



SARN- MOZAMBIQUE MISSION REPORT

25th to 26th July, 2011

**SARN
Gaborone, Botswana**



1.0 BACKGROUND

A meeting of the Lubombo Spatial Development Initiative (LSDI) Regional Control Commission (RCC) was held in Tzanini, South Africa in June 2011 to discuss the problems affecting the operations of the LSDI and consequent failure by Mozambique NMCP to carry out IRS in 2009 and 2010. This has resulted in increases in malaria cases and deaths in the Gaza and Maputo provinces including Maputo city. The impact has also spread to Swaziland and South Africa where the number of cross-border (imported) malaria has increased significantly as a result of the breakdown in malaria control in Mozambique.

Following the Tzanini meeting, the program managers for Mozambique, South Africa and Swaziland, the director of Medical Research Council (MRC-Durban), South Africa and the SARN Focal Point, held a side meeting during the SARN Annual Constituencies Consultative meeting, in Pretoria. At this short meeting, it was agreed that a meeting to review this pressing situation in Mozambique be held within two weeks to review the operations of the LSDI, the problems affecting Mozambique, develop an action plan and recommendations for the LSDI health ministers to consider. Thus, the Mozambique was carried out to:

2.0 OBJECTIVES OF THE MISSION

- a. Identify program strengths, weakness, opportunities, threats and good practice
- b. Identify current state of Global Fund (GF) implementations including PSM bottlenecks and challenges affecting GF implementation and performance
- c. Review problems affecting the operations of the LSDI and failure by Mozambique to achieve high IRS coverage rates and the increase in malaria cases and deaths
- d. Develop jointly with NMCP and partners agreed corrective measures and plan of action
- e. Identify the type of technical support required to deal with the situation and resources for executing such TA beginning with resources available within the country partnership
- f. Follow up on 2011 roadmap, RBM USB Key implementation, development of the 2012-13 road maps and activities/priorities for 2012 as agreed during the SARN Constituencies meeting in Pretoria
- g. Follow up on MPR report and implementation of MPR recommendations, review of the Malaria strategic plan, National Malaria Policy including the operational/M/E plans.

3.0 EXPECTED OUTCOMES

- a. Bottlenecks and challenges affecting Global Fund Implementation
- b. Action plan and recommendations for LSDI health ministers
- c. Commitment by partners to support bottleneck resolution and provision of TA
- d. Activities and priorities for 2012 - 2013
- e. Type of technical and /or implementation support required
- f. Recommendations on the way forward and next steps
- g. Updated 2011 roadmap, USB Key Tool and 2012-13 roadmap



4.0 MISSION PROGRAM

Day 1: 25 July 2011

1. Meeting with the NMCP, MACEPA, PMI, WHO and the UNICEF focal point was contacted by teleconference as he had travelled to the northern districts
 - É Reviewed the 2011 Roadmap implementation
 - É Reviewed RBM USB Key Tool
 - É Discussed activities and priorities for 2012 ó 13
 - É Discussed Global fund performance, bottlenecks and resolutions
 - É Reviewed program management/performance and human resources
 - É Discussed the planned LLINs mass distribution

Day 2: 26 July 2011

1. LSDI meeting
 - review the LSDI
 - develop action plan
 - plan for 2011 IRS activities
 - outline ways of sustaining cross-border collaboration activities
 - discuss recommendations for the LSDI health ministers
2. de-briefing the National Director of Public Health
3. Meeting with Malaria Consortium

5.0 MAIN OUTCOMES

- LLINs universal coverage achieved in 8 districts (3 Nampula; 2 Tete and 3 Inhambane)
- Planning mass distribution of 2.2 million LLINs (already in country) in 33 districts (August to October 2011) ó delivery/distribution supported by the RBM in-country partners, microplanning finalized and teams currently visiting 5 provinces (Inhambane, Tete, Nyasa, Cabo Delgado, Sofala) in preparation for mass distribution
Supporting Partners: UNICEF, DFID and GF
- MPR report needs final editing and translation into Portuguese
- Malaria Strategic Plan, Operational /M&E plans and National Malaria Policy to start on finalization of MPR report
- Malaria cases and deaths on the increase in Gaza and Maputo provinces and Maputo City
- 2011 Roadmap and filling in of USB Key Tool to be ready by 29 July 2011
- IRS ó program achieved 48 and 24% coverage in 2009 and 2010 respectively
- ACT ó have 100% coverage of Public sector but stock outs are on going.
- RDTs ó Partners supporting are: USAID (3.1 million); GF R6 (1.6 million); WB (2.6 million); and the gap is for 2011 is 1.4. million and 2012 is 7 million.
- Training of Community Health Workers to perform RDTs and give ACTs on going
- PMI supporting provision of ACTs and RDTs



