Pilot on Integrating Drug Store Operators into Sub-National Health Systems with the Context of Family Planning

Anambra and Enugu states are two of the five South-East States in Nigeria. The health system in both states is similar to that at the federal level where health policy and implementation is driven by the state ministries of health (SMOH) and funding for service delivery is publicly and privately funded. Private funding consists mainly of out-of-pocket expenditures and donor aid.

Both States are implementing health sector reforms aimed at solving the issue of inequity in health distribution. One reform which they currently implement is the Task Shifting and Task Sharing (TSTS) policy which aims at increasing access to health services in the rural areas by building capacities of lower cadre health workers to perform tasks which they would not ordinarily perform as per their pre-service training and medical statutes. This policy implementation is to be scaled to prioritized health programs like HIV/TB and Reproductive Maternal Neonatal Child and Adolescent health (RMNCH). Within RMNCH, the priority program area for TSTS is Family Planning (FP).

Problem

According to data from the National Population Commission, Nigeria's population is estimated at [1]198 million and with a [2]Total Fertility Rate (TFR) of 5.6 (Urban-4.9; Rural – 6.3), the population is expected to keep growing exponentially over the next decades. This presents a challenge to the country and to family units as resources required to provide for the population at these organizational units are limited. Family Planning, especially modern methods, presents a solution to this as it enables family units space their children to a number that they can adequately provide for, however, the supply and demand for FP services are also limited.

[3]Table 1: Anambra and Enugu FP Indices

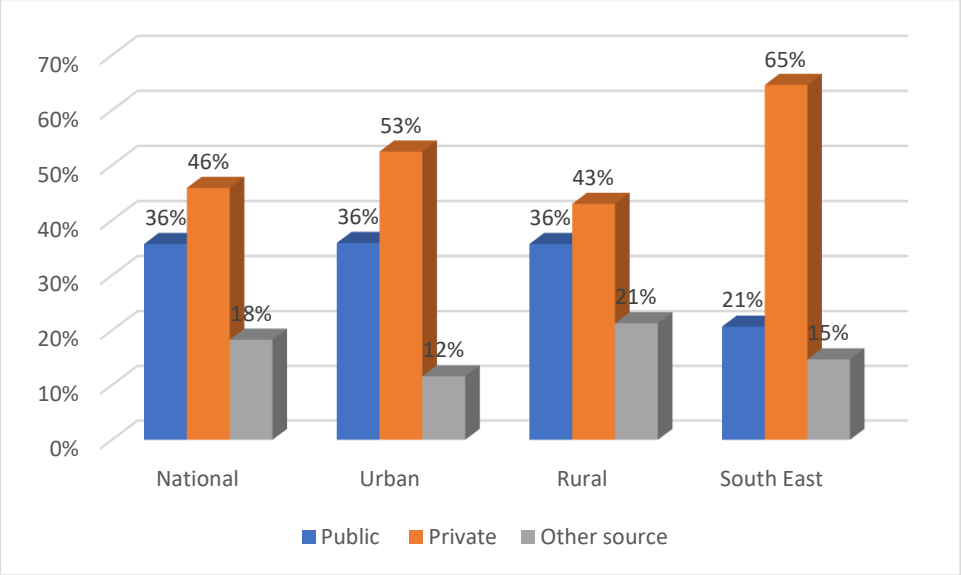
	[4]CPR (Modern Method)	CPR (Any Method)	[5]Unmet Need for FP
Anambra	16.9%	28.2%	22.0%
Enugu	18.0%	22.1%	25.1%
Urban (Nigeria)	17.9%	21.1%	27.5%
Rural (Nigeria)	7.7%	10.0%	27.7%

[1] National Population Commission http://population.gov.ng/
[2] MICS 2016_17
[3] MICS 2016_17
[4] Contraceptive Prevalent Rate - Percentage of women age 15-49 years currently married or in union who are using (or whose partner is using) a contraceptive method.
[5] Unmet need for FP -Percentage of women age 15-49 years currently married or in union with an unmet need for family planning and percentage of demand for contraception satisfied

Table 1 above shows FP data for two South East States – Anambra and Enugu. It reveals that both CPR and Unmet needs for FP are low and the country average shows that there is in-equity in distribution with the rural areas worse off. The unmet need for FP, an indirect indicator of the supply of FP services is quite high in both states and is mainly due to the paucity of skilled health workers who have the capacity to provide FP services. It can be inferred that the unmet need is a low hanging fruit which can be harnessed if the supply of a workforce, skilled in FP service delivery is increased.

