Policy brief.
What and why?

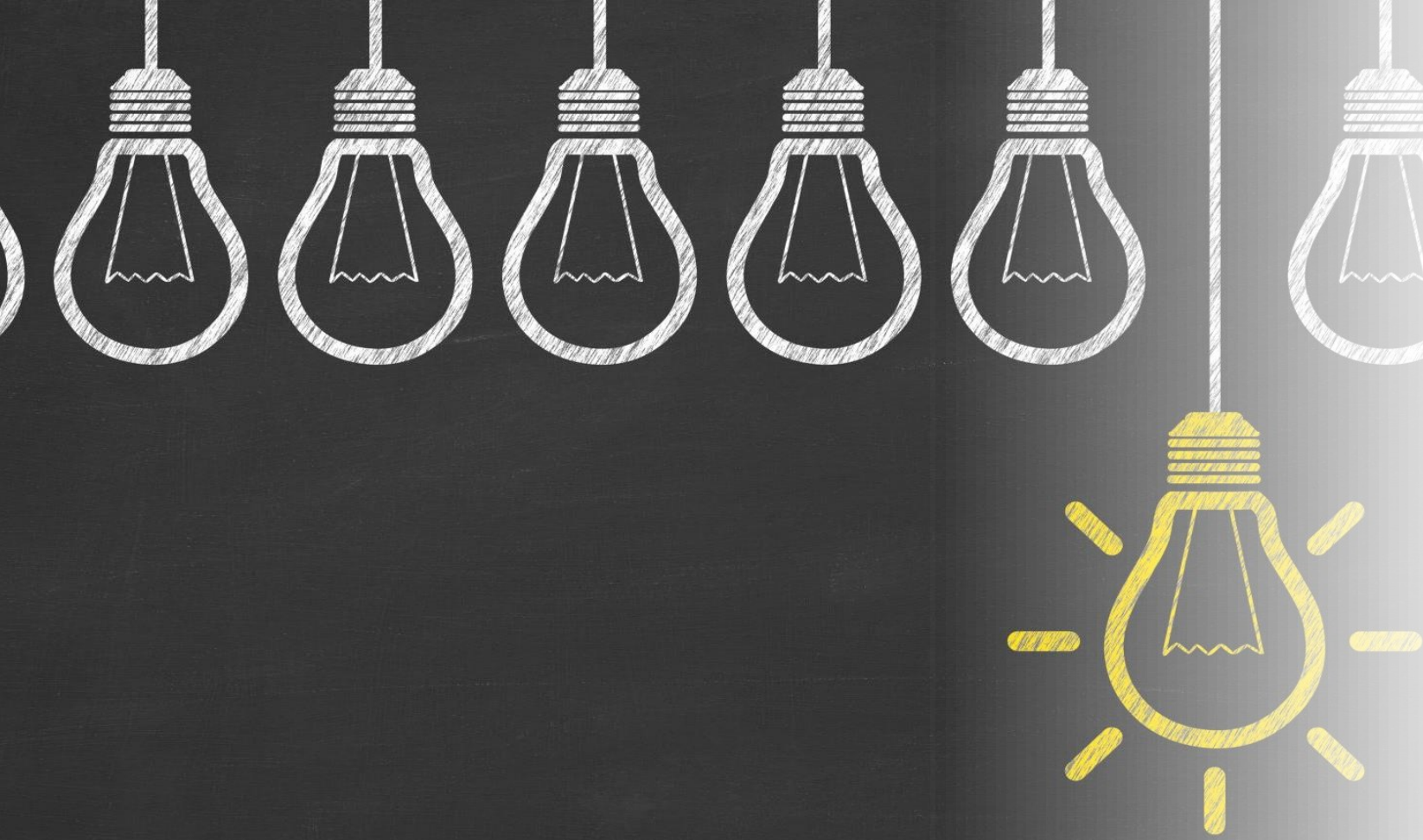
Talk’s plan

- What? Definition of policy brief
- Why? The place of policy brief in decision making
- Content of a policy brief

