

Population Services International  
Artemisinin Monotherapy Replacement Project

Mid-Term Milestone Review

Aide Memoire for  
PSI Myanmar, DFID Burma and BMGF

Louise Mellor, Health Adviser, DFID  
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## **Aide Memoire Outline**

- Methodology
- Changes to context
- Progress against Outputs 1, 2 and 3
- Key issues and recommendations
- Table showing actions to recommendations following the First Annual Review (October 2012)

# Methodology

- PSI presentations 6<sup>th</sup> May 2013
- Key document review
- Meeting with AA Medical Products Ltd, in Yangon
- Visit in Tier Two areas (Lashio and Hensi, Northern Shan) with PSI and DFID
- Visit and discussions with -
  - Associate State Health Director, Lashio, Ministry of Health
  - Township Medical Officers, Lashio and Hensi
  - Sub Rural Health Post, Hensi
  - AA office and warehouse in Lashio
  - PSI office, Lashio
  - Beneficiaries at a SUN primary health clinic and in markets
  - PSI field staff, product promoters and supervisory staff
  - 25 outlet visited, comprising the 5 outlet types as well as drug wholesalers :
    - Drug wholesalers in Lashio
    - Pharmacies (non trained), urban and rural
    - General retail stores, urban and rural
    - Informal drug vendors, rural
    - Trained private service providers, urban and rural, including SUN primary health care workers
    - SUN General practitioners, Lashio
- Feedback meeting PSI/M and DFID 15<sup>th</sup> May 2013.

# Context

- The import of **both artesunate and artemether are now banned** in Burma.
- Public sector and NGO roll out of RDTs and QA ACT is under way – but a long way from reaching universal coverage. Government overall health budget increased four-fold, but from a very low base.
- Many reports of decline in the incidence of malaria, nationally and in MARC areas.
- **No changes in geographic drug resistance designated Tiers 1, 2 and 3 within Burma.**
- 2012 Positivity rate of 27% - reported through the PSI SUN franchise (down from around 45%)
- **Insecurity remains** in many border areas, with many townships in Kachin and Shan inaccessible, while other areas open up due to ceasefires.
- There are high levels of **mobility** along the eastern border, including displaced people and armed forces in conflict areas; returnees in post-conflict areas, and large numbers of economic migrants, including in the south-east of Burma as well as in Shan State.

## **Expected AMTR Impact and Outcome**

To prevent (or at minimum significantly delay) the spread of artesmisinin resistant Plasmodium falciparum parasites within Myanmar and beyond its borders.

Sub-standard antimalarials in the private sector (particularly artesunate monotherapy), replaced with government approved and quality assured ACT and sub-optimal dosing reduced among the target population in eastern Myanmar.

## Background

- The project suffered a late start due to not having an MOU in place. This meant that the first Annual Review in October 2012 showed that the project had not met many of its targets at that stage.
- Specific delays of concern included:
  - Late distribution and sales of ACTs, thus delaying the time critical impact of replacing AMT with ACTs.
  - Late start of the RDT pilot, and hence much of the treatment takes place without testing.
  - Late finalisation of household, outlet and supply chain surveys, which means that information could not be used to inform programme delivery or be disseminated in a timely manner to external stakeholders.
- The project has revised many of its targets and timelines, with implementation informing actual costs and timelines. PSI feel that it will 'catch up' and meet the overall goals of the project.
- The mid-term review will provide useful monitoring information for PSI to assess its progress.

## Progress on Output 1:

### availability of QA ACT in outlets/ less AMT / providers aware

- **Baseline Outlet Survey** finalised. Data used for baseline for logframe and for informing project strategy
- PSI sales to AA to date: **900,000 QA ACT (Supa-arte)** doses (against Year One target of 1,800,000 doses). AA have sold 450,000 courses to 1,400 wholesalers and retail outlets in 66 townships. This indicates a retaining of the market share following cessation of AA Artesunate supply. PSI will revise sales targets based on actual demand.
- PSI has provided around 12,000 outlets with samples of QA ACT (Supa-arte). These will be monitored on monthly basis to assess ACT availability, including using GIS-based data entry. It remains unclear as to how many of these outlets will choose to resupply from the AA supply points.
- In Lashio and Hensi (Tier Two), **24 out of 25 outlets visited had QA ACTs.**
- The 5 types of outlets were visited. For the 3 priority types of interest - pharmacies, general retail stores (GRS) and informal drug vendors (IDV) - the ACTs were 'Supa Arte' 1 - 4 with Padonmar seal.
- The one outlet which did not have ACTs was a IDV, however, the provider stated that they had previously had stocks and had recently sold out. Two outlets had samples only and had not yet resupplied.

