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ROLL BACK MALARIA

COUNTRY STRATEGIES & RESOURCE REQUIREMENTS

No population
No malaria
Epidemic malaria
Endemic malaria, controlled
Endemic malaria, uncontrolled
Countries excluded
Lakes
Country boundaries

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* Provisional plan

ROLL BACK MALARIA

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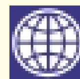

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Various sources of information, including telephone interviews, e-mails, face-to-face communication with country level partners, and partner mission reports were used in this report. Synthesis and compilation was done by the RBM secretariat's partnership team at WHO HQ.

Preface

ROLL BACK MALARIA was launched in November 1998 to catalyse vigorous and innovative collaboration to halve the global burden of malaria by the year 2010. The RBM partnership was founded by four international agencies and rapidly grew to include malaria-endemic countries throughout the world and over 90 multilateral, bilateral, non-governmental and private sector organizations.

In the first thirty months of the project, the RBM partnership has set the stage for a massive scale-up of action against malaria. RBM has established an evidence-based approach to malaria control which aims to increase access to high-quality, cost-effective interventions, while promoting operational research and the development of new tools to fight malaria. RBM partners have worked hard to raise public awareness about malaria, secure political commitment from the highest levels of government and lever practical regulatory and policy reforms in order to establish an enabling environment for RBM action. RBM has also established the causal relationship between malaria and poverty and the centrality of "the malaria problem" in both the formal and informal health sectors, particularly in Africa. The partnership has promoted a focus on malaria as pathfinder for health sector reform as well as the integration of malaria control into sector-wide approaches and poverty reduction strategies.

Today we are at a turning point. The stage has been set and many malaria-endemic country governments and their local partners have developed Country Strategic Plans (CSPs) to roll back malaria. CSPs are based on a rigorous analyses of the local situation, cost-effective interventions, partnerships for implementation, integration of malaria control into health sector development and realistic estimates of current resource gaps and the implementation capacity of the country partnership. As the RBM partnership shifts from planning to scaling-up implementation, the RBM secretariat in WHO has been re-organized to focus on support to country partnerships and the achievement of outcomes.

RBM country partnerships are poised to depart from "business as usual" and take the first truly innovative steps forward. However most countries are constrained by the lack of adequate resources to support their efforts. Country partners have pledged resources to support CSPs, but to date these do not come close to meeting the estimated resource gaps. These gaps are projected only for the short term, are based on current health system constraints and show an incremental, rather than order of magnitude, approach to scaling-up. As a result they are the most conservative estimate of RBM resource needs, underlining the truly acute need for significant additional resources.

The RBM Secretariat has staged the resource requirements according to urgency. In the immediate term, there is an absolute need for start-up funds to set the CSPs in motion and promote additional resource mobilization at international and local level. In the short to medium-term significant resources are needed to support funding gaps identified in CSPs as well as structural and functional changes in health systems and procurement of essential commodities to enable the much-needed order of magnitude increases in access to malaria control interventions. It is in this context that malaria-endemic countries could benefit greatly from a strong malaria component in the proposed Global Fund to support AIDS, TB and Malaria, particularly given the already high cost of bednets and anticipated increases in the cost of antimalarial drugs as countries begin using combination treatments. It is important to note that the prospect of a new Global Fund places even greater responsibility on RBM to assure that endemic countries have the needed technical support to implement evidence-based malaria control and to effectively draw upon new resources and monitor their impact.

Finally, we are working now and plan to redouble our efforts to assure that in the longer term reductions in malaria will continue. The inclusion of malaria in poverty reduction strategies, the demonstrated impact of RBM, strengthened health systems and the possibility of new tools, such as vaccines favour the long-term sustainability of action against malaria.

Key interventions

Many technical interventions are already available. However, enabling those in need to exercise their rights to health and access these interventions is difficult through conventional government-funded services.

Key RBM interventions and their justification include:

- ✘ Prompt and effective treatment reduces mortality by at least 50%
- ✘ Mortality can be further reduced if treatment is available at home. New tools for home treatment include:
    - dipstick diagnosis;
    - pre-packaged medicines; and
    - artesunate suppositories
- ✘ The development of drug resistance can be delayed through combination therapy, which also reduces the risks of malaria transmission.
- ✘ Insecticide-treated nets can reduce morbidity by 60% and all-cause mortality by 24%.

Introduction

Background

MALARIA is a significant impediment to the social and economic development of the world's poorest people who suffer more than 300 million episodes of acute malaria illness each year. Malaria kills at least a million people each year, most of them children.

In addition to the direct costs of treating and preventing malaria illness and lost productivity, malaria has been shown to slow economic growth in Africa countries by up to 1.3% each year, creating an ever-widening gap in prosperity between malaria-endemic and malaria-free countries. At present malaria-free countries average a GDP three times higher per person than malaria-endemic countries, even after adjusting for other factors which might explain the difference.

Efforts to control malaria have often been fragmented, sometimes based on ineffective control strategies, and frequently vertical, failing to promote community-driven action and without integration into sector-wide planning. In recent years the success of control efforts has been further limited by insufficient human resources and donor preference for "project-funding" approaches. There is now ample evidence that sustainable reductions in the malaria burden depend not only on the use of effective tools, but also on broader health sector development, including the integration of behavioural change into community-level activities.

Partnerships to Roll Back Malaria

Unlike previous global malaria campaigns, Roll Back Malaria is not based on the vertical application of a single or small set of tools. RBM is concerned with establishing sustainable capacity within communities to help them access and use the tools to combat malaria, including those available today and those to be developed in years to come. RBM is also unique in the high level of political commitment it has secured for its goals and its success in establishing a framework for, and culture of, action through global and country partnerships.

RBM draws inspiration and support from the joint efforts of national governments and a range of development partners, including the international and local private sector, NGOs and civil society. RBM partnerships have been characterized as groups of people working together, toward a common goal, with agreed strategies and, most importantly, shared values, rather than limited inter-agency agreements. Most African nations have chosen this approach.

RBM partners are now building and strengthening national health services' capacity to roll back malaria and also to establish new capacities for the stewardship of malaria control services provided through the voluntary, private and commercial sectors.

Progress

During an energetic preparatory and inception phase, strategic consensus on overcoming policy and delivery barriers to effective malaria control has been built through country, regional and global partners' consultations. At the same time partners have developed the underlying technical and managerial concepts for RBM and, guided by governments, have drawn up country strategic plans of action which include the following elements:

- ✘ Rapid access to affordable quality antimalarial drugs;
- ✘ Insecticide treated materials;
- ✘ Preventive intermittent malaria treatment during pregnancy; and
- ✘ Epidemic preparedness and epidemic management.

An important part of these strategic plans is scaling-up from previous control efforts and measuring the resource gap created by expanded activities. On average, less than 40% of a country's estimated needs for expanded malaria control can be financed through resources available at country level such as government funds and through bilateral donations negotiated with the donor at country level.

At present, malaria-affected countries are at different points in the process of developing strategic plans. They can be categorized as follows:

- ✘ Countries which are ready to implement malaria control strategies outlined in the completed strategic plan.
- ✘ Countries which are in the process of developing their strategic plans of action and are continuing their current malaria control programmes.

Once a plan of action is in place a Round Table meeting is held to obtain full technical and institutional endorsement by all RBM partners. The plan's technical merit, stated budget, and operational budget gap are considered. The partners also examine resource constraints such as poor use and coordination of existing resources, unrecognized opportunities to tap into other sectors and programmes, the often limited appreciation for the private sector, and insufficient government capacity for planning, accounting and budgeting.

At Round Table meetings partners also review progress and determine funding approaches by examining the existing resources available at local level.

This document outlines the twelve country strategic plans which have been endorsed by country partners since January 2001. Summaries indicate the country's current status of malaria control, challenges faced, strategies for scaled-up RBM action and expected outcomes. A brief is also provided on management arrangements for effectively channelling resources to contracted parties. Where data is available each country's first year and five-year budget,

received pledges and budgetary gap is also provided along with an estimated budget for year one, a five-year period and the gap between available resources and needs.

THE CHALLENGE TO RBM GLOBAL PARTNERS

On behalf of the global partnership, the RBM Secretariat has been successful in catalysing the development of scaled-up country strategies which aim to reach the targets set at the Africa Summit on Roll Back Malaria in Abuja, Nigeria in April 2000. Ensuring that these scaled-up plans are properly implemented is the only way to guarantee that the momentum of the RBM movement is maintained. RBM's global partners must now make good on past pledges, and financially support these plans. Resource management within countries will be decided by country partners.

To ensure that immediate shortages of funds do not slow down progress at country level, a first priority for the RBM Secretariat is to be able to provide significant direct financial support to country partnerships' first-year budgets. This could be done by increasing seed-corn funding, or by leveraging funding levels provided by donors and routing the funds through the Secretariat.

It has also been suggested that long-term operational budgetary gaps could be filled in two ways:

a) In the medium term, the capacity of country partnerships to lobby for malaria control to be part of national poverty reduction strategies must be greatly increased. This will ensure the sustainability of RBM by providing access to poverty reduction funds financed through bi- and multilateral debt relief schemes such as HIPC.

b) Funds could also be made available through a global financial facility, capable of swift response to countries' budgetary gaps. This would provide the financial support necessary to maintain RBM momentum at country level and allow countries to scale-up according to their ambitions.

To ensure that essential new interventions such as combination drug therapy or permanently impregnated netting materials are accessible on a wide scale, subsidies will be needed which could be provided by a global fund.

Such an approach to RBM country level financing will allow a rapid shift away from vertical programming and allow countries to prioritize their own needs. Once implementation is under way the funding strategy will establish RBM sector-wide activities, through sustainable poverty reducing measures.

The additional funding required for malaria control can be categorized into three broad areas:

1. Country Strategic Plans — Plans have been, or are being developed by local and situational consultation. They will include an evidence-based technical strategy; an estimate of the resource gap and of implementation capacity; a defined and transparent resource distribution mechanism; and an agreed monitoring and evaluation scheme. These plans can be easily converted into tactical business plans.
2. Commodities — The three main commodities used in malaria control are antimalarial drugs, insecticide-treated materials and diagnostics.
3. Government Stewardship — Quality assurance, resource management, consumer protection, subcontracting and outsourcing are the responsibilities of country governments.

Table 1 (*pages 6-7*) shows the budgetary gap resulting from the planning process in twelve African countries.

The twelve strategic plans and the outcome of seven country Round Table Meetings indicate that countries' current scaling-up capacity is in the order of US$ 600,000 to US$ 1.1 million, depending on the degree/strategy of public subsidy used to enhance accessibility of RBM commodities. On average country Round Table Meetings have managed to mobilize 37% of budgeted resources.

It is important to note that these budgets do not include the cost of changing to combination therapies. In many cases such a move would triple the per capita cost of implementing strategic malaria control programme.

Using estimates based on these plans, an additional US$ 500 million of global funding is needed to fill budgetary gaps of scaling-up strategies in sub-Sahara Africa. A further US$ 560 to 780 million will be required for sub-Saharan Africa to support a global commodity fund which will ensure equitable access to interventions by poor populations and the continued availability of recommended drug therapies.

STRATEGIC PLANS AND RESOURCES

- This publication summarizes country Strategic Plans to Roll Back Malaria for twelve countries. These plans:
  ✘ Are evidence-based; ✘ Clearly identify the potential implementation capacities for new funds and the resource gap; ✘ Identify a resource distribution mechanism; and ✘ Outline a monitoring and evaluation mechanism.
  Additional funds are required for:

- Commodities, including:
  - ✘ Drugs;
  - ✘ Insecticide treated materials;
  - ✘ Diagnostic reagents and equipment;
  - ✘ Distribution mechanism.
- Strengthened government oversight and stewardship, including:
  - ✘ Quality assurance;
  - ✘ Resource management;
  - ✘ Consumer protection;
  - ✘ Administration of subcontracting and outsourcing.
- Supporting community empowerment and mobilization, including:
  - ✘ Communications;
  - ✘ Training;
  - ✘ Monitoring;
  - ✘ Encouraging community participation in malaria control.

Table 1: Indicative Strategic Resource Gap by Country

(all figures in US$)

Burkina Faso	Year 1	5-year total
Total Budget	3,377,141	12,485,711
Pledges	Pledges not yet processed	Pledges not yet processed
Gap	-	-

✘ Round Table has not taken place.

Eritrea	Year 1	5-year total
Total Budget	10,483,849	42,725,853
Pledges	7,000,000	(7m for year 1)
Gap	3,483,849	35,725,853

Ethiopia	Year 1	5-year total
Total Budget	20,905,920	122,037,434
Pledges	2,552,400	(2,552,400)
Gap	18,535,520	119,485,034

✘ Year one pledge from government is 2,552,400.

Ghana	Year 1	5-year total
Total Budget	2,995,140	12,371,900
Pledges	1,800,000	(1,800,000)
Gap	1,195,140	11,767,040

Kenya	Year 1	5-year total
Total Budget	16,900,000	84,500,000
Pledges	990,000	(990,000)
Gap	15,910,000	83,510,000

✘ Total budget for five years is an RBM estimate (assuming level expenditure).

Mali	Year 1	5-year total
Total Budget	3,145,376	43,543,522
Pledges	—	—
Gap	—	—

✘ Round Table has adopted the strategy, but has not advanced to pledging.

