*Version control*

| *23-May-22* | *Initial version of the table with content based on information held by ORSZCA put online and members invited to edit and comment* | *SB* |  |
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| *To 14-Jul-22* | *Content added by ORSZCA members* | *Various* |  |
| *15-Jul-22* | *Content added during ORSZCA Roundtable: Enablers & Barriers to ORS/Zinc coverage* | *EP* |  |
| *18-Jul-22* | *Event chat comments added* | *JB* |  |
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| *25-Jul-22* | *Re-posted online for members to suggest edits and comment* |  |  |
| *9-Oct-23* | *Updated Pakistan enablers (co-pack on national EML) and colour-coded Enablers and Barriers* | *SB* | *This document* |

 

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**Enablers and barriers to increased ORS and kiko kiZinc coverage in the countries with t ee ok uuhe highest diarrhoea burden**

Document status: *work in progress*

*ADD CONTEXT - eg This document results from an online round tablejb wilby jni organised by ORSZCA under the auspices of PATH and the Child Health Task Force. Thirty-two experts came together, 15 July 22, to share their views on enablers and barriers to expanding ORS and zinc coverage. Participants included several organisations that have run ORS/Zinc programmes and academics with experience in evaluating these activities, as well as two co-pack manufacturers (Nigeria and Zambia). These enablers and barriers have been captured in our Enablers & Barriers table which is open for additional views and comments here, either in French or English. The colum ll kkns in this table are based on the framework suggested in the review: Progress over a Decade of Zinc and ORS Scale-up (Feb-2016) - Diarrhoea & Pneumonia Working Group.*

*We have also recorded the main contributions made during the event* [*here.*](https://docs.google.com/document/d/1qyFdPbpOz8ID1omFiVoqcNFw6U7xbhPCf4XqSVV-Ids/edit) *This document is also open to comments.*

This table is split into two sections:

1. GENERAL - these are a statement of the generic enablers and barriers.

2. COUNTRY SPECIFIC - this section reflects, or will reflect, the current situation in each country. It will list actual and current enablers and barriers.

| **Country** | **Burden Rank** |  | **Enabling environment (policy, regulation, funding etc)** | **Product supply (inc quality, affordability, public & private sectors)** | **Institutional demand (public & private sector health providers & their agents)** | **Caregiver demand** |
| --- | --- | --- | --- | --- | --- | --- |
| **Scroll v^ to see table content** |
| **GENERAL** | **N/A** | kk**Enablers** | • Co-packaged ORS/Zinc now recommended by WHO (since 2019). • GFF ‘Reclaim the Gains’ focus on diarrhoea treatment.• ‘We know what works’. • Need for focussed effort on countries/areas falling behind in diarrhoea case management, building on 18 years of learning. • Getting co-packaged ORS/Zinc on the national EML. • Getting commitment from the Ministry of Health to a change in strategy (quicker than the EML route). • OTC status. • Licence-free OTC status (ie any retailer can sell Zinc without the need for a licence). • Continued advocacy. • Capacity-building as part of national policies. • ORS/Zinc treatment included by WHO as one of the published core indicators for paediatric QoC• Improving the quality of diarrhoea management programmes to include zinc/ORS (cf Nutrition International in Ethiopia, Kenya, Nigeria, Senegal, Pakistan and Bangladesh). • Comprehensive programs that to encompass policy, supply and demand (caregiver and provider). • Strengthen both prevention and management of diarrhea, efforts improve national policies, coverage and care-seeking behaviour together. • Large scale programming, adapted to the country context with tactics that will work. • ROI is an enabler because coverage is dierctly related to a reduction in diarrhoea mortality; the countries with the highest prevalence have the lowest coverage of ORS and Zinc. • Raw material suppliers (eg of Zinc) may be open to supporting local manufacture through supply at no/low cost (eg linking into SDGs – eg SDG 17 - for CSR). | • Local manufacture.• Availability of co-packs in the public and private sectors.• Viable value-chain for co-pack (ie an ex-factory price that enables good margins to be made by those in the distribution chain AND for the product to be affordable for the majority).• UNICEF Supply Division have opened a call for tenders for ORS/Zinc products including co-packs (RFP-DAN-2022-503459: Medicines for diarrhoea treatment) (5-Jul-22)• Pandemic preparedness (no disruptions in global supply chain, etc.)