Beyond the public sector: Lessons learned through early ACT deployment in Zambia

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American Society of Tropical Medicine and Hygiene Annual Conference

Philadelphia, 5th November, 2007

Background – malaria in Zambia

- Leading cause of illness and deaths
- Predominant parasite: *P. falciparum*
- Vectors: *An. gambiae* and *An. funestus complex*
- 4 million clinical cases per year
- 6,500 deaths (HMIS 2006)
- In-hospital CFR: 49/1000 admissions

Priority malaria interventions

- Case management
  - with ACTs (Coartem©) as first line treatment
  - improvements in diagnostic services using microscopy and RDTs
- Prevention
  - Insecticide-treated mosquito nets (now LLINs)
  - Indoor residual spraying (IRS) in 15 mainly urban districts
  - Prevention of malaria in pregnancy, including IPT(SP) and ITNs

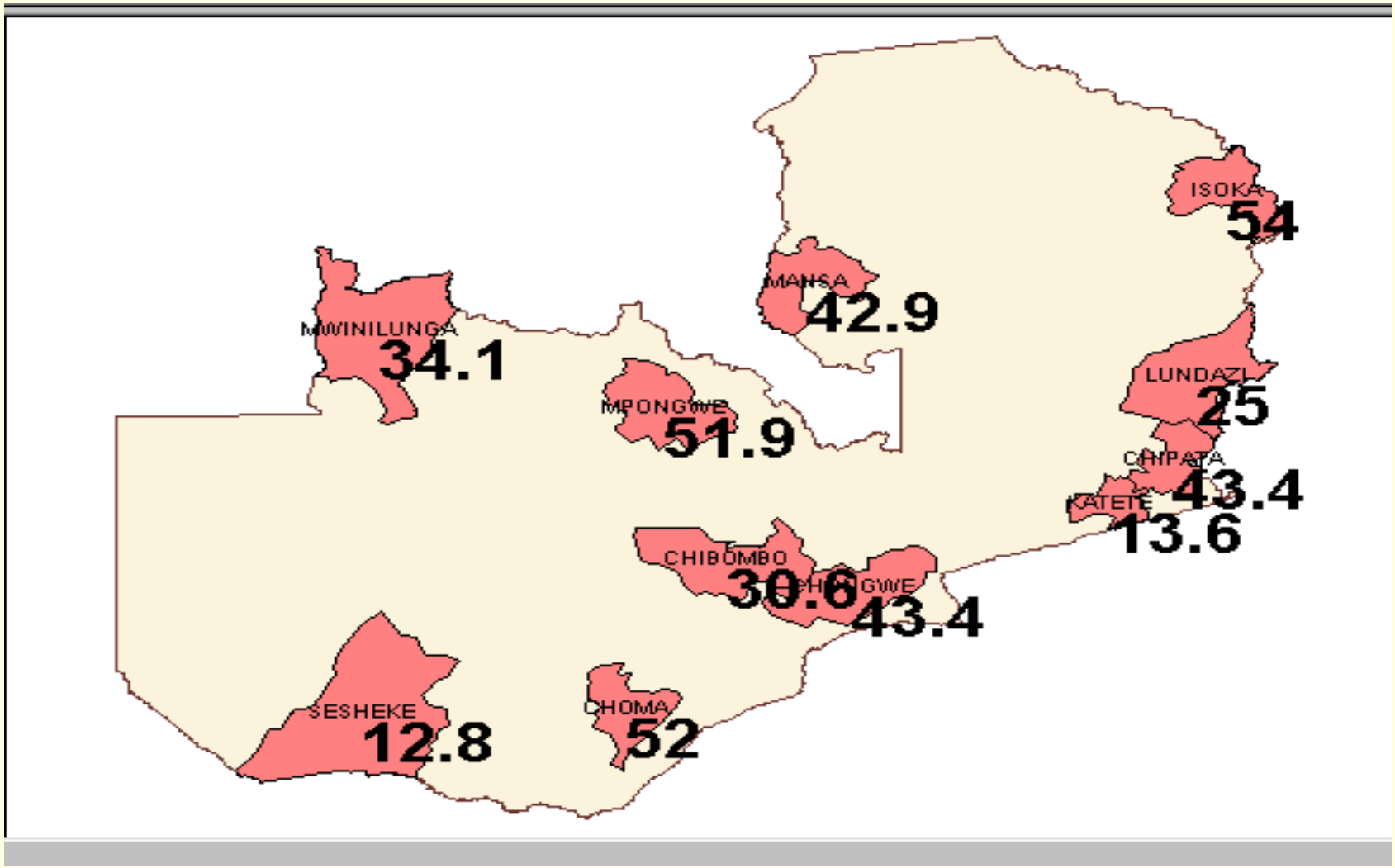
Health System Context

- Ministry of Health HQ
  - National Malaria Control Center: MOH + many partners
- Decentralized system
  - Provincial Health offices (9)
  - District health management teams (72)
- Health facilities, NHCs, CHWs
- Drugs centrally procured, free in public health facilities