Nigeria	Year 1	5-year total
Total Budget	55,600,000	204,800,000
Pledges	5,405,000	(5,405,000)
Gap	50,195,000	199,395,000

Senegal	Year 1	5-year total
Total Budget	6,363,625	38,489,377
Pledges	—	—
Gap	—	—

✘ Round Table has adopted the strategy, but has not advanced to pledging

Sudan	Year 1	5-year total
Total Budget	16,791,562	83,957,810
Pledges	4,380,000	(4,380,000)
Gap	12,411,562	79,577,810

✘ Total budget for five years is an RBM estimate (assuming level expenditure).

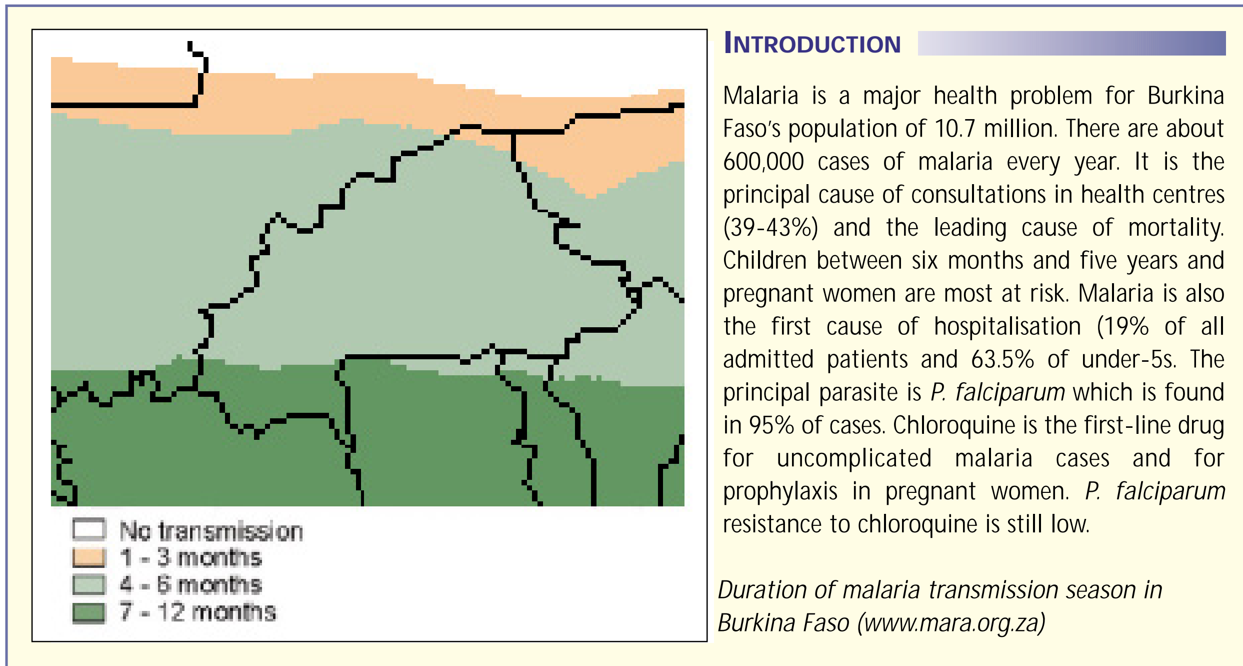
Togo	Year 1	5-year total
Total Budget	876,604	8,994,870
Pledges	159,000	(159,000)
Gap	717,604	8,835,870

Zambia	Year 1	5-year total
Total Budget	9,142,500	33,408,000
Pledges	8,342,000	28,842,000
Gap	800,500	4,566,000

Zimbabwe	Year 1	5-year total
Total Budget	2,991,000	7,157,000
Pledges	1,038,000	(1,038,000)
Gap	1,953,000	6,119,000

✘ Total budget for five years is an RBM estimate (assuming level expenditure).

Burkina Faso



Introduction

Malaria is a major health problem for Burkina Faso's population of 10.7 million. There are about 600,000 cases of malaria every year. It is the principal cause of consultations in health centres (39-43%) and the leading cause of mortality. Children between six months and five years and pregnant women are most at risk. Malaria is also the first cause of hospitalisation (19% of all admitted patients and 63.5% of under-5s. The principal parasite is *P. falciparum* which is found in 95% of cases. Chloroquine is the first-line drug for uncomplicated malaria cases and for prophylaxis in pregnant women. *P. falciparum* resistance to chloroquine is still low.

Duration of malaria transmission season in Burkina Faso (www.mara.org.za)

State of the movement

Burkina Faso's Strategic Plan has been developed through a systematic situation analysis, consultative meetings and workshops in which partners from a wide range of sectors have participated and the country has been engaged in RBM since the Regional Consensus Meeting in Abidjan in March 1999.

As well as carrying out an intensive campaign to build a dynamic national movement to Roll Back Malaria, Burkina Faso has attempted, during the inception phase, to maintain the momentum of malaria control action initiated by the Accelerated Implementation of Malaria Control (AIMC) programme.

Among other accomplishments, Burkina Faso has trained 72 district trainers in management of severe malaria, 36 laboratory technicians and 822 health personnel in management of simple cases of malaria and 180 health care providers in case management. Eleven other people have been trained in the impregnation of materials; and some hygiene technicians have been trained in vector control and in materials impregnation.

Six songs, in national languages, have been written and recorded. IEC materials have been produced and sensitization and information programmes have been broadcast on national TV and radio.

A National Steering Committee and a Facilitators Group were set up to ensure that partners are involved both in political and technical management of RBM. A situation analysis has been completed and the results used to draft a five-year RBM strategic plan. The next stage will be a partner's Round Table meeting to determine what resources are available.

Active partners include WHO, UNICEF, UNDP and the World Bank with whom meetings are are held regularly to undertake advocacy activities for building partnership for RBM. Other partners include Si Italia, Plan International, Pharmaciens sans Frontières, AMMIE (Association Appui Moral, Matériel et Intellectuel à l'Enfant). Religious associations, particularly the Catholic Church, are well represented and at the community level effective partnerships have been established with chiefs, religious leaders, and traditional healers.

A number of research institutions are also actively involved in the RBM process. They include the National Research and Training Centre on Malaria, the Research Centre on Health of Nouna, the Unit of Studies and Research in Demography and the Institute of Research in Sciences on Health.

Goal

To reduce the disease burden of malaria in the country by 50% by 2010.

Strategic components

- ✘ Improved case management: Dissemination of guidelines on case management; training at different levels including in the community.
- ✘ Improved knowledge and skills through IEC: Production and dissemination of materials; training of community health workers in IEC techniques.
- ✘ Multiple Prevention: Promoting ITMs with emphasis on their use by children under-5; prophylaxis for pregnant women and environmental management.
- ✘ Epidemic surveillance: Periodic demographic surveys; training health personnel in data management and disease surveillance.
- ✘ Operational research: Main topics for research should include case management at facility and community

Burkina Faso

level; use of ITNs; new therapies and sensitivity of vectors to insecticides.

Main implementation strategies

- Editing guides on case management. Training or retraining of health care providers at different levels in both public and private sectors.
- IEC promotion using a variety of educational resources, including audio-visual materials and community health workers.
- Supervision. (Formative supervision; integrated supervision as possible.)
- Monitoring. (Reinforcement of capacity monitoring.)
- Improved management of the programme. (Reinforcement with human resources and logistics.)
- Promotion of ITN use; promotion of prophylaxis; environmental management.
- Establishing a national procurement and distribution system for ITNs.
- Making ITNs affordable through taxes and tariffs waiver.
- Improved epidemic surveillance measures, monitoring, supervision and evaluation.
- Improved responses based on evidence provided by operational research.
- Improved management by staffing the programme and providing more logistics.

Management arrangements

A Facilitators Group has been created. Its members include representatives of partners and various government departments. This group is chaired by a member of the Prime Minister's office. There is also a National Technical Committee made up of representatives of government departments, UN agencies, research institutions, Bilateral Cooperation, NGOs and civil society.

The National Malaria Control Programme will serve as secretariat to the partnership.

Major expected outcomes by 2005

- At least 50% of households sleeping under an ITN.
- 80% of severe cases of malaria correctly managed at referral facility level.
- 95% of simple cases of malaria correctly managed at peripheral level.
- 75% of cases of fever/simple malaria correctly managed at home.
- Effective contribution of operational research to malaria control activities.
- Reinforced management of RBM process.

Budget Estimates (US$)

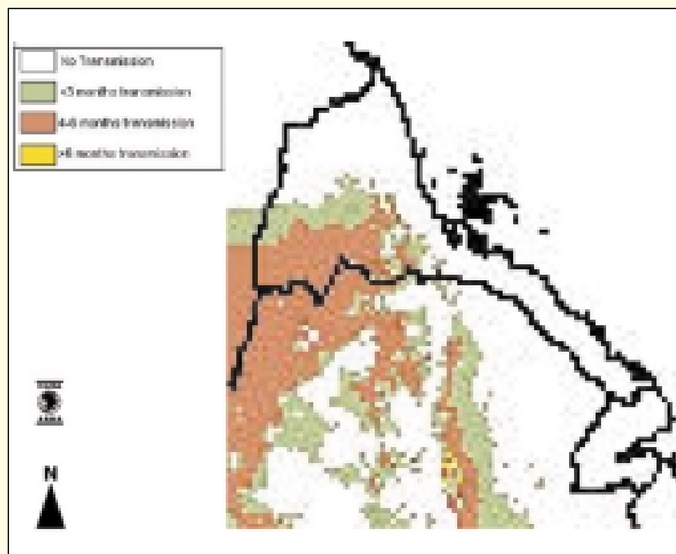
(Without all public sector salary costs)

Strategy component	Year 1	5-year total
Case management (including prophylaxis)	1,628,571	5,407,142
Multiple prevention	1,062,857	3,950,000
IEC	431,142	1,685,713
Epidemics	92,857	442,857
Monitoring	85,714	357,142
Evaluation	—	42,857
Operational research	100,000	600,000
Management	107,142	378,571
Total	3,377,141	12,485,711

Resource availability

Resource availability still to be determined.

Eritrea



Estimated duration of malaria transmission (in months) in Eritrea (see www.mara.org.za)

Introduction

Eritrea's population is an estimated three million with an annual growth rate of 3%. Malaria is the country's most serious health problem and 67% (1.7 million) of the population live in the 41 out of 56 sub-regions where the disease is endemic.

Malaria accounts for about 31.5% of total out-patient morbidity and 28.4% of all admissions. The case fatality rate in children in hospitals is 7.4%. Among children in health facilities 19.6% are admitted because of malaria.

Malaria is the first cause of death in those five years and above and the third commonest cause of death in children under-5. It accounts for more than 10% of all facility-based deaths. The most common malaria parasite is *P. falciparum*, found in more than 94% of all cases. *P. vivax* is the second most common. Chloroquine remains the first-line drug; Sulfadoxinen pyrimethamine is the second-line drug while quinine is reserved as a third-line drug for severe malaria.

State of the movement

Eritrea's Ministry of Health has resolved to implement the RBM initiative across the country. A programme of work has been drawn up with the aim of establishing committees, undertaking conferences at different levels, identifying the required resources, promoting the RBM initiative, and resuming main activities concerning malaria control and other actions. A wide range of partners including USAID, UNAIDs, UNFPA, UNICEF, UNHCR, UNDP and WHO attended a National Conference on RBM in July 1999 along with various government departments and NGOs, including AMREF.

A five-year Plan of Action (2000-2004) has been adopted as well as a one-year POA for 2000 for each zone. An intensive advocacy campaign has begun using mass media in local languages. Malaria control activities—including distribution of ITNs to the six zones, monitoring chloroquine efficacy, undertaking residual house spraying and source reduction through community participation—have been intensified.

Malaria morbidity records at all levels of health facilities and community levels through the community health agents have shown considerable reduction. The overall malaria morbidity rate was reduced to 16.4% in 2000 from 23.6% in 1999, a 30.5% decrease. Health facilities morbidity has fallen from 13.9% in 1999 to 8.7% in 2000 (37.4%). In general malaria deaths were reduced to 5.8% in 2000 from 14.1% in 1999. Compared with 1997 there has been a massive reduction in mortality and morbidity.

Some of the positive impacts of the RBM initiative include better motivation for malaria control, a flow of efficiently developed information on malaria, a spirit of partnership (especially between various ministries), better management and planning for malaria control with annual, mid-year and quarterly planning at national and zonal levels and progress reports on mortality and morbidity reduction. Case management of malaria at the community level is more advanced than for any other disease. Regular training of health staff now takes place.

Goal

To reduce malaria mortality and morbidity by 80% by 2004.

Strategic Components

The strategy package consists of four priority areas, with community awareness as a cross-cutting item.

1. Improved management of malaria cases (by health workers at health facilities, by community health agents and private providers in the community and by mothers/caretakers at home).
2. Early detection, prevention and rapid containment of epidemics. Establishing a system for early detection, prevention and control of epidemics; contingency plans for the provision of emergency drugs, insecticides, spraying equipment and laboratory supplies.
3. Routine integrated vector control and management.
4. Community mobilization for ownership and action.

