ERITREA ROLL BACK MALARIA CONSULTATIVE MISSION: ESSENTIAL ACTIONS TO SUPPORT THE ATTAINMENT OF THE ABUJA TARGETS AND ACCELERATE AND CONSOLIDATE PROGRESS IN MALARIA CONTROL

22-25 September 2003

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1. EXECUTIVE SUMMARY

The Roll Back Malaria Board, representing the global RBM partners, requested the RBM Partnership Secretariat to conduct a series of country consultative missions to determine what additional inputs Category 1 countries would require to support the attainment of the Abuja Targets. The purpose of the country consultative missions is to re-invigorate co-operation between the RBM partnership and countries to support progress towards achieving the Abuja Targets.

The Country Consultative Mission for Eritrea took place 22-25 September 2003.

As regards progress towards attaining the Abuja targets 2005, the following information was noted. In 2002, 58% of households owned one or more ITNs. Given the continuing distribution of free ITNs in malarious areas, coupled with free net re-treatment, Eritrea is on course to exceed the Abuja Target of 60% of under-fives and other vulnerable groups sleeping under ITNs. There is inadequate information on the percentage of under-fives receiving effective treatment within 24 hours. However, Ministry of Health data indicate antimalarial supply is good and drug efficacy monitoring results from 2002 found the first-line combination of CQ and SP to be effective. The presence of Community Health Agents means access to treatment is good. Together, these factors suggest Eritrea is likely to attain the Abuja Target of 60% of under-fives (and all other age groups) receiving effective treatment within 24 hours. IPT is not appropriate in Eritrea's epidemiological setting and ITNs are the main intervention for malaria in pregnancy.

The following essential actions were identified to ensure that the Abuja targets are met and long-term sustainability of an effective malaria control programme is realised

1. Expand TORs for antimalarial drugs committee; establish ITN/vector subcommittee; ensure external technical assistance is timely and of high quality
2. Secure continued technical assistance in epidemiology; establish a malaria communication MoH position, recruit a communication adviser; design and implement a NMCP HR capacity building strategy
3. Review and refine existing and planned community-based malaria interventions
4. Establish a quality control system for insecticides and ITNs
5. Further define and consolidate the malaria early warning system
6. Assess the impact on the malaria burden and malaria transmission
7. Prepare and submit a Global Fund Proposal for Round Four or Five in 2004
8. Define the inputs required to ensure the long-term sustainability of malaria control in Eritrea

The essential actions listed above were discussed and agreed at a Consensus Meeting held on 24 September 2003 and attended by 29 participants, including the Honourable Minister of Health, the Director-General of Health Services, Ministry of Health and representatives of national and international partner organisations and agencies

It should be emphasised that the gaps, resource requirements and essential actions identified are additional and complementary to those currently planned and budgeted for within existing resources in the country, including Global Fund monies.

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3. ABBREVIATIONS

ANC	Antenatal Care
AQ	Amodiaquine
AS	Artesunate
BCC	Behaviour Change Communication
CCM	Country Co-ordinating Mechanism
CHA	Community Health Agent
CQ	Chloroquine
DTP	Desktop Publishing
EHP	Environmental Health Project
GFATM	Global Fund to fight AIDS, TB and Malaria
HAMSET	HIV/AIDS, Malaria, STIs and TB control project (World Bank)
HIV/AIDS	Human Immunodeficiency Virus/
HMIS	Health Management Information System
HRD	Human Resources Development
IDSR	Integrated Disease Surveillance and Reporting
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IPRSP	Interim Poverty Reduction Strategy Paper
IPT	Intermittent Preventive Treatment
IRS	Indoor Residual Spraying
ITN	Insecticide-Treated Net
IVCNA	Integrated Vector Control Needs Assessment
LLIN	Long-Lasting Insecticidal Net
MEWS	Malaria Early Warning Systems
MoH	Ministry of Health
NMCP	National Malaria Control Programme
REAPING	RBM Essential Actions Products Investment Gaps
RBM	Roll Back Malaria
SP	Sulphadoxine-Pyrimethamine
STI	Sexually Transmitted Infection
SWAp	Sector-Wide Approach
TB	Tuberculosis
TBA	Traditional Birth Attendant
TOR	Terms of Reference
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

4. INTRODUCTION

The Roll Back Malaria Board representing the global RBM partners requested the RBM Partnership Secretariat to conduct a series of country consultative missions to determine what additional inputs Category 1 countries[1] would require to support the attainment of the Abuja Targets. The RBM Partnership Secretariat requested the Eastern Africa RBM Network – which represents partners in the sub-region – to participate in these country consultative missions.

