Malaria Bytes

Volume 2, Issue 2 ISSN 2006-0149 April - June 2008

Care Net Nigeria

Scaling up Interventions for Impact

The world is once again witnessing a truly unique moment of heightened awareness and action in the history of global health. Health today stands high on the global political agenda, similar to what happened around the environment two decades ago.

This brought about an outpouring of new initiatives as well as concrete actions. A clarion call was made at the beginning of the first decade in this Millennium to scale up the response against diseases of poverty including malaria. But at the twilight of this 'glorious' decade, the report card especially for Sub– Saharan Africa (SSA) is still not looking encouraging.

This may be partly due to inability of health systems to respond to the disease, in addition to failure of integration of prevention and control activities with the economic, social and political structures of the countries.

Yes, there has been additional resources to fight the disease, but these have been mainly directed at carrying out interventions and upgrading global public goods. Not much has been spent on building national health systems needed to sustain the high impact interventions.

Moving up to Scale?

Up until now governments in many countries are still not able to re-define their appropriate role in providing the much needed stewardship while allowing private, voluntary and public providers undertake the task of delivery of essential goods and services.

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PPPs: Rhetoric or Reality

Private sector participation in health is still regarded as 'a child of circumstance' by public policy makers in many countries - despite the outward show of willingness to collaborate.

This is partly due to the attitude of public sector managers towards private sector operators as profit maximizers and also the lack of knowledge of policy makers on how the private sector works. But the main reason could be discomfort in the shift of balance of power between the two sectors.

It should be recalled that the need for Public-Private Partnerships (PPPs) in health has occurred because of both market and government failures.

The market in healthcare has failed because of several reasons - information asymmetries, inability to produce public goods, externalities, monopolistic market power, moral hazards and adverse selection. Similarly, government has failed in healthcare delivery due to poor public accountability, failure in policy formulation, abuse of monopoly power and corruption.

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For Enquiries Contact:

CARE - NET LTD

Plot 16 Ibaa Street

TMC Estate, Abuloma

Port Harcourt

Rivers State, Nigeria

Phone: +234-84-770232

E-mail: info@carenet.info

PPPs: Rhetoric or Reality... Cont'd

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Nevertheless, another background leading to an interest in PPPs is due to inefficient management of health resources. For example, while public expenditure in many sub-Saharan Africa countries is less than $8 per capita per annum compared to $34 recommended internationally, over 70% of all health expenditure is spent in the private sector. Meanwhile, the activities of both the public and private sectors have been left uncoordinated, leading to poor performance of the health sector as a whole.

Therefore, it is largely on the basis of combining the resources of both sectors as well as joining together the managerial approaches of the private sector and social orientation of the public sector that has enabled PPPs to emerge in the health sector.

However, on close examination it would appear that private sector participation has been tolerated rather than seen as a significant resource. Even Global Initiatives

Everyone is a winner irrespective of where you stand

continue to rhetorically acknowledge the importance of this sector, but has failed to develop true partnerships. And some of the relationships are perceived to be very patronizing ◊◊◊

OPINION

Is there a positive synergy between Malaria Programmes and Health systems? - Felix Obi

A great spiritual leader once taught his disciples a very useful lesson on systems approach to management. The little agrarian community in Israel had no much difficulty understanding the analogy. In his words, "No one puts a piece of unshrunk cloth on an old garment; for the patch pulls away from the garment, and the tear is made a worse". Nor do they put new wine into old wineskins, or else the wineskins break, the wine is spilled, and the wineskins are ruined. But they put new wine into new wineskins, and both are preserved".

This common sense systems thinking helped the peasants and farmers of premodern age manage their resources efficiently such that undue wastages and irreparable loss were eliminated from their managerial systems. Following the establishment of the Roll Back Malaria Partnership, the Global Fund for AIDS, Malaria and HIV/AIDS, funding for malaria programs have improved exponentially over the last couple of years. More bilateral donors like DFID have upped their malaria-specific program funding to Nigeria and other countries in Africa. In some of the donor-funded programs and projects, emphasis has been more on the prevention, control, and management of malaria. Most of the deliverables and outputs have been measured in terms of commodities like ACTS, and ITNs distributed, among others.