- Possibility of peer-review publication through policy brief

Policy brief? – 1st definition IDRC (International Development Research Centre)

- A short document that presents the findings and recommendations of a research project to a non-specialized audience
- A vehicle for providing policy advice



Policy brief – 2nd definition by FAO

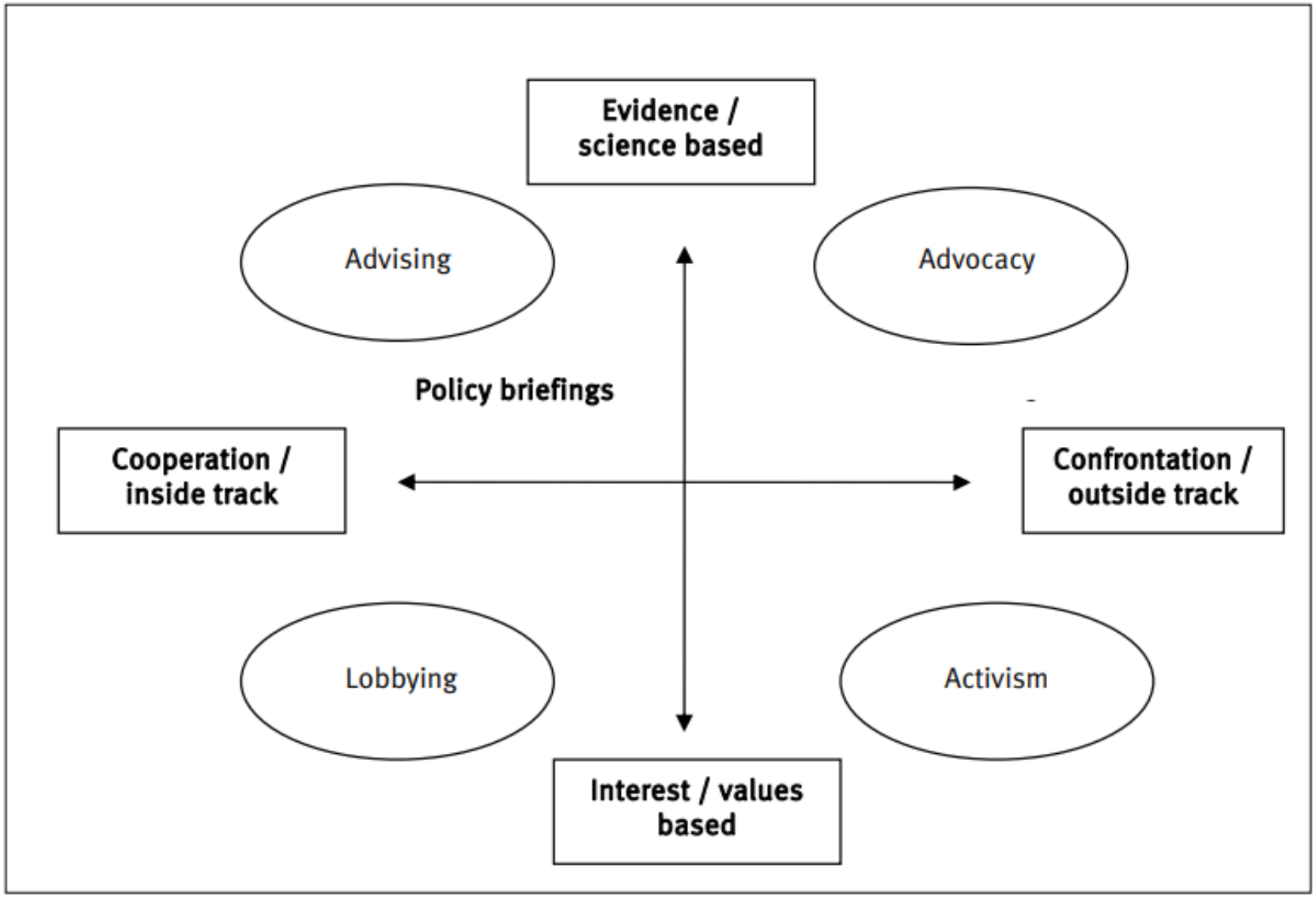
- Is a concise summary of a particular issue, the policy options to deal with it, and some recommendations on the best option. It is aimed at government policymakers and others who are interested in formulating or influencing policy.