The purpose of the country consultative missions is to:

- Re-invigorate co-operation between the RBM partnership and countries to support progress towards achieving the Abuja Targets.

The expected outcomes of the missions are:

- Determine the status of RBM implementation in relation to the Abuja plan and targets and the milestones set for the remaining two years of the Abuja plan period
- Identification of the essential actions (beyond those already planned) that need to be implemented during 2004 and 2005 to maximise country action to achieve the Abuja Targets
- A Country Support Package that details the additional investments required to carry out these essential actions

Eritrea was the second country to have a Country Consultative Mission, which occurred between 22-25 September 2003.
The mission team comprised: Dr Tewolde Ghebremeskel (NMCP Manager), Alex Lang (Technical Officer, RBM Partnership Secretariat), Dr Edith Lyimo (Entomologist, WHO East Africa Inter-country Programme and East Africa RBM Network) and Dr Graham Root (East Africa Regional Director, Malaria Consortium and East Africa RBM Network).

5. METHODOLOGY

The methodology employed included document review (see Annex 3), interviews with Ministry of Health personnel and partners (see Annex 1) culminating in a Consensus Meeting (see Annex 2). In addition, there was a field visit to a sentinel site (Adiquala Hospital, Debub Zone).
Following the Consensus Meeting, the Essential Actions and Country Support Package were revised accordingly and next steps agreed on with the Director-General of Health Services.

[1] The RBM Partnership Secretariat categorised African countries into 3 groups. Category One countries are those considered most ready to rapidly scale up the coverage of interventions. Eritrea is classified as a Category One country.

6. SUMMARY SITUATION ANALYSIS

6.1. Malaria transmission and burden

Malaria is seasonal, highly focal and unstable in Eritrea with 67% of the population living in malarious areas. In 1998, there was a major epidemic and since then the Government has intensified efforts to control malaria.

Since 1998 reported malaria cases and deaths have been on a downward trend. Low rainfall totals for most of the years since 1998 are likely to have contributed to this downward trend. In addition, variations in reporting rates and the appropriateness of the indicators being used (e.g. proportion of total disease/mortality burden attributed to malaria) need also to be taken into consideration. However, it is probable that the increased coverage of interventions has also contributed to this reported decline in the malaria burden.

6.2. Policy and strategy environment and partnerships

Eritrea has a sound policy and strategy environment for malaria control. The NMCP was established in 1995 and a three year strategic plan was prepared for 1998-2001. Following the launch of RBM, this three year plan was superseded by a five year strategic plan for the control of malaria (2000-2004). The NMCP has an updated malaria policy (2003), and new antimalarial drug (2003) and insecticide-treated net (ITN) policies (2003).

For the health sector, a new National Health Policy is currently being drafted. Following this, a Health Sector Strategic Plan will be prepared. The Government of Eritrea has prepared a draft Interim Poverty Reduction Strategy Paper (IPRSP) that is being circulated among partners for their comments. Within the IPRSP health is identified as a key area.

Partners supporting malaria control in Eritrea are the World Bank (through the HIV/AIDS, Malaria, Sexually Transmitted Infections and Tuberculosis [HAMSET] project), USAID, WHO, UNICEF and, by early 2004, the Global Fund to Fight AIDS, TB and Malaria (GFATM). The HAMSET project and its co-ordination committee covers HIV/AIDS, TB, STIs as well as malaria. RBM efforts in the country are co-ordinated by the HAMSET co-ordination committee and an antimalarial drug monitoring committee.

6.3. ITNs and other vector control measures

An ITN policy of free distribution of ITNs to households in malarious areas, and women attending antenatal and/or maternal and child health clinics, and the very poor has resulted in a sharp rise in net coverage. This has been coupled with annual mass campaigns of free net re-treatment. In 2002, 58% of households in malarious areas had two or more ITNs.