- Autonomous pharmaceutical regulatory authority
- Distribution subcontracted to Medical Services Ltd

Historical Context

- Chloroquine first line for more than 40 yrs
- SP adopted as second line
- Quinine – for severe and complicated disease
- CQ treatment failures rose from 0% (1980) to 50% (2002)
- Malaria incidence increased ~3-fold (HMIS)

Treatment Failure Rates (%) to CQ by 2003



Policy Change Process

- Consultative process
- Review of available evidence
- Stakeholder management
- Review of global position on malaria treatment policy in SSA
- Review goals on the NHSP
- Policy adoption and dissemination
- Develop implementation plan for roll out

Policy Statement

- Uncomplicated malaria: Artemether-lumfantrine
- Severe malaria : Quinine
- Children <5kgs: Sulphadoxine-Pyrimethamine (SP)
- Malaria in pregnancy
  - Quinine 1st trimester
  - SP 2nd and 3rd trimester of pregnancy and for IPT

Policy Implementation

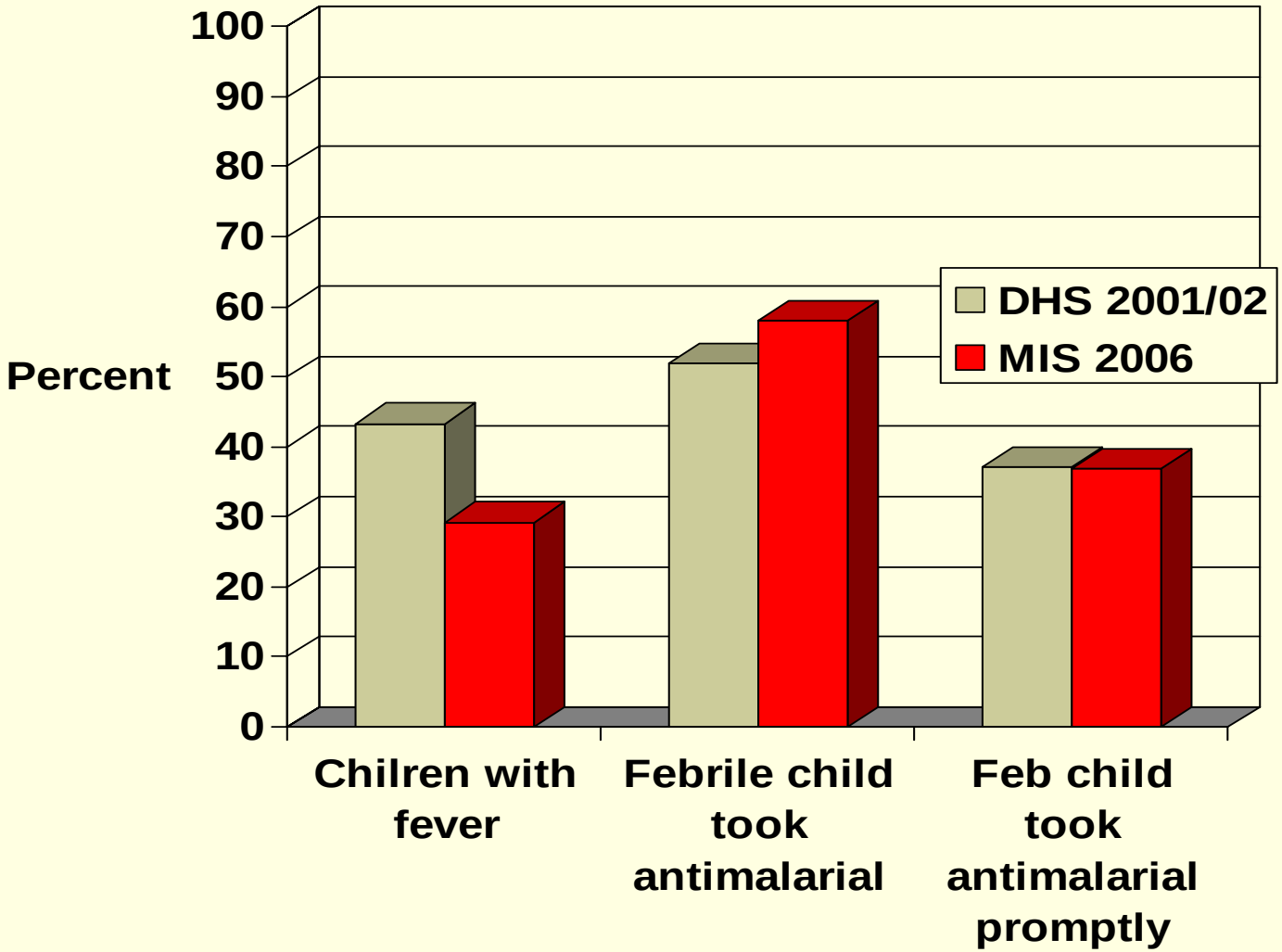
- Phased approach:
  - Started in 7 pilot districts (Feb 2003)
  - Scaled up to 28 districts (Nov 2003)
  - Further scaled up to all 72 districts (Nov 2004)
- CQ use was discontinued in all health facilities
- Used SP in the interim