• Large scale-up programs• Availability of raw material at reduced/low cost; coordination on supply chain logistics, etc. • Partnerships with international and local pharma companies can address gaps in supply and to ensure high-quality products are available. • Consider innovative supply models such as having the co-pack alongside vaccine delivery. | • On the national EML.• Government procurement.• High caregiver demand.• Free distribution within communities.  | • Affordability. • High awareness (social marketing, making co-pack a household name). • Effective on-going multi-channel advertising (needs profits to be big enough - relates to there being a viable value chain. Could be paid for with donor assistance). • Celebrity engagement. • Affordability. • Highly desirable product that delivers on expectations. • Geographical accessibility • Co-investing in demand generation with Ministries of Health, pharma manufacturers and other suppliers; sharing/ collaborating on demand generation plans to coordinate on messaging, branding, and aligning distribution with demand activities.  • Ensure ORS/zinc already primed on the shelves at the same time as community demand generation activities.   |
| **Barriers** | • No current donor supported ORS/Zinc Diarrhoea *specific/vertical* programmes (except GFF). • Waning momentum globally on diarrhoea. • Current donor emphasis on neonatal health. • Infrequency in updating national EMLs. • Licensing for retailers of Zinc (even if it is ‘over the counter’). • Lack of clarity/recent research insights into how much ORS and how much zinc should be in a co-pack (eg could zinc duration be reduced?eg given changing epidemiology due to rotavirus vaccination; eg reduction in Zinc deficiency;eg issues with 10 day adherence.(cf the recent publication about the need to reduce the dosage of zinc from 20 mg to probably 5 mg: NEJM 2020 Lower-dose zinc for childhood diarrhea - a randomized, multicenter trial<https://www.nejm.org/doi/full/10.1056/NEJMoa1915905>.) • Lack of programmes designed to fundamentally change the local systems to ensure long-term demand/supply for ORS/zinc. • Co-packaging is a narrow focus in terms of policy attention; yet also a high impact / high return one, which doesn't actually require much (any) more money. • EQUITY: National level numbers uptake of a co-pack is not telling enough of a story. How can we better leverage the focus on "zero-dose" kids in immunisation to make sure we are getting to the kids most likely to die from diarrhoea? • Poor adherence to IMCI in general (see 7 country analysis, Boggs, USAID)Lack of high-quality data to monitor programs and assess progress. We need to better use data to improve targeting, especially to reach "zero dose", and the most vulnerable and marginalised children. • COVID has caused the focus of public healthcare to move away from diarrhoea. | • High cost of co-packs in the UNICEF catalogue. Currently (Jul-2022) co-packs in the UNICEF catalogue are more than twice the price of the component parts bought separately. However, UNICEF have recently started a re-tender for ORS/Zinc products (see Enablers above). • Limited outlets (relates to: OTC status; type of OTC status; viability of value chain etc).• No local manufacture of co-packs. • Supply chain gaps, globally (Maternova), Including cost efficient logistics and shipping challenges. • Limited registered suppliers locally is a great challenge. • Finding dedicated international distributors who are willing to guide and partner with equally dedicated local suppliers is rare. • QUALITY - (product and care provision) see the just-published WHO proposed Pediatric QoC core indicators which explicitly reference treatment with ORS/Zn. Improvement will require both public and private sectors. • Lack of manufacturer ‘agency’ and certainty over what a co-pack should include (how many sachets of ORS? How much zinc?) • Local manufacturer tends to see the NGO as a short-term (project-based) customer, rather than seeing the MOH as a long term customer or designing manufacturing for their own local market. | • Affordability.• High cost of co-packs in the UNICEF catalogue.  | • Affordability. • Lack of awareness. • ORS Zinc co-therapy and co-packs have not been promoted with the same vigiour as ORS was originally to make it a household name. • Multiple strategies are necessary to generate demand; social marketing, ramping up demand side actions.In many settings with rapidly urbanizing populations and economic development, interventions that are perceived as being “for the poor” achieve lower coverage/compliance as wealth and education increase - need for improved strategies to market ORS/Zinc as an important intervention for all and to destigmatize it as an intervention only for the poor |