WHO definition

- Evidence-based policy briefs (or “evidence briefs for policy) bring together global research evidence (from systematic reviews) and local evidence to inform deliberations (policy dialogues) about health policies and programmes.

What should be components of a policy brief

- Brief
- Policy advice
- Options
- Evidence based


Evidence / science based
Advising
Advocacy
Policy briefings
Cooperation / inside track
Confrontation / outside track
Lobbying
Activism
Interest / values based

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Health Research Policy and Systems

RESEARCH Open Access

Systematic review and policy dialogue to determine challenges in evidence-informed health policy-making: findings of the SASHA study

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Majdzadeh *et al.*
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Health Research Policy and Systems

RESEARCH Open Access

Policy options for strengthening evidence-informed health policy-making in Iran: overall SASHA project findings

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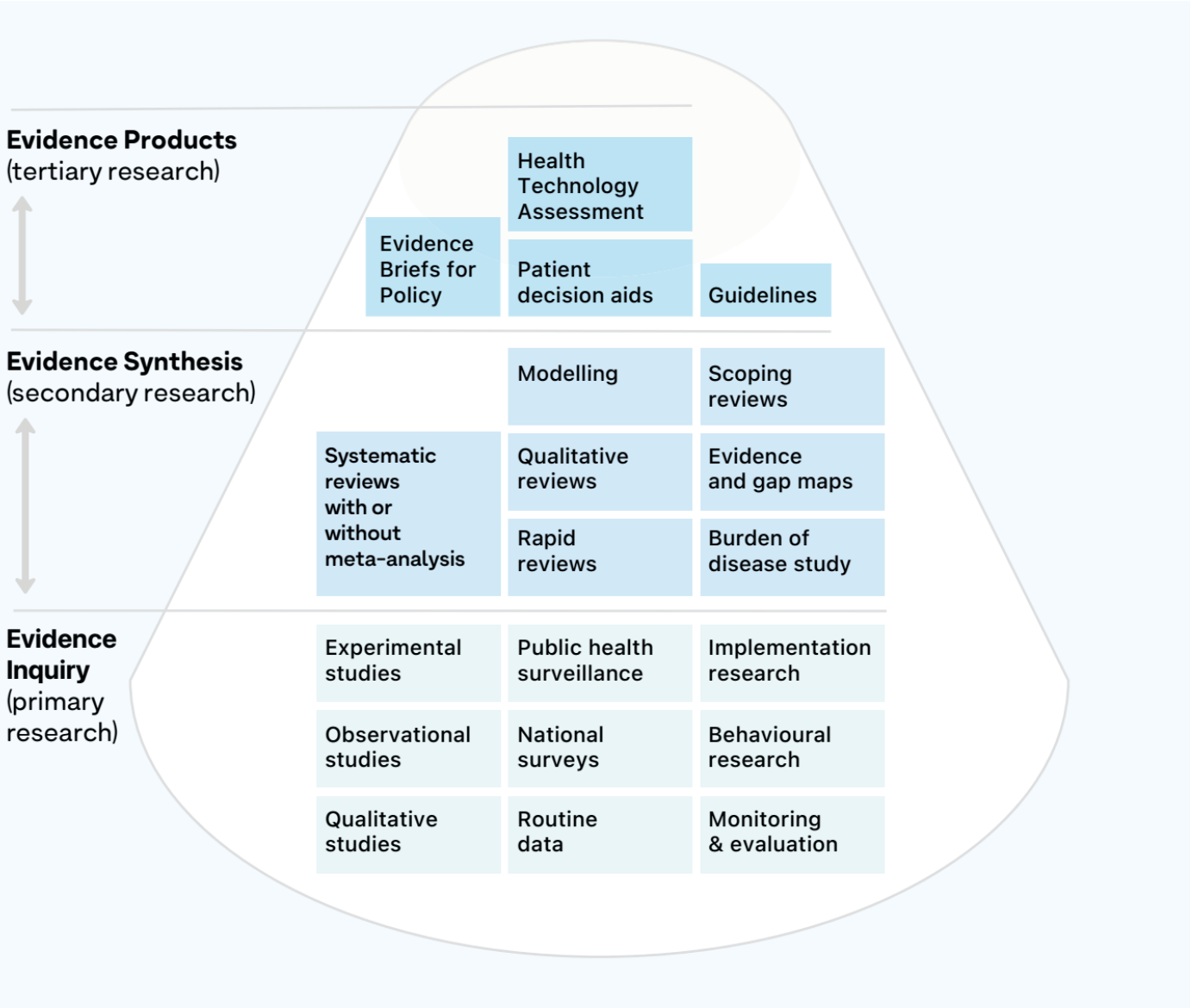
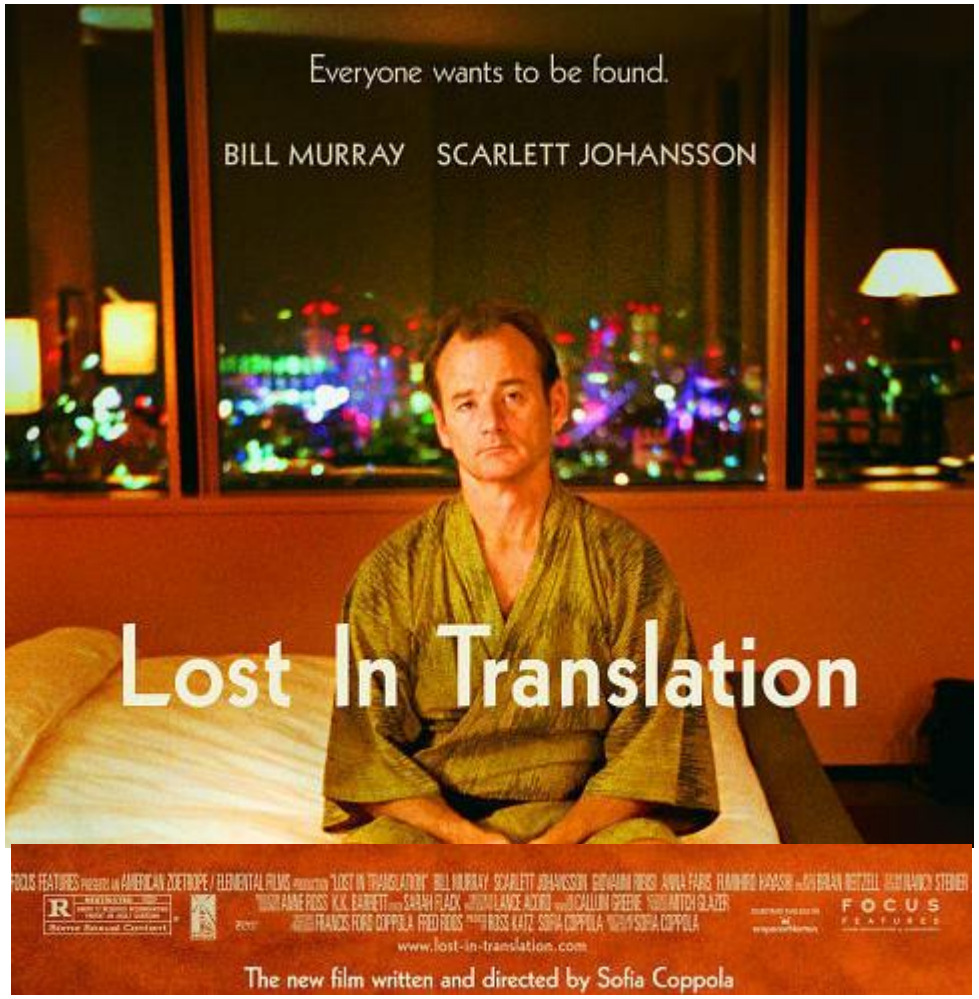
Target audience	Appropriate tools
Researchers	**Scientific articles**
Patients, People	**Patient Decision Aid (PDA), Media**
Service providers	**Clinical guidelines and Public health guidance**
Policy makers	**Policy brief**