## Progress on Output 1 (contd):

- In and around Lashio and Hensi, Supa Arte 4, was selling between **K 300 – 500 per packet course**.
- Supa Arte retail price **matches incomplete AMT dose price**, which ranged from K 100 to 500 per one tablet.
- **Arthemeter was still available** at retail and wholesale levels and was still popular with customers/ patients. Some providers reported declines in sales, while others did not, and some even reported increasing sales. This is in contrast to reports from Tier One areas.
- The central stock levels of oral AMTs by some distributors following the important ban remain unclear. This will be investigated further.
- While all providers reported that they procured drugs from distributors within Burma this was hard to verify by observing packaging alone, which is developed at source beyond Burma's borders (e.g. in Kunming). There are still risks for inflows from China.



## Progress on Output 2: User knowledge on accessing QA ACT

- Beneficiaries interviewed were able to **name a range of anti-malarials, including Supa Arte** and the ‘Padonmar’ (lotus) Quality Seal
- Beneficiaries reported the **correct use** of Supa Arte, including completing the full course. There was no evidence of blister cutting of Supa Arte, although blister cutting was very evident for AMTs and other ACTs.
- Packaging with Burmese language for Supa Arte appeared to be effective.
- Beneficiaries had heard of the Padonmar seal through **mass media channels**, such as Cherry FM (Shan language radio) and through posters.
- Some beneficiaries and providers stated that Supa Arte had unpleasant side effects, and that they preferred taking fewer tablets of AMTs. Others showed ‘brand loyalty’ or familiarity in their preference for AMTs and non-QA ACTs.

## Progress on Output 2 (cont.)

- Mass communications for the Padonmar seal have commenced, while Supa Arte promotions are very evident at the point of sale
- Baseline Household Survey has been completed. Key findings have been used in the logframe baseline. These include:
  - **0% of the target population with suspected malaria had received QA ACT**
  - 7.6% of the target population had seen/ heard of Padonmar quality seal.
- The household and outlet surveys will be completed **annually** to fit into timings of annual reviews.
- The importance of providing an advance supply to untested migrants at risk of malaria (e.g. plantation and forest workers) still valid

## Progress on Output 3 – RDTs: availability and provision and correct use

- **The RDT pilot commenced in April 2013** in 6 townships (3 in Mon – Tier 1, and 3 in Shan – Tier 2). Focus on pharmacies, IDVs and general retailers
- 327 outlets trained and starting activities. Results will be collected monthly, with first collection of data due at the end May 2013. Inter-personal communication has been undertaken to 600 people.
- During the visit to Hensi, the team met 5 outlets who were participating in the pilot. 3 had done one test each, which were **negative and had NOT provided their customer/ patient with ACT** following the negative result. 1 correctly kept the used test and recorded the correct information for the pilot, while the other 2 threw it away.
- However, discussions with most providers stated that they would sell ACTs following a negative result if the customer wanted drugs.

## Progress on Output 3 (cont.)

- All outlet providers (apart from those from the SUN network) were asked about RDTs. Two stated that they would be interested to provide RDTs to their customers/ patients. However, most said that they were too busy, in particular busy general retailers.
- People were observed asking for specific drugs, while others were observed discussing symptoms and being given drugs guided by the provider. The latter was apparent with the IDV and more remote outlets. It appears that the more **informal and remote outlets would be the most interested to undertake RDTs.**
- The baseline surveys also showed a distinction between “**customers**” and “**patients**”. Most pharmacies and retail stores tend to provide drugs as requested by the customer , while IDV and some remote stores treat patients, contributing to diagnosis and treatment outcomes.
- The pilot will further analyse the motivation, skills and quality of providers undertaking RDTs .

## Progress on Output 3 (cont.)

- PSI received approval for the pilot, including monitoring and evaluation by the central MOH. During the meeting with the Associate Director, Northern Shan, the Director **did not agree to the 'research' element of the M & E** (specifically the household survey). The ostensible reason was due to miscommunications between the central and decentralised levels, however, it was clear that the Associate Director had a number of issues against external NGOs operating in Burma. *Since the visit, full approval for all elements of the M & E was been given (20<sup>th</sup> May 2013)*
- The mystery client survey showed that **10.8% of providers proposed a malaria test** to customers/ patients before providing with treatment in the 3 priority outlet types. This was carried out before the RDT pilot, and represents current practice for use of RDTs among these provider types.
- Further, RDTs are routinely being used in the public sector as well as the formal private sector (including SUN GPs and primary health care). RDTs (not project related) were seen to be sold by one pharmacist. This indicates some level of normality for testing , which could assist in the acceptance and use of testing by providers and customers/ patients.
- Completion of the pilot is due in October 2013, with results disseminated by December 2013. Decision on roll out of results will take place from January 2014.