| **Nigeria** | **1st** | **Enablers** | • Co-packaged ORS/Zinc already on the national EML (although many don’t know this). • [GFF Partner country](https://www.globalfinancingfacility.org/where-we-work) and [IDA Borrowing Country](https://ida.worldbank.org/en/about/borrowing-countries)• GFF contact Munirat Ogunlayi • Co-pack in Drug Recovery Fund scheme • Advocacy • Programmes by CHAI/USAID to develop the market for ORS/Zinc.  |  • Local manufacture in place (see<https://orszco-pack.org/orsz-status/nigeria/>). • Availability of co packaged ORS/Zinc in all outlets and OTCs to have an approval.[3]  • Availability to co-pack at appropriate levels of care, closest to caregiver. • (Possibly) include Zinc/ORS co-packs in the drug revolving funds to attempt a sustainable supply to health facilities.  • Product supply is adequate. (see demand/awareness barrier). | • Co-packaged ORS/Zinc included in NEML. • High caregiver demandAccess to ORS/zinc; appropriate counselling • Involvement of CHWs (typically via a project, experience stockout, lack of motivation, etc.) • Need to strengthen community-based platform, including access to co-pack • Funded multi-sector coordination, on messaging, branding, and aligning distribution with demand activities (e.g. ensuring there was ORS/zinc already primed on the shelves at the same time as we did community demand)  | • Affordable ORS/Zinc exists in the market. • Caregiver perceptions/awareness • Sustained demand generation to ensure long-term use of ORS and zinc. (No drop seen post-intervention in Nigeria; DHS 2018)- (Needs verification, see Barriers)  |
| **Barriers** | • The structure of the national EML is confusing. • Lack of awareness that co-packaged ORS/Zinc is already on the national EML. • Only 20% of rural health centres are functional. • Lack of support for a community-based platform. • Lack of institutionalisation of ORSZ projects into mainstream/nationwide. • Lack of uniformity in terms of co-pack design and treatment administration guidance (confusion over correct number of sachets of ORS combined with pack of 10 zinc?) | • Frequent stock out• Product distribution aligned with NGO project work; lack of broader advocacy/sensitization. • Falling of sales and awareness after project end/donor withdrawal. • Distribution may only be to the states that have NGOs/donors running projects. • Distribution needs to be backed up with and co-ordinated with community awareness and sensitisation, detailing with pharmacies.. | • Awareness and prescriber preferences. Majority of doctors/health personnel not prescribing or advising the patient to go with ORSZ. • Inadequate detailing with pharmacies. • Community-level awareness in ORS/Zinc has fallen since withdrawal of donor-funded initiatives (USAID/SHOPS, CHAI, IKEA).  | • Awareness – biggest problem. • Continuing awareness falls after donor support removed/end of advocacy/sensitisation projects • Lack of on-going support for community-based platform (a co-ordinated ongoing advocacy approach).   |
| **India** | **2nd** | **Enablers** | • Central Drugs Standard Control Organization (CDSCO) has approved ORS/Zinc co-packs. • From 2019 the Government introduced co-packaged ORS/Zinc in their Intensified Diarrhoea Control Fortnight (IDCF) guidelines. Free distribution by ASHAs, timed at beginning of Monsoon Season. • Focused health programs related diarrhoea control.(IDCF/MDD) | • Local manufacture (needs verification) but only for export. • ORSZ supply is free to caregivers prior to onset of high-risk diarrhoea season every year. (IDFC). • ORS uptake good. • Co-pack approved by WHO (2019).  |   | • Vital role of community health workers in education /compliance. • Sustained demand generation to ensure long-term use of ORS and zinc. (No drop seen post- intervention in India: NFHS data 2019-20).   |
