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Assessing access to insulin in Mali, Mozambique and Zambia

Insulin treatment is essential for the survival of people with Type 1 diabetes. But uninterrupted insulin supplies are not available in many developing countries. Researchers from University College London (UK) tested a Rapid Assessment Protocol for Insulin Access (RAPIA) in Mali, Mozambique and Zambia to identify barriers to good diabetes care.

An estimated 35,100 African children are living with type 1 diabetes. Patients with this disease need an ongoing supply of insulin, syringes and monitoring. They also need access to a health care system staffed by trained health workers able to provide these supplies. The RAPIA aims to assess all these factors through a protocol that is rapid, cost-effective, uses multiple data sources, and is practical rather than scientifically perfect.

RAPIA consists of a series of questionnaires and a protocol for gathering other data through site visits, discussions and document reviews. Countries can choose from a range of data collection tools for their own situation. The researchers implemented the protocol in three areas in each country: the capital city, a large urban centre and a mainly rural area. The process involved a total of 472 interviews and group discussions.

In each country, RAPIA delivered information covering:

- estimates of diabetes prevalence and life expectancy in different areas
- purchase procedures, pricing, distribution, supply and availability of insulin and syringes throughout the country
- levels of diabetes care in different facilities
- availability and cost of diagnostics
- levels of health worker training
- role and activities of diabetes associations
- policies regarding diabetes
- role of traditional healers
- other barriers to care and insulin, such as travel, distance and cost.

The protocol was developed to help make recommendations to national ministries of health and diabetes associations. The researchers report other benefits from its use, including:

- collecting valuable information on patients' access to insulin, syringes, monitoring and care
- bringing diabetes to the attention of the health authorities through the involvement of local stakeholders
- raising the profile of diabetes associations
- improving public awareness of diabetes and other non-communicable diseases (NCDs).

Type 1 diabetes may be a marker for effective health care systems. Continuous supplies of drugs, diagnostic facilities, health worker training and retention, and patient education are vital in the management of other NCDs and chronic communicable diseases such as tuberculosis and HIV. The researchers conclude that health planners could use this tool to assess the capacity of their health system to deal with all chronic conditions.

David Beran
International Insulin Foundation, International Health and Medical Education Centre, University College London, Holborn Union Building, Archway Campus, 2-10 Highgate Hill London N19 5LW, UK
david.beran@access2insulin.org

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Joint TB/HIV activities are more cost-effective in South Africa

South Africa has the largest number of people living with HIV and AIDS in the world – an estimated 6.29 million people. The country has also seen a related increase in incidence of tuberculosis (TB). National reviews have recommended joint TB/HIV programmes but how affordable are they?

Researchers from the University of the Western Cape (South Africa) and the London School of Hygiene and Tropical Medicine (UK) looked at a community health centre, a primary health care clinic and a sexually transmitted infections (STI) clinic in Cape Town. These were among 12 pilot facilities in one of four TB/HIV pilot districts in South Africa that used ProTEST, a package of joint TB/HIV interventions supported by the World Health Organization (WHO).

The interventions in ProTEST were: voluntary counselling and rapid testing (VCT); screening for TB through intensified case-finding (ICF), isoniazid preventive therapy (IPT) and cotrimoxazole preventive therapy (CPT); and improved management of HIV-related opportunistic infections. The costs and estimated cost-effectiveness of these interventions were measured.

They found that total costs varied widely among the facilities, ranging from US$7-11 for VCT, US$81-166 for detecting a TB case, US$92-183 for completing IPT, and US$20-44 for completing six months of CPT. Staff accounted for the highest proportion (78-85 percent) of total costs, while supplies including HIV tests, isoniazid and cotrimoxazole were a much lower proportion (11-17 percent). Results showed that:

- the estimated cost per HIV infection averted by VCT was US$67-112; this compared favourably with other HIV prevention interventions
- the cost of HIV counselling and testing per person was lower in the STI clinic due partly to the use of lay counsellors
- the cost per TB case prevented through VCT (by preventing HIV) was US$129-215, by ICF was US$323-664 and by IPT was US$86-962; these were all less than the cost of treating a new case of TB as reported in a previous study from Cape Town (estimated at US$823-1,362)
- the use of chest X-rays for IPT screening decreased the cost-effectiveness of IPT in TB prevention by 36 percent

The researchers argue that the ProTEST package is cost-saving in South Africa. In particular, VCT was less expensive than previously reported in other African countries. They recommend that:

- VCT services should be expanded for prevention and to link HIV-positive clients to care and support
- ICF, IPT and CPT should be available at all primary health care facilities in South Africa for HIV-positive clients
- when assessing the affordability of these interventions in other settings, policymakers should consider the high proportion of total costs attributable to staff and the fact that salary costs are lower in many other African countries.

Harry Peter Hausler
School of Public Health, University of the Western Cape, PO Box 51093, Cape Town 8002, South Africa
T +27 82 779 0045 **F** +27 21 438 7148
hhausler@uwc.ac.za

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What do people think about mental health care in Pakistan?

Mental health problems affect people throughout the world. In low-income countries, improved treatment and prevention strategies are needed. To be effective, these must be informed by knowledge of who is providing mental health care and how clients view the different forms of care available.