Other areas of emphasis are:

- Building capacity for research.
- Strengthening the health system so that it becomes more responsive to the problems presented by malaria.
- Strengthening the health management information system so that future planning is evidence-based, practical and focused.

Eritrea

Main implementation strategies

- Strengthening the capacity of health centres, hospitals and referral centres.
- Improving outcomes at the community or household level by using community-based health agents, mothers or caretakers to encourage appropriate treatment and health-seeking behaviour.
- Increasing access by communities to appropriate treatment by private providers.
- Strengthening information management systems from a community to national level and building the capacity of communities for effective participation in planning and resource mobilization, ownership of plan and monitoring.
- Develop local capacity for monitoring *P. falciparum* sensitivity to antimalarial drugs
- Increasing access to affordable ITNs and increasing their coverage and appropriate use.
- Developing contingency plans for the provision of emergency drugs, insecticides, spraying equipment and laboratory supplies.
- Providing technical and financial support for malaria research activities.
- Development of human resources support for programme management and for improving diagnostic and clinical systems at all levels.

Management arrangements

Multi-partner committees for malaria control have been established at national, zonal and sub-zonal levels.

Existing health committees at facility level have been strengthened.

Major expected outcomes by 2005

- 100% of community health agents (CHAs) and health workers are able to detect and refer patients within 24 hours of onset of fever.
- 75% of health workers and CHAs are trained in specified areas (such as management, supervision, health information systems and data analysis).
- Proportion of target groups with severe malaria correctly managed by health personnel increased by 80%.
- 80% of existing health facilities are stocked with necessary drugs and diagnostic materials.
- 50% of health workers are aware of early epidemic warning systems, able to use them and take adequate action.
- Over 90% of the population is aware of the need for personal protection against malaria.
- 60% of people living in malarious areas sleep under ITNs.
- 50% of households participate in environmental control.
- 100% of villages in malarious areas are covered by insecticide residual house-spraying during epidemics.
- 75% of health facilities are equipped with machinery, equipment and supplies to improve the quality of health care they deliver (including radio communication, transportation and office equipment).
- 100% of health workers, including CHAs, trained in the basic principles of IEC and communication skills.
- 80% of children's caregivers and affected individuals can recognize the signs and symptoms of severe malaria.
- 80% of affected individuals seek prompt and effective treatment for malaria.
- 80% of the households own at least one ITN.
- Multi-sectoral committees established at national, zonal and sub-zonal levels for malaria control.

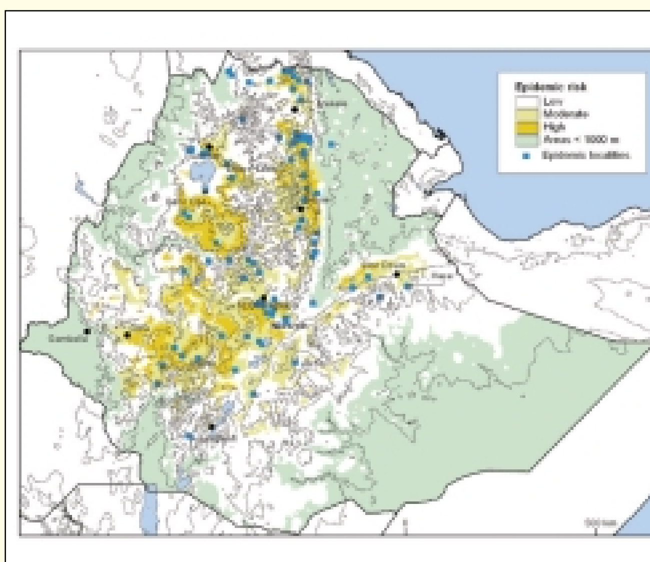
Budget Estimates (US$)

Strategy Component	Year 1	5-year total
Case management and prophylaxis	4,221,335	12,957,689
Programme management	1,583,024	5,217,562
Vector control	1,916,828	12,240384
Biological control	95,000	–
IEC	128,000	1,290,000
Epidemic preparedness/control	1,857,662	11,020,218
Applied research	574,000	–
Monitoring and evaluation	108,000	–
Total	10,483,849	–

Resource availability

Partners still have to review resource availability. Currently, most of the costs are financed through a facility from the World Bank.

Ethiopia



Risk of malaria epidemics in Ethiopia (see highlands malaria project, MARA/LSHTM, www.lshtm.ac.uk)

Introduction

Ethiopia's population is estimated at 63.5 million. Malaria ranks first in the list of communicable diseases with 65% of the population living in malarious areas and up to 40 million of the population estimated to be at risk of malaria. The problem is compounded by increasing epidemics, mixed *P. vivax* and *P. falciparum* infections, as well as increasing drug and insecticide resistance. *P. falciparum* accounts for 60-70% of cases and *P.vivax* 30-40%.

Clinical malaria accounts for 10-40% of Ethiopia's out-patient consultations. Corresponding proportional morbidity among children under-5 is 10-20%. Malaria accounts for 13-26% of all in-patient admissions in sampled health facilities and remains a major cause of mortality with proportional rates of 13-35% in health facilities. Case fatality rates were 15% and 17% across the facilities surveyed. Malaria illness accounts for approximately 15% of the overall DALYs lost in the country.

State of the movement

Ethiopia's strategic plan has been developed in line with the global RBM initiative. This has involved structured situation analysis supported by partners in regions. Regional and national level consultations, and a partners' retreat, were held to finalise the draft in March 2001.

A regional Situation Analysis was conducted in May 1999 and, at the same time, regional workshops were held to review plans of action and to introduce the RBM initiative at regional level. An advocacy campaign for national sensitization to RBM which began in August 1999 included national TV and radio broadcasts. By December 1999, Ethiopia had completed estimates and mobilization of supplies for impending epidemics. A national conference on RBM was held in February 2000. A documentary on malaria was produced, banners, posters and lapel pins as well as a special RBM logo for Ethiopia.

An RBM malaria support team has been formed with membership representing various partners. There is a growing formal involvement by NGOs and the private sector. Many NGOs which had evolved independently participated actively at the national conference. They included the Anti-Malaria Association and the Malaria Eradication Alumni. The Tigray experience continues to provide an entry point to community-based service.

Dialogue has taken place with IMCI on guidelines, contribution and participation in the development of the national POA for integrated surveillance. The programme has also worked with the Health Services and Training Department to develop the training curriculum on basic malariology, and collaborated with the Drug Administration and Control Department of MOH on procurement and quality control of drugs and insecticides.

There is a plan to produce insecticides locally in collaboration with a processing factory. Collaboration with ITN importers and distributors is also under way.

Early moves are being made towards collaboration with Ethiopia's neighbours. Dialogue has been initiated on a bilateral basis with Kenya, Sudan and Djibouti.

There has been a notable increase in financial resources with new support from UNICEF of about US$ 800,000 and about US$ 1million from USAID. Further resources are available from UNDP and other partners. UNICEF provided US$1 million in 2000, allocated US$ 1.7 million for 2001 and is mobilizing further resources. WHO added US$ 400,000 in 2000 to its regular budget of US$ 400,000.

Goal

To eliminate malaria as a public health problem and an obstacle to socio-economic development through intensified effort by a strong, sustainable partnership over 20 years.

General objectives include:

- ✘ To reduce overall burden of malaria by 25% compared to a baseline level which will be the average of the past five or more years for health facility-based indicators, and 2000 level for other indicators.
- ✘ To protect malaria-free areas from re-introduction and establishment of the disease through strong surveillance and preventive measures.

Strategic components

Ethiopia has four main strategic approaches to RBM:

1. Disease management.
2. Selective vector control.
3. Epidemics prevention and control.
4. Prevention and control of malaria in pregnancy

Ethiopia

The package of supportive strategies includes:
- Human resource development.
- Information, Education and Communication (IEC).
- Operational research.
- Management information system.
- Monitoring and evaluation.

Main implementation strategies

- Expansion and rationalization of home treatment, scaling-up of community care and improved disease management by private drug vendors and other outlets.
- Establishment of community drug shops (Bamako initiative).
- Improved quality of care in health facilities, and regular updating of drug policy and disease management guidelines.
- Improved targeting of localities, coverage and quality of indoor residual spraying.
- Introduction and scaling-up of ITN use in targeted areas.
- Improved and effective epidemics early warning and detection systems and a mechanism for fast response.
- Incorporation of antimalarial services into routine ANC.
- Prophylaxis for pregnant women during epidemics.
- Intermittent presumptive treatment in stable malaria transmission areas.
- Pre- and in-service training in malaria control for workers from all sectors.
- Integration of malaria information system into integrated disease surveillance.

Management arrangements

The development and management of RBM will be overseen by a broad-based partnership at various levels. At the central level, the Malaria Control Support Team (MCST), which was established in 1998 to respond to an epidemic, has been sustained through the inception phase as the task force of partners (WHO, UNICEF, UNDP, USAID). The MCST will be expanded to oversee implementation by including partners such as Ministries of Agriculture, Water Resources, Meteorology and Education as well as the Ministry of Information, mass media and research institutions.

Major expected outcomes by 2005

- 80% of those at-risk have access to affordable, appropriate treatment within 24 hours of onset of symptoms.
- Case fatality rates reduced by 30% in referral facilities.
- The existing 7-15% of epidemic-prone areas covered by IRS will be increased on a selective and systematic basis using epidemic forecasts and epidemiological stratification to reach a level of 50% by the end of 2005.
- In all regions distribution and use of ITNs will increase annually by 10%, up to 60% by the end of the fifth year.
- 50% of malaria epidemics will be detected within two weeks of onset and properly controlled.
- 50% of pregnant women in stable malaria transmission areas will have access to PIT and during epidemics, 50% of pregnant mothers living in affected communities will be protected using efficacious prophylactic drugs.

Budget Estimates (US$)

Strategy Component	Year 1	5-year total
Disease management	2,151,488	17,846,361
Vector control	7,488,682	38,382,443
Epidemic prevention and control	1756945	9,927,407
Malaria in pregnancy	396816	2,659,552
Pharmaceuticals	3244253	18,127,544
Human resource development	1,983,612	11,729,420
IEC	1,011,098	6,832,462
Operational research	270,352	3,382,153
HMIS	314,881	1,453,110
Monitoring and Evaluation	753,736	4,414,328
Implementation arrangements and coordination	1,441,886	7,366,992
Total	20,905,920	122,037,434

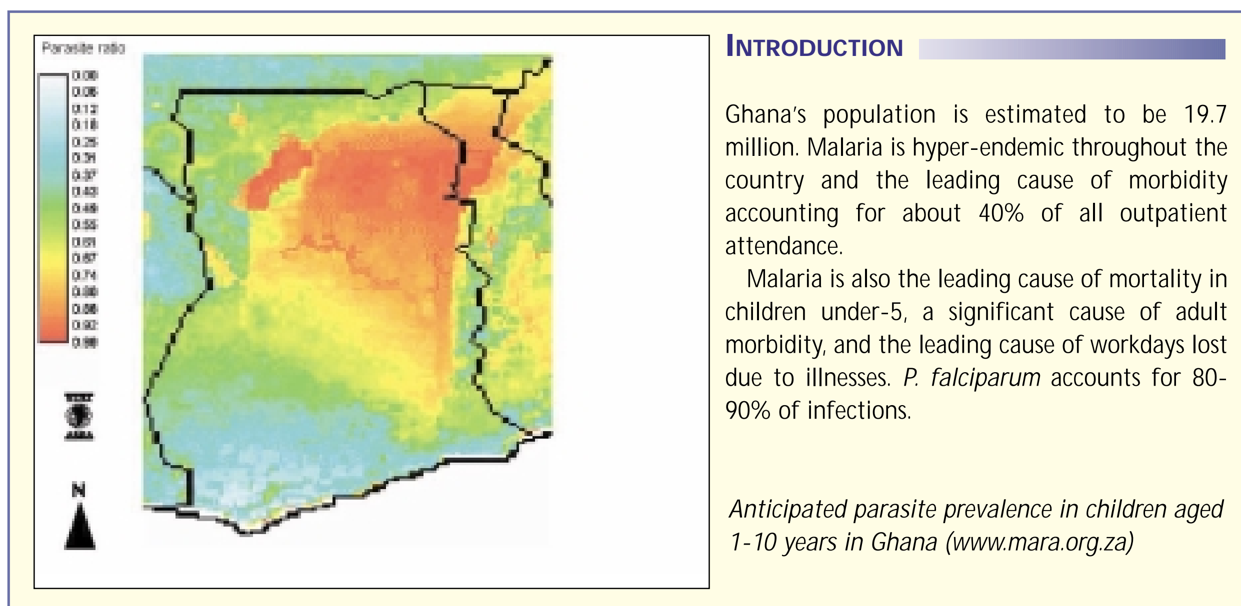
Resource availability

Required resources for year one
20,905,920

Available resources from government
2,552,400

Gap in the first year before partner pledges
18,353,520

Partner pledges are not yet recorded.



Introduction

Ghana's population is estimated to be 19.7 million. Malaria is hyper-endemic throughout the country and the leading cause of morbidity accounting for about 40% of all outpatient attendance.