- PMI is supporting two consultants for development of Malaria Strategic Plan (MSP) and National Malaria Policy document these documents will be published by end of September 2011
- Currently negotiating with PMI to cover training of IRS in the Central and Northern regions
- GF R 9 is on hold until the audit on malaria commodities that expired in the National stores has been finalized
- IPT was affected by a 6 months period of stock outs of Fansidar from November 2010 however currently they have adequate stocks to achieve 65% coverage by end of 2011
- MACEPA is supporting development of M/E Plan
- GF R6 finalized in June 2011 ó having delivered

5.1 Case Management

- There are no gaps at present: all health facilities have enough stocks
- PMI procures RDTs and ACTs
- Replenishment will be required in 2012
- Training for RDTs and ACTs started in July with the Central level and then it will be cascaded to provincial and district levels up to September 2011
- Some health workers still have a negative attitude towards negative RDT tests ó BCC/IEC was not carried out due to lack of funding
- Microscopy is done where available
- Management of Severe Malaria ó while Quinine has been the main drug but the new National Malaria Policy has added injectable Artesunate and suppositories for children (suppositories are not yet available)

5.2 In-country RBM Partnership

- The in-country RBM partnership is fully operational and the main actors are: WHO, UNICEF, PMI-USAID, CHAI-SAMEST, Malaria Consortium and DFID. These have by and large provided the greater bulk of support.
- The other support is being provided by some organizations from Italy, Canada (CEDA), Denmark and Ireland and the Civil society is also providing support through the MoH
- Most of these organizations are withholding their support until the Audit results have been published as a result; the program will continue to struggle due to shortage of resources.

6.0 NEXT STEPS

- Finalization of the document for the LSDI Minister
- Presentation of the recommendations to the LSDI Ministers
- Meeting to be arranged by Mozambique MoH for the LSDI Ministers, senior health officials, program managers, Military Health Services (Mozambique, South Africa, Swaziland and SADC), partners, SARN Secretariat and SADC Secretariat during which the recommendations will be presented for their decision



- Strengthen support to Mozambique NMCP to ensure IRS is carried out in Gaza province, Maputo province and Maputo city in 2011
- SARN Secretariat to ensure in country RBM partners continue to provide support through resource mobilization
- The issue of sustainability of cross-borders to be discussed at SADC Level
- Issues related to good governance, accountability, transparency to be discussed at SADC Level ó this problem has also affected Malawi and Zambia and it is recommended that the SADC Ministers of Health discuss this during the November 2011 meeting
- Follow up with Mozambique NMCP on progress towards the LSDI Ministers meeting



Annexure 1

MINUTES ON: SUSTAINING THE GAINS ON THE MALARIA CONTROL COMPONENT OF THE LUBOMBO SPATIAL DEVELOPMENT INITIATIVE (LSDI)

25 - /26 July 2011

Venue: Ministry of Health Mozambique

Chairperson: Dr Abdul Mussa
Secretariat: SARN - Dr Kaka Mudambo

Participants:

Dr Abdul Mussa: Malaria Programme Manager; Ministry of Health, Mozambique
Mr Simon Kunene: Malaria Programme Manager, Ministry of Health, Swaziland
Dr Devanand Moonasar: Director Malaria; National Department of Health in South Africa
Prof. Rajendra Maharaj: Director Malaria Lead Programme, Medical Research Council of South Africa
Dr Kaka Mudambo: Focal Point Southern African Roll Back Malaria Network (SARN)

1. Background

Professor Maharaj provided a background on the LSDI, this included: its history; progress on LSDI objectives for past 10 years; challenges associated with sustaining the LSDI and current Indoor Residual Spraying (IRS) coverage, his feedback is detailed below.

