



**Report of the Joint SARN – PMI Mission to Madagascar carried out from  
08 to 11 May 2012**

**National Malaria Control Program, Ministry of Health  
Antananarivo, Madagascar**

**SARN  
Gaborone, Botswana**

## 1.0 Background

The SARN Secretariat carries out assessment/support mission to all the SARN countries once year and when necessary, a follow up mission is carried out. Following intense communication with the Presidential Malaria Initiative HQ, it was agreed that joint SARN-RBM missions will be conducted in all PMI countries in the SARN region. Since the PMI had already planned its calendar of conducting **Malaria Operations Planning (MOP)**, SARN agreed to align/harmonize its missions to Madagascar, Malawi, Mozambique, Zambia and Zimbabwe with those of the PMI. The mission to Madagascar would be the third joint mission following the Zimbabwe and Zambia and would be used for assessing the value addition of these harmonized missions. The SARN Steering Committee has drafted generic TORs for carrying out missions which are adjusted to meet the requirements of each country. The mission was carried out by the SARN Focal Point and the PMI team was made up of members of the Malaria Operations Planning (MOP) from the USA and those based at the UASID in Antananarivo, Madagascar. Madagascar is in the middle of malaria outbreaks in the East, South East and South as a result of the cyclone and heavy rains. Immediate evaluation of the impact of the epidemics and establishment of mitigatory measures was needed.



**NMCP, PMI, SARN and Partners Conducting a Gap Analysis**

## 2.0 Objectives

The main objectives were to:

1. Assess progress made in malaria control and program management.
2. Support the NMCP to finalize and upload the 2012 roadmap.
3. Assess the Global Fund performance, challenges and determine solutions.
4. Determine bottlenecks/challenges and conduct a Gap analysis for identifying technical (TA) support/resource needs that would inform the development of an action plan for support and resolution of bottlenecks.
5. Review EPR and support development of measures for responding to the current epidemics affecting the county.
6. Develop a harmonized TA and action plans for follow up.
7. Review impact of the cyclone and floods that affected the country.
8. For the PMI, the mission would help them in consolidating their MOP.

## 3.0 Method of work

The work schedule included updates by NMCP/discussions with the following partners (WHO, CHAI, Principal Recipient – PSI, UNICEF) at their offices. Gap analysis sessions, debriefing and development of joint TA and action plan for follow up and a field visit by the PMI-MOP team. A special all stakeholders meeting was organized to discuss the current epidemics/increase in cases and deaths in the East, South East and South of the country.



PMI, CHAI, WHO, SARN and NMCP During a planning Session at NMCP



## 4.0 Main Outcomes

The main outcomes of the joint mission were:

### 1. Program management:

- a. The NMCP has a compliment of 70 people – all program areas are covered however, most of staff members require training in their program areas.
- b. HR Gap: – The HR is concentrated at the NMCP (central) level but the district levels have HR shortages.
- c. Community Based Health Workers (CBW) were trained in Community Case Management (CCM) and are deployed in most rural communities.
- d. Procurement, Supply Chain Management (PSM) is very weak as evidenced by the current stock outs affecting all rural health facilities, thus, availability of consumption data remains a challenge. The program emphasized that they need TA to build capacity in performing a stock audit, forecasting and quantification.
- e. Monitoring and Evaluation is made weak by shortage of trained data focal points at district level. Although CBWs are collecting data and recording on templates, when these are delivered to the district for feeding into the HMIS, this system does not capture the essential malaria information. Thus, the CBWs data ends up being lost due to lack of data focal points at this level.
- f. **The 2012 roadmap** had not been finalized since January 2012 however, following sessions with the SARN Focal Point, it was finalized and posted/published.
- g. The Malaria Strategic Plan (MSP) was finalized and undergoing final editing before publication and distribution.
- h. M/E – remains a challenge because of HR shortage at district level, HMIS not picking all essential data. In 2013 and 2015 MIS will be done while MDGs will be dine 2013-14.

### 2. Epidemics/current increases in cases and deaths

- i. Madagascar has experienced epidemics which started in the eastern coast and then spread through south east to the southern coastal areas. The situation in the eastern coast is now stabilized and the epidemic appears to be leveling off as a result of the measures taken by the NMCP and partners. In the south east and southern costal areas, cases are still high. The epidemic has affected pregnant women and <5 more than other groups. Although data is being compiled, over 45 cases and 21 deaths have been recorded in the whole country and of these deaths, 10 were from the south east.