Malaria is also the leading cause of mortality in children under-5, a significant cause of adult morbidity, and the leading cause of workdays lost due to illnesses. *P. falciparum* accounts for 80-90% of infections.

Anticipated parasite prevalence in children aged 1-10 years in Ghana (www.mara.org.za)

State of the movement

Ghana has been involved in RBM since November 1998 when it participated in field-testing RBM situation analysis instruments. Since then a multi-sectorial National Roll Back Malaria Committee chaired by the Director of Noguchi Memorial Research Institute for Medical Research, has been meeting quarterly to oversee RBM activities.

Ghana's national strategy for RBM has been prepared jointly with all partners, and was subjected to scrutiny at two national forums, held in November 1999 and March 2000. The strategic plan has been introduced to all districts, who have used it to incorporate RBM action into their annual health plans for 2001 according to SWAPs requirements. The strategic plan was also endorsed by a SWAPs partners meeting in October 2000 and a partners Round Table meeting in January 2001 at which financial pledges were made to support implementation.

Major malaria action during the implementation phase has included: assessment of malaria control programme management in all ten regions; establishment of a National Technical Committee (later merged into the national coordinating committee); establishment of an ITM task force; training 231 regional focal point persons in ITM; developing a proposal for private-public partnership for the promotion of ITMs; distribution of bednets to hospitals; and negotiations with the Ministry of Finance and other stakeholders to waive tax on insecticides and bednets.

Flood victims in the northern part of the country were donated 1,000 bednets and 100 litres of insecticides. Ghana has also produced an RBM advocacy package for national sensitisation. Direct one-to-one partner dialogue on RBM with, in some instances, participation by the RBM Secretariat has been conducted.

Major partners include, USAID, Johns Hopkins University, UNICEF, the Ghana Social Marketing Foundation, a number of private sector organisations, WHO, DFID, and DANIDA. Other health-related sectors are involved including: education, local government, Ministry of Environment Science and Technology, Ministry of Finance, Centre for Scientific and Industrial Research). The research and university communities (Noguchi, School of Public Health, GIMPA, Institute of Social and Economic Research, traditional leaders, and NGOs (including Plan International) are also involved.

Goal

To facilitate human development by reducing the burden of malaria (morbidity and mortality) by 50% by 2010.

Strategic components

1. Improved case management. (Early case detection, appropriate response and referral, adequate quality of care, effective and equitable access to care).
2. Multiple Prevention. (insecticide-treated materials, prophylaxis for pregnant women, limited indoor/outdoor residual spraying, limited larviciding, drainage and mosquito proofing).
3. Focused research and development. (Increased funds; focused agenda; improved dissemination and utilisation of results; and capacity development for research).
4. Improved partnerships. (Encouraging functional partnerships within the health sector, between agencies, between government sectors, with and between NGOs, private sector, informal sector, traditional health providers and communities).

Main implementation strategies

- ✘ Improved home-based care, including promotion of pre-packaged medicines.
- ✘ Countrywide introduction of the Community-Based Health Service Initiative (CBHSI) with trained community health practitioners in community-based single person facilities and CHWs. Outreach facilities as appropriate.
- ✘ Strengthened informal providers from other sectors including the chemical industry.

Ghana

- Improved referral, including establishing communication networks (including radio), use of community surveillance volunteers and improved ambulance systems.
- Improved management of severe malaria, including increased diagnostic capacity and structured quality assurance mechanisms in the health facilities.
- Collaboration with other programmes, such as IMCI.
- Improved incentive structure for health workers, and development of HIS.
- Publicly-supported demand creation for ITMs including commissioning an integrated consumer-oriented campaign. Demand creation will be supported through health facility networks, schools, hotels, etc.
- Making ITMs affordable through waiving taxes and tariffs and promoting local production of ITMs.
- Targeted subsidy and distribution of ITMs to the poor.
- Free chloroquine to all facilities for pregnant women. New policy on prophylaxis in pregnancy.
- Participation in the Ghana/Dutch project to strengthen the research agenda for RBM.

Management arrangements

RBM management arrangements at all levels will focus on brokering and coordinating the partnership rather than implementing specific interventions. All levels will integrate relevant RBM actions into their regular plans and budgets and implement these actions as part of their mandate.

At the national level, the RBM partnership is spearheaded by a National Coordinating Committee which meets quarterly to review malaria control activities in the country and revise policies and strategies as appropriate. Chairmanship is currently provided by the director of the Noguchi Foundation and the committee's membership currently includes representatives from the World Bank, DFID, WHO, Ministry of Local Government, Ministry of Environment, Science and Technology, Plan International, and members of the National Technical Committee.

The National Malaria Control Programme will serve as secretariat to the partnership as well as providing technical support functions to the regions. Operational plans will be elaborated annually and feedback provided quarterly to the partnership by the secretariat.

Major expected outcomes by 2005

- 60% of caretakers in rural areas and 70% in urban areas will be able to respond to the cases of malaria they identify.
- The proportion of households with physical access to health facilities within 5km will increase to cover 75% of the population.
- The number of people sleeping under an ITN, especially children and pregnant women, will increase from the current 4% to 70%.
- All pregnant women receiving appropriate prophylaxis.

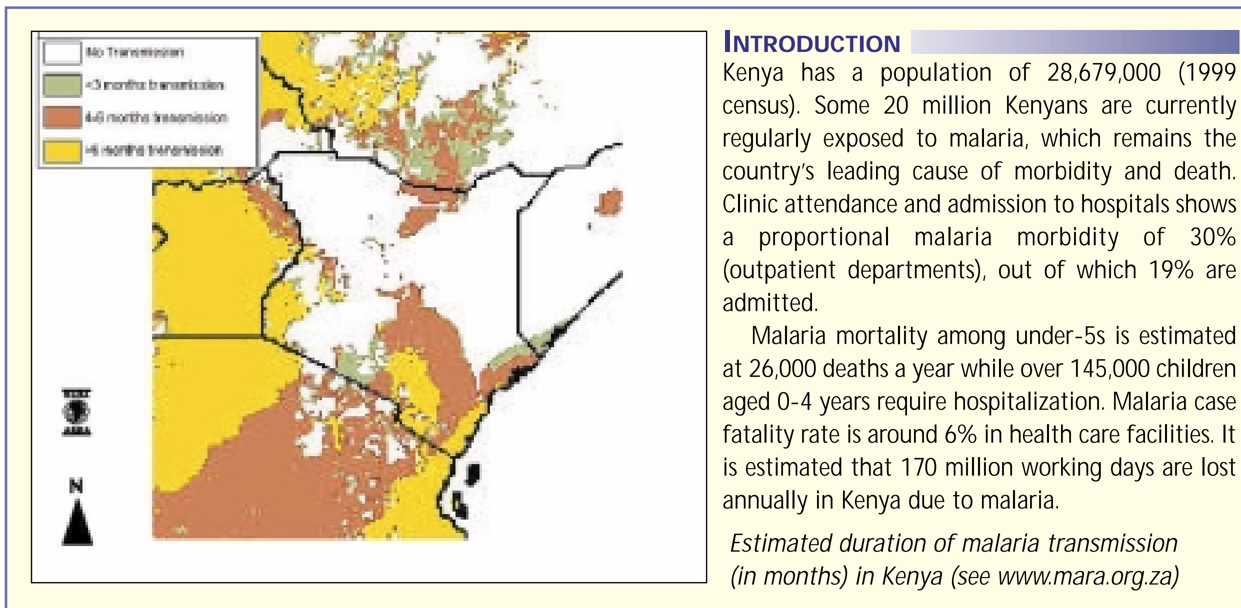
Budget Estimates (US$)

(Excluding costs for drugs for clinical care, commodity costs for ITM-related commodities, and all public sector salary costs due to the existing cash and carry system for drugs and the decision to allow the private sector to take care of the supply side of ITM promotion).

Strategy Component	Year 1	5-year total
Case management	1,982,300	7,927,900
Multiple prevention	3,953,900	1,926,300
Focused research	181,500	895,500
Partnerships	34,300	171,500
Management (secretariat)	258,620	1,028,100
Monitoring and evaluation	84,520	422,600
Total	6,495,140	12,371,900

Resource availability

- Resources pledged by the partners' Round Table meeting towards the first year of implementation amounted to 1,800,000 through common pot (USAID, WHO, UNICEF, DFID/DANIDA/GOG).
- There were no pledges towards the five-year budget.



Introduction

Kenya has a population of 28,679,000 (1999 census). Some 20 million Kenyans are currently regularly exposed to malaria, which remains the country's leading cause of morbidity and death. Clinic attendance and admission to hospitals shows a proportional malaria morbidity of 30% (outpatient departments), out of which 19% are admitted.

Malaria mortality among under-5s is estimated at 26,000 deaths a year while over 145,000 children aged 0-4 years require hospitalization. Malaria case fatality rate is around 6% in health care facilities. It is estimated that 170 million working days are lost annually in Kenya due to malaria.

Estimated duration of malaria transmission (in months) in Kenya (see www.mara.org.za)

State of the movement

RBM action is spearheaded by the National Malaria Coordinating Committee, chaired by the Director of Medical Services. Membership includes MOH (all heads of MOH departments are members), external partners, local NGOs and the private sector. The committee meets quarterly and functions as an executive board supervising the National Malaria Control Programme. This allows the MOH and partners to jointly manage national malaria action. A monthly partners' meeting is also held to discuss issues before they go to the NMCC.

Restructuring and enhancing the capacity of the National Malaria Control Unit led to its elevation to MOH division status as the new Division of Malaria Control. New offices have been constructed with DFID support and new staff appointed.

The country's ten-year strategy is complete and was endorsed by partners at a Round Table meeting in April, 2001 during which resources were pledged by partners. The strategy was launched nationally by the Minister of Health in April 2001.

Early RBM achievements include: zero-rating of VAT on mosquito nets; new guidelines on epidemic preparedness and response; training health personnel in epidemic-prone districts; drug policy has been reviewed and SP adopted as the first-line drug; the Health Sector Strategic Plan (HSSP) for 1999-2004 gives malaria the highest priority; the Interim Poverty Reduction Strategy paper commits the government to effective implementation of its malaria control action plan.

Active partners in RBM in Kenya include MERLIN in Kisii district, CARE in Siaya district, AMREF in Transmara district, and MSF-F in Homa Bay District. ADB, WHO, UNICEF and DFID.

Goal

The goal of the National Malaria Strategy is to reduce morbidity and mortality caused by malaria by 30% among Kenya's population by the year 2006 and maintain this progress through to 2010.

Strategic components:

The plan has been developed through consensus building approaches which have collectively involved over 200 stakeholders from the government, private, mission, and NGO sectors at central, provincial and district levels. The strategy also draws upon previous MoH proposals, plans of action and a review of the institutional framework carried out in October 2000.

Strategic components

Four Strategic Approaches

- Guaranteeing access to rapid and effective treatment.
- Providing malaria prevention and treatment to pregnant women.
- Ensuring the use of ITNs by at-risk communities.
- Improving malaria epidemic preparedness and response.

Supporting structures for strategic approaches

- Information, Education and Communication (IEC).
- Monitoring, evaluation and research.

Main implementation strategies

- Fostering awareness among client communities and promoting confident and correct use of appropriate drugs and services by the community.
- Improved case management by service providers. (Guidelines for health workers, in-service and pre-service training, supervision and continuing training, collaboration with IMCI and Safe-Motherhood programmes, collaboration with national public health laboratories, etc.).

Kenya

- Drug registration, legislation and quality. (Appropriate formulations, packing and dosing, enabling access to first-line therapeutics through informal drug sellers and monitoring drug efficacy.)
- Provision of prophylactic iron, folate and Preventive Intermittent Treatment to pregnant women through collaboration with reproductive health programmes.
- Creation of an enabling environment to foster private sector growth in the provision of unsubsidized, affordable ITN services which complement alternative approaches offered by non-profit, social marketing organizations, NGOs and the public sector. (Demand creation, waiver of taxes and tariffs, strictly targeted subsidies).
- Effective epidemic preparedness and response. (Creating of Disease Outbreaks Management Units, use of indoor residual spraying, and innovative drug management schemes).
- Targeted IEC (use of workshops, mass media, website and resource centres, school health and Africa Malaria Day celebrations, etc.)
- Measuring target indicators of the national malaria strategy and impact assessment.

Management arrangements

In order to take forward the National Malaria Strategy the principals and structures articulated in the National Health Sector Strategic Plan will be adopted throughout the country. Malaria is one of the six essential packages of the HSSP and complete harmonisation between the National Malaria Strategy and the National Health Sector Strategic Plan will guarantee RBM success in Kenya.

The National Malaria Coordinating Committee (NMCC) will provide a forum for partners in the National Malaria Strategy to exchange information, coordinate malaria control plans and activities, and measure progress against objectives. The NMCC will report to the Ministers of Health.

Development partners will be represented on the NMCC but may also need to meet separately. Twice-yearly donor meetings may therefore be appropriate to provide input to annual plans and review mid-year financial positions. These will be convened through the WHO Country Office.

Detailed planning and monitoring of activities will be the role of the DOMC, which will function as the movement's secretariat, with support provided, where appropriate, from technical working groups.