1.1 LSDI History:

The LSDI is a trilateral initiative between the governments of Mozambique, South Africa and Swaziland aimed at accelerating the economic development of the areas bordered by the Lebombo Mountains, which includes: the northern parts of KwaZulu-Natal; the eastern parts of Swaziland and southern Mozambique. Mozambique had the highest malaria transmission of the three countries, posing a threat to increased morbidity and mortality and economical development in the



region. To address this concern, the malaria control component of the LSDI was launched in 1999 by the Heads of State in the three respective countries and managed by the Medical Research Council (MRC) of South Africa.

The key strategies of the LSDI malaria control initiative include: IRS with an appropriate insecticide and treatment with effective combination therapy. These measures have been strengthened in all three collaborating countries through resource mobilisation. To date almost R350 million has been raised for implementing the control programme in the LSDI, most notably in Mozambique. The implementation of the programme is the responsibility of the Regional Control Commission which consists of a core group of public health experts from Mozambique, South Africa and Swaziland.

1.2 Achievements

Malaria incidence declined in South Africa: KwaZulu-Natal and Mpumalanga and Swaziland: Lubombo regions by approximately 99% in the year 2008 compared to the baseline of 2000. Furthermore, the prevalence of the disease has decreased by 92% in southern Mozambique, for the same comparative years. This model has proven to be successful in malaria control hence the SADC Ministers of Health have endorsed the LSDI as a model to be used in the Trans-Zambezi Malaria Control Initiative, involving: Angola, Botswana, Namibia, Zambia and Zimbabwe, as well as in the Trans-Kunene Initiative involving Angola; Namibia and Zimbabwe.

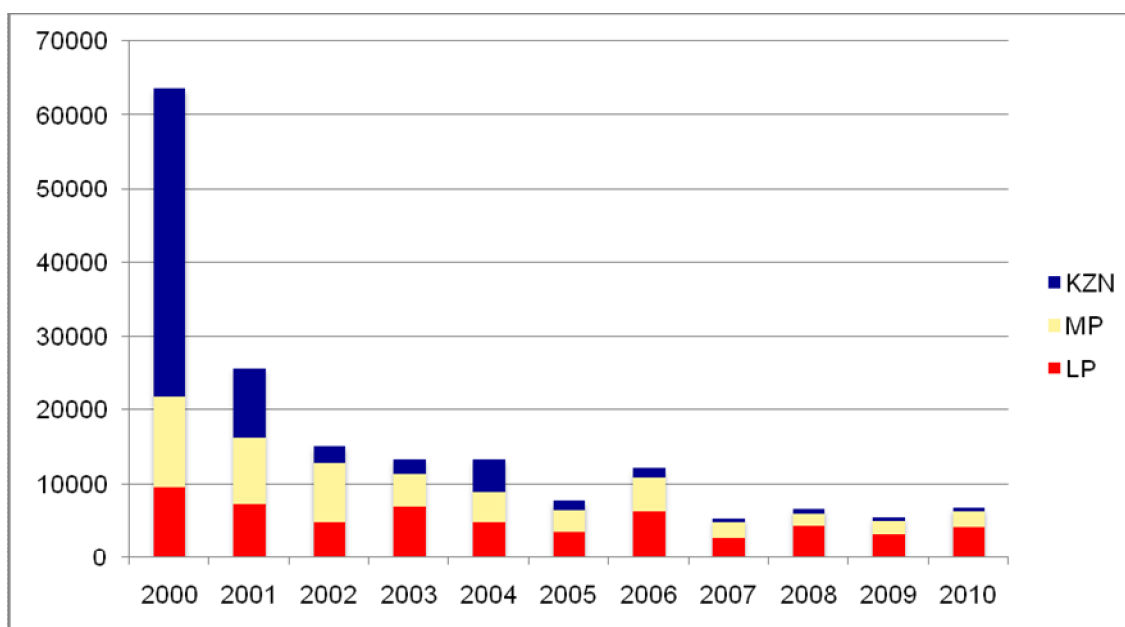
1.3 Challenges

The key challenge to sustaining the gains made from the LSDI is the need for a stable source of funding to implement the proven interventions (viz: IRS) and human resources to manage operations of the project. Since its inception, the LSDI has received funding that was temporary in nature. The LSDI was initially funded by the Business Trust of South Africa for a period of one year, and was able to demonstrate proof of concept. As a result of this, the project received funding from the Global Fund. This was initially for a period of five years and then another three years of funding. However, the funding from the Global Fund is nearing its end. The intention had been to integrate the LSDI Programme into the Government Malaria Programmes. Due to funding challenges at the Ministry of Health in Mozambique, the integration has not taken place. As a result of this, resources to implement the activities of the LSDI were not available and an upward trend in the incidence of the disease is currently being experienced in Maputo province (32% increase when

comparing January to June data for 2011 to that of the year 2010) in Mozambique, a similar pattern is being experienced in South Africa, see table 1 and figure 1 below and annexure A.