A recent survey by the NMCP and EHP/Tulane University on ITN usage was conducted. The results of which will update knowledge on the degree to which high household ITN ownership translates to actual usage.

Currently, Eritrea is considering the pace at which to move towards long-lasting insecticidal nets (LLINs) and how this will necessitate an adaptation of their net re-treatment system

Selective indoor residual spraying (IRS) is used. Over the last 24 months, operational research on the distribution of vector mosquitoes and the appropriateness of IRS for different structures has led to more focused spraying efforts. The Northern Red Sea Zone has ceased IRS due to low transmission and unsuitability of structures. In the remaining two zones where IRS is employed – Debub and Gash Barka – it is carried out in limited areas near mosquito breeding sites, as from previous experience these are considered to be high malaria risk areas.

The above measures are complemented by source reduction, namely larviciding isolated water bodies and environmental management in Northern Red Sea Zone, Debub and Gash Barka.

6.4. Access to effective treatment

The current antimalarial drug policy is CQ + SP for first-line treatment and Quinine for second-line treatment and severe cases. First-line treatment is provided by health facilities as well as Community Health Agents (CHAs). Currently, there are 1300 CHAs with an additional 650 to be trained using GFATM monies. IMCI is at an early stage of implementation with relatively few health workers trained on IMCI.

Quinine is available and given as a pre-referral loading dose at Health Stations (lowest level of care). The majority of hospitals have ambulatory services.

In 2002, health workers, community health agents and not-for-profit and for-profit private sector providers were trained on the new antimalarial policy. Adherence to the new policy is reported to be good with the first dose directly-observed by the health provider or community health agent.

Results from the 2002 drug efficacy monitoring studies give a treatment failure rate of below 5% for CQ + SP.

Supply of antimalarials is good and the Ministry of Health reports that drug stock-outs are very rare. In 2003, efforts have been made to improve diagnostics. To this end, during the malaria season rapid diagnostic tests (Optimal™) have been distributed to health facilities without laboratory facilities.

6.5. Malaria in pregnancy

Due to the unstable nature of malaria transmission in Eritrea, intermittent preventive treatment (IPT) is not an appropriate intervention. Hence, during pregnancy the focus is on use of ITNs (free for pregnant women attending antenatal care [ANC]) and prompt, effective case management.

6.6. Supportive strategies

Monitoring and evaluation

Monitoring of programme implementation is excellent. The NMCP produces realistic and well-defined annual plans, holds monthly team meetings, conducts quarterly supervision visits to the zones and carries out an annual review and report. Health

Management Information System (HMIS) data are used to monitor changes in morbidity and mortality. However, given the unstable (and potentially changing) epidemiology of malaria in Eritrea other approaches and indicators may need to be used in the future to measure the impact of interventions on the burden of malaria and malaria transmission.

Communication
Malaria communication is supported by the Health Promotion Centre. As well as producing and disseminating information, education and communication (IEC) materials, community mobilisation is used to sensitise households on malaria prevention and treatment. Currently, a malaria communication strategy is under development. There is scope for greater emphasis on behavioural change communication (BCC) methods in the future. Implementation of a malaria communication strategy has been delayed due to lack of capacity in the country.

6.7. Malaria control and health systems

Organisation of malaria control
Malaria control in Eritrea is organised as follows: the NMCP falls under the Division of Disease Prevention and Control. The NMCP is responsible for policy and strategy development and supporting the six zones to implement malaria control. At the zonal level, there are zonal malaria co-ordinators who form part of the Zonal Health Management Team. The zonal malaria co-ordinator is directly responsible to the zonal medical officer and works with the subzonal malaria co-ordinators. CHAs are supervised by health facility staff and report to the health facility.

Health systems development
A National Health Policy and Health Sector Strategic Plan are being drafted. Decentralisation is proceeding but at a relatively slow pace due to human resource constraints at the lower levels. Some integration of programmes occurs at lower levels. Malaria control activities at the subzonal levels receive considerable support and supervision from the zonal malaria co-ordinators and the NMCP.

Human resources
As the central level, the NMCP comprises a programme manager, a secretary, entomologist, entomologist technician, two biologists, laboratory technician and an operations officer. A data manager is supported by USAID. Technical assistance on epidemiology and entomology is provided by two resident advisers supported by USAID.

