**: Discusses documents and proposals of Task Force Secretariat
- **Case Management Committee**: Reviews recommendations of Task Force and submits proposal to ICCM
- **Inter-Agency Coordinating Committee (ICCM)**: Reviews proposed strategy and submits to HPAC
- **Health Policy Advisory Committee (HPAC)**: Approves proposed strategy and recommends scaling up
Goals of the initiative

• To reduce malaria related death and disability by improving access to effective treatment - a subsidized ACT provided through the private sector (formal and informal)

• To inform national policy / international community on scaling up private sector distribution of a subsidized ACT and determine its place in the context of
  - Home based management of fever / community drug dispensers
  - No stock-outs in public health facilities
Specific objectives

Supply side

• Availability of the subsidized ACT in most retail outlets
• Improved management of malaria in the private sector
  – Dispensing the right drug, in right dosage, at the right price (subsidized) with adequate information to ensure correct use

Demand side:

• Prompt and appropriate health seeking behaviour
• Good compliance with treatment schedules

Health impact

• Reduced malaria related morbidity and mortality
Expected outcomes

• Functional system for distribution of subsidized ACTs through the private sector
• Reduction in the availability and use of ineffective antimalarials
• Reduction in the use of artemisinin monotherapy in the private sector
• Framework for monitoring the impact of private sector distribution of subsidized ACT on the malaria burden
• Key lessons, challenges and policy implications for national scale-up of private sector provision of ACTs
Principles of the pilot design

• Developed in a participative manner with communities, health services and key stakeholders
• Supply and demand surveys will guide the design and provide the baseline for future tracking
• The pilot study will be conducted as community intervention study in 6 districts with 2 control districts
• Powered to test different training approaches in districts
• Subsidized ACT available for all ages
• Continuous assessment to monitor impact
Study areas

Eastern Region
- Intervention districts: Palisa, Budaka, Kamuli, Kaliro
- Control district: Soroti

Western / Central Region
- Intervention districts: Kamwenge, Kabarole
- Control district: Mubende
Rationale for selecting the areas for the pilot

- Different transmission settings (one high and one low/medium)
- No other major malaria pilot on-going
- District borders within Uganda
  - Any drug leakage stays within Uganda
- Not over-studied areas
- Homogeneous populations with similar dialects who can understand each other
  - 2 languages or less can be used for IEC purposes
- Predominantly rural populations
  - undeserved with health services, more stable, more cooperative
  - constitute the majority of Ugandan population
First step: Understanding antimalarial reality in study areas
June – September 2007

• The Antimalarial market
  – Who sells antimalarials? What type of outlet?
  – What type of antimalarials are sold? What price?
  – Where do the drugs come from?

• Patients
  – What drives choice of outlet and antimalarial?
  – What is their experience with treatment?
  – How can their access to treatment be improved?

• Impact of malaria
  – What is the occurrence of severe malaria?
  – Absenteeism from schools (teachers and children)
Key activities:
Ensuring broad-based buy-in

• Obtaining endorsement of wider distribution and use of subsidized ACT by
  – National health authorities
  – Health services (public and private)
  – Manufacturers and the trade
  – Communities
  – Media and opinion leader
Key activities: Establishing the right policy framework

• Ensuring National policy and regulatory preparedness
  – Alignment of national regulations with the pilot e.g.
    • Provide limited OTC status to ACTs
    • Define outlets authorized to stock subsidized ACT
    • Introduce limited price control / recommended sales price / transparency (e.g. cotton)
    • Approval of re-branded ACTs
Key activities: Ensuring sound supply chain management

- Ensuring adequate stocks through the supply chain
  - Quantification of needs
  - Buffer stocks to meet fluctuation in demand
- Providing incentives for wholesalers and retailers
  - To ensure stocking at a large number of outlets within easy reach of communities
  - To limit distribution of the product to the study areas
  - To sell at the recommended sales price
Key activities: Provider Training and supervision

- Ensuring improved management of malaria in the private sector
  - Correct dispensing of ACTs
  - Recognize warning signs to advise referral
- Establishing links between the health services and dispensers
Key activities: 
Launching a strong marketing campaign

• Developing an appropriate product offering
  – Re-branding of public sector ACT for private sector use
    • To differentiate from public sector offering
    • To reduce the impact of drug leakage on the trade
    • To create “umbrella branding” for MoH approved products
      – To ensure inclusion of more ACTs in line with future changes to national policy
  – Clear and easy to follow dispensing and user instructions

• Designing effective communications to generate demand and change behaviour
  – Private sector (to stock subsidized ACT and dispense correctly)
  – Care givers (to seek timely treatment and provide ACTs correctly)
Strong Monitoring and evaluation component

Key questions

• Geographical access:
  – Is the subsidized product on the shelves? At what types of outlets? How far from communities?
  – Is private sector distribution of ACTs synergistic to home based management of fever?

• Trade stocking /dispensing patterns
  – Has the subsidized product displaced currently used antimalarials?
  – Are ACTs being correctly dispensed?

• Use
  – Are ACTs being correctly taken?
Strong Monitoring and evaluation component

Key questions

• Financial access
  – What price are consumers paying?

• Equity
  – Is it being purchased by the poor?

• Health impact
  – Has the proportion of children receiving prompt treatment with ACTs increased?
  – Has school absenteeism fallen?
  – Has the occurrence of severe malaria decreased?
Key steps and timelines in the process

- Understanding the current situation: June – September 2007
- Designing the intervention: Consultative meetings: Sept - October 2007
- Preparatory Phase: Oct - December 2007
- Launch of intervention: January 2008
- Monitoring and evaluation: June / Dec 2008
- Policy recommendations: Jan 2009