ZIMBABWE ROLL BACK MALARIA CONSULTATIVE MISSION (REAPING): ESSENTIAL ACTIONS TO SUPPORT THE ATTAINMENT OF THE ABUJA TARGETS

10-14 May 2004

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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.

At the end of the mission, the essential actions were presented to the Minister of Health and Child Welfare and the Top Management Team. The Minister and his team responded positively to the proposed essential actions.

The goal of the Zimbabwe RBM Strategic Plan, launched in 2001, is to "prevent mortality and reduce morbidity, social and economic losses due to malaria in Zimbabwe." Principal elements include: Case Management, Vector Control including IRS, Epidemic Preparedness and Response, and Health Promotion. There are several mechanisms that are used for partnership co-ordination including the Malaria Technical Committee, the GFATM CCM, and the nascent Inter-agency Co-ordinating Committee for Health. IRS remains the MOHCW's main strategy for malaria vector control and malaria prevention. The malaria control strategic plan cites ITNs as one of the key malaria prevention strategies that should complement IRS. However, ITN coverage rates are low throughout the country and currently estimated to be below 5% nationally. The overall (untreated) net crop in Zimbabwe is likely to be between 300,000 and 400,000. Treating these nets would markedly increase ITN coverage rates. Malaria outpatient care is free in government health facilities. Malaria inpatient care for pregnant women and under-fives is also free in government hospitals. An interim policy of SP plus CQ was officially adopted in 2002 in districts with unacceptably high chloroquine resistance. Under the current malaria in pregnancy policy, SP and CQ are given in combination through ANC as three treatment courses during pregnancy.

Essential actions to reach the Abuja targets identified during the consultative mission include the following:

1. Partnership strengthening, primarily through Inter-agency Co-ordinating Committee for Health (IACCH)
2. Human resource strengthening
3. Strategic planning for now and the future, including harmonisation of malaria control with the National Health Revival Plan (2004)
4. Solving Global Fund bottlenecks
5. Revitalising and sustaining IRS, including financial sustainability plan and purchase of sufficient insecticide for 2004/2005 transmission season
6. Reducing the price of ITNs in the commercial sector
7. Developing and implementing a strategic approach to scaling up ITNs
8. Strengthening surveillance
9. Successfully implementing the interim antimalarial drug policy
10. Rapidly implementing IPT
11. Planning for the long-term policy change to an ACT
12. Developing and implementing a malaria communication strategy
13. Strengthening community-based malaria control
14. Monitoring expenditure on malaria control
15. Monitoring progress towards achieving the Abuja Targets

The total cost of the essential actions identified above has been estimated at US$ 7,841,000 over the period 2004-2006.

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

ACT	Artemisinin-based combination therapy
ANC	Ante-natal care
CCM	Country Co-ordinating Mechanism
CMED	Central Mechanical Engineering Department
CSO	Central Statistical Office
CQ	Chloroquine
DDC	District Development Committee
DFID	Department for International Development, United Kingdom
EDLIZ	Essential Drugs List Zimbabwe
EU	European Union
GDP	Gross Domestic Product
GFATM	Global Fund for HIV/AIDS, Tuberculosis and Malaria
GOZ	Government of Zimbabwe
HARP	Humanitarian Assistance and Recovery Programme
HIPC	Heavily Indebted Poor Countries
HMIS	Health Management Information System
IEC	Information-education-communication
IMCI	Integrated management of childhood illness
IPT	Intermittent preventive treatment
IRS	Indoor residual spraying
ITN	Insecticide-treated net
LFA	Local funding agent
LLIN	Long-lasting insecticidal net
MCAZ	Medicines Control Authority Zimbabwe
MMG	Malaria Management Group
MODO	Ministry of Health and Donor Co-ordination Meeting
MOFED	Ministry of Finance and Economic Development
MOHCW	Ministry of Health and Child Welfare
NatPharm	National Pharmaceutical Company of Zimbabwe
NGO	Non-Governmental Organisation
NHS	National Health Strategy
NMCP	National Malaria Control Programme
NOCZIM	National Oil Company of Zimbabwe
PMD	Provincial Medical Director
PSI	Population Services International
QN	Quinine
RBM	Roll Back Malaria
RDC	Rural District Council
SADC	Southern Africa development community
SAMC	Southern Africa Malaria Control
SP	Sulphadoxine-Pyrimethamine
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation
ZDHS	Zimbabwe Demographic and Health Survey

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

At the end of the mission, the essential actions (see sections 8 and 9) were presented to the Minister of Health and Child Welfare (MOHCW) and the Top Management Team. The Minister and his team responded positively to the proposed essential actions.

The mission team comprised: Stanley Midzi (Deputy Director, Department of Disease Prevention and Control), Vonai Teveredzi (National Epidemiology and Disease Control Co-ordinator), Robert Mudyiradima (PMD Manicaland), Simon Chihanga (PMD Midlands), Martin Netsa (National Vector Control Officer), Alec T. Mugove (Chief Field Officer), Lincoln Charimari (WHO Malariologist), Jasper Pasipamire (WHO Malaria NPO), Susan Mutambu (Acting Chief Medical Research Officer, National Institute of Health Research), Colleta Kibassa (Health Officer, Unicef Zimbabwe), Norah Ngwenya (IEC Officer, WHO-SAMC), Khoti Gausi (Research, Monitoring and Evaluation Officer, WHO-SAMC), James Banda (Senior Adviser, RBM Secretariat), Kopano Mukelabai (Senior Adviser, UNICEF New York), Tom O'Connell (Adviser, RBM Secretariat) and Graham Root (Regional Director, Malaria Consortium East and Southern Africa).

5. METHODOLOGY

The methodology employed included document review (see Annex 23), interviews with MOHCW personnel and partners, a one and a half day workshop involving districts, MOHCW and partners, and a debriefing and presentation of the proposed Essential Actions to the Minister of Health and the Top Management Team on the final day of the mission (see Annex 1 for list of persons met). Following the debriefing, the Essential Actions and Country Support Package were revised accordingly and next steps agreed on with the Minister of Health and the Deputy Director of Disease Control.

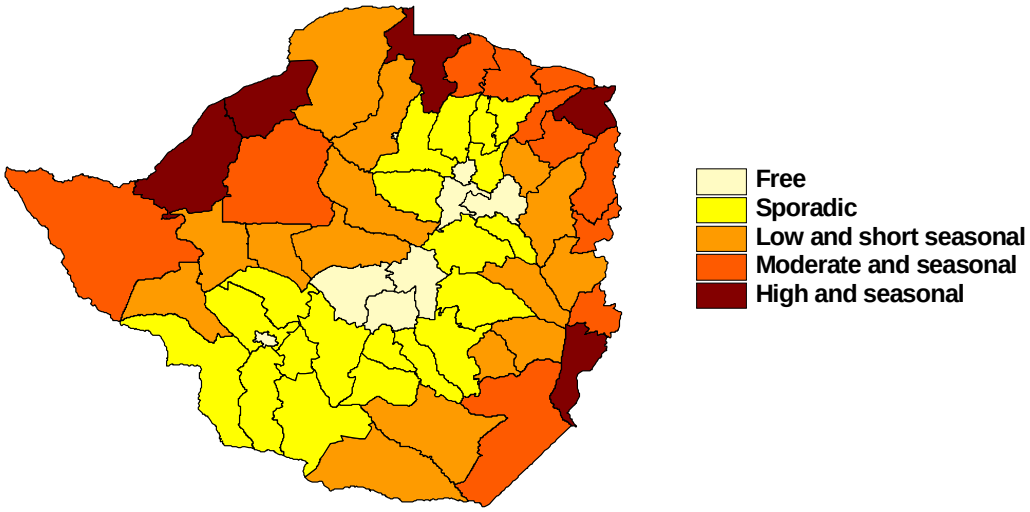
[1] The RBM Partnership Secretariat categorised African countries into 3 groups. Category One countries are those considered most ready to rapidly scale up the coverage of interventions. Zimbabwe is classed as a Category One country

6. SUMMARY SITUATION ANALYSIS

6.1. Malaria transmission and burden

Malaria transmission in Zimbabwe is largely unstable in nature. Approximately 5.5 million people out of a total population of 12.7 million live in malarious areas. Out of the 56 districts, malaria transmission occurs in 42. In 2002, a revised stratification based on a national parasite prevalence survey, HMIS data, entomological data and expert opinion was prepared. This draft stratification is shown in the figure below.

Figure1. Preliminary new malaria stratification, 2002 (MOHCW)



Malaria remains a major public health problem in Zimbabwe. As transmission is primarily unstable, protective immunity does not readily develop and as a result all age groups are at risk of malaria. In 2002, 740,000 clinical malaria cases and 2,200 malaria deaths were reported by the HMIS. In the same period, 12% of outpatient attendances and 15% of inpatient admissions to public health facilities were due to malaria. In the 'endemic districts', the burden of malaria is greatest among under-fives, pregnant women and people living with HIV/AIDS due to development of a degree of acquired immunity among adolescent and adult (non-HIV) populations.