Districts	2009		2010		2011	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
Boane	3.827	3	5.186	1	14.811	3
Magude	2.715	1	2.971	3	8.354	11
Manhiça	17.621	10	11.021	8	23.611	5
Marracuene	3.929	2	3.261	1	3.789	0
Matuine	513	1	231	0	635	0
Moamba	1.091	4	2.511	4	7.977	3
Namaacha	565	0	446	0	1.265	2
C/Matola	21.785	7	14.214	5	26.532	0
Maputo Província Total	54.541	28	39.841	22	86.974	24

Cases and Deaths Comparison of malaria cases and deaths in Maputo province January to June



Malaria Cases in South Africa 2010-2011

The key concern as articulated by Professor Maharaj is the need to ensure that a malaria preventative intervention such as IRS is scaled up to 80% so that the gains on the LSDI can be sustained. In addition he suggested that, there is a need to identify mechanisms for sustaining the gains made by the LSDI in the medium to long term.

The meeting was therefore held to discuss scaling-up of IRS interventions in Mozambique and discussing options for sustaining long term gains.

2. Objectives of the meeting

Dr Abdul Mussa outlined the following key objectives of the meeting:

- Ensuring coverage of IRS in Maputo and Gaza to 80% for the coming malaria season;
- Sustaining the gains made on LSDI on case management and vector control;
- Identifying funding sources for filling gaps identified in sustaining the gains and
- drafting an action plan for sustaining short and long term gains on the LSDI



3. Key issues arising from the Discussion

3.1 Ensuring the IRS for Maputo and Gaza to 80% in the coming malaria season

A discussion was held by all participants to ascertain the gaps for scaling up IRS to 80% and options for mitigating these, to ensure that spraying will commence in September this year. Potential resources were identified for most of the activities for conducting the spray operations this year, however potential funding sources for payment of supervisory staff for IRS could not be identified, see annexure . The total estimated cost for this activity is 10.1 million Meticaais. This issue was later discussed with the Director of Public Health who acknowledged this challenge and undertook to address the issue by bringing it to the attention of his Minister for Health and engaging with partners to overcome this bottleneck.

4. Sustaining the Gains made on the LSDI on Case Management and Vector Control

Resources exists for funding malaria diagnosis and treatment for the coming year in Maputo and Gaza Provinces, however this funding needs to be sustained for the medium to long term. The Mozambican authorities have already integrated this activity into their routine programming. Sustaining Vector Control for the medium to long term will prove challenging especially if there is a salary differential between the Ministry of Health salaries and that for LSDI salary scales (ranging between 3 to 5 times more). The technical team recommended that all existing LSDI contracts be terminated and new contracts be instituted with Provincial Directorate of Health (DPS), the Director for the Malaria Programme undertook to address this issue. The Director for Public Health in Mozambique, suggested that a high level meeting between all 3 Ministers take place to review the progress on the LSDI and endorse recommendations by a technical team comprising of LSDI experts and existing partners in Mozambique. Alternative Vector Control methods will need to be explored for the medium to long term in Maputo and Gaza such as the use of ITNs.

5. Identifying funding sources for filling gaps identified in sustaining the gains and

As resources are limited in the Ministry of Health in Mozambique to absorb the activities of the LSDI, the team discussed potential funding sources. It was suggested that all existing partners be approached for supporting malaria prevention activities in Gaza and Maputo Province, a list of existing partners, comprising of the following was drawn up which included: WHO; UNICEF,



Malaria Consortium-DFID, President's Malaria Initiative (PMI) and Research Triangle International. It was agreed that a Partner Stakeholders Meeting be convened by the Ministry of Health in Mozambique, to secure short-term, medium term and long term support for malaria control in the LSDI and other malarious areas of Mozambique.