Why thinking of a policy maker is different from a researcher?

- To manage pressures,
- Non-essential demands,
- Non-technical agendas,
- Financial dialogue the finance sector,
- Competing priorities.

Evidence creation funnel





A good aim for any policy brief is to pass the **BREAKFAST TEST**.

A policy brief should be read and understood in the length of time it takes to drink a coffee over breakfast!

Kottelmann, here is your report back. Why don't you just summarize the most important items and send it to me as an SMS...

Clarify a problem

Frame options to address a problem

(and describe each option's costs and consequences)

Option 1
- Benefits
- Harms
- Costs/cost-effectiveness

Option 2
- Benefits
- Harms
- Costs/cost-effectiveness

Option 3
- Benefits
- Harms
- Costs/cost-effectiveness

Implement an option

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International Journal of Health Policy and Management

Policy Brief

Improving Injectable Medicines Prescription in Outpatient Services: A Path Towards Rational Use of Medicines in Iran

Firoozeh Bairami[1], Fatemeh Soleymani[2,3], Arash Rashidian[1,4*]

Abstract

Injection is one of the most common medical procedures in the health sector. Annually up to 16 billion injections are prescribed in low- and middle-income countries (LMICs), many of them are not necessary for the patients, increase the healthcare costs and may result in side effects. Currently over 40% of outpatient prescriptions in Iran contain at least one injectable medicine. To address the issue, a working group was established (August 2014 to April 2015) to provide a comprehensive policy brief to be used by national decision-makers. This report is the extract of methods that were followed and the main policy options for improving injectable medicines prescribing in outpatient services. Thirty-three potential policy options were developed focusing on different stakeholders. The panel reached consensus on seven policy options, noting effectiveness, cost, durability, and feasibility of each policy. The recommended policy options are targeted at patients and public (2 policies), insurers (2), physicians (1), pharmacies (1), and the Ministry of Health and Medical Education (MoHME) (1).

Keywords: Injectable Medicines, Outpatient Services, Prescribing, Rational Use of Medicines, Policy Brief

Citation: Bairami F, Soleymani F, Rashidian A. Improving injectable medicines prescription in outpatient services: a path towards rational use of medicines in Iran. *Int J Health Policy Manag* 2016;5(5):321–324. doi:10.15171/ijhpm.2016.24

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Statement of the Issue and Background

Rational use of medicines is an important component of an effective health system.[1] According to the World Health Organization's (WHO's) definition, rational use of medicines means "patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements, for an adequate period of time, and at the lowest cost to them and their community"[2] but when the use of medicines is not compatible to the components of above-mentioned definition, the problem of irrational use of medicine does happen.[3] Excessive use of antibiotics, overuse of injections rather than oral formulations, and not taking the full course of medications are among the most common types of inappropriate use of medicines.[4] The magnitude of problem in overuse of injections and antibiotics is vast and worldwide and it is much more common in low- and middle-income countries (LMICs).[5]