The monitoring and evaluation mechanisms and dashboards have only failed to capture the actual impact in and palpable and tangible deliverables that translate into improved health status of our communities. Every democratic and people-oriented government ensures that the resources of the state are deployed to improve the livelihoods of the

Most deliverables and outputs have been measured in terms of commodities like ACTs, and ITNs and not actual impact on disease outcome.

community members for whom the systems were set-up in the first place. In essence, every vertical disease intervention program besides meeting the requirements of the monitoring dashboards and bench-marking standards, should translate to qualitative improvements in the lives and livelihoods of the populace, by enhancing their collective health and wellness potential.

An Ibo proverb says that one cannot be swimming in the river, yet ends up dying from severe thirst and dehydration! Yet we have an unacceptable paradox that we have allowed for too long.

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Scaling up for Impact ...

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Although some donor funded programmes have been designed with this new way of working in mind, but their internal reporting systems have not changed to allow for the sort of flexibility required to actually put governments on the 'driver's seat'.

With the focus on measuring outputs, in terms of the quantity of commodities distributed, impact monitoring through a system of independent and reliable reporting with rapid and open feedback loop is yet to be on the agenda.

While there appears to be a loose global advocacy network of actors catalyzing the emergence of a social movement against malaria and other diseases of poverty, there are no sustainable advocacy and consumer communications programmes at the local level, working through NGOs and the media to catalyze and maintain the momentum for massive social mobilization on a continuous basis.

Nonetheless, a number of global functions aimed at going to scale with malaria interventions are taking place. They include: partnerships to lower drug prices and improve access to the poor; efficient purchase and equitable distribution of vital commodities, including quality low-cost medicines; and research to develop essential new drugs, diagnostics and vaccines. There are also investments in infrastructure and better logistics to distribute medicines and other essential commodities and services.

Similarly, resource transfer mechanisms such as the Global Fund, which allow decision-making at the country level with feedback related to results, while ensuring transparency are progressing well. But the challenge of integrating these activities into a well functioning health system still remains.

Surviving against all odds

No doubt the lack of capacity of national health authorities to coordinate the myriads of activities by various actors is the main impediment to achieving harmonized national malaria control programmes. The absence of streams of actions deliberately targeting this inadequacy mean that we are still far from having a focus on a sustained effort to going up to scale with malaria prevention and control activities ◊◊◊

Malaria Programmes and Health systems? ...Cont'd

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Though access to malaria control intervention rose sharply between 2004 and 2007, the global malaria burden remains high based on the statistics from The World Malaria Report 2008 recently published by WHO. Admittedly, the increased funding accelerated access to malaria interventions, including bed nets and effective medicines, but we know little of how these deliverables and consumables have helped in revamping ailing health systems. A recent research published in PLoS ONE, a peer-reviewed open access journal, shows that some 35% of antimalarial drugs sold in six major African cities located in Ghana, Kenya, Nigeria, Rwanda, Tanzania, and Uganda. The study led by Dr. Roger Bate, Resident Fellow at the American Enterprise Institute , further found that artemisinin monotherapies remain common in Africa, and an estimated 200,000 avoidable deaths occur each year from use of substandard antimalarial drugs.

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Such avoidable deaths may not have occurred if health systems were functional to enforce regulations and post-market surveillance as some 78% of the artemisinin monotherapies were manufactured after WHO had proscribed their manufacture in 2006. The repeated outcry by health systems strengthening "advocates" has led donor agencies to start thinking about strengthening country-wide health systems, and subsystems in recipient countries.

However, this appears to be a politically-correct trite considering that donors may not easily change their bureaucratic systems to facilitate the re-aligning of their official development assistance to be in sync with the age-old systems approach to development. Do we have to wait for another long stretch of hoping for the best before the policies and institutional frameworks of donor and recipient countries unite for the common good of delivering tangible health outcomes.