- ii. The NMCP and partners have formed a committee that is meeting regularly to discuss and share updates on the developments. Partners together with the NMCP are gathering emergency resources/commodities such as RDTs, ACTs and LLINs for distribution in the affected communities. Targeted IRS is also being planned with a possibility of assessing for use of Larviciding. Teams are working in the affected areas to support screening and treatment.
  - iii. **URGENT ACTs SITUATION:** currently there are no ACT stocks at the national stores and the rural communities stocks are as follows:
    - 50,000 doses of **Actipal** in various regions and is divided as follows:
      - 18,000 doses for <1
      - 32,000 doses for >1 -<5
  - iv. Although the 50,000 Actipal is supposed to last up to end of July, stock outs are likely to start in June due to the current high number. RDTs are available.
  - v. PMI reported that they have ACTs which they are offering as a Gap bridging measure.
  - vi. Deaths are being caused by late presentation to the health facilities and compounded by malnutrition/poverty and decreased immunity (those communities in low endemic areas).
  - vii. **IRS requirements for covering the epidemic:** The IRS focal point has put in place plans for spraying in selected communities in the epidemic zones, they do not have operational funds to do the campaign. Pyrethroids are available but they have a Gap of USD846,000 for protective equipment, paying spray operators and higher vehicles.
  - viii. There are no funds for EPR.
3. **GF implementation:** Delayed procurement and release of funds by the PR remains a challenge. Madagascar is currently implementing GF R7, NSA R4 – RCC and AMFm. The NMCP and partners agreed that the timing of NSA Phase 2 will be difficult to predict and that 2013 will be a difficult year due to shortage of resources. R4 - RCC ends in 2014.
4. **Case management:**
- a. Have stock outs in all rural health facilities/communities.
  - b. They have adequate stocks of RDTs.
  - c. AMFm project will be closed by end of 2012.
  - d. **Community Case Management:** they trained CBWs who have been deployed in all communities but their work is currently hampered by ACT stock outs and the HMIS which is failing to capture the essential data they are recording. There are total of 17,000 CCM sites.



- e. Private sector TOT started this week – this should increase private sector compliance when it comes to the national malaria policy and guidelines.
- f. Although PSI is the PR, procurement is done by UNITAID and UNICEF. To procure the agreed 1 million doses of ACTs, UNICEF, UNITAID and GF were supposed to have signed a tripartite agreement so that procurement and supplies are made available in June 2012. To date, they have not signed and the delivery of the 1 million doses will not meet the June target.
- g. ACTs from PMI are already in the country and are likely to have been distributed by July 2012. In 2013, there will be a Gap of 100,000 doses.
- h. 92 districts are targeted for IPTp which is supported by GF R7 and NSA between 2012 and 2013. However, in 2013, there will be a Gap of 90,000 doses.

#### **5. Diagnosis:**

- a. They have adequate RDTs to last up to 2012 however, the current need for scaling up CCM will make it difficult to estimate the actual 2012 – 2014.
- b. Deliver has the responsibility of RDTs distribution but do not have stocks.
- c. PMI have 800,000 kits hence no anticipated stock outs.
- d. UNITAID has made a proposal to distribute 500,000 kits to private sector in 2012.
- e. Additional 234,000 from GF R7 is expected to be delivered in 2012.

#### **6. IRS Gap:**

- a. 2012-13 IRS requirements should be covered by GF R7 but the NMCP should request GF to provide the funding. It is anticipated that NSA Phase 2 may be disbursed late hence the need for sending a request to the GF.
- b. PMI will support IRS in some districts from October 2013 to October 2014 in accordance with their planning cycle.
- c. There will be an IRS Gap in non-PMI districts from the 2013-14 season going beyond because they have not yet secured funding.
- d. The insecticides of choice are Pyrethroids and Carbamates.

#### **7. LLINs:**

- a. 91 districts were targeted to be covered between 2008 and 2012.
- b. The Cyclone destroyed 50,000 LLINs.
- c. In 2012, GF R7 will supply 2 million LLINs. They received 630,000 LLINs and the balance is expected by end of May. Because UNICEF is the LLINs PR for R7, distribution is via social marketing.

