



**Southern African Regional
Network SECRETARIAT**

SARN PMI-MOP (PMI – AF2015) MISSION REPORT TO MADAGASCAR

ANTANANARIVO, MADAGASCAR

26 – 30 May 2014

**SARN
Gaborone, Botswana**

1.0 BACKGROUND

The Presidential Malaria Initiative (PMI) conducts its Malaria Operation Planning (MOP) in the five PMI countries (Madagascar, Malawi, Mozambique, Zambia and Zimbabwe) every year. In 2013 a PMI MOP was carried out to plan for the 2014 PMI funded activities and the Madagascar 2014 MOP to plan for the 2015 MOP (**MOP AF2015**) was held from 26 - 30 May 2014 in Antananarivo. The PMI team included the country PMI, CDC and USAID Focal Points and representatives from Washington. SARN was represented by the Regional Coordinator/Focal Point.

Since the start of the political crisis in Madagascar, USAID had suspended its support for Malaria and other diseases and had scaled down to basic community level activities i.e., no direct funds were being given to the Government/Madagascar Ministry of Health.

The return of USAID – PMI funding to Madagascar.

Following the changes in the political landscape, the US Government announced on 28 May that it has lifted the embargo and hence USAID-PMI funding for malaria is now available.

2.0 MAIN OBJECTIVE

The purpose of the MOP was to plan for the activities to be implemented utilizing the USD26 million given to Madagascar by the PMI for disbursement from October 2015 to September 2016 (**MOP AF2015**) and to review progress made in implementing the PMI community level funded activities during the 2013 period.

3.0 METHOD OF WORK

The MOP started with a meeting at the NMCP to agree on the 5 day MOP program. The meeting was attended by the NMCP thematic area team leaders, MOP-team, WHO, UNICEF, PSI and SARN Secretariat. All parties took turns to outline the current situation and the challenges/bottlenecks that needed either short-or-long-term resolutions. The PMI-MOP team then set aside a day during which they met all the in-country partners individually to tease out details of the activities each organization was carrying out and how they could collaborate with PMI and other stakeholders. SARN and PMI also held a consultative meeting at the Taboho Hotel. The SARN Coordinator then dedicated a full day at the NMCP discussing with the program manager and also with each thematic area focal point. SARN also held separate brief consultations with UNICEF, WHO and the visiting Global Fund team. An all stakeholders meeting was held on the final day during which the NMCP and PMI presented on the current status of program implementation and support for Madagascar respectively. All partners took turns to outline what they were offering and SARN also provided a short briefing of the partnership including the NFM

Concept Note TA and the need for aligning the partnership. After these presentations, discussions were held and the NMCP manager summarized and concluded the proceedings.