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EDITORIAL

Going to Scale .....several missing links

When the Roll Back Malaria (RBM) initiative was lauched in October 1998, by the four founding partners - WHO, UNICEF, UNDP and the World Bank - there were high hopes of curtailing the menance of malaria by focusing on building sustainable community capacity to deal with the problem.

This horizontal approach to malaria control was noted to be unique as opposed to previous global campaigns against the disease. While considerable levels of political awareness and advocacy has been raised at the country level, national governments have not been empowered to act as stewards to drive coordinated actions jointly with a range of development partners, including the international and local private sector, NGOs and civil society.

Secondly, this partnership was meant to facilitate scaling up by supporting country strategic plans of action that focus on increased coverage for the prevention and treatment of malaria. But what we see on the ground is a continous fight for supremacy among these partners and the pursuit of independent agendas. For example, States in Nigeria have very little say on how the World Bank Malaria Booster Programme is implemented. Similarly, international donors and local development partners still roll out programmes and projects that are not integrated with the National Malaria Strategic Plan of Action in Nigeria.

Again, RBM was supposed to help health systems deliver cost-effective interventions including better health care - especially for pregnant women and children. In reality we are only counting number of commodities - insecticide-treated nets and anti-malarial drugs - distributed to these target groups. Health systems are still unable to deliver adequate and appropriate services that integrate malaria control with strategies for the prevetion and treatment of childhood dieases at the community level.

Finally, RBM was based on the principle that people at risk of malaria should be at the centre of a movement to reduce the impact of the disease in their communities. What we see are very patronising efforts by governments promted by donors, that undermine local knowledge and processes.

Lets face it. Actions required to scale up efforts for malaria control and prevention are not just technical. There are political, social, cultural as well as instituional issues that need to be properly understood and addressed. Unfortunately, the competencies required to engage with these issues as well as leadership capacity to cordinate the activites of the myriads of actors is lacking at national health authorities. Genuine efforts at scaling up must first address these capacity gaps ◊◊◊

Dr Tarry Asoka

Editor

tarry@carenet.info

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This calls for a renewed thinking that ensures that the new wine is poured into a new wine skin. The global business community seems more prepared to deal with the emerging consequences of globalization referred to by experts as 'constructive destruction' where what exists today is destroyed for something better to emerge. The public health community needs to start thinking out of the box to maximize the huge resources available for the delivery of the health-related MDGs. The changing health trends and constant flux throws up a lot of developmental challenges that require change management expertise. Public health experts need to know that what worked yesterday may not work today, hence not applicable tomorrow.

The public health experts in donor agencies and recipient country health systems need to understudy and utilize lessons from emerging managerial approaches that have helped business stay afloat in the turbulent economic milieu of today. The days of focusing on complex operational and administrative mechanisms for health intervention programs should be over and done with. Donors and recipients have to ensure that the concept of "performance management' truly becomes a vital part of the health system. This policy change makes it possible for harnessed resources are used to produce the right results that impact the health system positively.

In addition, efforts should be made to strengthen feedback loops, information management systems, supply chain management, budgetary and financing mechanisms that support and enhance the overall performance of the health system. The Human Resources for Health need a lot of re-engineering to ensure that the right mix of workers are deployed to address the disease burden. This will involve the use of evidence-based HR strategies that create the right culture and organizational environment that will attract and retain the health workforce whose interests and skills-set are aligned to the systems over-arching goals of delivering quality services and health outcomes. Hence a substantial part of the budget for disease intervention programs should be devoted to building the capacities and capabilities of the health workforce in-country. Though physical and non-tangible structures make up the health system, without the human resources, no tangible and lasting outcome will be derived from the system ◊◊◊

Felix ABRAHAMS Obi works with the Nigeria Office of Japan International Cooperation Agency (JICA) based in Abuja, and can be reached via:

halal3k@yahoo.com