



**SOUTHERN AFRICAN REGIONAL NETWORK (SARN) – RBM MALAWI MISSION**

**14<sup>th</sup> to 19<sup>th</sup> February 2011**

**SARN Secretariat  
Gaborone, Botswana**

## 1.0 Background of the Mission:

The SARN Steering Committee Members on 17<sup>th</sup> November 2010 agreed to carry out a joint-partner mission to Malawi to consult with the National Malaria Control Program (NMCP) and in-country RBM partners, review progress in program and road map implementation, identify bottlenecks/challenges affecting program and Global Fund implementation and performance and develop a strategy to support the program to maximize implementation performance. Some key issues that the mission was requested to look at include:

1. Bottlenecks associated with the Global Fund, Principal Recipient (PR) and Procurement, Supply-chain Management (PSM)
2. Programmatic issues related to rising malaria morbidity/mortality regardless of the improved coverage of prevention interventions
3. Weak M&E systems for planning and tracking progress
4. Identify support required from SARN Secretariat and RBM Secretariat



***The SARN-RBM Mission Team being briefed by the NMCP Manger (2<sup>nd</sup> from Right)  
From left to right Martha Mpisaunga (SARN Co-chair), John Gowele (WHO-IST-ESA), Bertha Simwaka (MACEPA), Kaka Mudambo (SARN Coordinator), Doreen Ali (NMCP Manager) and James Kalimbuka (Military Health Services)***

## 2.0 Objectives of the mission

1. Identify program strengths and good practice
2. Identify program implementation challenges delaying signing of GF R2, 7, and 9 and achievement of targets
3. Develop a partnership strategy to resolve implementation challenges and agree on next steps to support the program to maximize implementation performance.

## 3.0 Approach

The SARN mission acknowledges that many solutions to challenges facing the malaria control program in Malawi lie within the national program and the wider partnership in the country. In view of this, a participatory and inclusive approach was used to understand good practices and identify challenges and solutions. The following activities were conducted:

- Reviewed program documents (MIS, MPR, draft Malaria Strategic Plan, previous mission reports, Global Fund Grant documents and those from partners);
- Consulted development partners including GFATM mission team, WHO, CHAM, UNICEF, USAID, PMI, DFID, Malawi Military Health Services, GIZ, Malaria Alert Centre and Christian Health Association in Malawi;
- Conducted a field visit to Mchinji District Hospital and Kochilira health facility to understand district systems, good practices and identify challenges.
- Convened a partnership consultation workshop;
- Convened a high-level round-table to de-brief Government Officials and partners on mission findings and to reach consensus on next steps; and
- Will initiate agreed follow-up support activities and follow-up support missions as necessary.



**Group Photo of the Malawi RBM In-country Partnership Consultative Meeting held at CHAM Offices, Lilongwe, Malawi, 14-19 February 2011**

## 4.0 Findings

### 4.1 GFATM

Much progress has been made in fulfilling the Conditions Precedent (CPs) and Time Bound Actions (TBAs) required to access funds from the Global Fund round 2 and 7 phase 2 and round 9 malaria grants. Some of the issues raised are systemic and others programmatic. The GF has agreed to sign R2 and 7 (combined) and are reviewing the R9 documents in preparation for signing. A major weakness is that the NMCP has no functional organogram/structure

### 4.2 Program strengths, good practice and opportunities

1. Increased staff from 2 in 2000 to 9 in 2011 at the Central Unit
2. Functional health system in place as observed at the district level i.e. availability of HMIS and District malaria coordinators provide a platform for innovation and improvements
3. Available partners who can be garnered to improve and enhance program capacity
4. Prospective disbursement of Global Fund will help to achieve universal coverage and could lead to reduction in disease burden
5. Dedicated resources for capacity building provide an opportunity to strengthen program implementation capacity at the central and district levels.
6. The program managed to meet the 15 February 2011 deadline for submitting CPs required for release of GF R9 funds.