At the zonal level, malaria co-ordinators are in place. At the subzonal level, human resource capacity in public health and malaria control is being bolstered through the Public Health Technician Training Programme. The first cohort (33) will graduate this year and the majority will be assigned to work at the subzonal level.

Logistics
Transport at the subzonal and zonal levels is relatively good for referrals. However, transportation for supervision and monitoring from the centre to the zones remains a problem.

Financial resources
Currently, malaria control is supported by:
World Bank - HAMSET project (commodities and equipment)
WHO (ITNs, training, technical assistance)
UNICEF (ITNs)
USAID (technical assistance through EHP and John Hopkins)
Italian Co-operation

It should be noted that in the next two years, the EHP and HAMSET projects will end.

7. ABUJA TARGETS

The Abuja 2005 targets are:

- 60% of under-fives and pregnant women sleeping under ITNs by 2005.
- 60% of pregnant women receiving IPT1 and IPT2 by 2005.
- 60% of under-fives with fever receiving effective treatment within 24 hours by 2005.

Due to the lack of empirical data and models that would allow us to make firm estimates, the estimates given below should be interpreted as broad indications.

7.1. ITNs

In 2002, 58% of households owned one or more ITNs. Hence, in 2003, it is estimated that ITN coverage among under-fives and pregnant women is already greater than 60%. Given the continuing distribution of free ITNs to households in malarious areas, and women attending antenatal and/or maternal and child health clinics, coupled with free net re-treatment, Eritrea is on course to exceed the Abuja Target of 60% of under-fives and other vulnerable groups sleeping under ITNs.

7.2. Access to effective treatment

There is inadequate information on the percentage of under-fives receiving effective treatment within 24 hours. However, data from the Ministry of Health indicate that the supply of antimalarials in health facilities is good. Drug efficacy monitoring results from 2002 found the first-line combination of CQ and SP to be effective with a treatment failure rate below 5%. The presence of Community Health Agents means access to treatment is good. Together, these factors suggest Eritrea is likely to attain the Abuja Target of 60% of under-fives (and all other age groups) receiving effective treatment within 24 hours.

7.3. Prevention and control of malaria in pregnancy

As noted above, IPT is not appropriate in Eritrea's epidemiological setting. However, free ITNs distributed through antenatal clinics are likely to be providing high levels of protection against malaria for pregnant women. Likewise, pregnant women have access to effective treatment. However, it should be noted that due to reluctance among clinicians to use SP during pregnancy, quinine is the first-line treatment for malaria during pregnancy.

8. ESSENTIAL ACTIONS

The essential actions given below are those deemed necessary by the NMCP, the East Africa RBM Network and the RBM Secretariat to accelerate implementation and exceed the Abuja Targets. *More importantly*, the essential actions aim to take RBM in Eritrea to the *next phase* of implementation (2006-2010) whereby the gains of the previous five years will be consolidated and a long-term, sustainable malaria control programme will be in place to take Eritrea towards achieving the ultimate aim of RBM – namely, for malaria to cease to be a major public health problem in Eritrea. It should be emphasised that these essential actions only include those that are not currently planned and budgeted for within existing resources in the country, including Global Fund monies. The GFATM proposal includes the following three major strategies: strengthening of community-based activities for malaria control and prevention through distribution of ITNs and IEC, improving the capacity of health workers in case management of uncomplicated and severe malaria, and strengthening of malaria epidemic preparedness and response at all levels. The actions proposed by the country consultative mission will in large part support the implementation of the GFATM proposal. For example, the REAPING mission has proposed a review of existing and planned community-based malaria interventions to maximise the impact of GFATM and other monies targeted at the community level. The establishment of a quality control system for imported nets, ITNs and insecticides proposed during the REAPING mission is also complementary to the GFATM strategy of increasing ITN coverage. Whilst equipment for MEWS is covered by the GFATM proposal, technical assistance is necessary to further define MEWS particularly in respect of linkages with IDSR, data transfer from sentinel sites, and data analysis, including the use of different threshold calculation techniques.