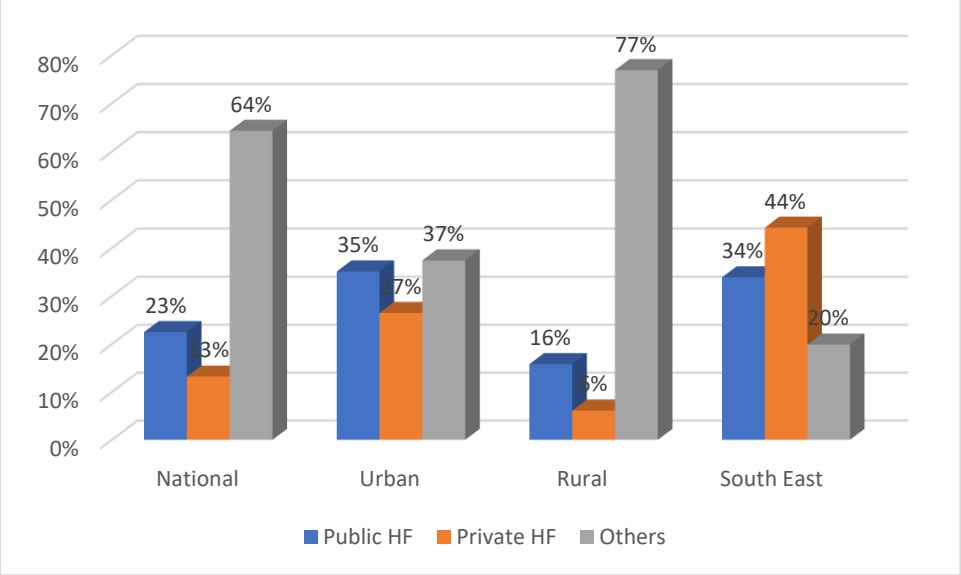
In order to increase the HRH workforce, most funders train providers especially in the public sector and this is fraught with the following problems

1. The high attrition rates in the health sector usually leave gaps in the health workforce especially when one-off training are instituted without adequate plans for effective step-down
2. The private sector is largely left out of these capacity building exercises despite the fact that over 60% of the population access health care from the private sector as illustrated in the example of figure 1 and 2 below which shows that for Malaria and delivery, over 50% of the population seek services from non-public providers. It can be inferred that this data might also play out in other diseases.



[6]***Figure 1: Source of Anti-Malaria***

[6] NDHS 2013



[7]***Figure 2: Place of delivery***

In an attempt to solve this problem SSDO implemented a pilot intervention to integrate drug store operators (DSO) which comprise of proprietary and patent medical vendors(PPMV) and community pharmacists(CP) into sub-national health systems to offer quality services to the huge number of Nigerians that rely on them for healthcare needs.

10 LGAs spread across Anambra and Enugu states, along with their major PHC and adjoining DSOs were selected for the pilot.

