

ment (PSM) problems have plagued provision of ACTs in the public arena, the problem of getting these down to the community or out to PMVs will be even more challenging.

PSM is not an inherent weakness of CCM; it is a challenge to the overall health system. PMVs do have a way of getting through larger retailers and wholesalers the medicines they want to sell, usually based on popular demand. This system can move ACTs, but the problem is that many ACTs in the system, though approved by national food and drug regulatory agencies, do not have pre-qualification approval by WHO. Some are counterfeit or expired. A new programme called Affordable Medicines Facility, malaria (AMFm)¹⁶ is endeavoring to provide country grants to strengthen availability of low-priced approved ACTs in both public and private sectors.

In the meantime we need to consider the mechanisms that will get ACTs out to trained CHWs on a regular basis. Previous relatively small-scale efforts by NGOs, FBOs, researchers, and pilot government programmes will not achieve the scale needed for UC. If we look around, we will find that the African Program for Onchocerciasis Control (APOC) has developed a platform for annual ivermectin distribution that has literally reached 100 000 villages regularly for over 12 years. WHO/TDR-sponsored research has determined that the Community Directed Treatment with Ivermectin programme can be turned into a Community Directed Intervention (CDI) approach that can accommodate additional interventions like malaria CM, insecticide-treated net (ITN) distribution, and vitamin A distribution.^{17,18} In fact agencies working on neglected tropical diseases have already been using CDI to distribute medicines for trachoma, lymphatic filariasis, and geo-helminthes.¹⁹

What is special about CDI is that the community becomes a full and active partner. The idea of the CHW takes second place to community decision making. The community decides who and how many volunteers will be involved. Possibly Mr X can be asked to be in charge if distributing ITNs and Mrs A can handle malaria CM. The CDI system has been shown to achieve better coverage results than the existing health systems alone.

In fact, what is good about CDI is that it is not



CHWs who distribute Ivermectin near Buea and also provide malaria community case management

an isolated pilot effort. It is integrated into the health system. Front-line health staff are trained to organise and support CDI, so that it becomes a natural extension of their public health efforts. Health staff mobilise the communities to participate in CDI, and they train the volunteers selected by the community. The front-line health facility becomes the supply store for all the commodities needed for CCM and disease prevention efforts. Villagers are trained to maintain records and submit these to the front-line health worker for collation and onward transmission so that all community-level intervention gets measured as part of national efforts to achieve UC.

A lesson from APOC is that CDI can be labour intensive to set up. Once it is up and running, the community partnerships it offers are the only way to sustain efforts to reach the communities 'beyond the end of the road.' It is this ability to sustain intervention with ACTs that is needed to take malaria CM beyond scale-up and into the sustained programming that will reduce prevalence and mortality and take us into the era of malaria elimination.

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CPD Challenge

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