



Improving targeting

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Rationale



Presumptive treatment was okay “yesterday”?

- Cheap and safe antimalarials were widely available.
- Microscopic confirmation not widely available
- High transmission in much of SSA

Presumptive treatment may not be okay “today”

- Changing epidemiology – reducing cases of malaria
- Switch to expensive ACTs
- Concerns about:
 - Overdiagnosis
 - Wastage (drugs and money)
 - Inappropriate treatment of non-malaria fever
 - Safety (adverse effects of repeated doses)
- Increasing availability of Rapid Diagnostic Tests (RDTs) for malaria



Specific questions

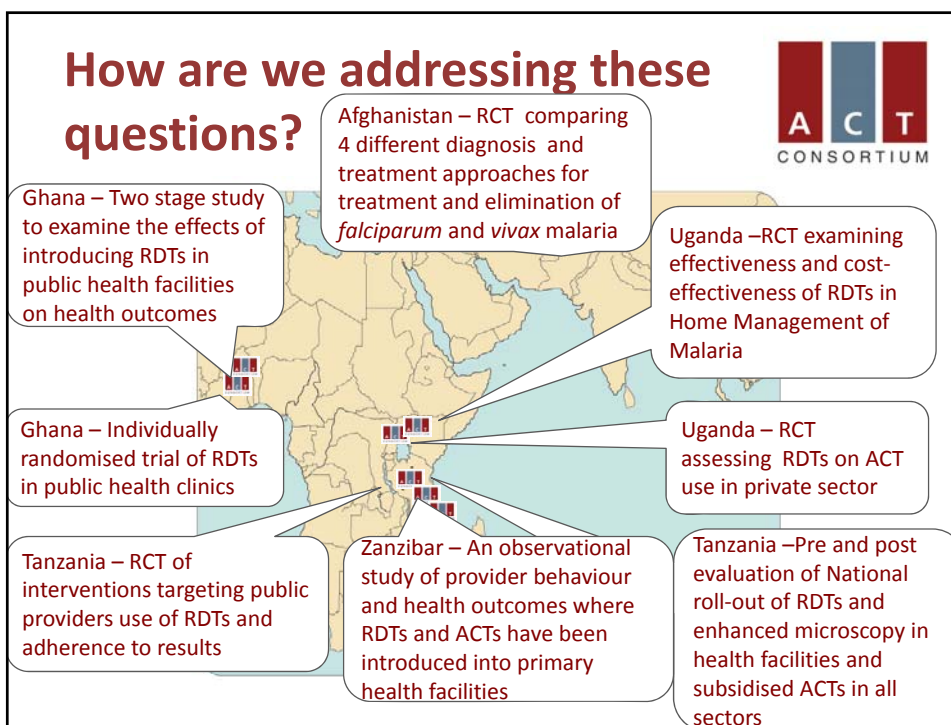


- Will the deployment of RDTs lead to an improvement in case identification and rational prescription of antimalarials?



- Can rational prescribing of antimalarials be improved by behavioural interventions targeting patients and/or healthcare workers?
- What are the possible clinical, economic and health systems impacts of restricting ACT use to only RDT-confirmed malaria?
- How cost-effective are RDTs in practice in different settings?

How are we addressing these questions?



Evaluation: Targeting



Main targeting outcomes:

- % of febrile patients treated appropriately according to RDT (or microscopy) result i.e. ACT if positive, no ACT if negative
- % of non-malarial patients treated with ACT
- % of malarial patients treated with ACT

Health outcomes (from cohort studies):

- Parasitological cure
- Malaria incidence and anaemia incidence or prevalence

Other outcome measures:

Range and type of treatments received by RDT negative patients, cost and cost-effectiveness, choice of provider, equity and acceptability