8.1. Strengthen co-ordination mechanisms

The HAMSET Co-ordination Committee currently acts as the co-ordinating body for malaria activities. As this committee covers HIV/AIDS, STIs, and TB there is a risk that malaria may not be sufficiently high on the agenda. Moreover, not all partners (e.g. UNICEF) are represented on this committee. Hence, consideration needs to be given as to how central level RBM co-ordination can be improved. Options include:

- Broadening the membership of HAMSET to include all RBM partners
- Using the GFATM Country Co-ordinating Mechanism
- Establishing a National RBM Co-ordinating Committee

The antimalarial technical committee needs to be broadened to include malaria in pregnancy and case management. A similar structure needs to be established for ITNs/vector control and should build on the nascent Integrated Vector Control Needs Assessment (VCNA) Committee. If a National RBM Co-ordinating Committee is established, these two technical (sub)committees could fall under it.

In the past, international technical assistance has not always been well co-ordinated. Also concerns have been expressed about the quality and timeliness of some of the technical support provided.

Proposed actions:
- Establish a RBM co-ordination mechanism either through expanding the TORs of an existing committee (HAMSET or CCM) or creating a new mechanism (National RBM Co-ordinating Committee).
- Revise terms of reference for antimalarial drugs committee to include case management and malaria in pregnancy
- Develop terms of reference for and establish an ITN/vector control committee
- East Africa RBM Network to ensure the co-ordinated provision of high quality, technical assistance to Eritrea**Strengthen human resources – central level**

Maintaining sufficient human resource capacity at the central level remains a priority. The continuance beyond early 2004 of external technical assistance on entomology and epidemiology through two resident advisers is uncertain.

Due to the overloaded Health Promotion Centre and the recognition that more intensified malaria BCC efforts are needed, there is a need for additional capacity in communication for malaria and related programmes (e.g. IMCI and Safe Motherhood). This capacity should include the establishment of a Ministry of Health post for malaria communication support. This national staff member would primarily work for the NMCP and be based in the Health Promotion Centre. In addition, a short term communication adviser should be recruited to work with this person so scaled up communication support to malaria control and other programmes can occur.

The above technical assistance needs to be coupled with a medium-term strategy for capacity building within the NMCP and potentially other relevant programmes (e.g. IMCI). Hence, funding should include national staff (e.g. recent graduates) to work with the technical advisers. More generally a central level human resource capacity building strategy should also include a general mentoring programme for more junior staff. This is particularly pertinent given the age profile of the current NMCP.

Proposed actions:
- Secure continued technical assistance in epidemiology (and to a lesser extent entomology)
- Establish a Ministry of Health position for malaria communication. Recruit a short-term malaria communication adviser. Together, these two persons will support malaria control and related programmes on BCC, including community level activities.
- Design and implement a NMCP human resource capacity building strategy that includes a mentoring programme for junior staff.

8.3. Review and refine the approaches used for community-based malaria interventions

Community-based malaria interventions were highlighted in the Eritrea RBM mid-term review as a key opportunity for improving access to effective interventions. The Global Fund plan will provide funding for the expansion of community-based initiatives. However, there are a number of issues that need to be addressed including:
- the sustainability of the CHA system including the extent to which volunteerism can be relied on in the medium-term
- the potential expansion of the CHA system to include other health problems and approaches (e.g. IMCI). Linked to this is the integration of CHAs with other

community-based cadres (e.g. traditional birth attendants [TBAs], hygiene promoters)
- More broadly, identify and utilise effective BCC approaches to ensure high and appropriate utilisation of interventions (e.g. re-treatment of nets; treatment compliance)

Proposed action:
- Review, refine and monitor existing and planned community-based malaria interventions to maximise the impact of GFATM and other monies targeted at the community level

This action should involve relevant partners working in this area, including UNICEF.

8.4. Put in place a quality control system for imported nets, ITNs and insecticides

Large numbers of ITNs, nets and insecticides are being imported into Eritrea by the NMCP but mechanisms are not currently in place to monitor their quality. This has caused problems in the past with suspected poor quality products being imported but no system in place to test them. It would not be appropriate to establish quality testing laboratories and capacity in Eritrea given the high costs involved in establishing and maintaining such a system. However, a system involving the utilisation of regionally-based laboratories and capacity would be appropriate. Such a system would need to be timely with a relatively quick turnaround (e.g. one month) for testing insecticides, nets and ITNs.

