



**Report of the Joint SARN – PMI Mission to Zimbabwe carried out from  
10 to 20 April 2012**

**National Malaria Control Program, Ministry of Health  
Harare, Zimbabwe**

**SARN  
Gaborone, Botswana**



## 1.0 Background

The SARN Secretariat carries out assessment/support missions 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 Zimbabwe would be the first joint mission that 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. Thus a mission team made up of the SARN Focal Point and the Botswana Malaria Program Manager was organized for the joint SARN-PMI mission. The PMI team was made up of Members of the Malaria Operations Planning (MOP) from the USA and those based at the UASID in Harare, Zimbabwe.



**Group Photo taken at Kotwa Rural Health Centre**



## 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 and challenges.
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. For the PMI, the mission would help them in consolidating their MOP.
6. Follow up on cross-border initiatives and preparations for pre-elimination.
7. Develop a harmonized TA plan and action plan for follow up.

## 3.0 Method of work

The work schedule included courtesy calls to the Directors/Principal Directors, the Permanent Secretary (PS) and Deputy Minister of Health. Discussions with the following partners (DELIVER/JSI, PSI, National Institute of Health Research – NIHR, MCHIP, ZINQAP, WHO, Principal Recipient – UNDP, UNICEF, EU/DFID) were carried out at their offices, a field visit to Kotwa Hospital in Mudzi District followed by a debrief with the NMCP. The PMI-MOP team also briefed the USA Ambassador and the Directors of USAID and CDC. The SARN team concluded their mission by attending a presentation of the preliminary results of the MIS (currently being carried out) and debriefing the PS and Deputy Minister of Health. The Botswana Malaria Program Manager had time to discuss with her counterpart (the Zimbabwe Manager) on cross-border collaboration and peer learning exchange visits in agreed areas.

## 4.0 Main Outcomes

The main outcomes of the joint mission were:

1. **Program management:**
  - a. The program management is now strong.
  - b. HR Gap: – they require a Chief Field Officer (the retired officer has not been replaced due to the recruitment freeze by the GF), a Vector Control Assistant and an Elimination Coordinator for Matabeleland South province.
2. The PMI confirmed their pledge to provide USD 12 million in 2013
3. **Progress towards Malaria elimination:** Matabeleland South Province is preparing for a move towards pre-elimination. The program will shift from vector control to parasite control and targeted larviciding, Active Case Detection (ACD) – tracking (follow up) all RDT positive cases and confirmation by microscopy. Emphasis will be on parasite clearance and zero deaths. Malaria will be a notifiable disease as



outlined in the national policy. However, there were delays by the GF in releasing funds and also approval of the recruitment of the Elimination Coordinator.

4. **The M/E system** is weak especially in tracking and reporting of consumption data
5. **Delayed procurement and release of funds** by the PR including disregarding NMCP specifications in the purchase of commodities which has resulted in the purchase of wrong spray pumps and tents.
6. **Data management** at Kotwa Rural Health Centre is good but they require more equipment and also re-fresher course for the data management focal points.
7. **Case management:**
  - a. Have achieved universal access in ACTs.
  - b. Have a surplus of injectable quinine that expires in 2014.
  - c. Use of Artesunate suppositories in the <5 is now enshrined in the Malaria National Policy.
  - d. Funding partners are PMI, UNICEF and UNDP.
  - e. PMI and GF are both supporting case management training.
  - f. Community Case Management (CCM) is now done in all districts and they are going to present this as a best practice in Ethiopia during the Novartis meeting.
  - g. Malaria is now a notifiable disease and included in the national policy and guidelines.
  - h. They have 8 active drug monitoring sites (1 per province) and the NIHR is responsible – under Government and GF funding. The last monitoring was done in 2010 due to delays in GF disbursement.
  - i. NIHR has PCR capacity which is now fully functional and could support neighboring countries such as Botswana.
  - j. Pharmacovigilance is done by the MCAZ.
  - k. The threat of counterfeits is from Mozambique and this includes cross-border import of malaria.
  - l. Measures are being taken for private sector compliance.
  - m. IPTp is done in 30 districts only and they have adequate SP and have achieved universal coverage.
8. **Diagnosis**
  - a. They have switched from paracheck to 1<sup>st</sup> Response.
  - b. Currently they have a buffer of 300,000 kits.
  - c. Delays in supplies have been experienced due to failure by manufacturers.
  - d. All cases treated are RDT positive and microscopy is available at district and provincial levels. Microscopes, reagents and accessories are inadequate.
  - e. Active case detection (ACD) will be launched once R10 has been disbursed.



#### 9. IRS Gap:

- a. The GF is not providing IRS commodities in 2013 but will in 2014. The decision is highly questionable as it is likely to cause disruption of spraying activities and an increase in cases and deaths. These disruptions are a threat especially in insecticide resistance.
- b. Supply of the 2012 – 2013 DDT is likely to delay due to the on-going PR bottlenecks and GF delayed disbursement.
- c. Government of Zimbabwe does not have adequate funds to purchase equipment.
- d. PR procured wrong Tents (they supplied tents that are not waterproof) and wrong type of spray pumps. This disregard of specifications provided by the NMCP is not acceptable and causes inefficiencies in spraying and may lead to insecticide resistance.
- e. The PMI will implement IRS in Manicaland and Mashonaland East and West Provinces.
- f. There are 16 insectaries in the whole country i.e 2 sentinel sites in each of the 8 provinces where they do entomological surveillance. Tests are done with the support of RTI and the National Institute of Health research (NIHR): No resistance has been detected yet.
- g. IRS coverage in 2011-2012 season was 93% which resulted in coverage of 93% of the targeted population compared to 91% (89% of population) in 2010-2011 season.
- h. Targeted Larviciding is carried out however, they have challenges in training, use of volunteers, Larvicides are expensive and mapping of potential breeding sites.

