CCAM IN PARTNERSHIP WITH CDBPH

POLICY BRIEF ON SCALING UP MALARIACONTROL INTERVENTIONS IN CAMEROON

Key Messages & Executive Summary

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Preface

The concept of Evidence Informed Policy Making is new and has come into focus in recent years, as a result of the observation that in the past, many a policy has been based on impression or how the boss sees it or what we think should be, to the extent that some policies are based on fallacy and ideology which when tested prove to be contrary to the reality.

It is therefore of utmost importance that policy-makers should use as basis proven facts in order to make policies. The example of the belief that Sudden Infant Death Syndrome (SIDS) was thought to be due to the situation whereby a baby is made to lie on their back which therefore made paediatricians to advise caretakers that babies should be laid instead on their bellies, which later on, following scientific studies, it was demonstrated that there is a predisposition at the brain of such babies who do not survive low oxygen level in their brains, and most of them die when lying on their bellies because breathing is compromised to some extent and therefore oxygen level in the body/brain, and that fewer deaths occurred when such children lie on their backs, completely reversed the attitude that was advised by paediatricians to the caretakers of young babies. This is just one among several examples and just to emphasis the importance of evidence to inform policy.

It is in this perspective that CCAM and partner CDBPH embarked on this project funded by WHO to research and write a policy brief on Scaling Up malaria Control interventions in Cameroon, which is aimed at providing evidence in line with the problem of these interventions not effectively reaching the people, such that these facts shall be taken into consideration when Cameroon engages in the universal coverage with malaria control interventions.

This comes at a time when the world has engaged to support all malaria endemic countries to achieve universal coverage, sustain it and move towards malaria elimination with the magic target of achieving universal coverage in all countries by December 2010.

Cameroon is ready to join the other endemic countries in achieving this target thanks to double funding from the Global Fund to Fight HIV, TB and Malaria in the 6th round in 2004 and the 9th round in 2009.

This policy brief is therefore timely and it is our hope that it will contribute in helping the policy-makers in Cameroon ensure that all malaria control interventions are reaching the people in an equitable manner and with their active participation to ensure sustainability, while addressing all the bottlenecks that may refrain this from being achieved.

Key messages

- Cameroon, Africa in miniature, presents diversified epidemiological strata of malaria transmission along with the corresponding parasites and vectors. Malaria continues to be endemic and the first major cause of morbidity and mortality among the most vulnerable groups - children under 5 years pregnant women People Living With HIV/Aids (PLWHA) and the poor accounting respectively for 18, 5, 5.5, and 40 percent of the total population estimated at 19 million.
- In spite of the efforts deployed by the National Malaria Control Program and its partners, the actual coverage and use of malaria services and commodities are dramatically below the national targets set in line with the Global Malaria Action Plan. Households with children aged below 5 years and pregnant women have benefited from free Insecticide treated Nets (ITNs) and the entire population from highly subsidized Artemisinin-based Combination Therapy (ACTs). However, the subsidized ACTs and SP for IPTp are unevenly available due to inadequate prescription by providers, multiplicity of licensed anti malarial drugs (over 90 in circulation) and frequent stock-outs. LLINs are not available for purchase for the non targeted groups. Recently proven effective control interventions are not available. Control strategies are not customised to epidemiological profiles of malaria and are mostly health facility based.
- Financial barriers, low utilisation rate of available interventions and low utilisation rate of health facilities stand as immediate causes to the low coverage of Malaria Control interventions (MCI).
- This evidence-based policy brief proposes remedial strategies to increase the coverage and utilization rates of the effective malaria control interventions targeting the whole population at risk as appropriate. These strategies include:
  - **Governance arrangements:** (i) Clearing the drug market of all antimalarials that are not in the national policy (Artesunate-Amodiaquin and Artemether-Lumefantrin for uncomplicated malaria and Quinine for complicated, Sulfadoxine Pyrimethamine for IPTp), (ii) Enforcing regulation through reinforced inspection and supervision activities, (iii) Shifting from the current unified approach to specific strategies according to epidemiological profiles and the emerging trends such as co-morbidity with HIV/Aids and, (iv) Transferring greater responsibilities to and empowering municipalities-communities for comprehensive and integrated malaria control interventions
  - **Delivery arrangements:** (i) Shifting from the current unified approach to specific strategies according to epidemiological profiles and the emerging trends in the epidemiology of diseases for example: Introduce the Intermittent Preventive Treatment for infants and preschool children living in high and moderate transmission zones and for PLWHA, (ii) Distribution of LLINs, IPTp, IPTi, IPTc by the communities supported by NGOs, CSOs, Community Health Workers (CHW) and Community Based Associations (CBAs) as it is the case with CDTI and , (iii) Fostering public private partnerships through Service Level Agreements (SLA) or Performance Based Contracting (PBF) as appropriate e.g. pharmacists selling only commodities and drugs recommended by the national policies, Effective private marketing approaches for LLINs distribution.
  - **Financial arrangements:** (i) Secure and sustain subsidies for IPT, LLINs and ACTs and, (ii) Financial incentives for pharmacists and prescribers who comply with regulations.
  - **Implementation considerations: (i)** Barriers such as resistance to change, low budget allocation to health, failure of the procurement chain, and inadequate knowledge among the stakeholders both on malaria and its effective control strategies, insufficient capacities of community stakeholders to take ownership; and **(ii)** Effective Strategies such as communication, education, advocacy building on the "malaria competence approach".