Major expected outcomes by 2005

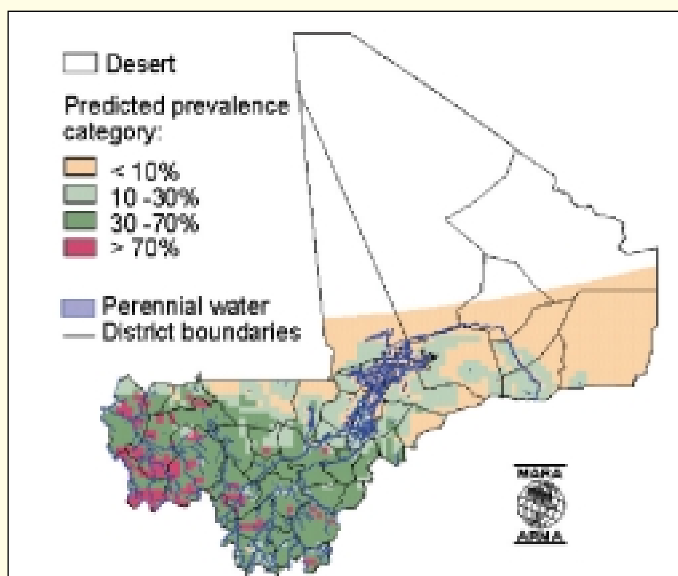
- 80% of all antimalarial drugs, provided through formal and informal sectors, are of internationally acceptable pharmacological standards.
- 60% of malaria cases are appropriately managed at home by family members or caretakers.
- 80% of first-line therapeutic failures and cases of severe, complicated malaria are correctly managed by health personnel in appropriate facilities.
- 60% of pregnant women have two PIT sessions (in their second and third trimesters).
- 80% of febrile or anaemia episodes are appropriately managed at ANC services.
- 60% of pregnant women sleep under an ITN.
- 60% of the at-risk population sleep under nets.
- 60% of epidemics are effectively contained through appropriate use of interventions, including community mobilization, effective case management, ITNs and/or IRS.

Budget Estimates (US$)

Strategy Component	Year 1
Institutional support	750,000
Improving case management	650,000
Procurement of drugs and commodities	1,350,000
Management of malaria in pregnancy	350,000
Provision of ITN services to at-risk populations	10,000,000
Epidemics	1,800,000
Behavioural change	1,400,000
Monitoring and evaluation	600,000
Total	16,900,000

Resource availability

Known commitments	
WHO	240,000
UNICEF	200,000
DFID	550,000
Total	990,000
Funding gap	4,927,000



Categories of expected parasite ratios in children aged 1-10 years in Mali (www.mara.org.za)

Introduction

Mali has a population of 9.8 million. Malaria is a major health problem with a national incidence of 40.9 per thousand and accounting for 33% of all consultations for health care. Children under-5 are the major at risk population and account for 63% of total cases. The principal parasite is *P.falciparum*. Chloroquine resistance is low.

In March 2001, a Round Table meeting attended by a wide range of partners including UNICEF, WB, UNDP, UNFUP, WHO, Swiss Cooperation, USAID, various government departments, associations and civil society, discussed the draft Strategic Plan and budget for RBM in Mali. The meeting formally adopted the Strategic Plan and various partners pledged unquantified financial and other resources towards implementation. The participants also set up a task force to finalise the plan based on the input from the Round Table.

State of the movement

Mali has been involved in RBM since 1998 when it participated in pre-testing of situation analysis instruments. Since then the country has mounted an intensive inception phase aimed at building country wide consensus on RBM with direct involvement by the Head of State, building a strong partnership and developing a medium to long-term strategy for RBM. In addition to inception activities, Mali has attempted to maintain momentum of its on-going malaria control activities. The Government removed taxes and tariffs on malaria control tools such as ITNs in April 2001.

A situation analysis has been conducted at national, district and community levels which provided evidence for strategic planning for RBM in Mali. The strategic plan was endorsed by partners at a Round Table meeting early in 2001. To spearhead implementation, a multisectoral Technical Committee and a Facilitators Group were set up.

Currently active partners include UN agencies such as UNICEF, UNDP, WB and WHO (who have funded some of the activities in the inception phase), UNDP, German Cooperation through GTZ, Belgian Cooperation, Swiss Cooperation, and many NGOs, such as Groupe Pivot Santé et Population and Plan International. Partners are represented on the Facilitators Group which provides technical assistance to the NMCP. Government ministries are involved in RBM and community health structures are contributing to the implementation of the strategic plan and helping take interventions to scale.

Goal

To reduce the socio-economical burden of malaria by reducing morbidity and mortality by 2030 so that malaria would no longer be a public health problem.

Strategic components

1. Improved case management at all levels, facility as well as community. Home management by involving community health personnel, extending coverage, developing community health approach in resource mobilization, capacity building for care providers at all levels, reinforcement of support systems, early case detection, appropriate response and referral.
2. Multiple prevention. Insecticide Treated Materials, prophylaxis for pregnant women and environmental management.
3. Epidemic surveillance and preparedness. Monitoring, supervision and evaluation of malaria control activities. Establishing rapid response mechanisms to epidemics and a policy of epidemic preparedness.
4. Focused research and development. Decentralisation of operational research by capacity building, joint identification of research topics by research institutions and the National Malaria Control Programme, increased funds, focused agenda.
5. Improved management of the programme. Development of intersectorial collaboration, use of task forces, development of capacity, outsourcing, involving stakeholders in decision-making.
6. Improved partnerships. Establishing mechanisms for coordination, setting up an interministerial committee for strategic orientation and coordination, putting regional level coordination mechanisms in place, institutionalisation of fora so that many partners are involved in implementing the strategic plan.

Mali

Main implementation strategies

- Improved home-based care by promoting home management, capacity building, reinforcement and extension of coverage though community health systems and community revolving funds for drug availability.
- Countrywide introduction of home management by involving trained community health practitioners and trained mothers.
- Improved referral, using communication networks (including radio), community surveillance volunteers and improved ambulance systems.
- Improved management of severe malaria — including diagnostic capacity and establishing structured quality assurance mechanisms in health facilities.
- Improved prevention measures including promoting ITN use, prophylaxis promotion, environmental hygiene.
- Supporting the creation of public demand for ITMs. Establishing a national plan to scale up ITN use.
- Making ITNs affordable through taxes and tariffs waiver.
- Improved epidemic preparedness, including monitoring, supervision and evaluation.
- Improved management of the programme by involving more stakeholders and setting up new mechanisms to support the programme.
- Strengthening partnerships with coordination mechanisms.
- Collaborating with other health sector programmes such as community and family health programmes.

Management arrangements

The National Malaria Control Programme will be linked to several institutions at both national and regional levels such as interministerial committees, facilitators groups, steering committees, regional coordination groups and others.

At the national level, the RBM partnership will be spearheaded by a Steering Committee which will meet regularly to perform review of policies and strategies as appropriate. The membership of the Steering Committee includes representatives of other government departments, UN agencies, research institutions, bilateral cooperation, NGOs and civil society. Although the private sector is involved it has no representatives on the Steering Committee. Technical groups are also being set up to deal with specific issues and provide general technical support to the NMCP which will serve as secretariat to the partnership.

Major expected outcomes by 2005

- 80% of fever, simple and severe malaria correctly managed within 24 hours of the first symptoms.
- 60% of pregnant women and children under-5 sleep under an ITN.
- 30% of the general population sleeps under an ITN.
- 60% of pregnant women use intermittent treatment.
- 80% of targeted facilities are reinforced for management and epidemic preparedness and to implement malaria control activities.
- 100% of facilities are reinforced for monitoring and evaluation of malaria control activities.
- Sentinel sites established for surveillance and clinical trials.
- Intersectorial collaboration is established for research.
- Mechanisms are established to reinforce partnership.

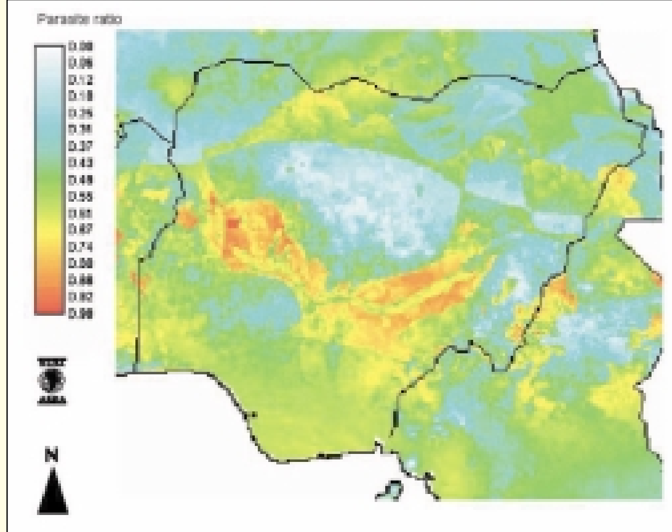
Budget Estimates (US$)

Strategy Component	Year 1	5-year total
Case management	528,271	3,434,228
Promotion of utilization of ITNs	1,165,957	16,871,662
Prophylaxis	4,000	212,501
Epidemics	272,974	492,563
Research and development	56,200	433,673
Partnership	845,000	165,500
Management	272,974	21,933,395
Total	3,145,376	43,543,522

Resource availability

Resource gap towards year one implementation can not yet be estimated because partners have to decide the total amount of resources they will commit to the funding of the Strategic Plan.

Nigeria



Anticipated parasite prevalence in children aged 1-10 years in Nigeria (www.mara.org.za)

Introduction

Nigeria's population was 121.3 million in 1998. Malaria is endemic throughout the country and more than 90% of the population live in areas with stable malaria. Malaria is one of Nigeria's leading causes of morbidity and mortality with a prevalence rate of 919/100,000. It is responsible for 25% of infant mortality and 30% of childhood mortality. Malaria accounts for 50% of outpatient consultations/visits and between 15% and 31.3% of hospital admissions.

Of the four species of Plasmodia infective to man, all except *P. vivax* are found in Nigeria with *P. falciparum* accounting for about 80% of cases. Chloroquine failure rates from studies in 20 sites between 1987-1990 range from below 10% in most parts of Nigeria except in the east part where they are above 25% for *P. falciparum.*

State of the movement

Nigeria has been active in the RBM movement since 1998 when it participated in pre-testing situation analysis instruments. Nigeria's Head of State convened and co-financed the African Summit on Roll Back Malaria in Abuja, Nigeria in April, 2000.

Measures have been undertaken in the country to develop a dynamic national RBM movement. These have involved all levels of the political structure and a broad range of partners.

- ✘ A National Malaria Control Committee has been inaugurated to play a pivotal role in advocacy, social mobilization and implementation of RBM in Nigeria. This has included expertise in the various areas and key representatives from the civil society.
- ✘ Four sub-committees were inaugurated to look into key areas of RBM—including publicity and community mobilization; case management and drug policy.
- ✘ The Federal Ministry of Health has accorded malaria control as one of its priorities in the current health sector development programme.
- ✘ Nigeria has reduced taxes and tariffs on bed nets from 50% to 5% and waived taxes and tariffs on insecticides.
- ✘ Manufacturers have committed to RBM and given assurances of their capacity to manufacture 10,000 bednets per month to meet the country's needs.
- ✘ A stakeholders and partners Round Table meeting was held in January, 2001. It adopted a six-months intensive plan which included the development of a medium to long-term national strategic plan.

Goal

✘ To reduce malaria mortality and morbidity by 50% by 2005.

Strategic components

Five strategic approaches of RBM in Nigeria are:

1. Disease Management.
2. Multiple Disease Prevention (ITNs, prophylaxis, environmental management and personal protection).
3. Operational research.
4. Partnerships.
5. Information, Education, Communication (IEC) and Social mobilization.

Main implementation strategies

- ✘ Recognize the home as the first point of treatment and strengthen home care with training and information packages for easy use of antimalarial drugs.
- ✘ Recognize the role of patent medicine vendors, improve their knowledge, encourage better practice and monitor the quality of their products.
- ✘ Ensure continued monitoring of the efficacy of first-line antimalarial drugs.
- ✘ Integrate micronutrient supplementation in malaria case management in collaboration with IMCI, reproductive health and others.
- ✘ In an integrated disease control approach, village health workers and traditional birth attendants will be involved with malaria control in the context of IMCI and other health care programmes.
- ✘ Improve regulation in collaboration with the National Agencies for Food Drugs and Control and intensify inspection of drug providers' and suppliers' premises.
- ✘ Consider reducing duty on imported anti-malaria drugs which cannot be manufactured in Nigeria.
- ✘ Promote local manufacture of antimalarials, including research into combination drugs and local herbal remedies.

Nigeria

- Review school curricula to include malaria issues.
- Create/promote a network of community pharmacies in line with the Bamako initiative for improved drug distribution.
- Regular updating of treatment protocols and distribution to all health care providers, including community-based health providers, private health providers, NGOs, Community-Based Organizations, and the private sector.
- Establish an adequate incentive system for motivating health care providers at all levels, which may lead to improved attitudes, and subsequently, improved services.
- Use a community education programme to mobilize men to encourage their pregnant spouses to use ante natal services and take appropriate actions to prevent and treat malaria. Mothers and care-givers of children under-5 will be encouraged to use maternal and child health services and take prompt, appropriate actions during illness.
- Increase accessibility and affordability of ITMs through reducing or waiving taxes and tariffs, targeted subsidies and promotion of local ITM production.
- Mount community-based education programmes to improve malaria awareness and the usefulness of ITMs. Establish mechanisms for advocacy at all levels.
- Build up numbers of skilled research workers through training and scientific exchange visits and establish an adequate infrastructure for conducting research.