Injection is one of the most common medical procedures in the health sector. Annually up to 16 billion injections are prescribed in LMICs. In some setting, over 70% of injections are unnecessary or can be given in other formulations like oral medications.[6] Injection is an invasive procedure which can lead to some side effects including bleeding, inflammation, atrophy, nerve injury, and in some cases hypersensitivity reactions such as anaphylactic shock.[7]

Current Situation

According to the WHO's estimation the average rate of injections per person per year is about 3.4 in LMICs.[12] A review in 1999 by the World Bank noted that 25%-96% of outpatient prescriptions in eight countries contained at least one injection.[8] In another review that was conducted in 2000 based on 14 regional division defined by the global burden of disease project of the WHO, in the 10 regions (four predominantly affluent, developed regions excluded) the annual rate of injections per person ranged from 1.7 to 11.3.[13] More recent reports from countries confirm the high rate of injections. A study from Bangladesh reported more than 75% of patients received injection.[14] This rate for Korea in 2004 was 30.9%.[15] India and Cambodia reported 2.9 and 5.9 injections per person per year, respectively.[16,17]

Studies in Iran reveal that the rate of injections is high. This rate in a study conducted in 2009 was 58%[18] and in another study the percentage was reported 41%.[19]

In 1997 to embed the concept of the rational use of medicines in health system body and to improve the standards of prescription issuance, the National Committee for Rational Use of Drug was established with 44 branches in medical universities across the country. Even though the committee and its subcommittees are working for more than 17 years, yet the rate of injections did not fall within the target range

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Policy brief on improving access to artemisinin-based combination therapies for malaria in the East African community

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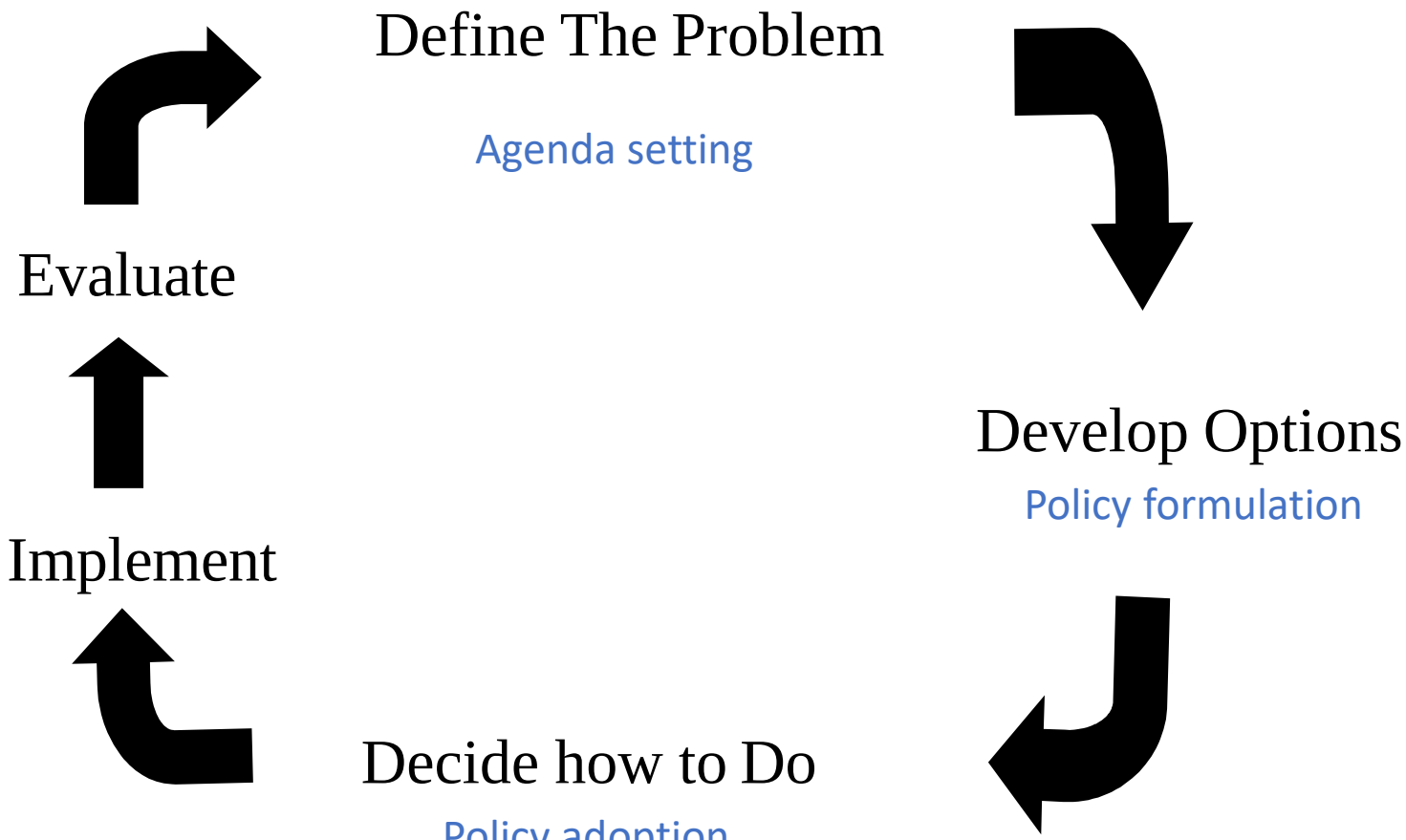
Keywords: Antimalarials, Care access, Health policy, East African Community, Tanzania, Kenya, Uganda, Rwanda, Burundi