6. Action plan with proposed resource options for sustaining the gains on LSDI

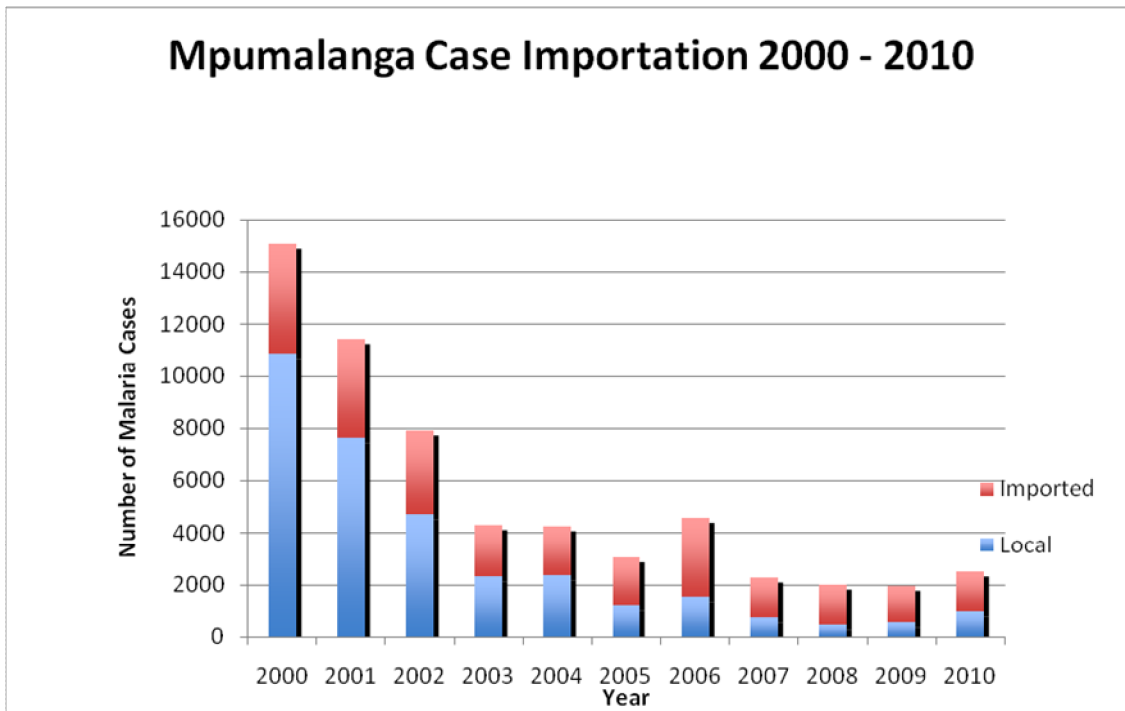
An action plan was drafted in parallel with the needs analysis that was undertaken, see actions annexure B.

7. Way forward;

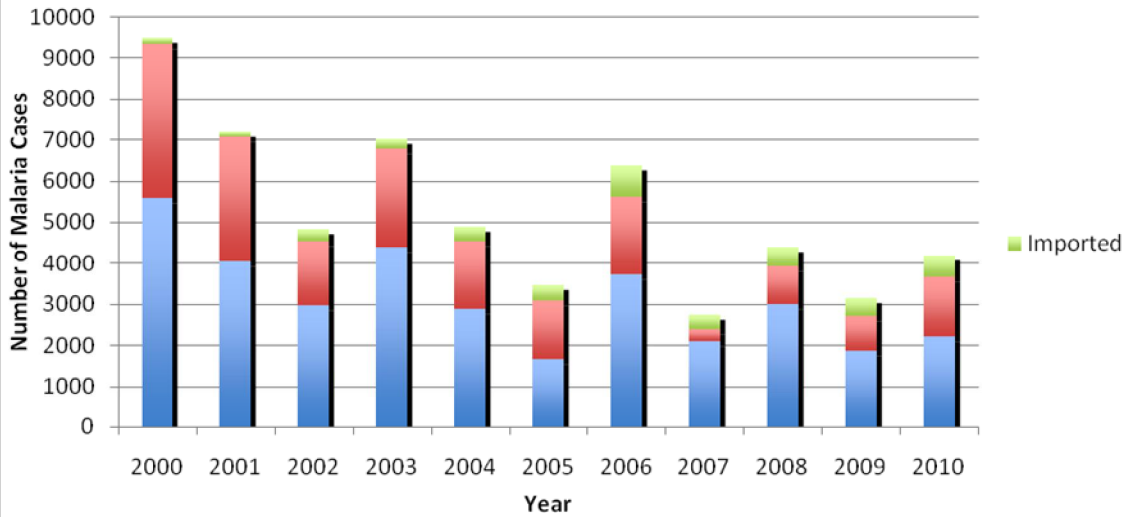
Dr Abdul Mussa thanked all participants for attending the meeting and supporting Mozambique in its efforts of sustaining gains on the LSDI. He undertook to fast-track the key activities indentified in the action plan and securing dates and invites for the Ministerial meeting. Emphasis was put on finalization of the action plan and the document for the LSDI health ministers.