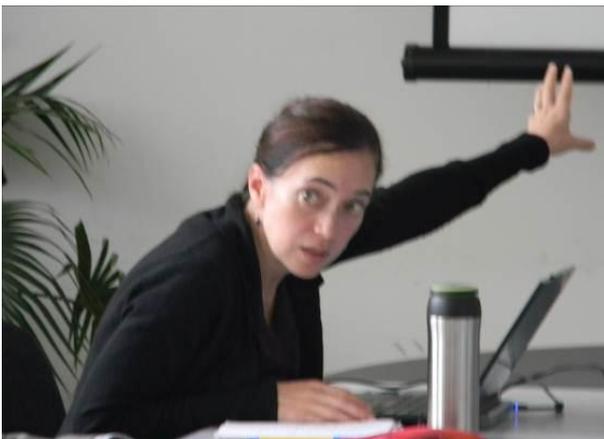
- d. GF R4 RCC will provide 4 million 957 LLINs for the 2012 mass distribution. The remaining 13 districts have a gap of 1.3 million nets to be supplied at end of 2012 by GF R10 for distribution in 2013. The main challenge is the disagreement between the GF and PSI which has delayed the grant signing. If the nets are not available by September/October 2012 then distribution will be affected by the wet season.
- e. It has been suggested that NSA phase 2 should include LLINs.
- f. In 2015, 1.8 million LLINs will be required to cover targeted districts. Replacement of nets distributed in 2010 will be needed between 2013 and 2014.



**Joint mission de-briefing session**



**Gap analysis and joint mission action plan**



**Alyssa (PMI) and NMCP(Dr Benjamin) stressing a point**



**NMCP & WHO team members**



**SARN and partners**

## 5.0 Conclusions

The joint team concluded that:

- a. The epidemic situation should be treated as a serious emergency requiring joint effort and support at Global Level. SARN Secretariat to request RBM Secretariat to mobilize support at global level and discuss with GF on delayed signing.
- b. The NMCP program management is now strong in most areas thus the NMCP management is doing well however, there is need for strengthening: M/E especially reporting of consumption data, district health systems and HR, supervisory visits and PSM.
- c. Delays by the GF and PR in disbursement and provision of commodities is causing problems in relationship to the seasonality and disease pattern. This problem has persisted since the SARN 2011 mission. It is not acceptable that PSI should fail to meet the GF requirements that are delay signing.
- d. EPR requires strengthening especially forecasting and establishment of EPR stocks for future responses.
- e. Advocacy at government level for them to increase domestic funding for malaria.
- f. A follow up SARN mission to check on progress made will be done in August 2012.
- g. Monthly TCs for all partners plus the GF FPM and PR to be arranged by SARN as a way of following up on progress.

### TA requirements and follow up plan

Activity	Responsible Organization (Follow up)	By who (Partner providing TA/support)	Time Line	Comments (current status)
Review of the Malaria Strategic Plan (MSP) 2012 - 2017	NMCP and PMI	SARN Secretariat	10 June 2012	1. TA provided 2. MSP finalized and submitted with the NSA

				application on 16 June 2012
Finalize NSA proposal	NMCP	NMCP, PR, partners and SARN	20 June 2012	Proposal finalized and submitted by 16 June 2012
Signing of GF R4 RCC for LLINs by PSI and GF	NMCP and PR	PSI and GF	20 May 2012	Signing not done due to differences between the GF and PSI
Mobilize resources (ACTs, RDTs and LLINs) for epidemic response	NMCP and SARN	PMI, PSI, CHAI, UNICEF, NITAID, Deliver	On-going	PMI to provide 800,000 RDT kits and some ACTs by July 2012 which are already in country
Mobilize Global support for epidemic response resources	SARN	RBM Secretariat	On-going	RBM Secretariat was informed and have discussed with the GF and partners
Hold monthly TCs	SARN	NMCP, PMI, PSI, UNICEF, DELIVER, UNITAID, CHAI	Monthly till end of 2012	On-going
Support for IRS from Oct 2013 – 14	NMCP	PMI	October 2013	To be reviewed in October 2013