Executive summary

In Cameroon, malaria continues to be endemic and the first major cause of morbidity and mortality among the most vulnerable groups - children under 5 years pregnant women People Living With HIV/Aids (PLWHA) and the poor accounting respectively for 18, 5, 5.5, and 40 percent of the total population estimated at 19 million. This means that 2/3 of the population is vulnerable to malaria

In spite of the efforts deployed by the NMCP and partners, the burden of malaria has remained the same over the past decade and the actual coverage and use of malaria services and commodities are still significantly behind the targets set in line with the Abuja commitments and the Global Malaria Action Plan goals on universal coverage for 2010.

According to Demographic Health Surveys 2004, MICS 2006, NMCP 2008 annual report, malaria accounts for 35 to 43% of all deaths in health units, 50 to 56% of morbidity among children under the age of 5, 40 to 45% of medical consultations and 30% to 47% of hospitalizations. It is also the cause of 26% of absences in the workplace and 40% of the health expenditure of households. Malaria is responsible for 49 % consultations and 59% of hospitalisations during pregnancy leading to abortions and premature labour and deliveries as well as low birth weight all exposing the babies to early deaths and mothers to death during delivery.

Data on coverage on malaria control interventions show that only 13.1 % of children aged under five years sleep under insecticide-treated mosquito nets, 37% of pregnant women received the second dose of Sulfadoxine Pyrimethamine and only 58% of complicated cases of malaria are promptly and properly managed. In a recent study in Obala Health District, the coverage was as follows: 15.1% for ACTs, 41% for LLINs, 67% for IPT2.

The burden of malaria stems from **the epidemiological and poverty profiles** that are inappropriately addressed in the formulation of the national strategies. The latter are not customised to local needs and are mostly health facilities based, consequently not reaching those most in need. In addition, some recently proven effective control interventions are not included within these strategies.

Based on the transmission pattern, the epidemiologic profile of malaria can be further categorised into 3 types: (i) **Endemic and perennial** zones of continuous transmission (7 to 12 months) covering the South Cameroonian Equatorial forest, the High western plateaux altitude and the Coastal region where about a hundred infective bites per man per month can be registered, (ii) **Endemic and seasonal** zones of long seasonal transmission (4-6 months) covering High inland plateaux (Adamawa) and the Savannah-forest transition regions where about twenty infective bites per man per month can be registered and, (iii) **Epidemic or strongly seasonal** zones of short seasonal transmission (1-3 months) covering the Sudano-sahelian region where about ten infective bites per man per month can be registered.

According to the last House Hold Survey (INS, 2007), 40% of the population are living under the poverty line with 55% in rural as against 12.2% in urban. The low purchasing power of this poor section of the population contributes to reduce their access to malaria control services.

From the results of Systemic Quality Improvement assessment of the performance of Health districts and regional health facilities carried out in 2007/08, service organisation and delivery is generally not satisfactory. Further more, LLINs are not available for purchase for the non targeted groups and also absence of an in-built mechanism within the health system to stimulate demand.

The subsidized ACTs and SP for IPTp are unevenly available due to inadequate prescription by providers coupled with the frequent stock-outs related to some failures in the Procurement and Supply Management Chain.

There is low acceptability of proposed interventions by the targeted populations leading to a low utilisation of the available services. The use of ITNs is not commensurate with their possession due to insufficient knowledge on recommended malaria treatment and preventive interventions. As a consequence patients indulge in inappropriate health seeking behaviours including auto medication with wrong drugs.

With regards to governance, the malaria control drugs and commodities have been liberalised favouring therefore their high commercialisation in a poorly regulated set up. The consequence is a multiplicity of licensed anti malarial drugs (over 90 in circulation) and insufficient popularisation and enforcement of regulatory texts exonerating drugs and medical commodities from taxation. The multiplicity of licensed drugs besides favouring the circulation of sub standard drugs, act as a catalyser to inappropriate prescription, self medication and poor compliance which all expose to the emergence of drug resistance.

The community organisations and municipalities are not adequately equipped (not empowered) to take the lead in the design, the implementation and the evaluation of malaria control measures relevant to their communities. The lack of specific strategies to empower communities has lead to and made them passive recipients of services.