Proposed action:
- Establish a quality control system for insecticides, nets and ITNs

8.5. Further define and consolidate the malaria early warning system

Over the last 24 months efforts have been made to design and implement a malaria early warning system (MEWS). Equipment for the MEWS is covered by the GFATM proposal. However, technical assistance is necessary to further define MEWS particularly in regard to:
- linkages with IDSR and data to be collected
- data transfer from sentinel sites to the zones and centre
- data analysis conducted at different levels including the use of different threshold calculation techniques.

In addition, human resource needs to maintain such a system should be reviewed.

Proposed action:
- Further define and consolidate the malaria early warning system

8.6. Assess impact on the malaria burden and malaria transmission

The post-Abuja evaluation of the Eritrean RBM Five Year Strategic Plan is scheduled for 2005. Given the success that Eritrea has had in increasing access to and coverage of malaria control interventions as well as the unstable nature of malaria transmission in Eritrea, it will be important for the evaluation to go beyond outcome indicators and consider the potential impact of the programme on the burden of malaria.

Particular attention should be given to how impact is measured in terms of morbidity and mortality as well as potential changes in transmission intensity. Such an evaluation should form the basis for the continued monitoring of the epidemiology of malaria in Eritrea.

Proposed action:
- Plan and conduct a detailed evaluation of the Eritrean RBM Five Year Strategic Plan including the impact on the malaria burden and malaria transmission

8.7. Prepare a GFATM proposal for Round 4 or 5

Major gaps that require substantial investment include human resources and logistics. The Global Fund provides an opportunity to seek additional financing for these areas as well as potentially implementing an artemisinin-based combination antimalarial (if growing resistance is observed following the next round of drug efficacy monitoring results) and strengthening IMCI.

Proposed action:
- Prepare and submit a Global Fund Proposal for Round Four or Round Five in 2004

8.8. Develop a long-term sustainability plan

Political commitment, sound management, committed health cadre at all levels and a mobilised population have meant that Eritrea has been able to rapidly scale up access to and coverage of interventions. Such efforts have made Eritrea very visible in the global arena. However, with success there is a risk that attention may turn away to countries with higher disease burdens and less advanced malaria control programmes. It is imperative that this does not happen as the success achieved needs to be consolidated otherwise there is a very real risk that the successes of the last five years could be quickly eroded. To avoid this happening, *it is strongly recommended that Eritrea*:

- Define the inputs required to ensure the long-term sustainability of malaria control in Eritrea and mobilise resources to fund such a plan.

Issues to consider in the long-term sustainability plan include:

Level and timing of financing
By 2005, the RBM Five Year Strategic Plan will have ended. Likewise, a number of projects supporting malaria control are likely to have been completed (e.g. EHP) or will be starting to close (e.g. HAMSET). To ensure continuous funding, resources should begin to be mobilised in 2004. A number of options include:
- Preparing additional GFATM proposals (see above)
- Securing increased funding from Government of Eritrea
- Actively participating in the HAMSET mid-term review and advocating for malaria control to be included in future project funding
- Ensuring malaria is prominent in the Interim Poverty Reduction Strategy Paper currently being drafted by the Government of Eritrea
- Monitor and utilise new financing mechanisms for donor support (e.g. Poverty reduction credits, sector-wide approaches)

Health systems development
The development of a long-term sustainability plan should include consideration of changes in the health system. These may include:
- new funding mechanisms (e.g. SWAp)
- increasing decentralisation including strengthening of the zonal system
- inter- and intra-sectoral collaboration
- joint-planning/working and integration with other programmes
- a decline in volunteerism
- human resource development strategies

Transmission patterns
Given the epidemiology of malaria in Eritrea, a high coverage of effective interventions is likely to reduce transmission. Specifically, high ITN coverage and other appropriately deployed vector control measures may succeed in reducing vector density to very low levels at least in some areas. In the future an artemisinin-based combination antimalarial may also impact on transmission intensity due to the potential of these drugs to reduce the gametocyte carriage rate and, hence, interrupt transmission.