While the overall malaria mortality may appear low in Zimbabwe, it should be emphasised that this can rise markedly if an epidemic occurs such as happened in 1996 and 1997. In addition, the relatively modest malaria mortality rate is in part due to sustained and successful control efforts dating back to the mid-1940s. The mainstay of the control programme has been indoor residual spraying (IRS) as well as larviciding of water bodies supporting mosquito larvae. IRS has resulted in an increase in the number of areas considered to be malaria-free or subject to low transmission. There is also evidence that IRS has suppressed the spread of chloroquine (CQ) resistance in Zimbabwe. A sensitive weekly surveillance system and good epidemic response capacity has meant outbreaks are detected and responded to. Lastly, good access to health facilities, trained health workers and the presence of community-based chloroquine distributors has enabled prompt and effective case management of malaria. To this end, over the years Zimbabwe's malaria control programme has come to be regarded as one of the most successful in Africa.

6.2. Economic context

16. Over the last decade, the macro-economic situation in Zimbabwe has deteriorated, straining the capacity of the public sector to provide essential health services. Under-five mortality rates went from 80/1000 in 1980 to 90/1000 in 1995, and topped 125/1000 in 2001[2]. While stock-outs of fuel and supplies led to decreased outreach services, the uncertainties of an inflationary economy have aggravated the "brain drain" of well-trained and well-qualified staff as well as the willingness of remaining public sector health providers to participate in social security schemes.

Current macroeconomic stabilisation policies continue to focus on economic diversification, reducing inflation and achieving more predictable exchange rates, and reversing the high unemployment rate. External sources of funds are limited. Zimbabwe is not a HIPC eligible country, nor able to access other World Bank/International Monetary Fund lending instruments at the current time. The budget deficit (as a % of GDP) is estimated to fall during fiscal year 2004, but not enough to significantly reduce the burden of debt servicing.

Currently, the Government of Zimbabwe estimated budget for 2004 shows a distribution to the MOHCW of 14.0% of the total budget, while 15.5% is allocated to Higher Education. The trend in year to year real spending is difficult to assess for two related reasons. First, hyperinflation induced price-rises result in budgeted funds not lasting the full fiscal year. This, in turn forces the MOHCW (and other ministries) to request supplemental funds on an ad hoc basis to fund current priorities. It is likely that spending has decreased when amounts are adjusted for inflation, despite the fact that government internal allocations to health have risen to 14% of the overall budget outlays.

6.3. Policy and strategy environment

The Government of Zimbabwe launched its *Roll Back Malaria: Strategy for Zimbabwe 2001-2007* on 11 May 2001. The strategy was designed to "coincide with the remaining period of the National Health Strategy for Zimbabwe (1997-2007)." As a results-oriented strategy, it commits the MOHCW to the use of a set of core indicators "to monitor both outcomes and impact of implementation" at regular intervals throughout the year.

The goal of the RBM Strategic Plan is to "prevent mortality and reduce morbidity, social and economic losses due to malaria in Zimbabwe." Principal elements include: Case Management, Vector Control including IRS, Epidemic Preparedness and Response, and Health Promotion. Following the launch of the strategic plan, a "scaling-up" Plan of Action was agreed upon in 2002, listing several specific products, including six products related to vector control, ten products relating to various aspects of case management, and five areas covering programme management.

The MOHCW is implementing the National Health Strategy for Zimbabwe 1997-2007 via a three-year rolling plan. Based on the rolling National Health Strategy, specific annual plans for malaria control are prepared. The current MOHCW 2002-2005 rolling plan identifies the following strategies for malaria prevention and control: disease management, forecasting, detection and control of epidemics, vector control and health promotion/community participation. Detailed implementation is described in the 2004 Malaria Annual Plan. These focus on strengthening malaria control in the ten RBM Frontrunner districts, selected on disease burden[3]. For 2004 it includes the following key interventions

[2] Source: World Development Indicators database, April 2002, Zimbabwe Country Profile
[3] Hwange, Binga, Gokwe, Guruve, Centenary, Uzumba Maramba Pfungwe, Mudzi, Nyanga, Kariba

1. To improve clinical diagnosis and treatment capacity at all levels
2. To improve laboratory diagnosis at all levels
3. To implement the new interim drug policy (free combination therapy)
4. To detect and control all epidemics on time in the 2004/05 malaria season
5. To scale up the use of ITNs
6. To re-treat at least 60% of the ITNs in use by December 2004
7. To increase and strengthen malaria awareness and mobilise community participation in malaria control in all districts.

This annual workplan should be put in the context of the current macroeconomic crisis (see previous section). The MOHCW's response to the impact the current economic situation is having on the health sector, was to develop a 'Health Revival Action Plan'. For 2004, a 'continuation' Revival Plan was drafted during a special Review and Planning Meeting in December 2003. Five Priority Areas were identified for the 2004 Malaria Control programme:

A) Vector Control
   1) House spraying and larviciding in all targeted areas
   2) Strengthen logistical and administrative support for the early purchase of insecticides
   3) Increased coverage and use of ITNs

B) Case management
   1) Diagnosis and Treatment of malaria improved
   2) Malaria Chemoprophylaxis (implementation of IPT)

These three plans (RBM Scaling-up Plan of Action 2002, the 2004 Annual Malaria Plan of Action, and the Health Revival Plan for 2004) have yet to be harmonised.

Linkages to other vital health areas should be explored, to assess opportunities for synergies and optimising scare resources[4]. For example, with a HIV prevalence rate of 35.6% of women age 25-29 receiving antenatal care (ANC), outreach services are planned to be increased. Advocacy messages relevant to Malaria in Pregnancy will likely be assessed for inclusion into HIV community advocacy and information strategies. Moreover, a more co-ordinated communications strategy could better integrate important malaria messages into all community-level training and advocacy activities.

6.4. The RBM Partnership in Zimbabwe

Currently, active partners outside the MOHCW are limited in number and scope of activities. WHO and UNICEF are the two main multilateral partners involved in malaria control. Traditionally important bilateral and multilateral partners in the health sector such as DFID, EU, and USAID have a significantly lower level of engagement than in the past, while the World Bank has ended all but two small projects. Much of the support provided to the health sector is now going through the Humanitarian Assistance and Recovery Programme (HARP) and/or NGOs. However, despite this it is reported that the bilaterals have a reasonably good working relationship with MOHCW. For example, during meetings with USAID during this mission, health focal points offered to explore co-ordinating training activities for community level health workers and volunteers with future community-based malaria training programmes.

[4] The Zimbabwean Hon Minister of Health & Child Welfare joined other participants of the Consultative Meeting of the African Representatives of the RBM Partnership Board and Constituency, (Harare, 9-11 March 2004), to recommend "Country partnerships to take measure to improve collaboration between malaria control, IMCI and other programmes."

Some NGOs are also active in malaria control. However, the extent of their activities is quite limited. For example, CEVSI is active in two districts, Save the Children UK two districts and PSI active in one district.

In terms of the private sector, pharmaceutical companies include DATLABS, CAPS and Varichem; insecticide manufacturers/agents include Syngenta, Chemplex and Ecomed, and there is a local ITN manufacturer, Emnet. In addition, the Malaria Management Group – which is a member of the Global Fund CCM – provides procurement, logistic and implementation support, particularly for vector control.

There are several mechanisms that are used for partnership co-ordination including the Malaria Technical Committee, the GFATM CCM, and the nascent Inter-agency Co-ordinating Committee for Health.

Under the Malaria Technical Committee there are subcommittees covering case management, ITNs/vector control, monitoring and evaluation, and advocacy/IEC. These subcommittees vary in terms of their activity and generally do not meet on a regular basis.

The GFATM CCM was originally formed in 2001 and membership was further expanded in 2002. The CCM meets monthly and quarterly and has responsibility for mobilising resources, managing and disbursing funds, reviewing implementation progress and co-ordination.

The Inter-agency Co-ordinating Committee for Health is linked to the HARP and chaired by the Deputy Director of Disease Control. While this is a relatively new mechanism, MOHCW and partners reported that it was useful and reasonably well-attended.

MOHCW and partners also referred to the Annual MODO (Ministry of Health and Donors Co-ordination and Planning) Meeting as previously being a useful fora for joint reporting and planning. The MODO did not meet in 2003 but there are plans for a meeting in 2004.

6.5. Vector control and personal protection

IRS remains the MOHCW's main strategy for malaria vector control and malaria prevention. Synthetic pyrethroids have been the chemical of choice since the discontinuation of DDT in the early 1990s. However, the comparatively higher cost of pyrethroids, declining IRS coverage and frequent epidemics have led the MOHCW to reintroduce DDT on a limited scale. For the current transmission season, a combination of pyrethroids and DDT (part of Beitbridge District) was used.