## Key issues and recommendations (1)

- The review meeting and field trip were well prepared
- **Good levels of Supa Arte were observed, but also still a lot of AMT and non-QA ACT present during the field trip.** There was also a lot of blister cutting still observed showing that people continue to take partial courses. There remains the possibility that poor quality malaria drugs could come from across the border.
  - Action: PSI to determine the amount of stock of AMT still held by the main distributors, and to monitor availability through on-going monitoring and outlet surveys.
  - Strategies to remove the perceived high levels of AMT need to be developed, including engaging with PolyGold, the second main distributor.
- The subsidy was seen to be passed down to the patient. More remote areas should be visited to ascertain variations further away from the main road and infrastructure.
  - Action: The next annual review should incorporate more village tracts and remote areas.
- There was good awareness of Supa Arte and the Padonmar seal. Mass communications were working well, in particular ethnic language radio stations. Posters are only in Burmese, and many interviewees mentioned that they would like posters in ethnic languages with ethnic minorities/ cultural dress included.
  - Action: PSI to consider further languages and imagery for communication material.

## Key issues and recommendations (2)

- The next outlet and household surveys will commence in June and August 2013 respectively to provide key information, informing further on the availability, knowledge and price of Supa Arte. Previous surveys experienced delays, in particular in dissemination. **Speed of surveys, and ensuring dedicated technical support**, is required for informing the next annual review as well as for project management and external advocacy. PSI plan to present progress on the AMTR at the Multilateral Initiative for Malaria (MIM) conference in October 2013.
  - Action: PSI to ensure timelines of surveys and of their dissemination of findings
- The **timing of the RDT** pilot at the start of the malarial season should prove useful. There appeared to be a diversity of interest amongst customers/ patients and providers over use of RDTs, with signs of interest already there (as seen in the mystery client survey and from the field visit). More remote and informal providers - seen as health 'practioners' - showed the most interest at this stage
- There is some **concern over the initial non-permission** in Lashio to undertake the evaluation of the RDT pilot. While permission has now been granted, careful relationship building is required for Associate Director who has known to be obstructive on other issues as well.
  - Action: PSI to continue to build constructive relationship with the MOH at all levels.

## Key issues and recommendations (3)

- The project appears **not to be sustainable** after the completion, and is likely to still need donor funding. Non subsidised ACT costs are too high for the target population; alternatives from the black market are likely to be available; blister cutting of ACTs is likely to take place; and the public sector is unlikely to have scaled up sufficiently.
  - Action: PSI to develop longer term funding strategies and different programme scenarios
- The **theory of change** was re-visited during the review. The model is still valid, but the timelines need to be revised - in particular the scaling up of public or voluntary sector service delivery will not be reached over the 4 years.
- **Programme management** has shown improvements, but some concerns remain:
  - There has been improved financial management, in particular improved forecasting. However, some delays financial reports occurred, and outstanding issues, such as use of programme income, have not been resolved
  - The outstanding reports are all now completed, however, there were several delays, such as Annual Report and revised logframe.
  - The risk matrix needs to viewed monthly at DFID-PSI meetings
  - The recommendations from the first Annual Review have largely been addressed.
  - Action: PSI to ensure timely submission of reports. PSI to provide revised sales targets for ACTs, and targets for the logframe on estimated numbers of diagnosed and treated cases



## Key issues and recommendations (4)

- External relations
  - PSI have built good relationships with the MOH, in particular at central level, which is striking considering some previous difficult relations. However, not having a senior representative during the field trip was a missed opportunity. More relationship building is required at the decentralised levels.
  - PSI have good visibility at malaria sector meetings, such as the TSG.
- Value for money
  - Economy – good procurement prices. Efficiency – some ‘catch up’ of outputs being observed, and will be further assessed by annual services. Effectiveness – addressing a key MARC strategy. Equity – providing affordable drugs to tackle malaria (the disease of rural poor people) and preventing resistance spreading to low income countries
- Fraud and corruption
  - Previous case of leaked RDTs (from the SUN network) has been investigated, and tighter controls put in place. **No cases of fraud were observed** during the field trip. In addition, there were no reports of items been sold in bulk to the military or to any institutions.
- Due Diligence
  - Information on the pillars of governance and control, ability to deliver and financial stability is being provided for an assessment on due diligence.
  - More input from the PSI-M senior managers would be welcome, including during this mid term review and future reviews.

