Namibia Mission Report

28-29 July 2011

Kaka Mudambo

SARN
Gaborone, Botswana
1.0 Background
The SARN Steering Committee Members held a teleconference meeting on 17 November 2010 and agreed that assessment missions should be carried out to countries as a follow up on progress in the Roadmap implementation and program delivery. In line with the RBM Secretariat directive and fulfilling the GMPAP targets and the RBM Key Performance Indicators (KPIs), the SARN Focal Point is required to make assessment missions to national programs.

2.0 Objectives of the mission
a. Identify programme strengths and good practices
b. Identify current state of Global Fund (GF) including bottlenecks and challenges affecting GF implementation and performance
c. Identify PSM bottlenecks affecting program/logistics delivery
d. Develop jointly with Government and partners agreed corrective measures and plan of action
e. Identify the type of technical support required to deal with the situation and resources for executing such TA beginning with resources available within the country partnership
f. Review roadmap, implementation of the SARN Work Plan, MSP and MPR recommendations
g. Discuss progress towards malaria elimination, TZMI and TKMI
h. Discuss the RBM USB Key Tool, Alma Sore Card, Country Score Card and Surveillance, Monitoring and Evaluation (SME)
i. Provide recommendations on the way forward and next steps

The mission also offered an opportunity for the SAN Focal Point to brief Dr Richard Kamwi the current chairperson of the SADC Health Ministers and E8, and RBM Board Member and Dr Petrina Uusiku (Program Manager) who is the current chairperson of the SARN.

3.0 Main Outcomes
1. Program implementation performing very well despite Global Fund (GF) bottlenecks related to delayed disbursement of resources
2. OIG have just completed their mission to Namibia and the program feels that the OIG is failing to understand the following:
   a. That – while the quantification of RDTs and ACTs in the GF proposal was based on the number of suspected fever cases, the ground situation has changed. Malaria has gone down significantly as a result, the demand for utilization of RDTs and ACTs cannot reach the forecasted target
   b. The OIG is insisting that this is poor performance since the target has not been achieved: this failure by the OIG to understand that there are no cases
2. to treat is a reflection of a serious weakness in the composition of the OIG team which has no Public Health Specialists in it.

3. Roadmap updated and uploaded into the USB Key Tool and submitted/published
4. The country Score Card was updated and submitted
5. LLINs 21% replacement target was achieved and although 87,900 nets are being distributed, a 600,000 gap remains. The program requires money to cover distribution costs and they are planning to hold a breakfast meeting to raise funds
6. ACTs Universal Coverage achieved using government funds
7. RDTs Universal Coverage achieved
8. IRS – government has given ND 14 million plus additional GF funds – more spray operators are being recruited
9. BCC and IEC remains a problem since they are failing to reach 100% coverage: BCC Strategic Framework is now available and the report from an agent contracted for 1 year is now available. IEC campaign has is on hold due to delayed GF disbursement
10. Recruitment for M/E has been completed and adverts have been floated for Surveillance and Data Management Officers for 2 regions
11. Data collection tools for weekly surveillance data are available and training will start in 2011
12. Develop plan to support Angola for launching IRS in 2011
13. TZMI district action/operational plans to be integrated into the TZMI Business Plan
4.0 Technical Assistance (TA)

- Program has GF TA for Data Expert to provide a format for data storage and guidelines for active case surveillance
- WHO will provide TA for case management
- Vector Control – external expert required to support development of a manual and guidelines
- GIS expert is required from Swaziland to provide a national TIT for the regions

5.0 Global Fund Bottlenecks

1. Round 6 Phase 2 is delayed disbursement – vehicles are grounded due to lack of funds for repairs. The program wants the GF to allow them to register the vehicles under the MoHSS so that they can be repaired together with the government pool of vehicles. The grounded vehicles will impact heavily on the 2011 IRS campaign
2. Round 2 Phase 2 – IRS funds are in-adequate
3. OIG problem (see 2 under main outcomes)
6.0 Elimination 8 (E8)