IRS coverage rates have severely declined over the past two malaria seasons. Of the 30 tonnes of pyrethroids needed, MOHCW could only procure 2.4 tonnes, while the NGO partners SCF UK, CESVI, Plan International and World Vision contributed just under one tonne. The cost of pyrethroids, the requirement of insecticide suppliers to receive payment in US dollars, and problems in accessing Global Fund resources (see Section 6.11) were the main factors contributing to the lack of sufficient insecticide. As well as shortage of insecticide, the IRS programme has faced challenges in terms of equipment and transport. However, Global Fund Round 1 resources have been used to procure 12 lorries, 780 pumps and overalls and protective equipment for sprayers and these are not expected to be a problem for the next season.

The current land reform programme has seen the movement of peoples to and from areas of differing endemicity, creating new needs for malaria control, including vector control and IRS. These needs need to be rapidly assessed and quantified.

The malaria control strategic plan cites ITNs as one of the key malaria prevention strategies that should complement IRS. However, ITN coverage rates are low throughout the country and currently estimated to be below 5% nationally. The overall (untreated) net crop in Zimbabwe is likely to be between 300,000 and 400,000. Treating these nets would markedly increase ITN coverage rates.

An ITN policy was developed in 2003. The MOHCW recognises the central role that NGOs, local authorities and private companies can play in ITN provision to various groups of people. However, the policy still needs to be disseminated and shared with the various stakeholders. In addition, issues relating to subsidies, cost recovery/sharing, high risk groups, re-treatment of nets, use of long-lasting insecticidal nets (LLINs) all need to be made clearer. An implementation strategy to effectively operationalise the policy is not in place.

6.6. Access to effective treatment

Malaria outpatient care is free in government health facilities. Malaria inpatient care for pregnant women and under-fives is also free in government hospitals. The aim of malaria treatment policy in Zimbabwe is to make safe, effective, good quality and affordable antimalarial drugs accessible to the population at risk of malaria, to allow prompt and effective treatment. Zimbabwe has a system of monitoring drug quality through the Medicines Control Authority in Zimbabwe (MCAZ); supplying drugs through the National Pharmaceutical Company of Zimbabwe (NatPharm); and, providing services through trained health personnel. Zimbabwe has been regularly monitoring the efficacy of first line malaria treatment using a network of eight (later increased to 12) sentinel sites countrywide.

In 2000 an analysis of the results of chloroquine sensitivity monitoring showed that in three of the eight sites, the total treatment failure rate was 27% (Gokwe), 36% (Chirundu) and 42.3% (Hwange). This prompted a pilot trial of free combination of SP and CQ in four districts with high levels of chloroquine resistance. Following the trial an interim policy of SP and CQ was officially adopted in 2002 in districts with unacceptably high chloroquine resistance. The policy is 1st line: CQ + SP: 2nd line: oral quinine (7 days); and, severe malaria: parenteral quinine. The policy was launched nationwide in March 2004.

Guidelines for identification and treatment of both simple and severe/complicated malaria in Zimbabwe are given in Essential Drug List in Zimbabwe (EDLIZ). Revised case management guidelines are being distributed to all provinces. There is a need to sensitise health workers on the new treatment guidelines.

Available drug efficacy monitoring data from the sentinel sites has found very low treatment failures rates for the current CQ/SP combination. In 2003, the treatment failure rate for CQ and SP in the ten sentinel sites ranged from 0 to 5%. Low levels of SP resistance indicate the potential for the combination to impact on morbidity and mortality. However, because of high SP resistance in neighbouring countries the intention is to move to a Artemisinin-based combination therapy (ACT). To this end, ACTs have been included in the proposal submitted to GFATM Round 4.

The EU Health Sector Support Programme is providing essential drugs, vaccines and essential spare parts for hospital equipment. Initially, it was intended that the project would supply NatPharm with 50% of the national drug requirements with NatPharm meeting the other 50%. However, due to severe foreign currency shortages in the country NatPharm could not meet its requirements, and EU drugs currently make up 86% of drugs held by NatPharm. This has resulted in health facilities having significant stock-outs of antimalarials and supplies during

the last two seasons. For example, in January and February 2004, although abundant stocks of chloroquine were available there was a critical shortage of SP and oral / parenteral Quinine. Seventy five per cent of Rural Health Centres visited by the NMCP reported stock outs of SP or Quinine of a week or more during the same period. Recently the situation has improved through funding from the Government of Zimbabwe, Red Cross, NORAD, UNICEF and WHO. In addition, the EU Health Sector Support Programme has recently procured antimalarials.

Under the previous antimalarial policy, community members were trained as Chloroquine holders in the 26 high burden districts and in selected wards in the remaining 16 districts. Chloroquine holders included village health workers, village community workers, school health masters, store-keepers, traditional healers, faith-based healers, and farm health workers. These Chloroquine holders are currently semi-functional due to difficulties in monitoring. Likewise, they have not yet been trained on the new antimalarial drug policy.

6.7. Malaria in pregnancy

Pregnant women and children under five years are the most vulnerable populations susceptible to malaria in Zimbabwe. Pregnant women are four times more likely than men to die from malaria attacks. Malaria infections in pregnant women can result in abortion, low birth weight babies and still births. In 2000, malaria was responsible for 21.6% of all major causes of maternal mortality reported.

All services to pregnant women are free in government institutions. Under the current malaria in pregnancy policy, SP and CQ are given in combination as three treatment courses at booking, and in the 2nd and 3rd trimesters to pregnant women attending ANC in stable and unstable transmission areas. Under the revised case management guidelines, there is a section on Chemoprophylaxis during Pregnancy/IPT. However, the policy is not clearly stated and could be interpreted as CQ weekly chemoprophylaxis plus SP for IPT. This policy has yet to be fully implemented. The high antenatal coverage in Zimbabwe means there is potential to rapidly increase coverage of IPT.

The ITN policy identifies pregnant women as a vulnerable group. However, as described earlier, ITN coverage is low.

6.8. Surveillance, epidemic preparedness and response

Due to a high risk of malaria outbreaks and epidemics in Zimbabwe, considerable efforts have been made to put in place sound surveillance and epidemic preparedness and response systems. The MOHCW has a weekly surveillance system that reports on communicable diseases of outbreak potential including malaria. It is reported that while reporting rates have declined somewhat over the last two-to-three years, overall the system is working well and remains sensitive.

Epidemic preparedness and response plans are in place in provinces and it is reported that districts and provinces have the capacity to respond in a timely and effective manner to malaria outbreaks if adequate material resources are available. However, it is recognised that both the surveillance system and response capacity need to be strengthened in some newly resettled areas.

6.9. Supportive strategies – Monitoring and Evaluation

Data collection

The MOHCW captures weekly surveillance data (see previous section) as well as monthly (outpatient) and quarterly (inpatient) routine information. The MOHCW produces and circulates the weekly surveillance electronically through e-mail data and also produces monthly and quarterly reports.

The MOHCW conducted a situation analysis in Zimbabwe in 2000 and a national malaria parasite prevalence survey in 2001. A Demographic and Health Survey (DHS) was carried out in 1999 and a future one is in the planning stages and will be carried out in mid-2005. The malaria module of the DHS is, however, limited and additional surveys are likely to be needed to properly assess progress towards the Abuja Targets.

Also the MOHCW together with the National Institute of Health Research conducts continuous drug efficacy and susceptibility studies in the country.

Monitoring implementation of planned activities
At provincial and district level, quarterly and monthly meetings are held to review implementation of plans. At national level, the National Task Force Meeting at the end of each month, chaired by the Minister of Health and Child Welfare, is a functional way of checking whether essential actions for the month were done in response to the various health issues at the various levels of the health system. The Inter-Agency Co-ordinating Committee for Health, chaired by the Deputy Director of Disease Prevention and Control, discusses with technical partners issues arising from the National Task Force meeting. The meeting is not exclusive to malaria, but malaria is prominently discussed at this meeting

Capacity at central level
As indicated earlier, the NMCP has no malaria-dedicated officer. To follow up on all malaria related figures there is need to have a data manager/monitoring and evaluation officer who would be responsible for tracking implementation and malaria indicators. It is evident that malaria specific expenditures are not known because they are included in the general MOHCW expenditure without specific mention of malaria. The creation of a database for malaria would be important at the technical and programme level. Some of this has already been done at district level with technical support (computers and other logistics). But the operationalisation has been limited.

6.10. Supportive strategies – Communication

Generally knowledge and awareness of malaria is high in Zimbabwe. A population-based survey in 2001 found respondents had a good knowledge of the causes (80%) and symptoms (81%) of malaria. In the same survey almost 90% regarded malaria as a problem in the communities.

Considerable efforts have been made to mobilise resources for developing IEC/Advocacy interventions on malaria. Examples of recent activities and achievements in malaria IEC include:

- Community participation and involvement in malaria prevention in Binga, Guruve and other districts
- Districts developing a wide range of IEC materials on malaria.
- Development of TV spots and malaria jingles
- Community-based malaria programmes implemented at community level
- Commemorative events like Africa Malaria Day and SADC Malaria Week are now community driven

However, areas that need to be addressed include:

- Limited documentation on best practices, experiences and lessons learnt
- Lack of evidence-based IEC interventions with an over-reliance on printed media.
- Few partners supporting IEC interventions
- Limited private sector partnership in advocacy and communication
- IEC programme is very extensive and sometimes lacks focus.