Management arrangements

The National RBM Coordinating Committee, which has already been constituted, will be strengthened. Its sub-committees, under government leadership, will oversee the different aspects of RBM in Nigeria. Monthly meetings will be held for all partners at the initial stages of RBM implementation but this may be flexibly adjusted to quarterly meetings. The secretariat will be provided by the National Malaria Control Unit.

Major expected outcomes by 2005

- 100% of health facilities will have pre-packaged drugs.
- A network of community-based practitioners will be established and cover 60% of the population by 2003.
- The network of laboratories at strategic locations will be strengthened and operate at optimal capacity by 2005.
- 80% of health centres and hospitals will be staffed with qualified personnel and will have sufficient capacity and incentive facilities to retain their staff by 2005.
- 80% of the most vulnerable groups (pregnant women and children under-5) will use ITNs and other effective methods of prevention by 2005.
- Achieve a 50% re-treatment rate for bednets by 2005.
- 80% of community members will be able to correctly identify the causes, prevention and management of both simple and severe malaria by 2005.
- 80% of caretakers will be able to recognize symptoms of malaria and provide correct treatment by 2005.
- 100% of pregnant women will be using prophylaxis by end of the year 2005.

Budget Estimates (US$)

Strategy Component	Year 1	5-year total
Disease management	19,200,000	68,900,000
Multiple prevention (ITN)	16,000,000	60,000,000
Multiple prevention (IPT)	14,500,000	53,900,000
Multiple prevention (Environmental management)	1,900,000	7,600,000
Operational research	1,800,000	6,500,000
Partnership	1,000,000	3,900,000
IEC	1,200,000	4,000,000
Total	55,600,000	204,800,000

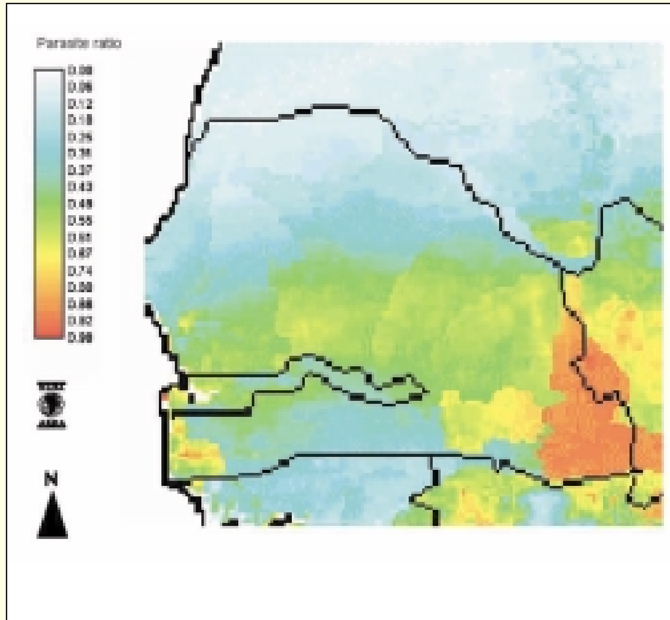
Resource availability

WHO	405,000
UNICEF	1,000,000
USAID	1,000,000
Net Mark	2,000,000
FMoH	1,000,000
Total	**5,405,000**

Resource gap towards year one implementation: **50,195,000**

UNICEF, DFID and Net Mark are covering only 10 out of 37 States in the country.
As health sector support DFID is providing DFID $35,500,000 (£25m) over five years.

Senegal



Introduction

Senegal has a population of 9.5 million of whom 60% live in rural areas. Since 1993 malaria has been the principal cause of mortality and morbidity (35% of cases). In 1996, 600,000 cases of malaria and 5,000 deaths were notified in the health centres. Severe cases of malaria are on the increase and both adult and child deaths are rising. In Senegal the transmission of malaria is seasonal—the rainy season and the beginning of the dry season—and the duration of the period of transmission is shorter in the south than the north of the country. The principal parasite is *P. falciparum* which accounts for more than 90% of cases.

Anticipated parasite prevalence in children aged 1-10 years in Senegal (www.mara.org.za)

State of the movement

Senegal has been engaged in RBM since the Regional Consensus Meeting of March 1999 which was followed by a national workshop in June 1999 aimed at raising awareness.

The five-year strategic plan has been developed in a process involving many partners. It was formally adopted at a Round Table meeting. in March 2001 attended by a wide range of partners including senior government staff, UNICEF, WHO, WB and UNDP as well as USAID, Basics and Plan International

Partner commitment has grown. UN agencies such as UNICEF, UNDP, UNPF and the World Bank are partners. The World Bank is helping finance a major health programme which includes malaria control. UNICEF, UNDP, NGOs and the private sector are involved in the promotion of impregnated materials. UNICEF is supporting case management at community level by supporting community health worker training. Japan Cooperation, through JICA, is contributing to health programmes, malaria control activities, financing and building health structures.

Many NGOs are involved at the community level. World Vision, La Foundation Solidarité Partage, Plan International, Lutherian Mission and CACAH Communities are playing a major role as partners and support malaria control activities through community support networks in some districts.

A multidisciplinary Steering Committee has been created to assist the NMCP. It has a consultative role and includes representatives from 16 Ministries as well as representatives from the University Cheikh Anta Diop, the Pasteur Institute, the Institute of Health and Development, the Senegalese Agricultural Research Institute and the Ecole Inter-Etat des Sciences et médecine vétérinaires.

A Facilitators Group has been created to provide technical assistance to the NMCP. Ministries involved in RBM take part in the Facilitators Group.

Parliament has voted to ask the Minister of Economy and Finance to allocate resources for malaria control in 2001 before the elaboration of the five-year strategic plan. A grant of 500.000.000 F CFA (approx US$ 653,000) has been allocated for ITN procurement.

The Ministry of Finances has now appointed a focal point to follow up the implementation of malaria control.

The adoption of RBM principles has led to a new approach—identification of priority interventions and elaboration of strategies based on the results of situation analysis on case management at facility and community level, on health system itself in the country.

Goal

To reduce malaria morbidity and mortality by 50% by the year 2010.

Strategic components

- ✘ Early recognition and affordable quality first-line fever treatment for all ill individuals at home or at health facilities.
- ✘ Multiple prevention: Preventive intermittent treatment for pregnant women; ITN promotion: cost recovery strategies; removal of import duty and sales tax on ITN-related materials; public pricing subsidy for ITNs to vulnerable groups; other vector control measures where appropriate.
- ✘ Epidemiological surveillance: Strengthen reporting systems.
- ✘ Operational research: Drug resistance monitoring;

Senegal

consumer and marketing studies; research on communication for behaviour change.

- Support and strengthening the supply of drugs, materials and consumables. Public sector: National purchasing agency and regional offices must offer subsidized drugs to health facilities. Private sector: Regulation is required for private sector drug quality. Nets and insecticides: Social marketing by voluntary and private sector needs to be encouraged.

Main implementation strategies

- Rapid diagnosis and treatment: Communication for behaviour change by health workers to ensure application of new case management guidelines.
  - Multiple prevention:
    - Preventive Intermittent Treatment for pregnant women.
    - ITNs require multiple distribution channels; import tariffs and sales tax on netting materials and insecticides must be reduced; subsidized nets to encourage public sector distribution channels.
- Community-based interventions. Microplanning is needed to develop activities which will improve access to RBM interventions; IEC is needed to communicate behaviour change and create demand for interventions.
- Epidemiological surveillance: Epidemic preparedness; drug resistance monitoring.
- Operational research: Market research and service quality evaluations; urban RBM strategy review.
- Partnership building: Institutional framework for national partnership to effectively subcontract the provision of some services.
- Commodity management: Drug supplies for health services, diagnostic facilities, netting materials and insecticides; identify contracting mechanisms.
- RBM advocacy for regional and district health planning cycles.

Management arrangements

National Coordination of RBM activity implementation is the responsibility of the National Steering Committee. In addition the programme benefits from technical assistance from the facilitators group where the various partners have representatives.

The National Malaria Control Programme will serve as secretariat to the partnership as well as providing technical support to the regions.

Operational plans will be elaborated annually and feedback will be provided quarterly to the partnership by the secretariat.

Major expected outcomes before 2005

- 60% of guardians will be able to respond effectively to cases of malaria they identify.
- 60% of the at-risk population has access to personal and community protection methods such as ITMs.
- 60% of pregnant women regularly use drug regimes as recommended by the NMCP.
- 95% of health staff apply national treatment guidelines.
- 90% of health facility users receive treatment according to national guidelines.
- 30% mortality reduction in under-5s.
- 20% morbidity reduction in under-5s.
- 50% reduction in severe malaria during pregnancy.

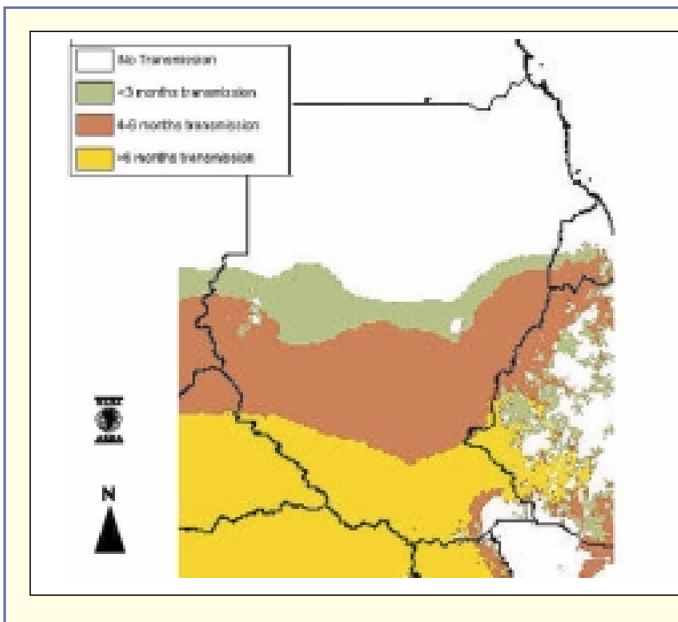
Budget Estimates (US$)

Strategy Component	Year 1	5-year total
Case management	2,898,211	11,782,294
Multiple prevention	2,489,391	19,953,955
Focused research	176,871	868,027
Partnerships	16,986	
Management (secretariat)	2,189,837	2,366,027
Monitoring and evaluation	150,439	619,963
Total	7,921,734	35,590,265

Resource availability

No pledges were made during the Round Table meeting. They are scheduled to be made during bilateral negotiations.

Sudan



Introduction

Sudan's population is estimated at 30.3 million (projected from 1993 census). Malaria is a major health problem, accounting for an estimated 7.5 million cases and 20% (or 35,000) of hospital deaths per year.

About 25% of total outpatient attendances and 32% of total admissions are attributed to malaria. Studies in paediatric hospitals showed case fatality rates of 8% in children with severe malaria. Children below three years of age were four times more likely to die than those older.

Estimated duration of malaria transmission (in months) in Sudan (see www.mara.org.za)

State of the movement

Roll Back Malaria was introduced to Sudan through the participation of a high-level delegation at the regional consensus meeting held In Nairobi, Kenya in April 1999. Since then Sudan has developed a number of measures towards a sustained action to Roll Back Malaria.

- The High Commission—a multisectoral co-ordinating structure—comprising various sectoral ministries and partners monitors the RBM inception process and facilitates its strategic development of RBM. A multisectoral technical subcommittee has been set up.
- Active partners in addition to UNICEF, WHO, UNDP, UNIDO and other NGOs include the African Development Bank, the Arab Gulf Fund, JICA, Ministries of Agriculture, Irrigation & Water Resources, Meteorology Department, Community Department, University of Khartoum, the Saving and Social Development Bank and sugar companies in Central Sudan.
- There is a bilateral agreement with Egypt on malaria control along the borders of the two countries.
- In North and Central Sudan, a strategy for forecasting, predicting and controlling malaria epidemics is being instituted, and therapeutic efficacy studies are being undertaken by the National Malaria Administration.
- In South Sudan, strategies for capacity building, strengthening of the drug supply system and therapeutic efficacy studies to determine the extent of chloroquine resistant *P.falciparum* are being undertaken.
- Desk analysis provided the basis for evidence-based strategy development. The Technical Support Network on Complex Emergencies in August-September 1999 undertook an analysis of the situation in the difficult to access states of South Sudan.
- In April, 2000 a Ministerial Resolution was made by the Federal Ministry of Health to restructure the National Malaria Administration to a National Project for RBM in Sudan directly answerable to the Under Secretary of Health.
- A Round Table meeting for partners was held in February 2001 to identify their contribution to the interventions needed to achieve the goals of the strategic plan and to identify resource gaps for scaling up. The partners formally adopted the national strategic plan and pledged resources to support it.