Table 1. Policy Options

Policy option	Home-based management of fever (HBMF) with artemisinin-based combination therapies (ACTs)	Working with the private sector to support ACT use	Health system financing
Description	• Increase number of community health workers (CHWs) • Training of CHWs • Provide ACTs in home-based kits	• Provide ACT subsidies and tax-incentives to the private sector • Train private practitioners about approved ACT use • Enforce regulations regarding appropriate ACT use	• Social health insurance (SHI) • Community-based health insurance (CHI)
Advantages	• Home-based management of malaria improves outcomes with prompt treatment using pre-packaged drugs (24) • CHWs reduce death and disability in children under five (11) • ACTs can be successfully incorporated in the HBMF strategy (8)	Waters and colleagues describe options for how governments can work with the private sector to promote health interventions, although there is little evidence of their effects (18). These include: • Subsidies and tax incentives • Regulation of the private sector with inspection of facilities and sanctions • Training of private providers A pilot study by the Clinton Foundation in rural Tanzania showed that • Subsidising ACTs improved access (3)	• The case for malaria treatment is an entry point for advocating system-wide changes to provide universal coverage • SHI can provide a sustainable, predictable self-reliant source of revenue for health care • No systematic reviews on effects of SHI were identified. However, the design and implementation of SHI is likely to determine efficiency (9) • CHI can improve resource mobilization, reduce out-of-pocket expenditures and protect against catastrophic health expenditures (2;4;10;16)
Disadvantages	• Minimum negative effects with ACTs were recorded in the studies cited above	• Harms from the ACT Subsidy Project (9) included under-representation of older children for anti-malarial purchases and potential inequity from higher socioeconomic classes accessing drug shops more frequently than poorer classes	• SHI could enhance social inequity if used alone as most of the population is in the informal sector. • CHI due to its voluntary nature has risks of pool fragmentation, lower subscription, and adverse selection where mostly the sick would subscribe making the scheme financially untenable (10) • The poorest of the poor often cannot afford even low premiums
Cost	• Considerable financial costs with scaling up of ACTs nationally • Training and supervision of CHWs • Licensure of CHWs to prescribe ACTs	• There is a lack of evidence on the costs of these strategies	• Financial implications for employers, workers, and government • Training of human resources in insurance management • Extensive country-wide network of health facilities
Acceptability	• The poor, rural public would find this option highly acceptable as services are closer to home	• The general public and the private healthcare sector would welcome most of these changes, particularly with regards to reducing procurement costs	• Consideration of health insurance could become politicized, obscuring an objective assessment; particularly of SHI, which is mandatory