In summary, the malaria control interventions are not reaching those most in need. Insufficiently decentralised programme with poor sense of ownership at the implementation level both by service providers and users are the main causes. This policy brief has been prepared to inform policy and decision makers, health workers and community to face this challenge by implementing effective malaria control interventions targeting the whole population at risk as appropriate.

These strategies include:

- **Governance arrangements:** (i) Clearing the drug market of all antimalarials that are not in the national policy (Artesunate-Amodiaquin and Artemether-Lumefantrin for uncomplicated malaria and Quinine for complicated, Sulfadoxine Pyrimethamine for IPTp), (ii) Enforcing regulation through reinforced inspection and supervision activities, (iii) Shifting from the current unified approach to specific strategies according to epidemiological profiles and the emerging trends such as co-morbidity with HIV/Aids and, (iv) Transferring greater responsibilities to municipalities-communities for comprehensive and integrated malaria control interventions

- **Delivery arrangements:** (i) Shifting from the current unified approach to specific strategies according to epidemiological profiles and the emerging trends in the epidemiology of diseases for example: Introduce the Intermittent Preventive Treatment for infants and preschool children living in high and moderate transmission zones and for PLWHA, (ii) Distribution of LLINs, IPTp, IPTi, IPTc by the communities supported by NGOs, CSOs, Community Health Workers (CHW) and Community Based Associations (CBAs) as it is the case with CDTI and , (iii) Fostering public private partnerships through Service Level Agreements (SLA) or Performance Based Contracting (PBF) as appropriate e.g. pharmacists selling only commodities and drugs within the national policies, Effective private marketing approaches for LLINs distribution.

- **Financial arrangements:** (i) Secure and sustain subsidies for IPT, LLINs and ACTs and, (ii) Financial incentives for pharmacists and prescribers who comply to regulations.

- **Implementation considerations: (i)** Barriers such as resistance to change, low budget allocation to health, failure of the procurement chain, and inadequate knowledge among the stakeholders on malaria and effective intervention strategies, insufficient capacities of community stakeholders to take ownership; and **(ii)** Effective Strategies such as communication, education, advocacy building on the "malaria competence approach". The table below presents a summary of these policy options and their respective implementation considerations

Summary of policy options and their implementation considerations towards scaling up malaria control interventions in Cameroon

	Governance arrangements	Delivery arrangements	Financial arrangements
Description Title and Activities in the strategic options	(i) Clear the drug market of antimalarials that are not in the national policy (Artesunate-Amodiaquin and Artemether-Lumefantrin for uncomplicated malaria and Quinine for complicated, Sulfadoxine Pyrimethamine for IPTp), (ii) Enforce regulation through reinforced inspection and supervision activities, (iii) Shift from the current unified approach to specific strategies according to epidemiological profiles and the emerging trends such as co-morbidity with HIV/Aids and, (iv) Transfer greater responsibilities to and empower municipalities-communities for comprehensive and integrated malaria control interventions	(i) Shift from the current unified approach to specific strategies according to epidemiological profiles and the emerging trends in the epidemiology of diseases for example: Introduce the Intermittent Preventive Treatment for infants and preschool children living in high and moderate transmission zones and for PLWHA, (ii) Distribute LLINs, IPTp, IPTi, IPTc by the communities supported by NGOs, CSOs, Community Health Workers (CHW) and Community Based Associations (CBAs) as it is the case with CDTI and , (iii) Foster public private partnerships through Service Level Agreements (SLA) or Performance Based Contracting (PBF) as appropriate e.g. pharmacists selling only commodities and drugs recommended by the national policies, Effective private marketing approaches for LLINs distribution.	(i) Secure and sustain subsidies for IPT, LLINs and ACTs and, (ii) Financial incentives for pharmacists and prescribers who comply with regulations.
Barriers to implementation	Resistance to change, inadequate knowledge among the stakeholders on both malaria and its effective control strategies, insufficient capacities of community stakeholders to take ownership. Presence of strong leadership and previous community empowerment strategies	The State supply chain fails to deal with private pharmacies and sales of other licensed antimalarials are often more profitable. IPTi is not part of the national policy because of the fear that S/P will lead to resistance as is the case in other countries e.g. Tanzania Developing partnerships between communities, policy makers and experts. Developing local organisational capacity and financial empowerment	Low budget allocation to health, Poverty, insufficient regulation leading to high commercialization of malaria control
Implementation strategies	Information, education and communication, " malaria competence approach", Promotional campaigns*, Use existing social structures and community groups	Communication, education, promotional campaigns, management and leadership training and careful selection to ensure only ACTs on MOH policy circulate in the market and are used, empowerment of parents, resources mobilisation	communication, decentralisation and Promotional campaigns, management and leadership training

** Advocacy targeting private and public, political and scientific spheres as well as the general population who should be encouraged to become partners and even actors of vector and malaria control at their household level.*