| **Barriers** | • Co-packs not on the NLEM (National List of Essential Medicines).• Government concerns over price of co-packs. • NOT a GFF Partner country. • NOT an IDA Borrowing Country. • Limited research; operational research. • Lack of advocacy at the national/state level; lack of government uptake (co-pack still not provided via main programs). • No Government supply of ORS-Zinc Co-pack. • No research related to ORS-Zinc co-pack. • No institutionalisation of the co-pack. |  • Before 2018 co-packaging was not allowed in India (changed in 2019 with WHO approval). • No co-pack availability in market or in-house programme. • OTC availability – if it were available OTC this would help. • Zinc uptake is low (2018). • ORS and Zinc are supplied separately but stocking rates may be variable. • Lack of implementation research related to co-packs (this would lead to government backing, improved uptake of the co-pack and better outcomes at community level). • COVID has impacted on other programmes and on government priorities; the new WHO recommendation came in the thick of COVID.  | • Lack of awareness; prescriber practices – health staff unlikely to prescribe both ORS and Zinc, nor a co-pack. • No institutional demand till now.   | • ASHAs/community level networks and caregivers have lack of awareness about co-pack. (70-80% of diarrhoea cases are treated at community level). • People as well as physicians and paediatric associations are are not aware about ORS-Zinc ORS-Zinc co-pack. • Insufficient awareness programes (especially during and since COVID).  |
| **Pakistan** | **3rd** | **Enablers** | • [GFF Partner country](https://www.globalfinancingfacility.org/where-we-work) and [IDA Borrowing Country](https://ida.worldbank.org/en/about/borrowing-countries)• GFF contact Supriya Madhavan• ORSZCA questionnaire respondent interested in undertaking systematic review. • Optimum zinc requirements might be revisited: a shorter course may be reasonable and may reduce costs and increase compliance. Zinc deficiency at population level has changed (reduced by 50% in Pakistan).• Co-packaged ORS and Zinc added to the national level EML. However, health issues are devolved in Pakistan and this change is not reflected in provincial level EMLs. | • USAID through the POUZN\*\* project partnered with four local manufacturers of zinc to increase the availability of the product through both the public and private sectors.[4] Sales of Zinc increased by 257% during a span of about two years. • Local production is strong (most ORS is local; over 12 zinc manufacturers), mitigating global supply chain issues seen elsewhere. • Sales of zinc increased by 257% during a span of about two years. \*\* POUZN was implemented globally from 2005-2010 and in Pakistan from 2008-2010 |   |   |
| **Barriers** | • NELM not found online. • No documentation of the benefits of zinc (including in GAPPD) in children under 6 months. • Issues with administration to very young infants (under 6 months) and seeing impact for this age group.• Re-evaluate research on use of ORS and zinc (new evidence, changes in epi, administration trends, etc.) • Optimum zinc requirements need to be revisited: a shorter course may be reasonable/• pragmatic:eg 2-3 days may be adequate, during the acute phase. This may reduce costs and increase complianceeg rotavirus has changed prevalence and severity.eg Zinc deficiency at population level has changed (reduced by 50% in Pakistan). | • No co-pack products available in local market. (check? ZB mentions bundling for studies?). • The barriers are more than the supply chain only. (Bhutta et al). • Need more than one way to provide co-packaged ORS-zinc treatment; evaluation of co-packaged product for shorter duration (focusing on the acute diarrhoea stage). | • Understanding of different ways to administer (both provider and caregiver perspectives); re-evaluate epidemiology. • The private sector is not scaling up themselves, eg detailing by manufacturers.Social marketing has been limited. (ED: Is this due to low return on a low cost product like ORSZ compared to eg antibioitics?)  | • Need better understanding of community dynamics, barriers and messaging. • Two products in a co-pack with difference duration/ dosing may offer a complicated message to caregivers; families should be able to emulate guidance easily.  |
| **Ethiopia** | **4th** | **Enablers** | • Co-packaged ORS/Zinc added to the NEML in 2020 (available online).• [GFF Partner country](https://www.globalfinancingfacility.org/where-we-work) and [IDA Borrowing Country](https://ida.worldbank.org/en/about/borrowing-countries)• GFF contact Brendan Hayes· Convenient for the prescribers, dispensers and end-users (once awareness is created among providers, it was easily accepted)· Its benefit of Improving treatment outcome is perceived as another enabling factor· The product introduction doesn’t need intensive training to prescribers and dispensers; On Job Training is enough· Avoids fear of stockout of either of the products; ensuring availability of co-pack not loose form· Starting from 2020 - GoE. through SDG-PF solely financing for procurement of Zn-ORS co-pack• Availability to co-pack at appropriate levels of care, closest to caregiver | • Co-pack