6.11. Malaria control and health systems

Organisation of malaria control

The NMCP falls under the Department for Disease Prevention and Control in the MOHCW. The Deputy Director for Disease Prevention and Control is responsible for co-ordinating a wide range of disease control programmes including malaria. The National Epidemiology and Disease Control Co-ordinator under the Deputy Director is responsible for the day-to-day co-ordination of the malaria control programme. This post has been there but had been vacant for close to 2 years However, there is no malaria-dedicated officer in the MOHCW at central level or below. The MOHCW decentralises operational responsibilities for malaria control to the provinces and districts.

At the provincial level, under the overall guidance of the PMD, the Provincial Epidemiology and Disease Control Officer, Provincial Environmental Health Officer and Provincial Health Promotion Officer are responsible for co-ordinating and providing support and supervision of malaria control in their province.

At the district level, the District Medical Officer, District Nursing Officer and the District Environmental Health Officer are responsible for implementing malaria control interventions in their district.

Health systems development

Since independence the government has improved accessibility of health services with more than 70% of the population living within 5km radius of a health centre. With the land reform exercise this is likely to have declined. However, the MOHCW is currently developing health centres in these areas. The current government policy allows free health services to all children under-five years, pregnant women and people above the age of 65 years.

Primary Health Care is the basic strategy of health services delivery, with the government aiming to ensure provision of a ‘comprehensive package of promotive, preventative, curative and rehabilitative services[5]. As outlined in the National Health Strategy 1997-2007, seven priority areas are being addressed, through successive ‘Three-Year Rolling plans’. These are then articulated into annual MOHCW workplans that include new initiatives such as RBM. See section 1.3 for more details of the overall policy framework.

Decentralised system

Under decentralisation, the central government retains responsibility for the "provision of trunk services which impact upon more than one local authority area or are of a national character." Local authorities remain bound by national regulations, polices and guidelines, meaning that health priority setting remains at the national level. However, local authorities are envisioned as having great flexibility to set objectives in line with local determinants of morbidity and mortality, as well as in deciding the mix of human and material resources that

[5] *Structures, Roles and Relationships, Draft proposal,* Ministry of Health and Child Welfare, 2000

can best deliver such services within the local context. The handing over of services to Local Government has not yet taken place

The MOHCW is committed to decentralise planning authority and resource allocation decision-making to provinces and districts in a staged manner, and only after ensuring sufficient management capacity exists at the district level. This has already been implemented and the programme is around five years old. The end goal is the institution of a system of 'Service contracts' in which the PMDs work with district health managers to come up with a contract covering resources given and results expected for each year. Monitoring and reporting occurs quarterly, and funds are also released on a quarterly basis.

The District Health Executive manages and co-ordinates the provision of Health Services within a District. Funds are disbursed by the MOHCW to these committees, in line with specific MOHCW guidelines. Districts are also able to generate their own resources through taxes, levies, fees and user charges. However, this is not yet functional

The District Health Services Fund was a mechanism that was used by partners for basket funding at district level. In the past, there had been efforts to advocate for districts to prioritise malaria control for spending under the District Health Fund. However, due to the lack of donor funding, the District Health Fund mainly receives GOZ funds now. With this fund they procure emergency services (e.g. drugs, fuel to an amount that is below the tender band).

Human resources

There are severe human resource shortages at all levels of the system. For example, vacancy rates among the medical professional grades are as follows: 92% Pharmacists, 55% Medical Doctors, 44% Registered Nurses, and 30% Environmental Health Officers. Such high vacancy rates are putting great strain on the system and the remaining health workers. Approximately 33% of rural health facilities are managed by nurse aides. The high attrition rate is mainly explained by economic hardship and poor working conditions, including poor remuneration in a hyperinflationary climate.

To stem this trend and begin to retain professional staff is a huge task and further complicated by the Public Service Commission working mechanisms. To find a solution, the MOHCW has begun the process of disengagement from the Public Service Commission by establishing a Health Services Board. If this planned reform goes ahead, the Health Services Board will be able to recruit and set salary levels for health workers.

In addition, an Expanded Nurses Training Programme has been started This includes the establishment of a new nursing cadre, the Primary Health Care Nurse. This cadre would be positioned between Nurse Aides and Registered Nurses and receive a training course of 18 months.

At central level (as described earlier), the MOHCW does not have a NMCP unit in its structure and, hence, no malaria-specific positions within the Department for Disease Control. Global Fund Round One resources are being used to establish five malaria positions within the Department for Disease Control. These are Malariologist/Epidemiologist (not yet recruited), Vector Control Officer (recruited), IEC Officer (not yet recruited), Administrator/Logistician (not yet recruited) and Secretary (recruited). However, these positions will only exist for the life of the Global Fund project.

Logistics

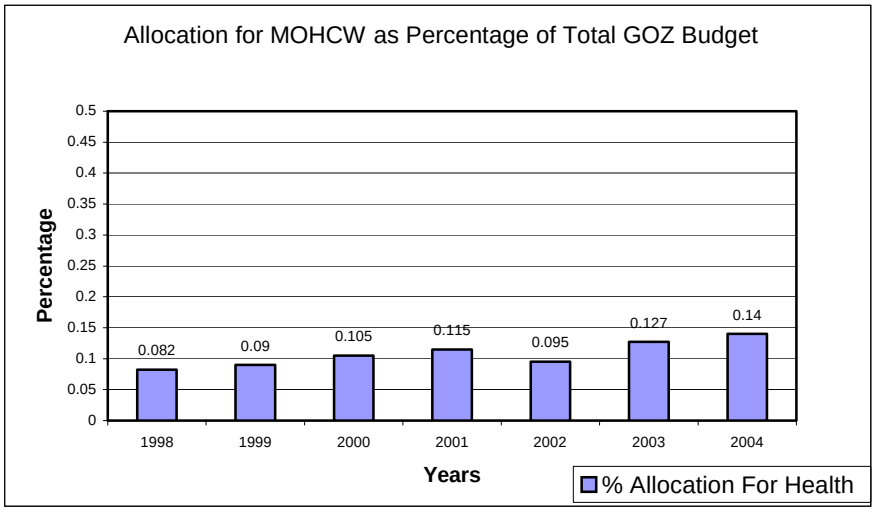
Severe constraints in fuel and availability of working, reliable vehicles are having a serious impact on MOHCW operations. The lack of available transport from ambulances to supervisory and programme vehicles has further constrained the ability of the MOHCW to deliver health services. However, there are recent efforts by the MOHCW to acquire ambulances and other vehicles.

Limited availability of fuel for vehicles has put further strain on the activities of the MOHCW. Fuel can now only be purchased with cash paid up front from the CMED and NOCZIM as they will no longer accept Government requisitions.

Financial resources
In Zimbabwe health financing comes from Ministry of Finance and Economic Development, households, donors, local government and employers. According to the National health Accounts 2001 the various financing contributors spent the following percentages in health. The 1999 figures are shown for comparison.

Source	**1999**	**2001**
MOFED	28	39
Households	23	30
Employers	7	13.4
Donors	13	5.4
Medical Aid Schemes	11	11
Others	-	1.2
Total		**100**

In relative terms, the Government's investment in health is high and currently stands at 14% of total government expenditure (see graph below).



However, in absolute terms it has declined considerably in this decade due to economic difficulties including high inflation and the depreciation of the Zimbabwe dollar. In 1994, health expenditure was USD25.00 per capita, and is now around USD8.00 per capita. Contributions from donors have continued to decline over the last three years.

The Global Fund has become a key financing partner for malaria control in Zimbabwe. The successful GFATM Round One proposal concentrates on three main areas consistent with the national RBM strategy: increased coverage of preventive measures such as vector control and ITNs, strengthened diagnosis and case management in children under-five years and pregnant women, and strengthened malaria programme management. The Global Fund has approved

funding for malaria control activities of USD6,716,250 for 2 years. So far USD1,415,000 has been disbursed and more than 90% of the funding has been expended. Zimbabwe has also put in a malaria proposal to the Global Fund Round Four.

However, the MOHCW has experienced major difficulties in accessing GFATM monies. Initially, due to foreign currency and exchange rate problems, the WHO Country Office received GFATM monies to procure vehicles, spray equipment and ITNs. However, the major expenditure for the 2003/2004 transmission season concerned procurement of insecticides for the IRS programme. These were budgeted at USD2,200,000. Following discussions with the Local Funding Agent, the MOHCW used the Government tendering procedure and invited bids from suppliers. Two bids were received and the contract provisionally awarded. However, the Local Funding Agent refused to recognise the tendering process. Consequently, no insecticide was procured using GFATM monies for the 2003/2004 transmission season.

Concerns were expressed from MOHCW and several partners on the capacity of the Local Funding Agent. It was felt that unclear and sometimes contradictory advice was provided by the Local Funding Agent. The team was unable to meet the Local Funding Agent during the week of the mission.

