INITIATIVE OF CAMEROON COALITION AGAINST MALARIA (CCAM) AND CENTRE for the DEVELOPMENT of BEST PRACTICES in HEALTH (CDBPH)

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KEY MESSAGES

POLICY BRIEF ON SCALING UP MALARIA CONTROL INTERVENTIONS IN CAMEROON

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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 policies have 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 the Alliance for Health Policy and Systems Research at WHO to prepare this 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.

Messages Clés

- Le Cameroun, Afrique en miniature, présente une diversité de faciès épidémiologiques du paludisme avec les parasites et les vecteurs correspondants. Le paludisme continue à être endémique et constitue encore la première cause majeure de morbidité et de mortalité au sein des groupes les plus vulnérables -enfants de moins de 5 ans, femmes enceintes, personnes vivant avec le VIH/SIDA (PVVIH) ainsi que les populations pauvres représentant respectivement 18, 5, 5.5, et 40 pour cent de la population totale estimée à 19 millions de personnes.
- En dépit des efforts déployés par le Programme National de Lutte contre le Paludisme et ses partenaires, les taux de couverture et d'utilisation effective des services et des produits antipaludiques sont encore considérablement éloignés des objectifs nationaux fixés conformément au plan d'action mondial contre le paludisme. Les ménages ayant des enfants de moins de 5ans et les femmes enceintes ont bénéficié de moustiquaires imprégnées à l'insecticide (MII) et la population entière de combinaisons thérapeutiques à base d'Artémisinine (ACT) fortement subventionnées. Toutefois, les ACT et le SP pour le TPIp subventionnés, sont disponibles de manière inéquitable en raison des prescriptions inadéquates des prestataires, de la multiplicité des médicaments antipaludiques autorisés (plus de 90 en circulation) et de fréquentes ruptures de stocks. Les MILD ne sont pas disponibles pour l'achat par les groupes non ciblés, les interventions de lutte antipaludique ayant récemment démontré leur efficacité ne sont pas disponibles. Les stratégies de lutte ne sont pas adaptées aux profils épidémiologiques du paludisme et s'appuient plus sur les structures sanitaires
- Les obstacles financiers, le faible taux d'utilisation des interventions disponibles et des structures sanitaires constituent la cause immédiate du faible taux de couverture des interventions de lutte contre le paludisme.
- La présente policy brief, basé sur des bases factuelles, propose des stratégies rectificatives pour accroître les taux de couverture et d'utilisation des interventions efficaces de lutte contre le paludisme ciblant toute la population à risque. Ces stratégies sont les suivantes :
- Dispositions relatives à la gouvernance : (i) Elimination du marché de tous les médicaments antipaludiques ne figurant pas dans la politique nationale (Artésunate-Amodiaquine et Artémether-Luméfantrine pour le paludisme non compliqué et quinine pour le paludisme compliqué, Sulfadoxine pyriméthamine pour le TPIp), (ii) Mise en application de la réglementation par le biais d'activités d'inspection et de supervision renforcées , (iii) Changement de l'approche unifiée actuelle pour des stratégies spécifiques aux profils épidémiologiques et les co-morbidités telles que le VIH/SIDA et, (iv) Transfert de plus grandes responsabilités aux municipalités-communautés pour des interventions intégrées de lutte contre le paludisme
- Dispositions relatives aux prestations : i) changement de l'approche unifiée actuelle vers des stratégies spécifiques aux profils épidémiologiques et les co-morbidités : introduire le TPI chez les nourrissons et les enfants d'âge préscolaire vivant dans les zones à transmission élevée et modérée et pour les PVVIH, (ii) distribution de MILD, TPIp, TPIi, TPIc par les communautés soutenues par les ONG, OSC, agents de santé communautaire (ASC) et associations à base communautaires (ABC) comme c'est le cas avec le TIDC et, (iii) stimulation de partenariats privés publics par des conventions sur le niveau de service ou des contrats basés sur la performance suivant le cas, exemple: vente exclusive des produits et médicaments figurant dans les politiques nationales par les pharmaciens, approches efficaces de marketing privé pour la distribution de MILD.
- Dispositions financières : (i) sécurisation et pérennisation des subventions pour le TPI, les MILD et les ACT, (ii) mesures financières incitatives pour les pharmaciens et prescripteurs qui respectent la réglementation
- Dispositions relatives à la mise en œuvre : (i) Des obstacles tels que la résistance au changement, la faible allocation budgétaire pour la santé, la défaillance de la chaîne d'approvisionnement, des connaissances inadéquates parmi les parties prenantes dans la lutte contre le paludisme et le manque de stratégies efficaces d'intervention, les capacités d'appropriation insuffisantes des acteurs communautaires ; et (ii) des stratégies efficaces telles que la communication, l'éducation, le plaidoyer s'appuyant sur " l'approche Compétences face au Paludisme".

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 inequitably benefited from free Insecticide Treated Nets (ITNs) and the entire population from highly subsidized Artemisinin-based Combination Therapy (ACTs). However, the subsidized ACTs and Sulfadoxine Pyrimethamine (SP) for Intermittent Preventive Treatment during pregnancy are unevenly available due to inadequate prescription by providers, multiplicity of licensed anti malarial drugs (over 90 in circulation) and frequent stock-outs. Long Lasting Impregnated Nets (LLINs) are not available for purchase for the non targeted groups. Proven effective control interventions such IPT for infants, preschool children and PLWHA are not available. Control strategies are not customised to epidemiological profiles of malaria and are mostly health facility based despite the low utilization rate of health facilities.
- 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, Artemether-Lumefantrin, Quinine and Sulfadoxine Pyrimethamine), (ii) Enforcing regulation through reinforced inspection and supervision activities, (iii) Shifting from the current unique nationwide approach to strategies tailored to epidemiological profiles and emerging trends such as malaria and HIV/Aids co-morbidity and, (iv) Transferring greater responsibilities to and empowering municipalities and 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 and Community Based Associations 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 and effective private marketing approaches for LLINs distribution.
- **Financial arrangements:** secure and sustain subsidies for IPT, LLINs and ACTs and financial incentives for pharmacists and prescribers who comply with regulations.
- **Implementation considerations: (i)** Barriers such as resistance to change, low budget allocation to health, failures 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".