*The SARN-RBM Mission Team Field Visit to Mchinji District Hospital, Mchinji, Malawi*

## 5.0 RECOMMENDATIONS

Thematic Area	Description of the Challenges	Proposed Actions/Recommendations	Driver/responsible person for the output
1. Partnership and coordination	<p>1.1. The partners working and delivering malaria services have increased over the years. However there is a perceived challenge of coordination and communication which undermines the potential of fully optimizing the capacity in the country to address technical and knowledge/research related challenges.</p> <p>1.2 Technical Working Groups (TWGs) exist, but some only meet on an ad hoc basis creating less opportunity for collective planning and tracking of progress.</p> <p>1.3. A strong well-coordinated RBM partnership is needed to advocate for malaria control activities, scaling up interventions and monitoring and evaluating impact.</p> <p>1.4. Global Fund proposals are prepared with inputs from partners. However changes may be made to the final proposal without consent of the partners.</p>	<p>1.1.1 NMCP needs to finalize Strategic Plan and then develop a comprehensive 3 year Operational Plan with inputs from all stakeholders.</p> <p>1.2.1. Work with existing structures and TWG to engage partners and donors on regular basis and schedule meetings well in advance to accommodate partners coming from outside Lilongwe</p> <p>1.2.3 Consider bringing in a partnership facilitator to support NMCP coordination , engagement of all partners and track progress against operational plan</p> <p>1.3.2 Participate in the monthly SARN-RBM teleconferences.</p> <p>1.4.1 Ensure that all partners understand the process on selection of PR, SR &amp;SSR for GFATM</p>	<p>NMCP and in-country Partnership</p> <p>Malaria donors nominate lead partner (or rotating lead partner to convene meetings)</p> <p>SARN, NMCP, partners</p> <p>NMCP and lead partner</p> <p>Working Group Chairs</p> <p>Technical working groups</p> <p>Partnership</p>
2. Capacity building for malaria control	<p>2.1 Although the number of staff at Central Unit has increased, but they do not possess the skill levels to meet targets under the Strategic Plan and for Global Fund (GF) grants.</p>	<p>2.1.1 Capacity building of NMCP staff through Recruitment of Senior Technical Advisors including an IPO and skill-based training to meet their diverse needs in line with MPR findings.</p> <p>2.1.2 Arrange for a 5 day study tour of 1country doing well for the Manager + 3 others (case management, SME and PSM)</p>	<p>Ministry of Health, NMCP SARN, Partners</p> <p>SARN</p>
3.0 Surveillance, Monitoring and Evaluation (SME)	<p>3.1 As outlined in the MPR, SME remains a critical challenge. Although data from the district is consolidated by the HMIS at district and national level, the NMCP does not have malaria data to assist planning. The HMIS form is limited and in addition there are challenges related to tracking of ACTs and validating consumption vs case load.</p> <p>3.2 Although data on laboratory diagnosis is kept at health facilities with microscopes, this has not been</p>	<p>3.1.1 Development of clear malaria data flow from health facility to district and NMCP with the role of district malaria coordinators clearly spelled out.</p> <p>3.1.2. Development of a malaria data collection tool to capture what is not on the HMIS as an interim measure while the HMIS is being improved.</p> <p>3.2.1 Consolidation of data through standardized registers (laboratory, LA) and computerization from the district</p>	<p>MACEPA is willing to engage Sr TA to support specific activities on M&amp;E for program</p> <p>NMCP</p> <p>NMCP; Laboratories</p>