An increase in unstable malaria areas as well as potentially more malaria-free areas will require different emphases in the interventions employed. The nascent malaria early warning system will need to be made more sensitive, to include active case detection, while selective vector control will become more focused. Cross-border malaria control with Sudan and Ethiopia will be necessary and should include monitoring imported cases as well as implementing common strategies (e.g. for antimalarial drug policies; vector control). Such a shift in malaria control efforts will have both financial and technical resource implications.

Drug resistance
It is unlikely that the current combination of CQ/SP will serve as anything more than an interim policy. When change does occur, it will most probably be to an artemisinin-based combination (e.g. AQ+AS). Planning for this drug policy change will need to begin early as it is a time-consuming process that will include:
- reaching consensus on the combination chosen
- financing the new combination
- withdrawal of the failed drug from the health system
- regulatory issues including, for example, enforcing pre-packaging of drugs
- sourcing of suppliers
- sensitisation of health workers and the population to a new antimalarial drug policy that involves unfamiliar drugs.

9. PROPOSED COUNTRY SUPPORT PACKAGE: ESSENTIAL ACTIONS AND INVESTMENTS REQUIRED

#	Essential actions (in addition to ongoing activities)	Products	Investments needed							Meeting the Gap
			Human resources	Commodities	Equipment	Cost 2003	Cost 2004	Cost 2005	Cost 2006	
1	Expand TORs for antimalarial drugs committee; establish ITN/vector subcommittee; ensure external technical assistance is timely and of high quality	Improved co-ordination of malaria control at national levels and delivery of external technical assistance	NMCP and partners time	N/A	N/A	N/A	N/A	N/A	N/A	NMCP, Country partners, EARN
2	Secure continued technical assistance in epidemiology; establish a malaria communication MoH position, recruit a communication adviser; design and implement a NMCP HR capacity building strategy	Capacity provided in epidemiology and communication; capacity built within NMCP and other programmes	Epidemiologist	N/A	N/A	-	100,000	100,000	-	USAID
			Communication adviser	N/A	N/A	-	60,000	100,000	-	
			MoH Malaria communication position	N/A	Computers/ DTP	-	5,000	-	-	GoE (salary)
			Intermittent HRD support	N/A	N/A	-	40,000	20,000	-	
3	Review and refine existing and planned community-based malaria interventions	Effective and sustainable community-based malaria control initiatives in place	NMCP, Technical assistance	N/A	N/A	-	40,000	40,000	-	
4	Establish a quality control system for insecticides and ITNs	Imported insecticides, netting and ITNs routinely tested for quality	NMCP, Technical assistance	N/A	Costs of laboratory testing	-	18,000	8,000	8,000	EARN (subject to funding)
5	Further define and consolidate the malaria early warning system	Capacity to detect malaria outbreaks at subzonal, zonal and central levels	NMCP, Technical assistance	N/A	N/A	-	40,000	40,000	-	
6	Assess the impact on the malaria burden and malaria transmission	Impact of five year strategic plan on burden and transmission determined	NMCP, partners, technical assistance	N/A	N/A	-	10,000	40,000	-	RBM Secretariat
7	Prepare and submit a Global Fund Proposal for Round Four or Five in 2004	Additional resources mobilised for HR development and other areas	NMCP, partners, technical assistance	N/A	N/A	N/A	5,000	N/A	N/A	NMCP, partners, Malaria Consortium
8	Define the inputs required to ensure the long-term sustainability of malaria control in Eritrea	Long-term sustainability plan in place	NMCP, partners, technical assistance	N/A	N/A	N/A	40,000	10,000	10,000	

10. NEXT STEPS

- NMCP/MOH to distribute Country Support Package to country partners
- Country partners to give feedback to NMCP/MOH on Country Support Package
- RBM Secretariat and East RBM Network to respond to Country Support Package
- NMCP/MOH to present Country Support Package at special RBM Board session at the Eastern Africa RBM Review and Planning Meeting, Jinja, Uganda (14 November 2003).