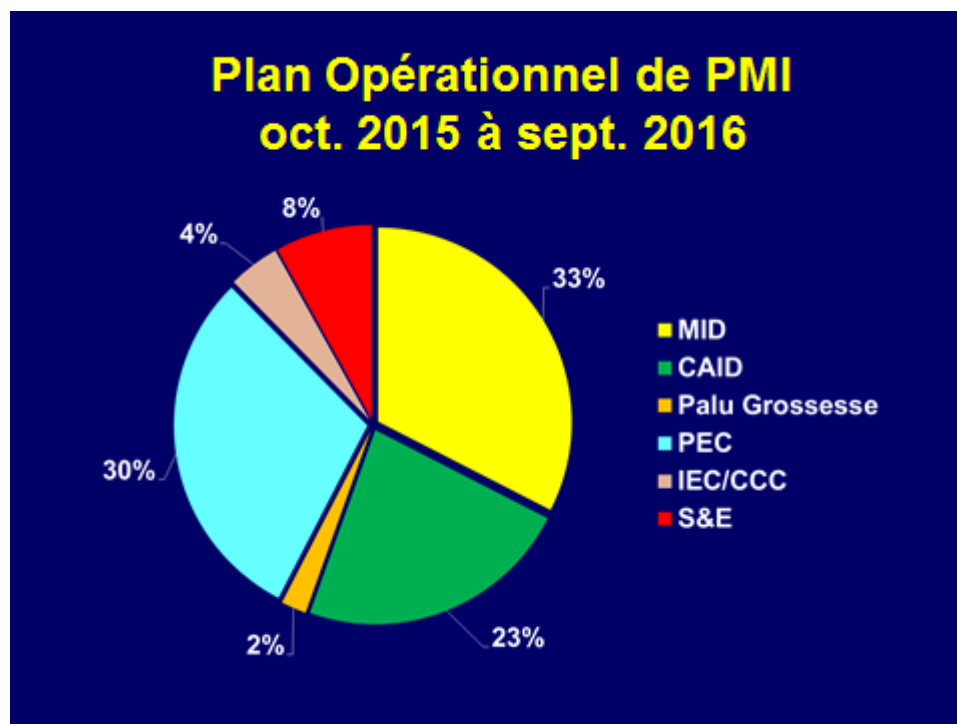
4.0 JOINT MISSION MAIN OUTCOMES

1. Main Concerns/Challenges/Bottlenecks

- a. **Downgrading of the NMCP:** the MoH was restructuring and in the process, the NMCP would be downgraded from a Malaria directorate to a unit under the same department as TB. This means that they would lose the Director's post.
- b. **PSM challenges/bottlenecks:** the country has been facing chronic stock outs of anti-malaria commodities (**since 2011**) especially at district level and the periphery. The causes relate to non-availability of stocks in the country, weak LMIS, poor delivery systems (lack of transport), poor access (long distances and poor road infrastructure) and chronic human resources shortages (both number and skill levels) and attrition. Failure to account for stocks delivered to districts and the periphery, non-functional reporting systems and lack of consumption data. The NMCP does not understand what is happening.
- c. **Fragmented in-country partnership:** partners do not share their plans, activities or what they are doing, where they are doing it and the challenges they meet including the results of their operations. As a result, the NMCP has no control over what is happening and partners continue to work in silos. This has led to confusion at ground level where community based workers are bombarded with instructions from multiple partners.
- d. **Stuck GF disbursement of NSA 2 funds:** for the past 2 years, the GF has not been disbursing the NSA 2 funds because of lack of accountability and transparency of the main PR - UGP (government). This has been the main cause of the current stock outs and non-implementation of IRS and in-adequate distribution of LLINs. Due to these delays, the program has only 1.5 years in which to implement the disbursement. Recently however, the CCM and GF finally stripped UGP of the PR-ship and awarded it to PSI. This change is expected to bring the needed efficiency in delivery, reporting and also aid in partner alignment.
- e. **Gap analysis challenges:** partners believe that the gap analysis does not reflect a true picture of the current status and shortages because it keeps changing. It needs to be reviewed so that it informs the MSP review and NFM Concept Note process.

- f. **The CCM** has not changed and lacks representation of the malaria constituency.
 - g. **VPP challenges:** the program managers cited challenges with the VPP system related to delays and failure to meet deadlines. As a result, commodities are supplied long after the activity time lines have passed. They would like to see this system removed in order to improve the situation.
 - h. Maternal deaths due to malaria not available at NMCP.
2. PMI will disburse USD 26 million from October 2015 to September 2016 for implementation of agreed activities and assured that the program has funds to take them into 2016.
- a. **IRS USD 5.3 million** (25,000 structures) for the Eastern coast: also supervision and resistance monitoring.
 - b. **LLINs USD 7.4 million** (2 million nets) for routine distribution at ANC, distribution support, vaccines for children, pregnant women at delivery.
 - c. **Case management and Diagnosis:**
 - i. **ACTs USD 4.2 Million** of which **1 million** is for ASAQ (1.2 million): ACT efficacy studies/monitoring at 6 sites.
 - ii. **RDTs USD 1 million** (2 million RDTs).
 - d. **IPTp USD 490,000** to buy 2.8 million SP tablets for distribution at Health Facilities (HF), strengthen capacity at National and HF levels and strengthen linkages between NMCP and MCH.
 - e. **Capacity building USD 4.1 million:** training of 6,000 CHWs, supervision, QA/QC at National laboratory and Peace Corps support.
 - f. **IEC/BCC: USD 1 Million** – coordination and harmonization of messages, dissemination of messages covering all thematic areas.
 - g. **Surveillance, Monitoring/Evaluation USD 1.9:** 15 sentinel sites for monitoring and for ACT efficacy (6 sites), nationally there are 34 sites for fever surveillance, building/strengthening routine/epidemic surveillance and support for launching the MIS.

Fig 1. PMI Operational Plan (Oct 2015 to Sept 2016)



3. Commitment by PMI to work closely with host government, in-country partners and to support activities outlined in the MSP.
4. In-country partners pledged to support the 2014 – 2015 activities.
5. The GF grants currently operating are Round 9 Phase 2. A disbursement of **USD 45 million** will be give to PSI but the challenge is that they have only 1.5 years in which to utilize the funds
6. Vector control strategy not available.
7. MIS will be done in 2014 – supported by PMI.
8. Other PMI support areas include: procurement of insecticides, ACTs, RDTs, LLINs and supporting training of CHWs, microscopy/RDT use, operational research, strengthening in M/E/ surveillance/data management and BCC/IEC.
9. PMI to provide NFM support till submission. Concept Note submission is by 5th January 2015 – NMCP wants to start preparations now. Mid-term review of the MSP in June 2014. SARN and HWG are providing TA for concept note development.
10. Alignment of partners plans, activities and TA to the MSP, SADC and SARN.
11. Endorsement of the MOP by all stakeholders.
12. Strengthened in-country partners' capacity for surveillance and early warning system for detecting and alerting impending implementation challenges and their proactive capacity.
13. Strengthened SARN-PMI collaboration.
14. Continued SARN - RBM visibility.
15. It was agreed that while the program is performing, there remains challenges with regard to supervision, PSM – consumption data is not available and

commodities distributed to districts and health facilities cannot be accounted for. Limited access to information/data from the health facilities and district as a result, the roadmap could not be developed.