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	<p>used to inform decisions.</p> <p>3.3 Laboratories lack standardized registers for malaria cases as a result each hospital devises its own way of recording data.</p> <p>3.4 From the district visited HMIS staff have access to internet and computer which could be a spring board for enhancing quick data turnaround.</p>		
4.0 Cross-border initiative	4.1 Some districts along the border bear the burden of patients from neighboring countries. This can affect consumption of ACTs.	4.1 Establishment of a cross-border initiative between Malawi, Mozambique and Zambia for harmonisation of activities.	SARN, NMCP, relevant DHOs, MHS, relevant authorities/organizations in neighboring countries: Malawi, Mozambique, Tanzania, Zambia
5.0 Supply Chain Management	<p>5.1 Many clinics have had frequent and prolonged ACT stock outs. There is a need to develop a secure distribution system. The HIV and TB programmes have been more successful in preventing stock outs. Lessons learnt from HIV - ARV shipments are pre-labelled for destination, a separate transportation mechanism has been contracted.</p> <p>5.2 The Global Fund outlined that there is evidence of ACT theft.</p> <p>5.3 The mission supports the parallel system created and understands that this system will be using existing resources at district level to function. The country has civil society organizations with experience in documenting and tracking essential drugs, however they have not engaged in malaria</p>	<p>5.1.1 SARN/RBM to provide TA to support NMCP on PSM, quantification and micro-planning.</p> <p>5.2.1. A comprehensive analysis of the distribution system at all levels should be conducted to identify weak points in logistical and distribution processes.</p> <p>The Ministry should speed up current efforts to make the Central Medical Stores a Trust, employ personnel qualified in logistics/PSM and ensure the NMCP has a functional organogram/structure Engage TA to train in PSM</p> <p>Parallel system requires monitoring to ensure delivery</p>	<p>NMCP</p> <p>Consultant</p> <p>Appropriate authority</p> <p>Ministry of Health,</p> <p>SARN, NMCP</p> <p>Malawi Health Equity Network</p>
6. Case Management	<p>6.1 A large number of severe malaria cases (400 per month - number not confirmed) were reported at the District hospital</p> <p>6.1 NMCP highlighted the need to undertake quantification of RDTs</p>	<p>6.1.1 The number of severe malaria cases needs to be confirmed.</p> <p>6.2.1 SARN to support NMCP in quantification of RDTs and support resource mobilisation to fill the gap</p> <p>6.3.1 The National Malaria treatment policy should be reviewed to consider</p>	<p>NMCP, District Malaria Focal Point</p> <p>District Malaria Focal Point</p> <p>NMCP, Partners</p>

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		introducing pre-referral paediatric treatment at the community level with rectal artesunate as appropriate.	
7. Vector Control	7.1 Insecticide resistance is a growing challenge  7.2 Universal coverage with appropriate vector control interventions (LLINS and/or IRS) has not yet been achieved.	7.1 Insecticide resistance needs to be monitored at sentinel sites, appropriate actions taken as required.  7.2 Scale-up vector control interventions to reach all at risk populations	NMCP, partners  NMCP, partners
8. Advocacy and BCC	8.1 Partners pointed out the need to promote use of LLIN and early treatment 8.2 It was also highlighted that there is need to promote visibility of NMCP	8.1.1 Community level BCC/IEC is needed to increase the number of patients that are brought in for treatment within 24 hours of the onset of fever. 8.1.2 BCC to promote compliance on RDT/laboratory result and treatment by both health workers and the community	NMCP

## 6.0 COMMITMENTS BY RBM PARTNERS

### 6.1 SARN

- a. Support finalization of National Malaria Strategic Plan/operational plan
- b. Provision of TA for quantification of commodities, PSM and micro-planning:  
**Action already taken:** SARN-RBM currently finalizing TORs for a consultant to be engaged in the coming few weeks
- c. Addressing some CPs depending on request and need
- d. Resources mobilization to fill gaps

### 6.2 MACEPA

- a. Support with TA to develop malaria data collection tools, M&E plan and capacity building:  
**Action already taken:** the NMCP has already send an official request to MACEPA - request being processed

### 6.3 MALAWI MILITARY HEALTH SERVICES

- a. Distribution of commodities into hard to reach areas
- b. Support implementation of IRS
- c. Case management of civilian population within cantonment catchment areas
- d. Support in Cross-border collaboration activities



#### **6.4 CHAM**

- a. In-service training and orientation on malaria policies
- b. BCC using the church machinery