[7] NDHS 2013

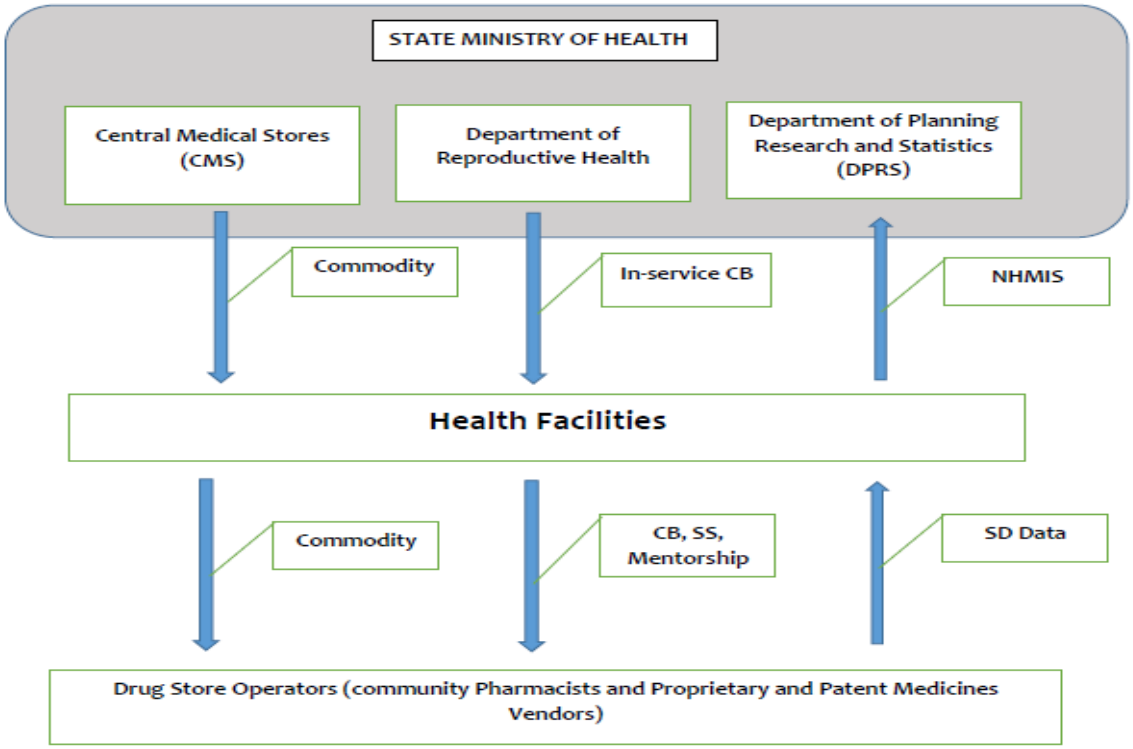


Figure 3:DSO Integration Framework

The Integration framework above was utilized in the pilot and on completion, results below show that the model is feasible and if scaled, can increase CPR to country targets and greatly reduce the rural-urban disparity in CPR.

2 states

10 PHCs

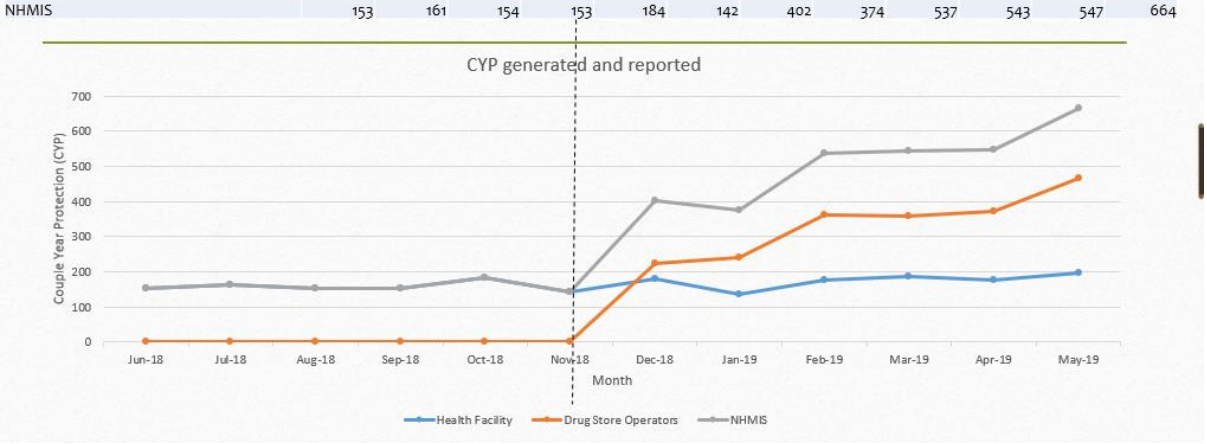
10 Master trainers (pictures)

69 Drug Store Operators (DSO) trained (pictures)

method mix (infographic) get some infographic from this http://crs.org.np/achievement

2020 CYPs generated and integrated into NHMIS within 6 months

CYP	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Health Facility	153	161	154	153	184	142	178	134	175	186	177	197
Drug Store Operators	0	0	0	0	0	0	224	240	362	357	370	467
NHMIS	153	161	154	153	184	142	402	374	537	543	547	664



It is conceivable that it could be more cost-effective and sustainable than current methods, hence scaling would be at a fraction of the cost of implementing the current methods of DSO capacity building, however, a cost-effectiveness study should be conducted to generate evidence for such policy.

Although implemented within the FP program area, it can easily be extended to Malaria, HIV/TB and iCCM.

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Integrating Drug Store Operators into S