1. Preparations for 2011 E8 meeting to be held in Maun, Botswana progressing well: program and invitations to be done by Namibia (E8 chairperson)
2. How can the E8 countries support each other to achieve elimination?
3. Will the GF allow countries to donate extra RDT/ACTs likely to expire due to decreased demand in low transmission countries
4. SARN Focal Point briefed and consulted on the following:
   a. Current Chairperson of the SADC Health Ministers/E8 Chairperson and RBM Board Member Dr Richard Kamwi on:
      i. Current developments in the SADC Malaria,
      ii. 21st RBM Board meeting 16 – 18 November in China
      iii. E8 preparations
      iv. SADC Malaria Day events
      v. Implementation of the SARN Work Plan
      vi. Bottlenecks in the hosting of the SARN at SADC – continued cancellation of approved activities
   b. SARN co-chair Dr Petrina Uusiku (Namibia Program Manager) on:
      i. Current developments in the implementation of the SARN Work Plan
      ii. Progress in the activities of the SARN steering committee
      iii. Preparations of the RBM 2012 Work Plan and 2012 priorities workshop to be held in Geneva 5 – 7 September 2011
      iv. Preparations of the 21st RBM Board meeting to held in China (16 – 18 November 2011), the RBM December Retreat in Geneva and the 2011
      v. SADC Malaria Day events including the need for the 2011 Theme and Slogan
      vi. Bottlenecks in the hosting of the SARN at SADC – continued cancellation of approved activities

7.0 Namibia Military Health Services

1. On-going participation in NMCP activities
2. Military malaria control based on national policy and the SADC Military Malaria Minimum Standards
3. In 2011 military will carry our IRS in military cantonment areas and catchment communities in malaria zones
4. Develop an action plan and TORs for collaboration with NMCP and document distributed to the Defence chiefs for endorsement: document should cover military support to access communities in difficult terrain and flooded areas
5. MHS to identify and train personnel to support vector control activities in 2011
6. Close collaboration with Angola MHS in the TKMI and with Angola, Botswana, Zambia and Zimbabwe MHS in the TZMI cross-border initiatives
7. Suggested that the SARN considers inclusion of the Security Sector (military, police, prisons, immigration, national parks) in the current Military Health Services (MHS) constituency
8. Space spraying of vehicles at all border sites and aircraft at airports in malaria zones
9. Screening of military personnel in line with the SADC Military Malaria Minimum Standards

8.0 Supporting Partners

WHO, CHAI-SAMEST, Red Cross, Nets for Life, SFH, DAP and Military Health Services
9.0 Recommendations

1. PSM systems training (forecasting, quantification, procurement) in 2012 (SARN Work Plan)
2. GF and OIG missions to include SARN and RBM Secretariat members
3. OIG to include public health specialists in their teams
4. GF to be requested to allow GF vehicles to be registered under government so that effective repairs can be carried out
5. Documentation of best practices and Impact Series
6. Training required on malaria trends, weekly surveillance systems, active case detection (ACD)
7. On site training required on supervision of health facilities to improve case management
8. SARN to provide TA for a GIS expert from Swaziland and support identification of a vector control expert
9. Develop action plan and TORS for collaboration with the Military Health Services and distributed to Defence chiefs for endorsement
10. SARN to send report of GF bottlenecks to RBM-Secretariat and HWG for further consultations with the GF
11. On the continued cancellation of approved SARN activities, Dr Kamwi ensured the SARN Focal Point that he will discuss with SADC and the SARN co-chair emphasized that the
Steering Committee should now discuss this serious issue during the next meeting and write formally to the SADC ES, the SADC Chairperson of the Health Ministers, the RBM Board member and the RBM Executive Director.

10.0 Implications for the SADC Secretariat

- Preparations for the SADC E8 meeting especially invitations should be handled by the SADC Secretariat and it appears that the countries do not understand this and hence the need to send reminders to avoid diplomatic bubbles.
- Since more cross-border initiatives are now operational (TZMI, TKMI, MOZIZA-TLMI) there is urgent need to discuss their sustainability to maintain the momentum and high level advocacy at ministers and Heads of State levels for government increased funding.
- GF bottlenecks in particular delayed disbursement of funds/malaria commodities is affecting all GF recipients and there is need for the SADC health ministers develop a position paper to the GF.
- BCC and IEC is becoming a problem especially convincing the communities to maintain uptake and use of LLINs, IRS and Laviciding in low transmission districts – the need to operationalise the SADC Advocacy and Communication Framework and Minimum Standards.
- Continued cancellation of approved activities constitutes a serious issue that impacts heavily on the ground delivery and achievement of targets. It also exposes the fact that the recommendations of the 2011 Rustenburg Retreat are not being implemented at directorate level.