products available (Lem Lem Plus - see<https://orszco-pack.org/orsz-status/ethiopia/>)• Local manufacture of co-packs (EPHARM, DKT Pharmaceuticals). • Availability of co-packs in the private and public sectors(Co-pack cost varies on public and private sector at USD 1.00 and USD 1.50 respectively) • When there are stock outs there can be procurement from the international market. • Currently Zinc is more available at public sector than at private through SDG-PF donors. • Availability to co-pack at appropriate levels of care, closest to caregiver. • Health posts and health centers make re-supply requests for ORS zinc co-packs, based on their actual need - ensuring a pull supply chain. • Private sector advocacy includes media coverage promoting Zn-ORS as an OTC treatment - this improved the population’s awareness of the benefits. | • Diarrhoea treatment with zinc and lo\_ORS integrated in pre service training of health care providers. • As part of the national ICCM/CBNC\* and IMNCI\*\* key life saving commodities it is integrated into the national pharmaceuticals logistic system and re-supply is made based on request coming from health facility consumption.(\*Community Based Newborn Care \*\*Integrated Management of Newborn and Childhood Illnesses) • Access to ORS/zinc; appropriate counselling• Involvement of CHWs (typically via a project, experience stockout, lack of motivation, etc.)• Need to strengthen community-based platform, including access to co-pack • A range of strong partners including, CHAI, USAID grantees, R4D and others work collaboratively to strengthen the NCH supply chain management: that bring significant progress on ensuring access to commodities: A Technical Working Group - from partners and government MOH maternal and child health case team oversaw the broader Neonatal and Child Health (NCH) Commodities Supply Chain Management.  | • Caregiver perceptions/ awareness • Private sector advocacy includes media coverage promoting Zn-ORS as an OTC treatment - this improved the population’s awareness of the benefits. |
| **Barriers** | • Donors in-kind product support decreased/ceased e.g UNICEF used to procure ORS and CHAI used to procure Zn • Gov/donor finance decreasing • Sustainable financing models.• Effective advocacy and communication to key stakeholders/top mgt in government, to mobilise domestic financial resources and increase government treasury investment. • Challenges in securing hard currency for government as well as for private sector to import finished or raw material continues to be a challenge. • Lack of support for a community-based platform. • Lack of instutionalisation of projects into mainstream. | • Frequent and long period stock outs due budgetary constraints among other issues. The other issue is poor procurement method which related with limited registered suppliers for the co-pack. ET has long procurement lead time which causes delayed budget disbursement that causes significant stock-out in between. There is also an issue of poor supplier performance and management. • Private sector unable to secure required hard currency to import the medicine same with local manufacturer unable to produce the product due to hard currency shortage and high API/Ingredients price inflation at global level • Good demand for ORS, but not the same for co-pack.• Limited registered suppliers in country to distribute co-pack.• Increase in price (almost 3x)  | • Product continue to be distributed to public health facility for free through donor funding. • Zinc never procured through revolving drug fund (No domestic fund to-date).• Awareness gap• Weak implementation of logistic management information system• Supply base challenges.   | • Lack of support for community-based platform • Good demand for ORS, but not so much for the co-pack – more caregiver awareness of co-pack needed.  |
| **Chad** | **5th** | **Enablers** |  • [GFF Partner country](https://www.globalfinancingfacility.org/where-we-work) and [IDA Borrowing Country](https://ida.worldbank.org/en/about/borrowing-countries)• GFF contact Alain-Desire Karibwami |   |   |   |
| **Barriers** | • ORS/Zinc status not widely known (NELM not found online) |   |   |   |
| **Niger** | **6th** | **Enablers** |  • [GFF Partner country](https://www.globalfinancingfacility.org/where-we-work) and [IDA Borrowing Country](https://ida.worldbank.org/en/about/borrowing-countries)• GFF contact Charlotte Pram Nielsen (cnielsen@worldbank.org) |   |   |   |
| **Barriers** | • ORS/Zinc status not widely known (NELM not found online) |   |   |   |
