

ASSESSMENT REPORT ON COMMUNITY COARTEM DISTRIBUTION AND AVAILABILITY IN GULU DISTRICT MAY 2007

By:

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Introduction

Following the new government policy on malaria management by use of Arthemether Combination Therapy (ACT), Coartem is currently being used in all the HFs in the whole district including Home Based Management of Fevers in the under five year old children. The use of Coartem in the community started late in 2006 and its availability, mode of request, and distribution is not clearly known by the DHT and Health Partners in the district. In a bid to establish the above facts, the WHO Sub-Office together with the DHT carried out an assessment in Aswa and Omoro Health Sub-Districts (HSDs) in the months of March and April this year. Gulu Municipality was not included because of being better served as a result of having many health facilities in a small geographical area.

Objectives

1. To establish availability of community Coartem stocks in health facilities (HFs)
2. To establish the number of villages served
3. To determine the number of Community Drug Distributors (CMDs) available per village
4. To establish the number of villages without CMDs in Return Areas
5. To establish the availability of Coartem among the CMDs in the community
6. To identify factors affecting community Coartem availability and distribution

Methods used in the assessment to obtain the information

- Interviewed DHT members
- Interviewed Health Workers in HFs
- Held meetings with CMDs
- Looked at Coartem stock cards

Findings

(a) Availability of community Coartem at HF

- Visited all the 23 functional HFs in the two HSDs
- 8 out of 23 HFs did not have community Coartem in stock
- HF based Coartem was available in about 90% of the facilities

(b) Number of villages served with community Coartem

- 261 villages were reported and are being served by the 23 HFs
- All the villages in the IDP camps were receiving the drug
- Number of villages served by one HF ranged from 3 to 25 villages

(c) Available number of CMDs

- 363 CMDs were active
- On average every 10 villages were served by 14 CMDs
- In a camp setting where 2 CMDs can fairly be enough to distribute drugs, a gap of 159 CMDs existed

(d) Villages in the return areas

- 55 villages are being inhabited in the return areas
- 42 out of the 55 had at least one CMD
- 13 did not have any CMD

(e) Availability of Coartem among CMDs

- About 90% (327 out of 363) of CMDs had at least one type of community Coartem

(f) Factors affecting Coartem distribution in the community

- Delays in processing of orders and dispatching of drugs at the DHO's office
- Most health facility in-charges do not supervise and convene monthly VHT meetings
- Monthly reports compiled and submitted by CMDs are not sent to the district
- Long distances between some distribution centers and CMDs
- Lack of incentives such as: Means of transport, Gumboots, Raincoats, Torches, Soap, Paraffin etc
- Lack of regular supply of summary forms and stock cards, and counter books for keeping minutes

Other findings

Positives:

- Reduced number of children presenting with fever in the HFs
- Presence of monthly reports from CMDs
- High compliancy/acceptability of Coartem in the community
- Willingness of VHTs to carry out community based disease surveillance including registration of birth and death
- VHTs were assisting in routine HF work in understaffed centers

Negatives:

- Many HWs (especially Clinical Officers and Nurses) were absent in most centers
- Some HFs were being run by Nursing Assistants alone e.g. Labworamor HC III
- Most HFs did not have staff houses and many of the HWs reside in Gulu Town
- Some CMDs were reported to be selling the drugs
- Some parents were said to be reporting to different CMDs during the same period in order to receive more drugs for personal gains. Others were reported to be receiving drugs from the community and HF for the same illness during the same period
- Inadequate number of volunteers for CB-DOTs. One CMD in Palenga was found to be observing 14 TB patients

- Septrin (HBC kit) was no longer being distributed to CMDs. Patients are demanding for the drug

Conclusion

- Community Coartem was available in the community
- The number of children under five years reporting with fever in HFs has reduced in the district
- Return Areas were less served with community Coartem
- The number of CMDs is not enough
- Supervision of VHTs at facility level is poor
- Flow of drugs from the district to HCs is slow
- VHTs are not well motivated (Incentives are irregular and inadequate)
- Absenteeism is high in HFs
- Staff housing is inadequate
- CB-DOTs is poor in many areas

Recommendations

- Strengthening of community Coartem activities such as supervision, monthly review meetings, provision of incentives at HF and levels
- Training of more VHTs especially in return areas
- Provision of logistics such as reporting forms, stock cards, and counter books
- Improve Community data collection and analysis at HF and district levels
- Improve drug requisition and supply mechanisms at HF and district levels
- Carryout out community data analysis for evidence based community Coartem impact on reduction of morbidity and mortality due to malaria among children in Gulu District