Table 2. Implementation of the Policy Options

Policy option	Home-based management of fever (HBMF) with artemisinin-based combination therapies (ACTs)	Working with the private sector to support ACT use	Health system financing
Barriers to implementation	• Selection criteria for recruitment of community health workers (CHWs) in countries that do not have an existing network • Training costs • Motivational incentives for CHWs • Leadership and supervision • Increase in ACT procurement to meet increased demand • Pharmacovigilance • Licensure of CHWs to dispense ACTs (5) • Public awareness	• Financial costs to governments for subsidies and tax-incentives • Resistance from private sector with conflicting interests; e.g. importers • Corruption; e.g. importers overcharging for ACTs despite government subsidies • Training costs for private health providers about approved ACT use • Inspection of private facilities and enforcement of sanctions on defaulters • Public awareness	*Common barriers for social health insurance (SHI) and community-based health insurance (CHI)* • Financial costs to employers, workers and governments • Adequate widespread health infrastructure • Adequate human resources in insurance management • Large informal economy • Lack of social solidarity • Public awareness *Specific barriers for CHI* • Insurance pool fragmentation • The poorest populations cannot afford even the low premiums. • Adverse selection; i.e., CHI is not mandatory, therefore, the sick are more likely to subscribe, making the schemes untenable • Lower subscription rates due to voluntary nature of CHI schemes
Strategies for implementation	•Use of mass media for public awareness and education for all three options • Some East African countries, such as Uganda, have a pre-existing CHW network and selection criteria for recruitment of CHWs could be modified • Resource mobilization for training of CHWs and procurement of ACTs could make use of existing funds such as the Global Fund to fight Malaria, TB, and HIV; and the Gates Foundation • Use of existing structures and personnel at the lowest functioning health facility level for supervision of CHWs and pharmacovigilance • Motivational incentives such as bicycles for transportation, small commissions on each ACT pack dispensed, small sustainable allowances for CHWs • Amend regulations to permit ACT administration by CHWs	• Governments could make use of existing initiatives to fund the subsidies and training programs such as the Affordable Medicines Facility-malaria (a global subsidy to increase access to ACTs), the Global Fund, and the Clinton Foundation • Use of a "suggested retail price" printed on drug packaging was found to prevent price inflation and variation in the intervention areas in the ACT Subsidy Project (3)	*Specific to CHI* • Management support could be subcontracted to an umbrella organization with merging of several CHI schemes to increase purchasing power • Government could integrate CHI schemes into a SHI scheme to increase risk sharing across the population • To reduce inequities government subsidies can be targeted at the poorest of the poor, who are otherwise unable to pay premiums
Evidence	In a high quality systematic review, Grilli and colleagues (7) found that health messages in the mass media can promote desirable health behaviors among healthcare practitioners as well as the general public. Higher income groups have better access to media such as television, radio, and the Internet, and are more likely to benefit from this exposure than lower income groups. This could increase inequities. This strategy is well accepted, but there may be considerable financial cost for sustained campaigns		


Define The Problem
Agenda setting
Develop Options
Policy formulation
Decide how to Do
Policy adoption
Implement
Evaluate

Policy dialogue:

1. The recognition of the need for locally contextualised 'decision support' for policymakers
2. The recognition that research evidence is only one input into the decision-making processes of policymakers
3. The recognition that many stakeholders can add significant value to these processes

Take home messages

There are different forms of policy briefs

Content of evidence policy briefs:

A description of a problem

Options

Impacts of options

Considerations about potential barriers to implementing

It follows by a policy dialogue

Talk's plan

- What? Definition of policy brief
- Why? The place of policy brief in decision making
- Content of the policy brief

- Possibility of peer-review publication through policy brief