| **DRC** | **7th** | **Enablers** |  • [GFF Partner country](https://www.globalfinancingfacility.org/where-we-work) and [IDA Borrowing Country](https://ida.worldbank.org/en/about/borrowing-countries). • Discussions underway about introducing co-packs. • GFF contact Patrick Hoang-Vu Eozenou. • Zinc available OTC. • No licence required to sell Zinc. |   |   |   |
| **Barriers** | • Low awareness of Zinc among caregivers. • Co-packaged ORS/Zinc not on NELM. • ORS/Zinc status not widely known (NELM not found online). |  • Co-packs not available |   |   |
| **Cameroon** | **8th** | **Enablers** |  • [GFF Partner country](https://www.globalfinancingfacility.org/where-we-work) and [IDA Borrowing Country](https://ida.worldbank.org/en/about/borrowing-countries)• GFF contact Jean De Dieu Rusatira. |   |   |   |
| **Barriers** | • Co-packaged ORS/Zinc not on NELM. • ORS/Zinc status not widely known (NELM not found online) |  • Co-packs not available |   |   |
| **Madagascar** | **9th** | **Enablers** |  • [GFF Partner country](https://www.globalfinancingfacility.org/where-we-work) and [IDA Borrowing Country](https://ida.worldbank.org/en/about/borrowing-countries). • GFF contact Jakub Kakietek |   |   |   |
| **Barriers** | • ORS/Zinc status not widely known (NELM not found online) |  • Co-packs not available |   |   |
| **Somalia** | **10th** | **Enablers** | • ORS and Zinc in National Clinical guidelines for diarrhoea treatment and in EML • Zinc available over the counter. • Discussions underway about introducing co-packaged ORS and Zinc. • [GFF Partner country](https://www.globalfinancingfacility.org/where-we-work) and [IDA Borrowing Country](https://ida.worldbank.org/en/about/borrowing-countries)• GFF contact Tawab Hashemi. • Government interested in developing a child survival strategy (20-Jun-22) |   |   |   |
| **Barriers** |   |  • Co-packs not available |   |   |
| **Bangladesh** |  | **Enablers** |   |   |   |   |
| **Barriers** |   |   |   |   |
| **Burkina Faso** |  | **Enablers** |   |   |   |   |
| **Barriers** |   |   |   |   |
| **Kenya** |  | **Enablers** | •  [GFF Partner country](https://www.globalfinancingfacility.org/where-we-work) and [IDA Borrowing Country](https://ida.worldbank.org/en/about/borrowing-countries) • ORS and Zinc in National Clinical guidelines for diarrhoea treatment and in EML(2019)    | • Availability to co-pack at appropriate levels of care, closest to caregiver • Availability of local production of co-pack product.   | • Access to ORS/zinc; appropriate counselling. • Involvement of CHWs (typically via a project, experience stockout, lack of motivation, etc.) • Need to strengthen community-based platform, including access to co-pack.  | • Caregiver perceptions/ awareness.   |
| **Barriers** | • Lack of support for a community-based platform. • Lack of institutionalisation of projects into mainstream.   |   |   | • Lack of support for community-based platform • Low awareness of Zinc amoung caregivers. |
| **Mexico** |  | **Enablers** |   |   |   |   |
| **Barriers** |   |   |   |   |
| **Nepal** |  | **Enablers** |   |   |   |   |
| **Barriers** |   |   |   |   |
| **Peru** |  | **Enablers** |   |   |   |   |
| **Barriers** |         |   |   |   |
| **Senegal** |  | **Enablers** |   | • Availability of co-pack at appropriate levels of care, closest to caregiver. | • Access to ORS/zinc; appropriate counselling• Involvement of CHWs (typically via a project). • Need to strengthen community-based platform, including access to co-pack. | • Caregiver perceptions/awareness    |
|  | **Barriers** | • Lack of support for a community-based platform• Lack of instutionalisation of projects into mainstream. | • Experiences of product stockout. | • Project based so far – not institutionalised.• CHWs, being volunteers, may experience lack of motivation, lack of access to sufficient stock etc |   |
| **Sudan** |  | **Enablers** |   |   |   |   |
| **Barriers** |   |   |   |   |
| **Tanzania** |  | **Enablers** |   |   |   |   |
|  | **Barriers** |   |   |   | • Drop in demand for ORS only seen post-intervention (CHAI, F Lam).  |
| **Uganda** |  | **Enablers** |   | • Local supply may assist in overcoming international supply chain challenges. | • Community health workers are the main facilitators (providing prior to illness); via ICCM.   | • Very large increases found in usage when BRAC Uganda community health workers distributed ORS prior to illness (Levine et al). |
| **Barriers** |   | • Stockout (45% CHWs have access, 2021 Study). • Provision to the lowest level and prior to illness. • Commodities provided free –> increase in use at household level. • Uganda presents challenges for international shipping (eg landlocked/geographically challenged). | • Only 45% of CHWs equipped with both ORS and zinc. • Demand is increaasing for ORS/Z, yet supply is shrinking – this is a unique market situation. |   |