7. ABUJA TARGETS – WILL THEY BE MET?

For Zimbabwe, due to the epidemiology of malaria and the nature of the interventions employed, the Abuja Targets are defined differently from countries with higher levels of malaria transmission. They are:

- 60% of the population living in malarious areas protected by IRS or sleeping under an insecticide-treated mosquito net
- 60% of pregnant women receiving 2 doses of IPT (IPT1 and IPT2)
- 60% of the population with fever receiving effective treatment within 24 hours
- 60% of outbreaks detected within 2 weeks of onset and 60% of these effectively responded to within 2 weeks of detection

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. Moreover, the estimates share an over-riding assumption: *Global Fund Round One monies are able to be accessed by MOHCW and implementing partners.*

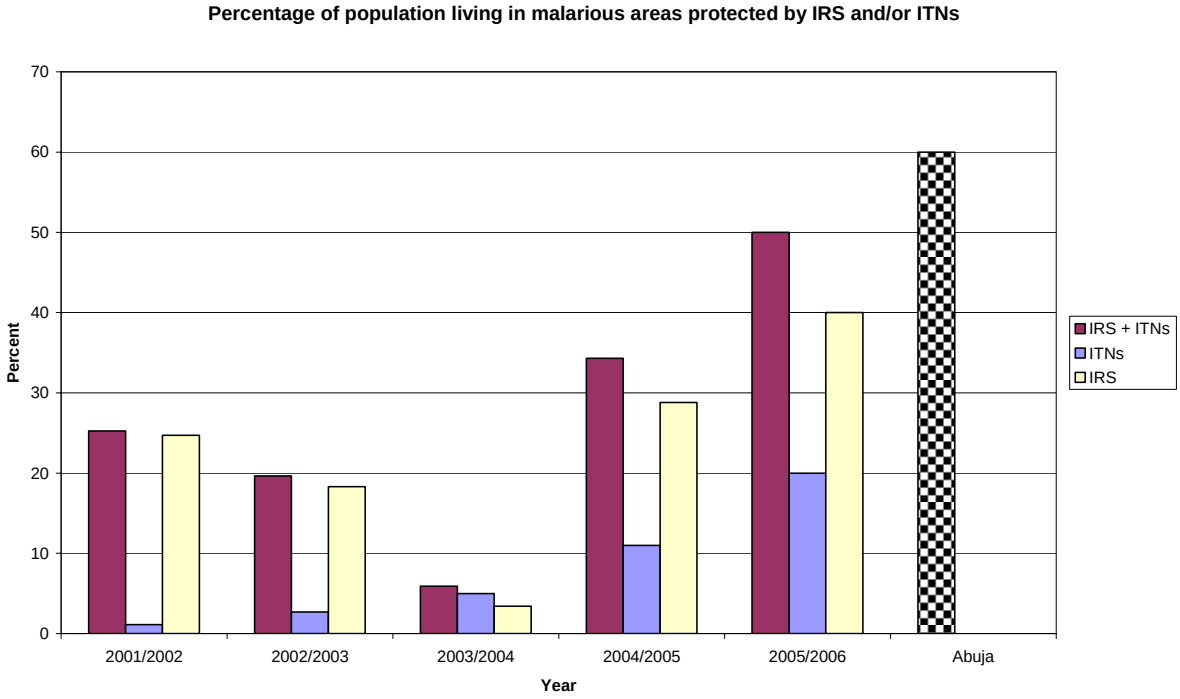
7.1. Vector control and personal protection for biologically vulnerable groups

It is estimated that by the end of 2005, 50% of the population living in malarious areas will be protected through IRS or sleeping under an insecticide-treated mosquito net[6] if the following occurs:

Year	Assumptions and actions
2001/2002	• Coverage was estimated based on available data from NMCP (including RBM Baseline Survey 2001) • Coverage is 24.7% for IRS and 1.1% for ITNs • Combined, 25.3% of the population living in malarious areas is protected against malaria by IRS, ITNs or both.

[6] Combined IRS/ITN coverage rates have been calculated using the following assumption: 50% of ITN users will also be protected by IRS. It should be emphasised that the *IRS coverage rates* given in the table refer to the percentage of the *total population* living in malarious areas that are protected with IRS. This indicator is fundamentally different from the commonly used programmatic indicator of percentage of *targeted households* that are sprayed. The latter is a performance indicator used for monitoring implementation of IRS.

2002/2003	• Coverage is 18.3% for IRS and 2.7% for ITNs • Combined, 19.7% of the population living in malarious areas is protected against malaria by IRS, ITNs or both.
2003/2004	• Insufficient insecticide procured due to problems accessing GF monies • Limited numbers of ITNs distributed • Limited numbers of nets re-treated • Coverage is 3.4% for IRS and 5% for ITNs • Combined, 5.9% of the population living in malarious areas is protected against malaria by IRS, ITNs or both.
2004/2005	• Sufficient IRS procured using GFATM monies • Net re-treatment system in place and operational in the 20 high burden districts • One-off free ITN distribution through ANC in the 20 high burden districts • Coverage increases to 28.8% for IRS and 11% for ITNs. • Combined, 34.3% of the population living in malarious areas is protected against malaria by IRS, ITNs or both.
2005/2006	• Sufficient IRS procured using GFATM and other monies • National ITN targeted subsidy in place that increases coverage among biologically and socio-economically vulnerable groups while at the same time supporting the growth of the commercial ITN sector • Net re-treatment system in the 20 high burden districts • Coverage increases to 40% for IRS and 20% for ITNs • Combined, 50% of the population living in malarious areas is protected against malaria by IRS, ITNs or both.

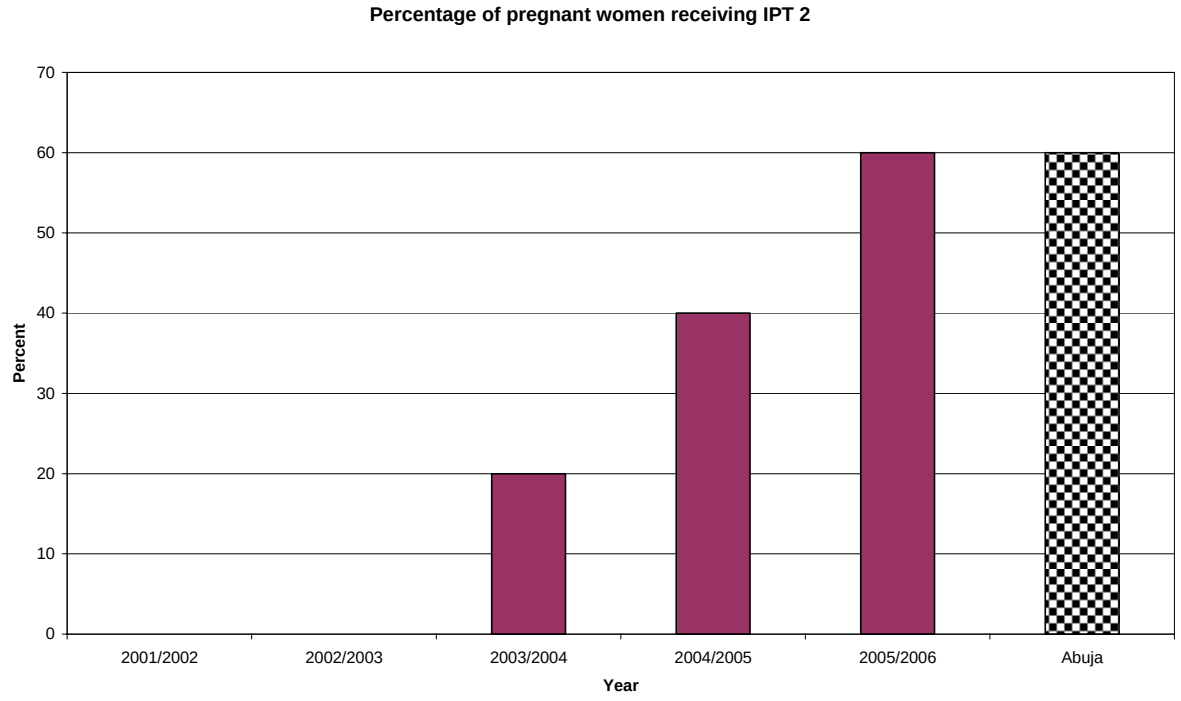


7.2. Prevention and control of malaria in pregnancy

It is estimated that by the end of 2005, 60% of pregnant women living in malarious areas will be receiving 2 doses of IPT (IPT1 and IPT2) if the following occurs:

Year	Assumptions and actions
2001/2002	• Not applicable (CQ Chemoprophylaxis)
2002/2003	• Not applicable (CQ Chemoprophylaxis)
2003/2004	• Policy launched (September 2003) • Policy begins to be implemented through distribution of guidelines

	• Coverage for IPT2 is 20%
2004/2005	• Policy fully implemented • Communities sensitised • SP drug supply is maintained • Health workers oriented on IPT • Free ITN distribution to pregnant women increases ANC attendance • ANC attendance remains high • Coverage for IPT2 is 40%.
2005/2006	• SP drug supply is maintained • Support and supervision to ensure correct implementation • High ANC attendance is maintained • Coverage for IPT2 increases to 60%.