Annexure A:

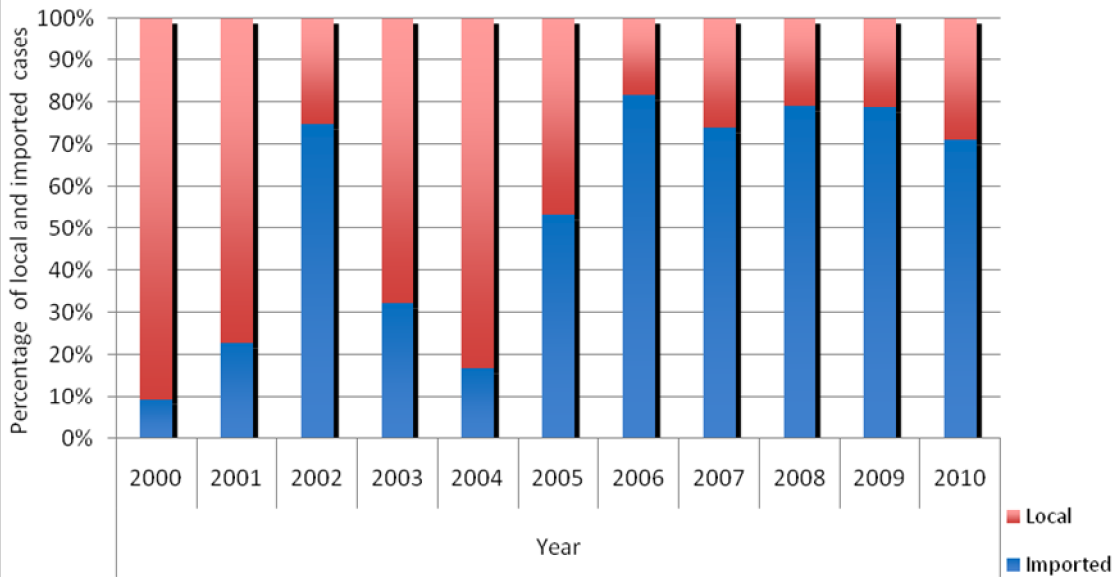
Malaria Case Importation South African Provinces



Limpopo Case Importation 2000 - 2010



KwaZulu-Natal 2000 - 2010 Malaria Case Importation Percentages





Annexure B. Needs Analysis for IRS and Action Plan for Short Term

Sustainability of LSDI Gains

Requirements	Current Situation	Need	Gap	Action
Insecticides	Insecticide Supplies Sufficient	No need	No gap	None
Equipment/ Personal Protection	All in place because of LSDI	No need	No gap	None
Vehicles	Vehicles exist from LSDI; alternative vehicles available from DPS	Maintenance of vehicles and fuel	Vehicle Maintenance and Fuel Estimated Cost: 3608930 Mts	Commit excess DFID funds from net distribution campaign to operational costs related to vehicles
HR Management Staff	Funding committed by BHP Billiton for 7 mos back pay; No funding committed for salaries beyond Sept. 2011	Salaries for Sept 2011- May 2012	At Govt Salary Level: 3,251,296 Mts for 8 months At LSDI Salary Level: 10,152,000 Mts for 8 months	Seek potential funding from various sources
HR Spray Operators	No funding available for salaries for Spray Operators	Salaries for 2011-2012 Spray Season	11,250,000 Mts for 2011-12 spray season (Gaza and Maputo Province only)	Commit excess DFID funds from net distribution campaign to salaries for spray operators
M & E	Lack of LSDI staff means no M&E mechanisms at national level	Support staff for M&E	1-2 employees at national level to monitor the output and impact of interventions	Engage partners to provide support staff for M&E