## Follow up to recommendations from First Annual Review, October 2012

Recommendations from first annual review	Action to date (as of end of May 2013)
Document AMTR project roles & responsibilities	Completed (as part of a broader effort underway in PSI Myanmar to restructure the organization)
Hold monthly meetings with DFID	Commenced and ongoing
Have annual household surveys to monitor progress	Household survey planned for August 2013 (year two)
Link timing of surveys with annual milestone reviews	Schedule of both surveys and next annual review reflect this linkage
Disseminate baseline survey results nationally and beyond	Hard copies disseminated at the National Malaria Seminar meeting in early 2013. Dissemination of results will occur internationally (e.g. at the Multilateral Initiative for Malaria conference and in peer-reviewed literature) following emergence of year two survey results in late 2013.

## Follow up to recommendations from First Annual Review, October 2012 – cont (2)

<b>Recommendations, from first annual review</b>	<b>Action to date (as of end of May 2013)</b>
<p>Lock in dedicated technical support from PSI for timely analysis and dissemination of survey findings (possibly link to 2<sup>nd</sup> phase of ACT Watch?)</p>	<p>The Principal Investigator of ACTwatch project (PSI Nairobi) has provided technical support to the PSI-Mynamar research team. The Deputy PI of ACTwatch project will spend 1 month in Myanmar to assist in OS data analysis and report writing. PSI/Myanmar has planned to present the OS survey findings at MIM’s conference in October this year.</p>
<p>Consider disaggregating the results of the outlet survey by containment zone</p>	<p>PSI/Myanmar will disaggregate the results into intervention (where intensive BCC activities exist) vs non-intervention to be in line with the key AMTR project interventions.</p>
<p>Monitor all five outlet types but with a focus on a subset of three – general retailers, pharmacies and IDVs given their importance for AMT and consider careful messaging.</p>	<p>The results from baseline outlet survey were analyzed according to disaggregated outlets. The log frame was revised based on those results. RDT Phase 1 will be implemented on “pure private outlets”.</p>

## Follow up to recommendations from First Annual Review, October 2012 – cont (3)

Recommendations, from first annual review	Action to date (as of end of May 2013)
Map other distributors and their comparative advantages (e.g., AMT and other market share, network, MIS, geographical coverage)	A matrix was developed and submitted to Competition assessment team and to DFID
Ensure adequate PSI resource for continued dialogue with additional distributors (e.g. Polygold)	Commenced and on-going
TA to support for Competition Assessment and forward strategy asap.	Competition Assessment completed by a competition specialist from the UK Office of Fair Trading in May 2013 (in conjunction with the mid-term review)
Update logframe using baseline data from OS and HH surveys.	Completed and submitted

## Follow up to recommendations from First Annual Review, October 2012 – cont (4)

<b>Recommendations, from first annual review</b>	<b>Action to date (as of end of May 2013)</b>
Provide Year One timeline for key events (surveys, survey findings, MOU & key agreements)	Completed. Year Two key event timeline is in process.
Monitor wider epidemic and QA ACT availability in the public sector in real time by accessing NMCP data where possible	TSG is the appropriate forum, to which PSI attends. However, data at central level is still fragmented.
Consider if further communication (from MOH etc.) regarding Artemether ban is required	There is no evidence to suggest this is necessary yet, but PSI are monitoring closely. Year two surveys will inform the programme about the severity of this risk relative to year one.
Assess sustainability of ACT market in the absence of a subsidy at the next review (May 2013)	Completed. The programme will require a subsidy for the foreseeable future (as outlined in the Mid-term Review and the competition assessment report)

## Follow up to recommendations from First Annual Review, October 2012 – cont (5)

<p style="text-align: center;"><b>Recommendations, from first annual review</b></p>	<p style="text-align: center;"><b>Action to date (as of end of May 2013)</b></p>
<p>DFID Burma &amp; PSI to agree a methodology to measure the DFID indicator ‘# of women &amp; men who receive appropriate treatment to contain the spread of drug-resistant malaria’ and incorporate this within the log frame</p>	<p>PSI has done estimations based on the ACT distribution data from distributor, RDT positivity rate and ratio of falciparum vs vivax through its SUN channel network to get this indicator. PSI has submitted the baseline figure to DFID, and will incorporate it into the logframe.</p>
<p>PSI to seek guidance from the MOH on the treatment of <i>P. Vivax</i> cases which are likely to increase as a proportion of all malaria and fever cases as <i>P. Falciparum</i> declines</p>	<p>This is not relevant to the concept of AMTR project. In the RDT scale up phase, PSI will incorporate the vivax treatment guideline into its training and communication messages/materials. However, commodities for vivax was not budgeted in the original proposal.</p>
<p>DFID &amp; PSI to seek to work with Parliament and wider stakeholders in order to engage more widely on malaria resistance containment.</p>	<p>PSI is not in a position to advocate the containment work up to parliamentary level, but PSI’s relationship with DOH and all key stakeholders, partners has improved particularly with FDA.</p>