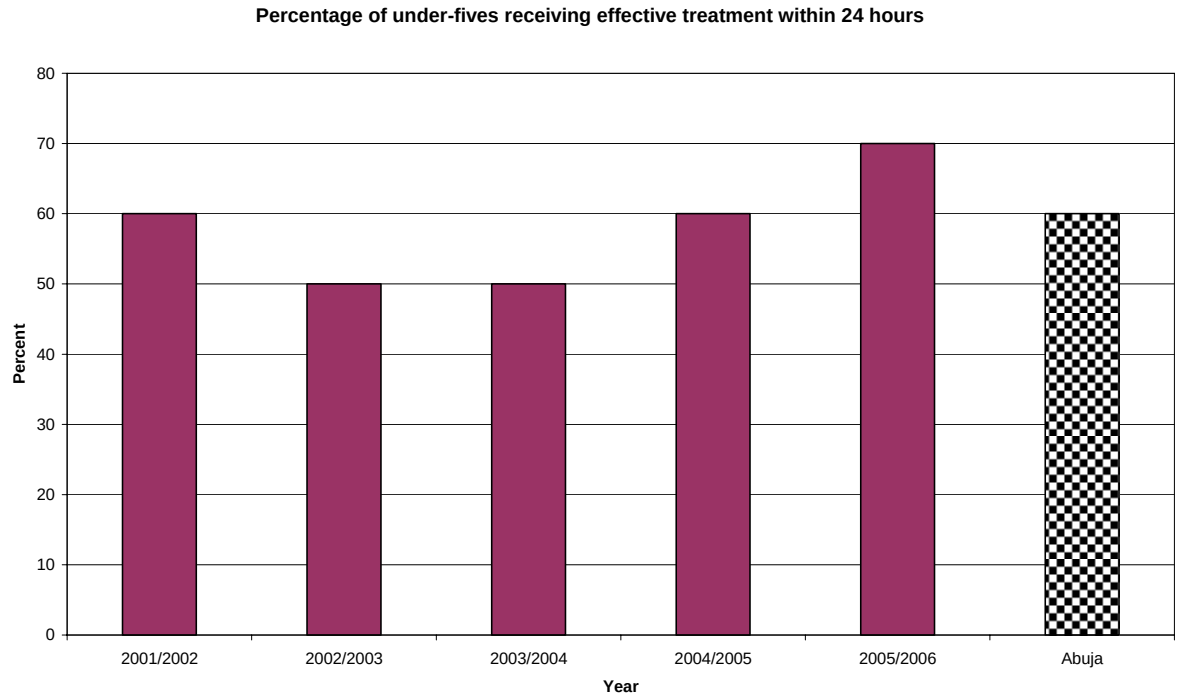


7.3. Access to effective treatment

It is estimated that by the end of 2005, 70% of the population with fever will be receiving effective treatment within 24 hours if the following occurs:

Year	Assumptions and actions
2001/2002	• Coverage was estimated based on available data from the RBM Baseline Survey 2001. • Coverage was estimated to be 60% (access)
2002/2003	• Coverage may have declined to 50% (access)
2003/2004	• CQ/SP policy launched • CQ/SP drug supply remains sufficient • First-line combination remains effective • Health workers informed of new policy • Coverage remains at 50% (effective treatment)
2004/2005	• CQ/SP drug supply remains sufficient • First-line combination remains effective • Health workers sensitised on new policy • CQ holders are trained to distribute CQ/SP • Coverage increases to 60% (effective treatment)

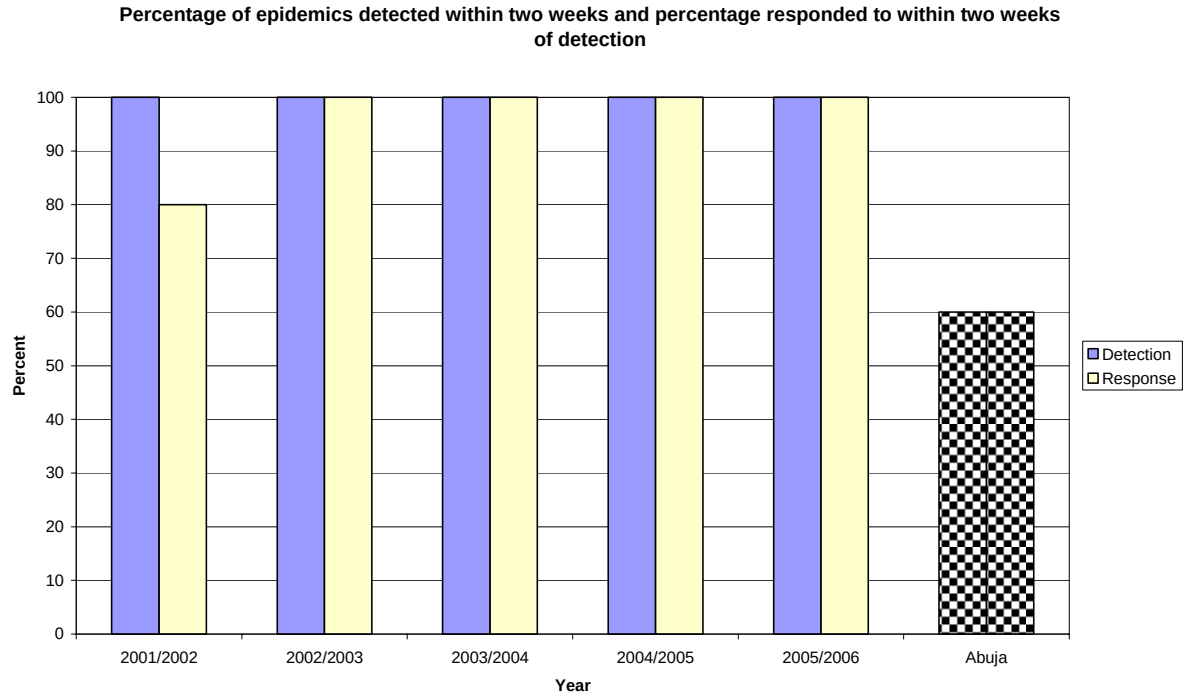
2005/2006	• First-line combination remains effective • CQ/SP drug supply remains sufficient • Health workers supervised • Other community-level cadres are trained to distribute CQ/SP • Shop-keepers stocking and selling over-the-counter CQ/SP (pre-packaged) • Coverage increases to 70% (effective treatment)



7.4. Epidemic preparedness and response

It is estimated that by the end of 2005, all (100%) outbreaks will be detected within 2 weeks of onset and all of these (100%) will be effectively responded to within 2 weeks of detection.

Year	Assumptions and actions (data from NMCP reports)
2001/2002	• Detection and response rates were 100% and 80% respectively
2002/2003	• Detection and response rates were 100% and 100% respectively
2003/2004	• Weekly surveillance system is strengthened and report completion rate rises to 80% • Detection and response rates are 100% and 100% respectively
2004/2005	• Weekly surveillance system is strengthened and report completion rate rises to 90% • Logistic capacity to respond is improved, particularly with regards to vehicles and fuel • Detection and response rates are 100% and 100% respectively
2005/2006	• Weekly surveillance system is maintained • Logistic capacity to respond is maintained • Detection and response rates are 100% and 100% respectively



7.5. Summary

INDICATOR	ESTIMATED PROGRESS			END 2005 TARGETS	
	2003/2004	2004/2005	2005/2006	Abuja	Strategic Plan / 2004 Annual Plan
Percentage of the population living in malarious areas protected by IRS or sleeping under an insecticide-treated mosquito net	5%	35%	50%	60%	70%
Percentage of pregnant women receiving 2 doses of IPT (IPT1 and IPT2)	20%	40%	60%	60%	80%
Percentage of the population with fever receiving effective treatment within 24 hours	50%	60%	70%	60%	80%
Percentage of outbreaks detected within 2 weeks of onset and percentage of these effectively responded to within 2 weeks of detection	100% 100%	100% 100%	100% 100%	60% 60%	100% 100%

The table above summarises Zimbabwe's progress towards attaining (or having already attained) the Abuja Targets. However, it should be noted that the projected estimates for 2005/2006 are lower in most cases than those given in the Malaria Control Strategic Plan and current Annual Plan (2004).

It is important to stress that Zimbabwe should not underestimate the implementation challenges that lie ahead, particularly given the overall macro-economic environment. The projections for the season 2005/2006 *presume* that *in addition to the current and planned activities*, the following *Essential Actions* will also be successfully carried out

8. THE ESSENTIAL ACTIONS

The essential actions given below are those deemed necessary by the RBM Country partnership, in order for the RBM Secretariat and Partners to accelerate implementation and reach the coverage rates given in the previous section.

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.