| **Zambia** |  | **Enablers** | • Although the co-pack development work and its initial scale-up was donor supported, everything was done exclusively through local organisations and systems. The donor-supported initiative did nothing to make itself a permanent part of the solution. The result was a self-sustaining that is locally managed. However, there are public sector budgetary constraints (see Barriers). • Participatory design of co-pack product and trial, adapted to local context, including local and iNGOs and manufacturer under oversight of MoH. • Customer consultation at key points on preferences, barriers to use of ORSZ and Willingness to Pay. • On-going wide, multi-sector consultative interest group throughout initial planning, trial and scale-up of adapted co-packaged ORSZ product, incl local and iNGOs, private sector, medicines regulator (ZAMRA) and public sector medicines distributor (MSL). • Strategic commitment to co-packs by MoH (even though they are not yet formally included in the national EML).       | • Local manufacturer included in initial project planning, co-pack product design and value chain trial, to ensure harnessing of local knowledge and to foster decision-making, product ownership and agency. • Local manufacturer now supplies to MOH as well as private sector – this supports a stable supply chain. • Adequate local manufacturing capacity (project development assisted with R&D process). • The government is currently ordering more litre sachets of ORS than co-packs (NB this is OK as co-packs are optimal for home treatment). • Co-packs available over the counter and retailers do not need a licence to sell (even supermarkets sell co-packs) • Co-pack is provided by the private/public sector; branded, national government engaged. • Co-packaging improved access to the combined treatment (ORS/Zinc coverage rate rose from close to zero to 35% - DHS 2019). • Focus on co-pack design incorporating design thinking and trial lessons. • improved ZInc adherence using co-pack. | • MoH involved from the outset (chair of the steering group) even though the original focus of the co-pack introduction was through the private sector. • MoH allowed CHWs to promote co-packs even though they were only available initially through the private sector. This led to high awareness of and enthusiasm for the co-packs in the public sector (MoH staff and CHWs). • Following the private sector trial, the government adopted co-packs as preferred means of home treatment. Co-packs now available in the public sector are government branded. • Project funded training/ awareness programme for government/district health personnel, decision makers, traditional leadership and retail sector (including small shops).  | • Focus on user involvement in co-pack design (design thinking) and pricing. • Co-pack retail price based on ability to pay and value chain designed based on ability to pay (value chain =wholesale/retail/ex-factory prices). Initial subsidy applied at the top of the value chain (ie to bring down ex-factory price to the necessary level). This subsidy was not necessary beyond the trial due to co-pack redesign (to make in cheaper) and economies of scale. • Project funded programme of sensitisation and marketing about the co-pack, integrated with local and government and NGO health provision (down to community health workers/other projects in similar fields). • Initial use of vouchers to launch value chain for co-pack and establish ‘pull’ into remote areas. • Local radio/billboards during project and scale-up; TV ads arranged by manufacturer/ MoH introduced after scale up projects ended (local ownership). • Good caregiver awareness and demand for co-packs now established. • Co-packs are now free at health centres. |
| **Barriers** | • Government budgetary constraints. | • Supply below demand levels due to budgetary constraints at MoH (free co-pack). • Affordable retail co-pack product but still limited use among low-income groups. • Zambia has a limited range of manufacturers in-country and only one co-pack manufacturer.   | • Demand outstrips supply due to budgetary constraints. • Zambia’s pharmacy network is still under-developed/ mainly concentrated in main towns. • MoH plans and policy to develop a network of trained, smaller drug stores (cf Tanzanian model of ADDOs – Accredited Drug Dispensing Outlets) not advancing due to budgetary constraints.  |   |
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