#### 10. LLINs:

- a. There is a Gap of 449,059 nets (needed to reach universal access in 17 districts) which the PMI will fill by providing 500,000 nets.
- b. 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.
- c. In 2013 there is need for replacement of nets distributed in 2012 and the Gap will be verified.
- d. **Routine distribution Gap:** there are no nets for routine distribution in 2012.
- e. Due to low malaria prevalence, there is no net distribution in Matabeleland South Province. They use targeted IRS.

11. 2012 Roadmap: they have experienced uploading the USB Key – the SARN Focal Point supported them to finalize the roadmap.

12. The current Malaria Strategic Plan (MSP) runs from 2008 to 2013 and SARN will provide TA for an expert to support the MSP review in 2013.

13. The GF is not funding IRS in 2013 and the Government will provide funding however, the NMCP requested if the PMI and other partners could also provide additional support. For procurement of DDT and Pyrethroids and funds for spray operators and other operational costs. This is a flow in the GF planning which leaves a 2013 Gap.
14. The GF has now signed the disbursement of the Single Stream funding (R8 Phase 2 and R10 Phase 1) of USD 35.6 disbursement.
15. The Government of Zimbabwe is providing funds for malaria every year.
16. 2012 Malaria indicator Survey (MIS): the MIS will be finalized in May. Preliminary results were presented during a meeting attended by the SARN team. Early indications are showing a significant decrease in <5 malaria cases.
17. **PR Issue:** The issue of reverting to the MoHCW as PR or other PRs is being reviewed. Relations between the NMCP and the current PR (UNDP) have not been good.

## 5.0 Field Visit to Kotwa Rural Health Centre in Mudzi District (Cross-border district with Mozambique in North Eastern Zimbabwe)

At Kotwa Hospital the team interacted with participants attending case management and diagnosis and Community Based Health Workers (CBW) – Village Health Workers (VHW). They also interacted with the hospital health workers in different sections of the hospital. In the data section they were shown the database which the team agreed was well organized.



**Community Based health workers under training at Kotwa Rural Health Centre**



**RDT training**



**PMI Team**

## 6.0 Conclusions

The joint team concluded that:

- a. 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.
- b. Delays by the GF and PR in disbursement and provision of commodities are causing problems in relationship to the seasonality and disease pattern. This problem has persisted since the SARN 2011 mission.
- c. The IRS gap in 2013 (GF is not supplying IRS commodities in 2013) is not justifiable, the GF should have considered the impending consequences of shortages in IRS commodities that could derail the current gains and lead to a resurgence in cases and deaths.
- d. The inclusion of the Botswana Malaria Program Manager has allowed the two managers to discuss collaboration (cross-borders). The Botswana manager identified areas for peer learning visits.
- e. This first joint SARN-PMI mission should be used as a model for future missions as it provides consensus on identification of gaps/challenges and development of an action plan for TA and follow up.
- f. The NIHR is now fully equipped and has capacity to support other countries.
- g. For the PMI, this process provides confidence in the use of the OGAC funds (TAs) by SARN for supporting national programs.



**The Program managers briefing the joint team on progress**

**TA requirements and follow up plan**

<b>Activity</b>	<b>Responsible Organization (Follow up)</b>	<b>By who (Partner/organization providing TA/support)</b>	<b>Time Line</b>	<b>Comments (current status)</b>
Review of the Elimination Coordinator's TORs	GF	GF, RBM Secretariat, SARN Secretariat	25 April 2012	Finalized and approved by GF end of April 2012
Recruitment of Elimination Coordinator	NMCP	NMCP and PR	TBD	Dates being determined
Establishment of Elimination Coordinator in Matabeleland South Province	NMCP	NMCP, WHO-IST-ESA, SARN	TBD	To be done soon after recruitment: need for briefing the Matabeleland



				South Team
Signing of single stream funding (R8 Phase 2 and R10 Phase 1)	NMCP and SARN	GF	End of April 2012	GF and PR signed the Grant for USD 35.6 by end of April 2012
Peer learning visit to Botswana	NMCP	SARN	TBD	NMCP to provide dates and prepare a request to SARN
Supply of 500,000 LLINs to cover 17 districts	NMCP	PMI	June 2012	Arrangements in process
LLINs distribution	NMCP	PSI and Plan-Zimbabwe	July – Sept	To cover 17 districts
Procurement of 1.3 million nets	PR and NMCP	GF	Nov- Dec 2012	To cover 2013 gap – replacement of nets distributed in 2010
PROCUREMENT OF				
Gap analysis for replacement of 2010 nets	NMCP	PR	TBD	Distribution to be done: Mid – 2013
TA for 2013 MSP review	NMCP	SARN	TBD	To be processed once request has been made
Reversal of the PR status	NMCP	RBM secretariat to lobby with the GF for a favorable result.	On-going	SARN has requested RBM secretariat to follow up