In Pakistan, there is relatively little research evidence available on mental health provision and user perceptions. A team of researchers from the Department of Psychiatry and Behavioural Sciences, Fatima Jinnah Medical College, Lahore (Pakistan) and the Institute of Psychiatry, London (UK) was invited to conduct a study in the small town of Choti in the Punjab, in order to describe the types of mental health care providers that are available, and clients' perceptions of the effectiveness of the different types of treatments offered.

The study involved a mental health consultation day, in April 2004. A total of 462 people attended the consultation day, of which 322 consented to participate in the study. 157 were 18 years or older. Questionnaires were used to gather information from clients while they were waiting to be seen by the psychiatrist. The questionnaires were in English and conducted by trainee clinical psychologists.

Five different types of health care provider were identified: general practitioner, religious healer, Hakim (traditional medicine), homeopathic doctor and faith healer. The general practitioner was the most commonly consulted. Clients considered general practitioner treatments to be the most effective.

The team report the following findings:

- The most common condition was depression (107 people).
- Most conditions were chronic, but the duration was shorter for depression than for other illnesses.
- Almost all patients thought their condition was treatable, but some stigma was associated with mental disorders: 22 percent said they hide their illnesses.
- A majority (52 percent) believed that mental disorders were due to problems in the mind, while 25.3 percent thought they were physical and 11.3 percent said they were a combination of both. A small number (6.7 percent) said they were due to magic.
- 56 percent of those who sought treatment for depression from a general practitioner considered their treatment effective. For other mental illnesses this figure rose to 78.4 percent.

The results point to a difference between peoples' beliefs and knowledge about available treatments. Lack of information makes it difficult to assess the effectiveness of the different treatments. The following recommendations are made:

- The variety of different types of health provider demonstrates a need to broaden the focus of research into primary mental health care in Pakistan.
- Further work is needed to map the similarities and differences in practitioners' knowledge of mental health.
- Drug treatments given by general practitioners need to be compared with the standardised treatments offered by homeopaths and Hakims.
- There is a need to further describe and standardise the mental health treatments offered by primary care providers, including both physical treatments, and spiritual and psychotherapeutic techniques.
- Improving patients' knowledge about primary mental health treatments would help set standards for treatment and may prevent conditions from becoming chronic.

Ilyas Mirza
Institute of Psychiatry and WHO Collaborating Centre for Mental Health, Rawalpindi Medical College, Murree Road, Rawalpindi, Pakistan
T +92 302 450 1584
iqmirza@gmail.com

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Can poor people access effective malaria treatment in Tanzania?

As Tanzania prepares to switch to artemisinin-based combination therapy (ACT) as its first-line anti-malarial treatment, researchers investigate the link between socio-economic status and access to effective treatment.

The research, involving the Ifakara Health Research Centre, the US Centres for Disease Control and Prevention and the London School of Hygiene and Tropical Medicine (UK) used blood samples and data on socio-economic status from 2,500 households in three rural districts in southern Tanzania. Half of the households completed a detailed questionnaire and were divided into three socio-economic groups. Key results include:

- There is no difference in reported fever between socio-economic groups.
- Better-off people are less likely to have malaria parasites in their blood than the middle or poorest groups, but more likely to get anti-malarial drugs for fever.
- One third of people with fever spend nothing on their treatment. The rest spend between US$0.0056 and US$5.50 per episode. Drugs are the biggest cost, followed by transport.
- Costs at non-governmental organisation (NGO) facilities are three times higher than at drug stores, seven times higher than at government clinics and 16 times higher than at general stores.
- The better-off spend two to three times more than the other groups, due to greater use of NGO facilities and higher expenditure generally.
- Location, religion and perceived severity of the illness also influence expenditure.

Only eight percent of the poorest people, six percent of the middle group and 19 percent of the better-off receive an adequate dose of effective anti-malarials. However, Tanzania switched to sulphadoxine/pyrimethamine in 2001 (after this survey) and since then, the proportion of people receiving effective anti-malarials has more than doubled to 34 percent. It is vital that the impending switch to ACT increases this proportion further. The researchers make the following observations:

- Government facilities are used by only a quarter of care seekers. This may change when they offer a more effective drug.
- ACT use could be increased by expanding distribution through the retail sector, especially drug stores, which are commonly used and whose staff have some medical training. However, the poorest people will need substantial subsidies to afford ACT.
- There is a need to improve drug dosage and adherence, possibly through pre-packaging, better instructions and patient education.
- Recommendations to countries to switch to ACTs must go hand in hand with strategies to improve anti-malarial coverage and use.

Joseph Njau
Ifakara Health Research and Development Centre, PO Box 78373, Dar es Salaam, Tanzania
T +255 222 744714 **F** +255 222 771714
jnjau@ihrdc.or.tz

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id21
Institute of Development Studies
University of Sussex
Brighton, BN1 9RE UK

T +44 (0) 1273 678787
F +44 (0) 1273 877335
E id21@ids.ac.uk

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Keywords: diabetes, insulin, sub-Saharan Africa, tuberculosis, TB, HIV, AIDS, cost-effective interventions, Mali, Mozambique, Zambia, South Africa, voluntary counselling and testing, mental health care, Pakistan, malaria treatment, Tanzania, access to health services