Essential Actions

- Procurement, supply and distribution systems developed
- Front line health worker orientation on treatment guidelines
- Extensive IEC for patients and providers
- Drug efficacy monitoring
- Pharmacovigilance (incl. pregnancy registry)
- Compliance monitoring

Comparisons: Children with fever and taking antimalarials

DHS 2001/02 compared to Malaria Indicator Survey 2006



Progress in support systems

	2004	2006
A-L wall charts	20%	75%
Availability of treatment guidelines	58%	92%
Inservice training on A-L	25%	41%
RDTs	0%	63%

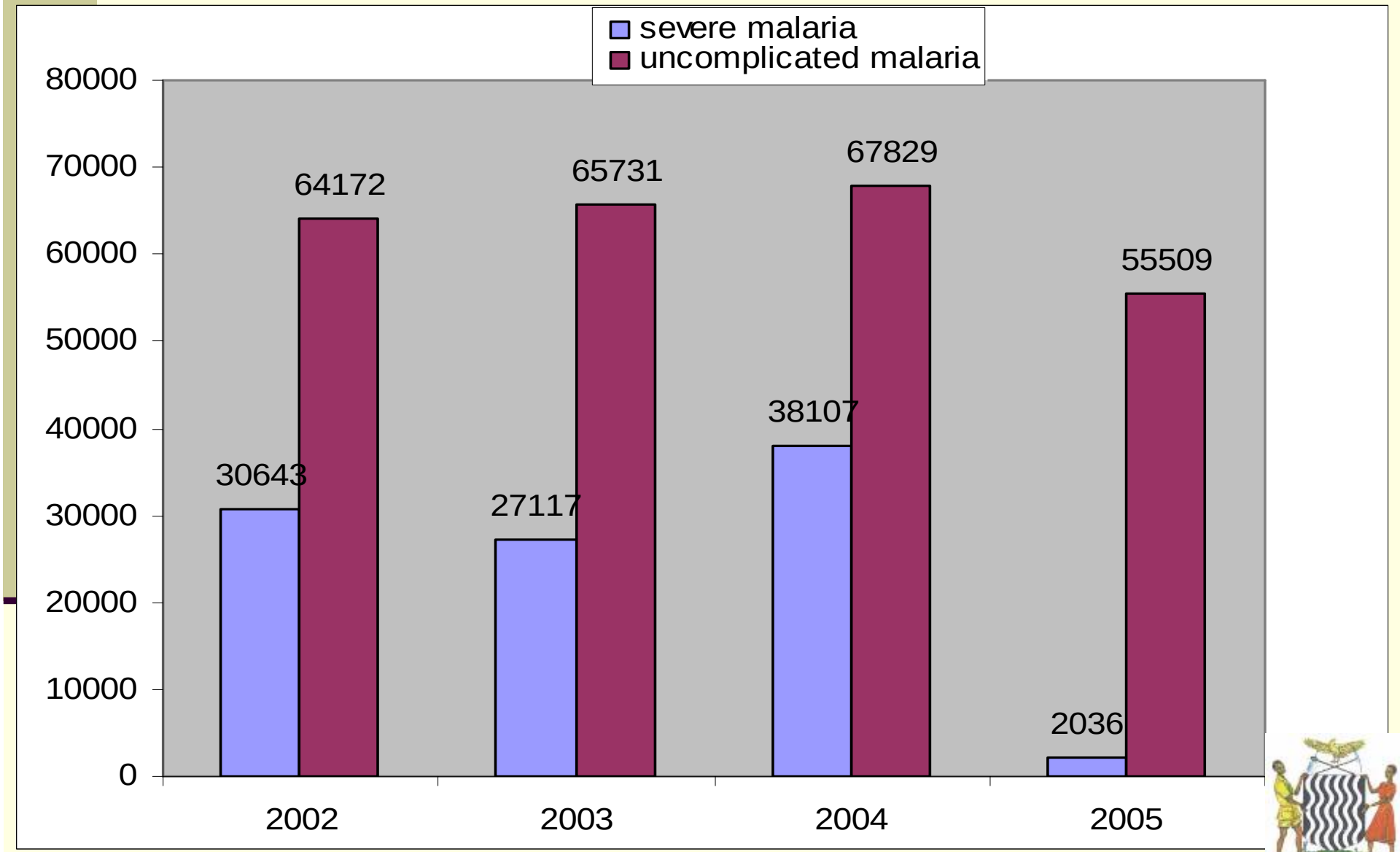
Progress in support systems

	2004	2006
Microscopy	17.0%	17.3%
Availability of AL	51%	60%
Availability of SP	100%	92.3%
Quinine	75%	80%
Chloroquine	75.5%	0%

Proportion of children with uncomplicated malaria treated

Characteristics	2004	2006
AL	10.7%	42.2%
SP	67.5%	27.6%
Quinine	4.8%	7.0%
5-9kg with AL	1.1%	27%
Chloroquine	0%	0%

Trends in Malaria Morbidity at Selected Health Facilities



Ministry of Health

Achievements

- ACTs rolled out to all government and mission health facilities for FREE
- Improved health worker readiness to deliver ACTs
- Increase in number of children treated with ACTs
- Ongoing efficacy, safety and compliance monitoring
- Cost-effectiveness analysis completed
- Improved diagnostic capacity
- Pregnancy registry on going

Lessons Learned

- Policy change is only the start of a lengthy process to introduce and implement the new policy
  - High level involvement needed at various stages of the policy change process
  - Evidence base for policy decision making is required
  - Implementing malarial drug policy change is costly
  - Phased approach was key to the success

- Effectiveness = efficacy + coverage + compliance

Lessons Learned

- **The two misses**:
  - Home management of malaria
  - Private sector engagement
- Harnessing the partnerships
- Training of frontline health workers in the revised treatment guidelines
- IEC needs were underestimated
- Improved diagnostic capacity is critical
- Implementing a dual/phased policy change is challenging

Way forward

- Improving drug logistics management at all levels
- Implementing the private sector component
- Deployment of ACTs with diagnostics including RDTs for home management of malaria
- Improving management of severe malaria

Conclusion

- Zambia has a strong public sector and case management improvements through these existing systems is now advancing and being prioritized
- Improving access to prompt and effective case management cannot be achieved by the public sector alone
  - Other service providers need to be brought on board : Private & community

Thank you