16. There is need for strengthening M/E and surveillance, delivery of commodities to districts and the periphery in order to minimize stock outs and availability of consumption data on ACTs and RDTs.
17. Improved capacity for reporting from health facilities, districts and provinces to the national level.

5.0 ACTION TAKEN ON SITE

The SARN Coordinator whilst in Madagascar, resolved the following:

Bottleneck Resolution – Downgrading of NMCP: Contacted the RBM EXD to discuss with the Madagascar Prime Minister (PM) who is also the Minister of Health. Discussed with the Madagascar Chief of Military Health Services, Major General (Dr) Johanesa, a member of the SARN Steering Committee who arranged for a phone conversation between the SARN Coordinator and the Chief of Staff of the Prime Minister’s Office. Following the tele-conversation, the Prime Minister’s Chef of staff had a follow up face to face meeting with General Johanesa during which it was agreed that all efforts should be made to ensure the NMCP is not downgraded. The Prime Minister/Minister of Health was informed. The issue is now being discussed at the PM’s level.

Next Steps:

A request to sent to ALMA for a presidential brief during the Malabo Head of States Meeting end of June 2014.

Concept Note development

Discussion carried out with NMCP who have indicated the consultant they want. SARN and HWG are in the process of getting the consultant. The Gap Analysis and MSP review has been planned to start before end of June. The program is developing the budget and roadmap for the CN development which is due to be submitted by 5th January 2015 - due to slow systems, they would want to start the processes now.

Next steps: Securing the consultant, budget review and determination by (HWG and SARN) of the level of support.

Roadmap/Annual Plan submission

The SARN Coordinator went through the roadmap with the M/E Officer – the challenge is that there is no data coming from the periphery (health facilities) and districts to the NMCP. They are expecting to get the data by mid-June and a roadmap will be developed including one for July. The Annual Plan will be submitted

by end of June. Discussions were carried out with PMI and in-country partners to support the data system and use their community based systems to provide more information and strengthen information systems at district, health facility and Community Based Workers to avail weekly reports.

Next Steps:

- a. Follow up on development of roadmap and annual plan and discuss any remaining challenges during the SARN ARPM in July 2014.
- b. Strengthen the in-country RBM partnerships.
- c. Provide TA for strengthening the data base and availability of epidemiological, entomological and consumption data.

PSM bottlenecks: next steps

- a. Provide a long-term consultant to strengthen the LMIS and ensure delivery of commodities to the districts/periphery (HFs), look at storage/consumption/record keeping/submission of reports and training.
- b. Country focused support in 2015 PWP – an activity for a **country focused support** by SARN Secretariat – the SARN Coordinator with partner support will spend more time working with the program.
- c. **VPP** – the program managers would like this to be removed as it causes serious delays in the delivery of commodities for example, insecticides arrive after the spraying season has started. This issue needs to be dealt with together with the **CCM issue – the CCM** has not changed and does not have malaria constituency representation.

Resolution strategy: ALMA and RBM secretariat have to conduct high political level discussions with the president in Malabo when they discuss reversal of the downgrading of the NMCP.

- d. **Stock outs:** The change from the government PR – UGP to PSI is hoped to stabilize commodity availability, delivery and reporting (availability of consumption data). There is however the need for monitoring and supervision of the new PR to ensure compliance. SARN will work closely with the GF-FPM/CCM/In-country partners and NMCP to ensure commodity procurement, storage, quantification, delivery and reporting is streamlined. The **USD 45** million from the GF to PSI will require all stakeholders' actions to speed up its absorption. SARN will work closely with the GF-FPM to ensure disbursement is carried out timeously and without delay since stock outs date back to 2011.

6.0 CONCLUSION

The Madagascar NMCP requires support to reverse the observed challenges. However due to systemic issues that relate to the entire MoH system a solution will have to be sought via high political level advocacy with the Minister of Health/PM/and President. SARN will be activating these systems to ensure the challenges are

resolved. The current transition through which the new Government is going through will affect the NMCP and it will require all stakeholders support.

The return of the PMI funding to Madagascar is most welcome but the program needs all the stakeholders support to ensure its timeous absorption together with the GF disbursement to PSI.