Goal

The overall goal of RBM in Sudan is to facilitate human development and poverty reduction by reducing the malaria disease burden. This will be achieved through overall health sector development, improved strategic investments in malaria control, and increased coverage of malaria treatment and prevention interventions, especially at the community level.

The immediate objective of the RBM strategic plan in Sudan is to reduce the morbidity and mortality of malaria by 50% by 2010.

Strategic components

1. Disease management: Diagnosis, treatment, drugs.
2. Disease prevention: Insecticides, environmental management for source reduction, biological control, insecticide-treated materials, epidemic preparedness and response.
3. Capacity building: Training, staffing health services adequately.
4. Operational research for evidence-based decisions.
5. Social mobilization: Information, Education and Communication (IEC) to empower communities.
6. Health sector reform: Decentralization, free management of cases and subsidies for preventive measures.

Sudan

7. Intersectoral cooperation: Between municipalities and different sectors such as agriculture/irrigation and immigration/refugees.

Main implementation strategies

- ✘ Strengthening of surveillance systems, establishing systems for proper forecasting, early detection and rapid response to ensure epidemics of malaria are prevented and adequately controlled.
- ✘ Institution of systems for early recognition and appropriate management of malaria cases at the individual, family, community and health facility levels.
- ✘ Deployment of multiple, cost-effective and sustainable preventative measures to reduce man-vector contact according to local epidemiological characteristics.
- ✘ Strengthen research capabilities to ensure the availability of appropriate and timely information for evidence-based decision-making.
- ✘ Increase community awareness of the socio-economic impact of malaria and the need for control measures as an inducement for active community participation.
- ✘ Build and foster partnerships among all stakeholders to support the social movement to roll back malaria.
- ✘ Contribute to and advocate for the strengthening of overall health system development and policies in line with the general strategic health plan.

Management arrangements

At a Federal level, the Higher National Committee for Malaria, chaired by the State President, was re-activated by Presidential Decree in March 1999. This was followed by the establishment of the National Advisory Committee for Malaria Control, which has the Federal Minister of Health as its focal point. The committee, which is multi-sectoral and includes private sector representatives, is supported by a secretariat housed at the National Malaria Administration. The Directorate of International Health is the focal point for partners. The RBM secretariat communicates all decisions and resolutions to partners, other sector ministries and institutions.

At State level, boards for RBM have formed in Khartoum, Gezira, White Nile, Red Sea, River Nile, and North Kordofan. The State Board for RBM, headed by the State Governor (Wali), will facilitate implementation and coordination of RBM activities RBM Technical Committees will be established at provincial level.

Major expected outcomes by 2005

- ✘ Improved disease surveillance system for timely prediction of epidemics in all epidemic-prone states.
- ✘ Adequate buffer stocks in all epidemic-prone states.
- ✘ Effective and efficient systems in place to respond and contain epidemics in all epidemic-prone states.
- ✘ Improved capacity of caretakers of children under-5 in areas of perennial transmission to recognise symptoms of simple malaria and provide home management.
- ✘ Change current policy to make chloroquine an over-the-counter drug.
- ✘ Improved quality of care for all types of clinical malaria at all health facilities
- ✘ Selective use of sustainable vector control measures based on epidemiological stratification and according to policy assured in at least 16 states by the end of the second year of the plan.
- ✘ Increased use of ITNs by 40% of households within the first two years of the plan.
- ✘ Evidence-based decisions on problems in malaria control through capacity building for operational research.
- ✘ Partnership between and among stakeholders at Federal and State levels strengthened within the plan's first year.

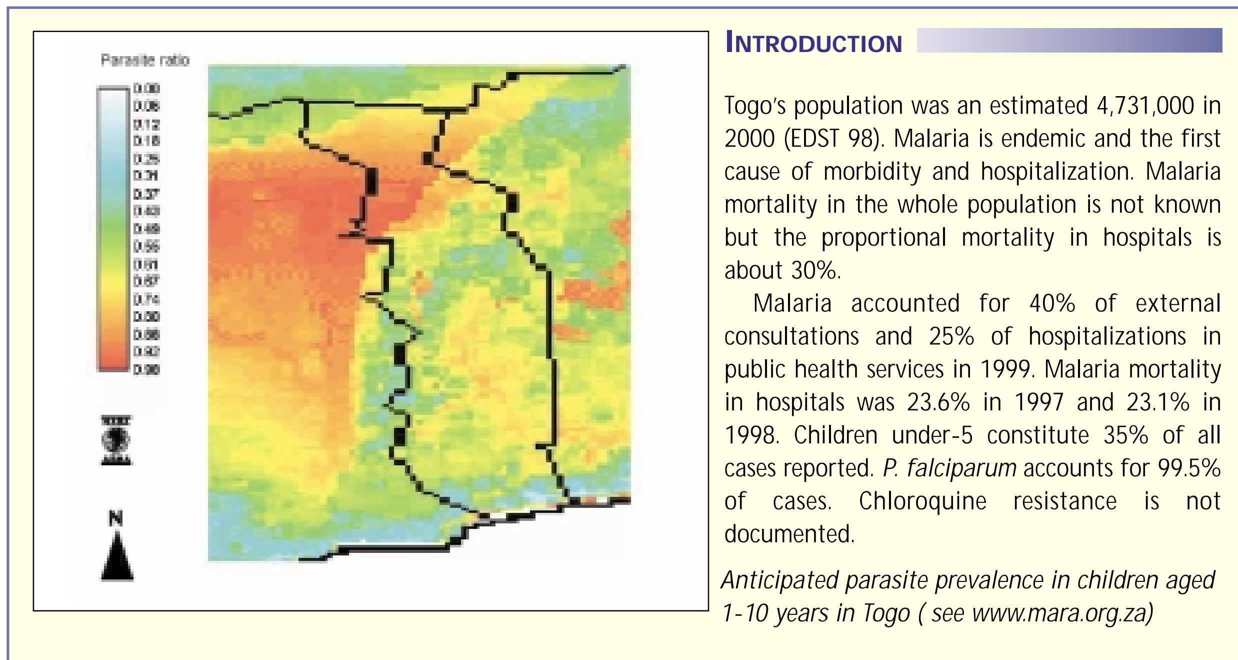
Budget Estimates (US$)

Strategic Components	Year 1
Epidemic management	4,052,940
Case management:	1,468,500
Vector control	2,000,300
Focused research	119,422
Partnership and social movement	20,400
Health system reform	9,130,000
Total	16,791,562

Resource availability

Available resources	4,380,000
Estimated resource gap	12,411,562

Togo



Introduction

Togo's population was an estimated 4,731,000 in 2000 (EDST 98). Malaria is endemic and the first cause of morbidity and hospitalization. Malaria mortality in the whole population is not known but the proportional mortality in hospitals is about 30%.

Malaria accounted for 40% of external consultations and 25% of hospitalizations in public health services in 1999. Malaria mortality in hospitals was 23.6% in 1997 and 23.1% in 1998. Children under-5 constitute 35% of all cases reported. *P. falciparum* accounts for 99.5% of cases. Chloroquine resistance is not documented.

Anticipated parasite prevalence in children aged 1-10 years in Togo (see www.mara.org.za)

State of the movement

Togo began participating in RBM at a regional consensus meeting in March 1999. Since then, national sensitization campaigns, national and district level situation analysis, district strategic planning and national level strategic planning have been conducted.

A Facilitators Group on RBM process and on technical activities now works with partners as well as government departments such as the ministries of Decentralisation, Commerce, Environment, Economy, Social Affairs and Agriculture.

WHO is currently the principal partner providing logistic, as well as technical and financial support. Other partners include UNICEF, UNDP the World Band as well as NGOs such as PSI, , ECHOPPE (a local NGO) and the Red Cross. UNFPA, European Union, German Cooperation, French Cooperation are also partners.

Togo's strategic plan was developed during a workshop in April 2001 attended by government departments and partner representatives. The plan, based on situation analysis and district strategic plans, is expected to be discussed at a forthcoming partners Round Table meeting at which partners' commitment to funding will be discussed.

Goal

To ease the socio-economical burden of malaria by reducing morbidity and mortality so that by 2030 it is no longer a public health problem.

Strategic components:

- Improved case management: Involvement of care providers in home management at community level.
- Multiple prevention: Insecticide Treated Materials, prophylaxis for pregnant women, physical and biological vector control and environmental management.
- Integrated epidemic surveillance, monitoring, supervision and evaluation of malaria control activities: Reinforcement of health information, integration of private health data, establishing a supervision strategy.
- Integrated vector control: Creating a vector control service within the Ministry of Health as well as involving communities.
- Focused operational research into, for example, acceptability of ITNs, prophylaxis compliance, vector sensitivity, determinants of environment hygiene.
- Reinforcement of the malaria control programme with human resources and logistics.
- Improving partnerships and mobilizing resources for their effective functioning.

Main implementation strategies

- Editing the malaria training guide for different levels of health care providers, conducting training sessions, equipping laboratories and diagnostic training.
- Improved management of severe malaria.
- Supporting public demand creation for Insecticide Treated Materials – including putting ITMs on the list of essential drugs, ensuring effective social marketing of ITMs and environmental management.
- Making ITMs affordable through the waiver of taxes and tariffs.
- Social mobilization to encourage community participation in integrated vector control activities.

Togo

- Staffing the programme and providing more logistics.
- Strengthening partnerships with more stakeholders and increasing partners' commitment.

Management arrangements

RBM management at all levels will focus on decentralizing the implementation process and giving responsibility to all partners. Implementation regions or areas have already been allocated to partners, most of whom are already willing to participate in funding activities in their targeted zones. Arrangements are being made so that the National Malaria Control Programme can have corresponding structures at regional and peripheral levels.

At a national level, the RBM partnership will be spearheaded by a facilitators group, a National Technical Committee (with representatives of other government departments, UN agencies, research institutions, bilateral cooperation, NGOs and civil society) and a secretariat built onto the National Malaria Control Programme which will also provide technical support to the regions.

Major expected outcomes by 2005

- 80% of fever, simple and severe malaria correctly managed within 24 hours of the onset of symptoms.
- 60% of households sleeping under an ITN.
- Reduction by 50% of actual morbidity and mortality.
- Effective integrated vector control.
- Effective contribution of operational research to malaria control.
- Reinforced health sector.
- Reinforced management of RBM process.
- An established and effective partnership.

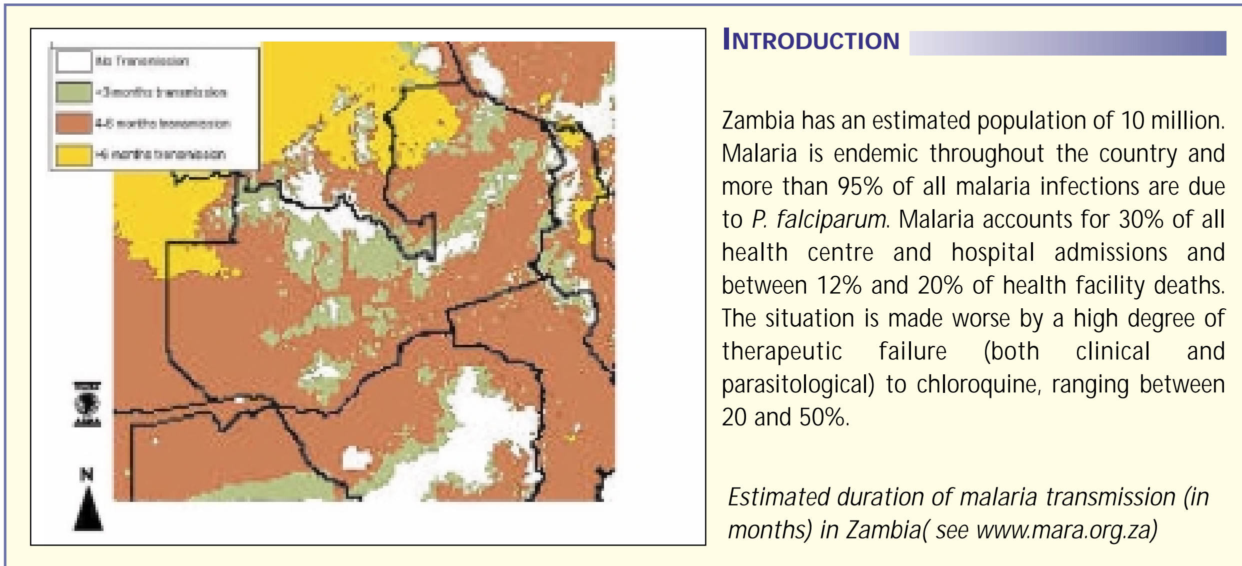
Budget Estimates (US$)

Strategy Component	Year 1	5-year total
Case management	121,620	495,500
Multiple prevention	521,142	5,170,000
Epidemics	120,000	374,000
Integrated vector control		175,000
Operational research	29,285	90,000
Partnership	30,000	45,000
Management	54,557	240,000
Total	876,604	8,994,870

Resource availability

Resource gap not yet determined.

Zambia



Introduction

Zambia has an estimated population of 10 million. Malaria is endemic throughout the country and more than 95% of all malaria infections are due to *P. falciparum*. Malaria accounts for 30% of all health centre and hospital admissions and between 12% and 20% of health facility deaths. The situation is made worse by a high degree of therapeutic failure (both clinical and parasitological) to chloroquine, ranging between 20 and 50%.