11. ANNEX 1. LIST OF PERSONS AND ORGANISATIONS CONSULTED

The Honourable Minister of Health Mr Saleh Meky
Mr Berhane Ghebretensae, Director-General of Health Services, Ministry of Health
Dr Goitom Mebrahatu, Director, Division of Disease Prevention and Control
Dr Tewolde Ghebremeskel, NMCP Manager
Dr Josephat Shililu, Resident Adviser for Vector Ecology and Control, NMCP
David Sintasath, Malaria Adviser, Health and Child Survival Fellow Program, USAID Eritrea Mission
Asgidom Mosazghe, Director of Medicines Control Division, MOH
Dr Berhana Haile, Safe Motherhood
Mr Kibrom Asmelash, Head of Adiquala Hospital, Debub Zone
Dr Yohannes Ghebrat, WHO DPC
Dr Sergio Rizzo, Officer-in-Charge, WHO
Marilou R. Bradley, Operations Officer, World Bank Eritrea
Ms Linda Lou Kelly, Health Adviser, USAID Eritrea Mission
Debesai Haile, UNICEF Project Officer Health
Mr C. Balslev-Olesen, UNICEF Representative
Ivan Camanor, UNICEF Health Co-ordinator
Mr Mark, Programme Co-ordinator, UNICEF

Participants at Consensus Meeting, 24 September 2003
The Honourable Minister of Health Mr Saleh Meky
Mr Berhane Ghebretensae, Director-General of Health Services, Ministry of Health
Tewolde Ghebremeskel, NMCP Manager
Yohannes Ghebrat, WHO DPC
Tekle Tewolde, MOH-CMRP
Sergio Rizzo, WHO Officer in Charge
Danizo Ghirella, Italian Co-operation
Francesco Leon, Italian Co-operation
Semere Ghebreghiorghis, USAID
Debesai Haile, UNICEF Project Officer Health
Mr C. Balslev-Olesen, UNICEF Representative
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Andom Ogbamariam, Research and HRD, MOH
Shashu Gebreselassie, HMIS
Bahlibi Kiflom, MOH/NATCOD
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Azenegash Ghebreselasie, Health Promotion, MOH
Edith Lyimo, WHO EAGL ICP and East Africa RBM Network
Alex Lang, RBM Partnership Secretariat
Graham Root, Malaria Consortium and East Africa RBM Network

12. ANNEX 2. AGENDA FOR CONSENSUS MEETING

COUNTRY CONSULTATIVE RBM MISSION:
ATTAINING THE ABUJA TARGETS AND ENSURING SUSTAINABILITY

24 September 2003

1. Opening Remarks – Chair
2. Roll Back Malaria – Alex Lang
3. Attaining and exceeding the Abuja Targets – Tewolde Ghebremeskel
4. Country Support Package – Tewolde Ghebremeskel
5. Discussion and consensus on the Country Support Package
6. Closing Statement – Chair

ANNEX 3. DOCUMENTS REVIEWED DURING COUNTRY CONSULTATIVE MISSION

Annual Report 2002, National Malaria Control Programme, Ministry of Health, Eritrea.

Diploma Program Curriculum – Public Health Technicians, Ministry of Health, Eritrea, June 2001

Five Year Plan of Action for the Control of Malaria in the context of Roll Back Malaria 2000-2004, Ministry of Health, Eritrea, August 1999

Highlights from the Sixth Annual Assessment and Mid-term Review Workshop on Malaria Control in Eritrea, Massawa, Northern Red Sea Zone, National Malaria Control, Communicable Disease Control Division, Ministry of Health, Asmara, Eritrea, 27-29 March 2003

Implementation of the Strategic Plan to Roll Back Malaria in the State of Eritrea, Ministry of Health, Eritrea, December 2001

Malaria Epidemiological Profile for Eritrea, Ministry of Health, Eritrea, April 2003.

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National Antimalarial Drugs Treatment Guidelines, Ministry of Health, Eritrea, June 2003

National Malaria Prevalence Survey – 2000-2001, Ministry of Health, Eritrea, May 2001

Policy and Guidelines for Malaria Control in Eritrea, National Malaria Control Programme, Ministry of Health, Eritrea, May 2003

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Roll Back Malaria REAPING Desk Review Eritrea, Malaria Consortium/RBM Secretariat, September 2003

Short Guidelines for the Distribution, Re-impregnation, and Use of Insecticide-Treated Nets (ITNs), Ministry of Health, Eritrea, April 2003

The HAMSET Project – Project Launch Workshop Proceedings, Ministry of Health, Eritrea, 6-8 March 2001