8.1. Partnership strengthening

Traditionally, the MOHCW has had a good working relationship with partners. However, due to factors beyond their control, participation of partners in co-ordination mechanisms has been limited. In order to strengthen the RBM partnership in Zimbabwe, it is important that bilateral partners, NGOs and the private sector participate in co-ordination meetings. There are a number of co-ordination mechanisms. It is proposed that the most suitable is the recently established Inter-agency Co-ordinating Committee for Health.

Proposed actions

- Ensure malaria remains prominent on the agenda of the Inter-agency Co-ordinating Committee for Health (IACCH)
- Pro-actively identify and invite partners to attend the IACCH
- Through the IACCH:
    - Advocate for humanitarian relief programmes to include malaria control
    - Regularly update bilateral agencies on the current malaria situation and needs so they are primed and when able can rapidly re-engage and provide support
    - Establish an effective working relationship with the private sector and NGOs
- In addition, use the MODO meeting to update partners on the malaria situation and needs

The MOHCW will carry out this essential action with support from the WHO Country Office.

Time-frame: immediate

8.2. Human resource strengthening

The human resource crisis is probably the biggest problem facing malaria control in Zimbabwe. Health worker retention has declined markedly. The crisis calls for macro solutions and some of these are already underway (see Summary Situation Analysis).

Proposed action

- The NMCP will continue to lobby MOHCW policy-makers to improve health worker retention and capacity development of health workers.

For the NMCP there are also human resource and institutional development issues. Global Fund monies have recently enabled the Department for Disease Control to recruit dedicated malaria control officers. However, there is currently no NMCP unit in the Ministry of Health structure and, consequently, no MOHCW malaria control-dedicated positions. Given the public health importance of malaria, it is strongly recommended that this situation be remedied.

Proposed actions

- The NMCP unit should be made functional and then institutionalised
- The positions currently supported by the Global Fund should be regularised by the MOHCW

This essential action will be carried out by the MOHCW.

8.3. Strategic planning for now and the future

Given the current resource-constrained environment that the MOHCW is working in, it has prepared a National Health Revival Plan that prioritises health interventions in Zimbabwe. It is important the NMCP ensures that its strategies and plans are in line with the National Health Revival Plan.

Proposed actions

- Harmonise the Malaria Control Strategic Plan (2001-2007) and Annual Plan (2004) with the National Health Revival Plan (2004)
- Under vector control in the National Health Revival Plan, propose that IRS and ITNs remain the priorities and exclude larviciding as a priority.
- Include drug efficacy monitoring and insecticide susceptibility monitoring as priorities in the National Health Revival Plan
- Share the National Health Revival Plan with partners and stakeholders using appropriate mechanisms including the Inter-agency Co-ordinating Committee for Health
- To complement the National Health Revival Plan, review current implementation strategies and adapt these to the current environment in which the NMCP is operating, including how to deliver malaria control to newly resettled areas and hard to reach areas. In addition, the NMCP should prepare implementation strategies that would allow it to be ready to rapidly change from emergency mode when the environment improves in terms of financial investment and economic stability.

The MOHCW will carry out this essential action with appropriate technical support. This activity will cost approximately USD15,000.

Time-frame: June-August 2004

8.4. Solving Global Fund bottlenecks

The Global Fund is an important external financing partner for malaria control in Zimbabwe. It is important that over the next 24 months the MOHCW and CCM are able to access, absorb and effectively utilise GF monies.

Proposed actions

- Reach mutual understanding with the GFATM and the Local Fund Agent regarding the latter's roles and responsibilities
- Revise and resubmit the Global Fund procurement plan
- Prepare detailed implementation plans for the Round 4 proposal

The MOHCW, LFA, CCM and GFATM will carry out this essential action. Technical support will be needed to ensure the current bottlenecks are quickly overcome. This activity will cost approximately USD10,000.

Time-frame: immediate

8.5. Revitalising and sustaining IRS

Indoor residual spraying remains the primary strategy to prevent malaria and reduce malaria transmission in Zimbabwe. Hence, it is vital that IRS is selective, high quality and attains high coverage in areas targeted for spraying.

Proposed actions

- Finalise preliminary stratification. This should include a subdistrict stratification, where appropriate.
- Advocate to partners to purchase sufficient insecticide for IRS for 2004/2005 transmission season
- Develop a financial sustainability plan for IRS.

The MOHCW will carry out this essential action. Purchasing sufficient insecticide for IRS for the 2004/2005 transmission season will cost USD2,280,000. Technical support will be needed to finalise the stratification and develop a financial sustainability plan for IRS. These activities will cost approximately USD40,000 and USD10,000 respectively.

Time-frame: July-September 2004 (stratification, advocacy/purchasing insecticide); July-September 2005 (sustainability plan)

8.6. Reducing the price of ITNs in the commercial sector

The Malaria Control Strategic Plan (2001-2007) states that insecticide-treated nets are a complementary malaria prevention that should be promoted. In order to develop the commercial market for ITNs in Zimbabwe, and hence access to affordable ITNs, it is important that taxes and tariffs are waived as stated in the ITN Policy (2003).

Proposed actions

- The NMCP should lobby Ministry of Finance to remove taxes and tariffs on ITNs, including netting materials.
- Existing and new ITN manufacturers and distributors should work in partnership with MOHCW to ensure prices fall.

The MOHCW will carry out this essential action. No financial resources are needed for this activity.

Time-frame: July-December 2004

8.7. Developing and implementing a strategic approach to scaling up ITNs

Given the low level of ITN coverage in Zimbabwe and their importance in the Malaria Control Strategic Plan as a complementary strategy to IRS, it is necessary that a strategic approach is taken to scaling up their use in Zimbabwe. This will require several actions.

Proposed actions

- Prepare an addendum to the ITN Policy that gives more detail on targeting vulnerable groups, the importance of nets being pre-treated or bundled, and the MOHCW position on long-lasting insecticidal nets.

- Prepare and implement a phased implementation strategy for ITNs that takes into account the current economic situation and future economic recovery. The strategy would likely comprise three components:
    - *Part One*: One-off distribution of free LLINs to pregnant women[7] living in high transmission districts/areas through antenatal clinics before the next transmission season.
    - *Part Two:* Design and implement a net re-treatment system that is carried out prior to the malaria transmission season.
    - *Part Three:* Develop and implement an ITN subsidy system that targets vulnerable groups. In tandem, support the development of the commercial market for ITNs through generic (i.e. non-branded) social marketing of MOHCW-approved ITNs.

The MOHCW and country-level partners will carry out this essential action. Funding and technical support will be sought to design and implement the phased implementation strategy for ITNs. The estimated costs are:

Part One: USD980,000
Part Two: USD140,000
Part Three: USD3,540,000

Time-frame: Policy addendum (July-Sept 2004); Part One (October 2004 – January 2005); Part Two (October 2004 – January 2005); Part Three (2005-2006).

8.8. Strengthening surveillance

Given that malaria transmission is unstable in Zimbabwe, there is need to ensure that the weekly surveillance system remains functional.

- Strengthen the weekly surveillance system in the newly resettled areas and other areas

This essential action will be carried out by the MOHCW with technical support from WHO-SAMC. The estimated cost is USD10,000.

Time-frame: ongoing.

8.9. Successfully implementing the interim antimalarial drug policy

The current interim drug policy was formally launched by the MOHCW in February 2004. It is important that implementation is done successfully so access to effective treatment is achieved quickly.

Proposed actions

- Preparation of training, job-aid and IEC materials on the interim policy
- Sensitise health workers to the new interim policy, giving particular attention to nurse aides through on-site sensitisation.

[7] This could include under-fives (using EPI) as well as pregnant women. However, this will increase the number the ITNs needed from approximately 150,000 to over 600,000. The NMCP need to decide whether it will be practical to resource, implement and properly monitor such a large-scale free ITN distribution in the time-frame of 4 months.

- Sensitise communities to the new interim policy.
- Sensitise the pharmaceutical manufacturers and distributors on the new interim policy
- Sensitise shop-keepers on the new policy so SP and CQ is sold in combination.
- Train former/current CQ distributors (and other community health worker cadres e.g. village health workers). Attention should be given to hard to reach areas.
- Liaise with the private sector to determine the feasibility of pre-packaging the combination, particularly for its use at the community level.
- Monitor implementation of the new interim drug policy, particularly:
    - The drug supply chain from NatPharm down to health facility
    - Health worker and community-based distributors adherence to the interim policy

This essential action will be carried out by the MOHCW in partnership with private and not-for-profit health providers. The estimated cost is USD200,000.

Time-frame: July-October 2004 (for Health Workers); July-October 2005 (for Community-based cadres)

8.10. Rapidly implementing IPT

The MOHCW has recently launched an IPT policy. Given the high antenatal attendance in Zimbabwe, if the policy is successfully implemented there is a high likelihood that the Abuja Target of 60% of pregnant women living in malarious areas receiving IPT will be met.