Estimated duration of malaria transmission (in months) in Zambia(see www.mara.org.za)

State of the Movement

Zambia participated in pre-testing situation analysis instruments for RBM. The first stakeholders meeting, called the Partners Briefing Meeting, was held in December 1999. Throughout 2000, the country embarked on galvanising a social movement and getting support from all levels from the grass roots, through district to central level, up to the Cabinet including the Republican President.

In March, 2001, a Round Table discussion attended by a wide range of partners—including USAID, DFID, WB, UNICEF, JICA, UNDP, DANIDA, WHO, various government departments and NGOs—met to discuss the national strategic plan for RBM. The meeting formally adopted the five-year strategic plan and partners pledged financial and other resources towards its implementation.

An inter-ministerial task force of deputy ministers has now been created and will be coordinated directly by the office of the Vice-President to oversee the implementation of RBM. The task force is served by an extended Secretariat, based in the Ministry of Health and chaired by the Central Board of Health.

RBM activity in Zambia includes:

- ✘ Baseline studies, research on the economics of malaria, and studies on child health.
- ✘ Creation of a vibrant intersectoral partnership in RBM which includes NGOs and the private sector.
- ✘ The Integrated Malaria Initiative, initially conducted in five districts, has been expanded to 14 districts as a model for scaling-up.
- ✘ The Government of Zambia has dropped all forms of taxation on nets, insecticides and other accessories.
- ✘ The social marketing of a branded ITN was undertaken in one of the commercial urban centres in Zambia. Public sector distribution of ITNs has reached 35 districts of the 45 initially projected.
- ✘ 86% of districts have completed their Situation Analysis and Strategy.
- ✘ SP has been adopted for IPT malaria in pregnancy.
- ✘ Malaria IEC has been conducted nationwide through print and electronic media.
- ✘ A technical advisory group has reviewed the chloroquine resistance data and made a formal recommendation for change to the Formulary Committee.
- ✘ Early developments of social action include the formation of a movement called Zambia Youth for RBM.

Goal

To reduce malaria morbidity and mortality by 50% by 2005.

Strategic components

1. Partnerships: Strengthened and broadened at all levels: national, provincial and district, health centre and community for planning prevention and control.
2. Multiple approaches to prevention: Insecticide Treated Nets and insecticides, targeted vector control, intermittent presumptive treatment in pregnancy, information, education and communication.
3. Multiple approaches for improving case management: Improved laboratory diagnosis, integration of nutrition and malaria interventions.
4. Improved human resources and capacity building.
5. Epidemic preparedness.
6. Monitoring and evaluation.
7. Research.

Main implementation strategies

- ✘ Expansion of partnerships at all levels—national, provincial and district, health centre and community.
- ✘ Segmentation of the ITN market among private sector, NGO and public sector programmes. Feasibility study on ITN production in Zambia.
- ✘ Ensure an appropriate mix of mass media, interpersonal and group approaches in promotion of messages.
- ✘ Improve home management of malaria, including early

Zambia

recognition, care-giving and care-seeking.

- ✘ Provide community and facility-based IEC in effective malaria case recognition, home management and prompt referral. Evaluate the impact of IEC.
- ✘ Establish community pharmacies and other informal providers.
- ✘ Fully integrate the standard operating procedure manual for laboratories into clinical guidelines for health centres and hospital laboratories.
- ✘ Establish quality control systems in all diagnostic centres.
- ✘ Integrate Vitamin A supplementation and the prevention of anaemia into malaria prophylactic regimes targeted at pregnant women.
- ✘ Integrate dietary management into malaria case management and Vitamin A supplementation into malaria case management.
- ✘ Health workers, NGOs and community cadres should be trained in appropriate prevention and control techniques including use of ITNs, IEC, and health education skills.
- ✘ Scale-up IMCI.
- ✘ Establish performance-related incentive systems.
- ✘ Train DHMTs, health centres, NHCs and community cadres in partnership skills and participatory approaches.
- ✘ Strengthen supervision and reporting at various levels of the health system through consolidation and expansion of the HMIS.
- ✘ Train researchers, health staff and community cadres in applied/basic research skills. Establish systems to facilitate applied and basic research in malaria.
- ✘ Complete a National Malaria Epidemic Situation Analysis and map malaria epidemic-prone districts in Zambia.
- ✘ Create District Rapid Response Teams (DRRTs) in epidemic-prone districts to prevent and respond to malaria epidemics.
- ✘ Establish an effective Malaria Information Surveillance System (MISS) in sentinel sites for malaria epidemics, linked from primary to national level.

Management arrangements

At the national level, the RBM partnership will be spearheaded by a National Malaria Task Force, chaired by the Deputy Minister of Health. It will report to co-operating partners semi-annually at consultative meetings. RBM implementation will be co-ordinated at national level by six multi-sectoral National RBM Strategy Task Groups and ad hoc Working Groups—Partnerships; ITNs and Vector Control; IEC and advocacy; Case management and prophylaxis; Epidemic preparedness and Monitoring, evaluation, surveillance and operational research. These report to the RBM Secretariat

Major expected outcomes by 2005

- ✘ 60% of households using at least one ITN instead of the current coverage of less than 10%.
- ✘ ITN re-treatment increased from current 10-12% to 60%.
- ✘ 80% of laboratories to have functional equipment and a preventive maintenance plan.
- ✘ 10% reduction in the proportion of pregnant women with Vitamin A deficiencies.
- ✘ 80% of pregnant women receive intermittent presumptive treatment.
- ✘ 50% reduction in low birth weights.
- ✘ 100% of DRRTs in epidemic-prone districts trained in malaria epidemics preparedness and response.

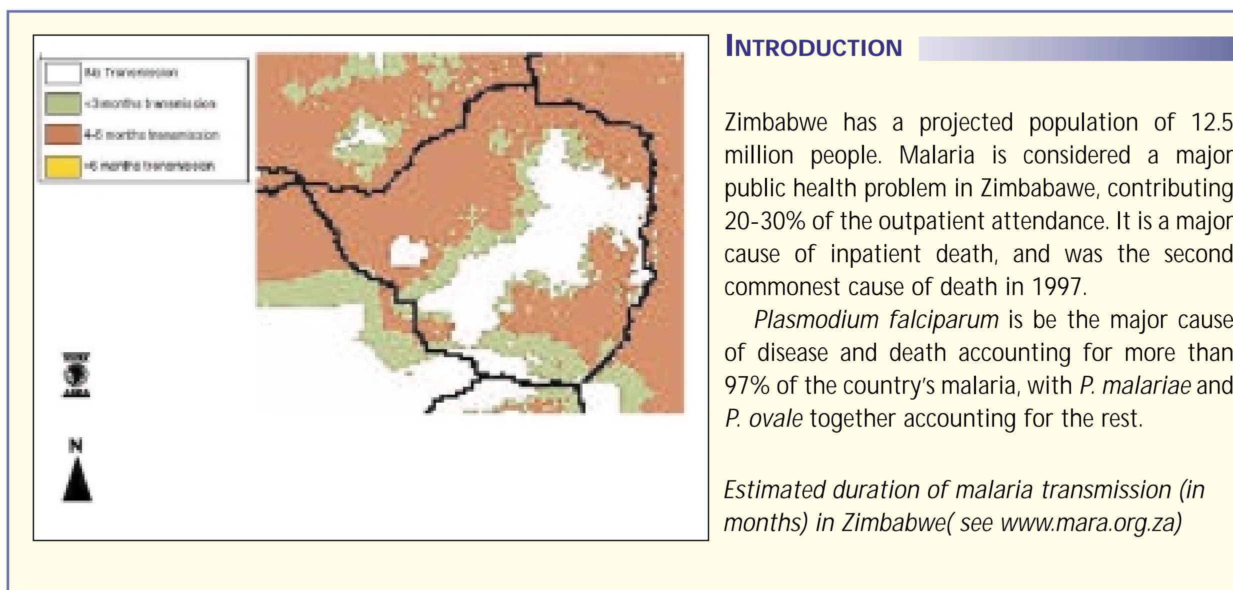
Budget Estimates (US$)

Strategy Component	Year 1	5-year total
Case management and prophylaxis	4,995,000	13,391,000
Multiple prevention—ITNs	2,508,000	12,231,000
Vector control	485,000	2,527,000
Focused research	181,500	1,077,000
IEC	275,000	1,965,000
Epidemic preparedness	250,000	1,663,000
Partnerships	40,000	190,000
Malaria and nutrition	25,000	133,000
Applied research	38,000	213,000
Monitoring and evaluation	345,000	418,000
Total	9,142,500	33,408,000

Resource availability

Available towards first year of implementation

Central Board of Health	3,700,000
USAID	4,000,000
WHO	280,000
UNICEF	142,000
SFH	200,000
CARE	20,000
Total	8,342,000
Year 1 resource gap	800,500
Total pledges: (5-years)	28,842,000



Introduction

Zimbabwe has a projected population of 12.5 million people. Malaria is considered a major public health problem in Zimbabwe, contributing 20-30% of the outpatient attendance. It is a major cause of inpatient death, and was the second commonest cause of death in 1997.

Plasmodium falciparum is be the major cause of disease and death accounting for more than 97% of the country's malaria, with *P. malariae* and *P. ovale* together accounting for the rest.

Estimated duration of malaria transmission (in months) in Zimbabwe(see www.mara.org.za)

State of the Movement

A series of RBM consensus-building meetings with various stakeholders and partners were carried out between July and September 1999. A core team of members (made up of six members from MoHCW, WHO and JICA) to carry out day-to-day RBM inception related activities was established in September, 1999.

A National Facilitators Group has been established. Its membership comprises the core team and various stakeholders from NGOs, government departments, bilateral and multilateral organizations, the private sector, provincial medical directorates, research and other academic institutions.

Zimbabwe has made considerable progress in developing an evidence-base for RBM. The NMCP has prepared a desk analysis and carried out a situation analysis in three districts.

A seven-year national strategic plan for RBM has been developed and launched nationally. Seven years was selected to fit in with the remaining seven years of the national health strategic plans.

Ten districts have developed costed plans for implementation in the first year. These plans are now being integrated into district level strategic plans.

A concerted effort has been made to mobilize resources to initiate the implementation of RBM strategic plan. However government remains the main financier as many partners have not yet committed resources.

There is a strong research partnership with the Blair Research Institute.

Goal

To prevent mortality and reduce morbidity, social and economic losses due to malaria in Zimbabwe.

Strategic components

The package of interventions includes:

- Case management;
- Prophylaxis in Pregnancy;
- Epidemic management;
- Vector control;
- Personal protection, particularly with the use of ITMs;
- Disease surveillance
- Management and coordination
- Community-based malaria control;
- Research;
- Advocacy;
- Monitoring and evaluation.

Main implementation strategies

- Improved health worker and community chloroquine holder performance.
- Improved policy guidelines on malaria in pregnancy.
- Strengthening of epidemic preparedness approaches at all levels to include re-stratification of all zones.
- Reduction of taxes and tariffs on imported raw materials used in ITM production.
- Strengthen community participation in vector control activities.
- Removal and waiver of taxes on ITMs.
- Countrywide ITM programme.
- Capacity building for data management through district-based epidemiological training.
- Improving conditions and establishing recognition and award systems for health workers.

Management Arrangements

Management of RBM action will be integrated into district health plans. The main channel for managing resources will be the Health Service Fund which allows

Zimbabwe

decentralised and pooled management of funds.

A secretariat comprising a malaria manager, supported by a team of a clinician, entomologist, surveillance officer and health promotion officer will be constituted.

The national strategic plan will provide the framework for development of two-year plans both at district and central levels.

Major expected outcomes by 2005

- ✘ Correct diagnosis in 90% of all fever cases by 2003.
- ✘ Correct treatment in 90% of all fever cases by 2003.
- ✘ Correct diagnosis and treatment of all cases of severe malaria in all institutions by 2003.
- ✘ All health care facilities practicing IMCI by 2002.
- ✘ 95% of pregnant women in malarious areas to receive prophylaxis by 2003.
- ✘ 95% of malaria epidemics properly controlled within two weeks of onset by 2003.
- ✘ 80% of all sprayed areas to be selected on sound evidence based on stratification by 2003.
- ✘ Spraying coverage to reach 95% in all sprayed areas by 2003.
- ✘ 40% of general population at risk sleep protected by ITNs.
- ✘ 40% of ITNs in use are retreated by 2003.
- ✘ 60% of under-5s sleeping under an ITN by 2003.
- ✘ 60% of pregnant women sleeping under an ITN by 2003.
- ✘ 90% of districts will collect, analyse and use routine information according to prescribed guidelines of the NHIS.
- ✘ All districts to allocate at least 40% of their HSF to disease control by 2002.

Budget Estimates (US$)

Strategy Component	Year 1	5-year total
Management and coordination	895,527	4,477,636
Epidemics	257,058	1,285,291
Vector control	827,269	4,136,347
ITNs and personal protection	477,705	2,388,527
Surveillance	193,378	966,891
Community-based malaria control	109,797	548,986
Case management	492,931	2,464,654
Total	3,253,665	16,268,332

Resource availability

For your notes