Proposed actions

- Harmonise Reproductive Health Guidelines and the NMCP Guidelines on IPT
- Prepare IEC materials and job aids on IPT
- Train health workers on IPT (carried out at the same time as sensitising on the new interim antimalarial policy)
- Sensitise pregnant women on IPT (carried out at the same time as sensitising communities on the new interim antimalarial policy)
- Monitor IPT implementation and periodically collect coverage data through record review at ANC facilities.

This essential action will be carried out by the MOHCW in partnership with private and not-for-profit health providers. The estimated cost is USD30,000.

Time-frame: July-October 2004.

8.11. Planning for the long-term policy change to an ACT

Zimbabwe intends to change its antimalarial drug policy to an Artemisinin-based combination policy. In the Global Fund Round 4 proposal, ACTs have been budgeted for.

Proposed action

- A detailed implementation plan should be developed when the decision to change to ACT has been made. This should include:
    - Determining the efficacy, safety and effectiveness of the combination
    - Building consensus
    - Undertaking costing that includes the cost of drugs and implementation costs (including adaptation of guidelines and IMCI, sensitisation, training, regulation, pharmacovigilance, efficacy monitoring)

- Developing a long-term financing / resource mobilisation strategy
- Selecting drugs for second-line and for treatment of pregnant women
- Ensuring the combination is registered and regulatory requirements are met
- Ensuring appropriate pre-packaging of the combination to improve compliance
- Building a sound partnership with the pharmaceutical industry (local and international) to ensure pre-qualified suppliers and uninterrupted drug supply is possible
- Supporting the MCAZ on quality control of the new combination at the port of entry and point of sale
- Liaising with the MCAZ, NatPharm and Pharmacy to ensure the drug supply system is fully prepared for the policy change. This includes building the capacity of district drug supply and management systems.
- Supporting the MCAZ in strengthening pharmacovigilance systems for the new policy including monitoring adverse events at sentinel sites.
- Recalling of current drugs no longer recommended in the new policy (namely CQ) and ensuring SP is only used for IPT.
- Determining the levels at which the new combination will be available. This includes determining the role of home-based management of malaria/fever vis a vis the new policy
- Determining the role of diagnostics, including the use of rapid diagnostic tests
- Training of health workers including the not-for-profit and for-profit sectors on unfamiliar/new drugs
- Sensitisation of the public to the new policy on unfamiliar/new drugs
- Drug efficacy monitoring for the new policy (including second-line treatment).

The MOHCW, the Case Management Subcommittee and RBM partners will carry out this essential action. Technical support will be needed. This activity will cost approximately USD50,000.

Time-frame: completed by December 2004

8.12. Developing and implementing a malaria communication strategy

Effective communication will support successful malaria control in Zimbabwe. This is particularly so when implementing new interventions and improving the quality and coverage of existing ones and raising the profile of malaria from the community level up to the political level. A strategic approach should be taken to communication activities rather than them being implemented in a piece-meal and reactionary fashion.

Proposed action

- Develop and implement a malaria communication strategy.

This essential action will be carried out by the MOHCW with technical and implementation support from partners. It is estimated that this action will cost:
USD30,000 (development of communication strategy)
USD400,000 (implementation of communication strategy)

Time-frame: August - September 2004 (strategy development); October 2004-December 2005 onwards (implementation)

8.13. Strengthening community-based malaria control

The MOHCW and partners recognises the important role communities can play in malaria control. Currently, as described in the situation analysis there are different efforts to involve communities in malaria control. These efforts should be strengthened.

Proposed actions

- Conduct a situation analysis on provision of malaria control services at the community level including documenting good practices (e.g. Binga District).
- Develop a strategic plan on how to increase and sustain community involvement in evidence-based malaria interventions giving particular attention to:
    - Treatment, particularly in relation to the new interim drug policy
    - Prevention, particularly co-operation and support during IRS and re-treatment of ITNs
    - Support, supervision and monitoring of community-based malaria control activities
    - Volunteerism, incentives and motivation
    - Options for integration with other community based activities

This essential action will be carried out by the MOHCW with technical support from partners. It is estimated that this action will cost USD15,000 (situation analysis) and USD15,000 (strategic plan for community-based malaria control).

Time-frame: February-April 2005 (situation analysis); June 2005 (strategic plan)

8.14. Monitoring expenditure on malaria control

Spending on malaria control should reflect its disease burden. It is recommended that the NMCP should eventually have a dedicated budget for malaria control. In the interim, it will be important for the centre as well as the provinces and districts to monitor expenditure on malaria control to ensure it remains a priority-funded disease.

Proposed action:

- The NMCP develop and implement a system to monitor expenditure on malaria control at the district, provincial and central levels. This will be done by using data available from the nascent Public Finance Management System.

The MOHCW will carry out this essential action with appropriate technical support to design the system. This activity will cost approximately USD5,000.

Time-frame: by December 2004

8.15. Monitoring progress towards achieving the Abuja Targets

As Zimbabwe is one of the signatories to the Abuja Declaration, it will be necessary to measure progress towards achieving the Abuja Targets by the end of 2005. A Demographic and Health Survey is planned for Zimbabwe in 2005. This will be supported by USAID, DFID and UNFPA. It will be important that this survey includes the collection of malaria indicators. Supplementary information (e.g. on access to effective treatment) may also needed to be collected in separate survey. Likewise, it will be necessary to evaluate the NMCP at the end of the 2005/2006 transmission season to inform the development of a new medium-term malaria control strategic plan.

Proposed actions:

- Appoint a team to liaise with MACRO, CSO and partners to ensure malaria indicators including for IRS are included in the 2005 ZDHS
- If necessary, conduct an additional malaria survey to capture data on other indicators not collected by the 2005 ZDHS
- Carry out a comprehensive evaluation of the NMCP at the end of the 2005/2006 transmission season

This essential action will be carried out by the MOHCW with technical support from partners. It is estimated that the additional malaria survey will cost approximately USD60,000 and the evaluation cost USD50,000.

Time-frame: July 2004 – December 2005 (ZDHS), March-May 2006 (Malaria Survey), June 2006 (Evaluation).

9. ZIMBABWE SUPPORT PACKAGE: ESSENTIAL ACTIONS AND INVESTMENTS REQUIRED

#	Essential actions (in addition to ongoing activities)	Products (outputs)	Investments needed (USD)					Meeting the Gap
			Human resources	Commodities/ equipment	Cost 2004	Cost 2005	Cost 2006	
1	Partnership strengthening	Increasingly engaged and supportive RBM partnership	NMCP, DDC		-	-	-	
2	Human resource strengthening	NMCP institutionalised as a unit and positions regularised	NMCP		-	-	-	
3	Strategic planning for now and the future	Implementation strategies in place that are suited to the current and future environments	TA		15,000	-	-	
4	Solving Global Fund bottlenecks	GF monies quickly accessed and effectively utilised by MOHCW and implementing partners	TA		10,000	-	-	
5	Revitalising and sustaining IRS	High coverage, high quality and sustainable IRS programme in place	TA	Insecticides	2,280,000 + 40,000	10,000	-	
6	Reducing the price of ITNs in the commercial sector	Competitively priced ITNs in the commercial sector	NMCP		-	-	-	
7	Developing and implementing a strategic approach to scaling up ITNs	Strategies implemented to achieve high ITN coverage among vulnerable groups while supporting commercial ITN market development	TA	ITNs, re-treatment kits, materials	980,000 + 141,000	2,000,000	1,500,000	
8	Strengthening surveillance	Weekly surveillance system successfully detects malaria outbreaks in a timely manner	TA		10,000	-	-	
9	Successfully implementing the interim antimalarial drug policy	The interim policy is implemented country-wide and access to effective treatment rises markedly	NMCP, MOH personnel	Materials	200,000	-	-	
10	Rapidly implementing IPT	IPT is implemented in all malarious areas	NMCP, MOH personnel	Materials	30,000	-	-	
11	Planning for the long-term policy change to an ACT	Detailed implementation plan for ACT policy change is in place	NMCP, CMSC, TA		50,000	-	-	
12	Developing and implementing a malaria communication strategy	High profile of malaria and positive behavioural change	NMCP, Partners, TA		30,000	400,000	-	
13	Strengthening community-based malaria control	Strategic plan in place for community-based malaria control	NMCP, Partners, TA			30,000		
14	Monitoring expenditure on malaria control	System in place to track expenditure on malaria control	TA		5,000	-	-	
15	Monitoring progress towards achieving the Abuja Targets	Programme evaluated and robust estimates available for Abuja indicators	TA, NMCP, MOH personnel	Materials	-	-	60,000 + 50,000	
	Total				**3,791,000**	**2,440,000**	**1,610,000**	**7,841,000**

10. FOLLOW-UP ACTIONS

- Core team to finalise report and submit to MOHCW and partners by 28 May 2004
- MOHCW to share report with country partners at the Inter-agency Co-ordinating Committee for Health (June 2004)
- RBM Secretariat to present report to RBM Board and Global Partners and request for support

11. ANNEX 1. LIST OF PERSONS AND ORGANISATIONS CONSULTED

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12. ANNEX 2. DOCUMENTS REVIEWED DURING COUNTRY CONSULTATIVE MISSION

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