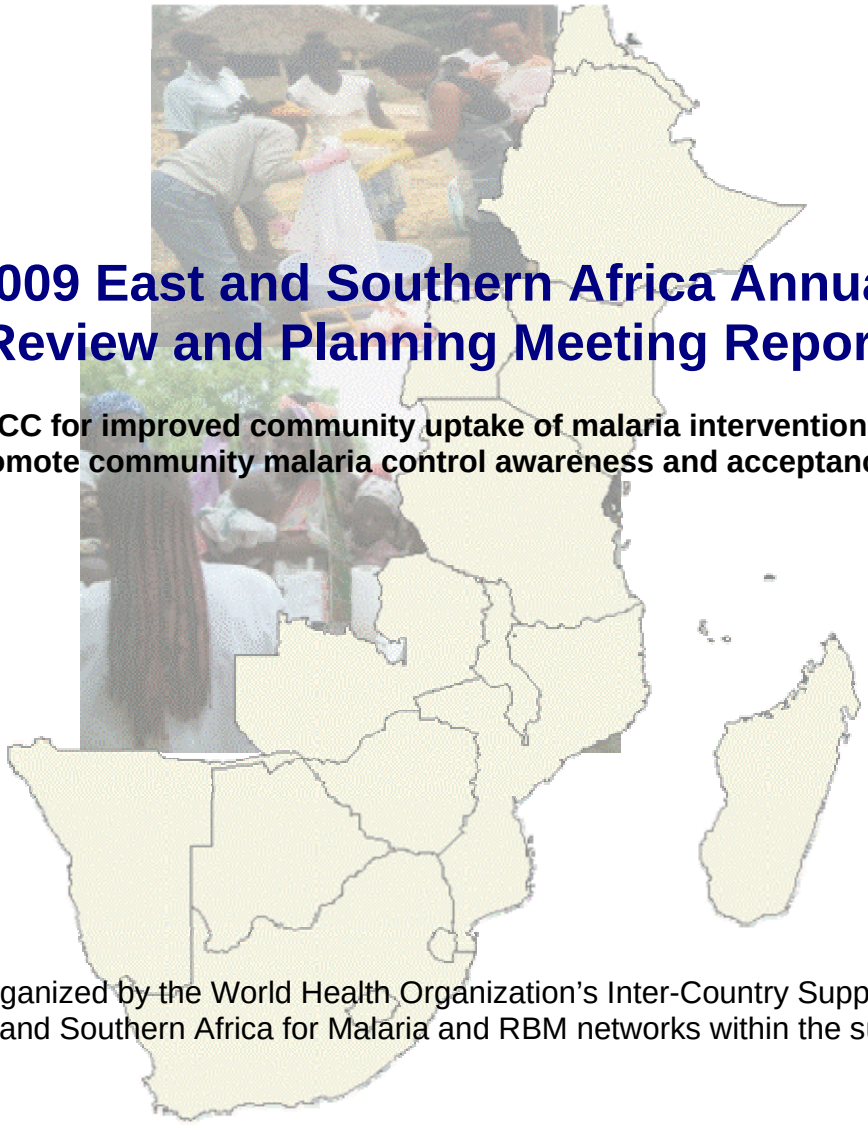
World Health Organization

REGIONAL OFFICE FOR Africa



# 2009 East and Southern Africa Annual Review and Planning Meeting Report

**BCC for improved community uptake of malaria interventions**"
**"Promote community malaria control awareness and acceptance"**".

Jointly organized by the World Health Organization's Inter-Country Support Team for East and Southern Africa for Malaria and RBM networks within the subregion

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## Acronyms

| | |
|---|---|
| **ACT** | Artemisinin-based combination therapy |
| **AFRO** | WHO Regional Office for Africa |
| **AL** | Artemether-lumefantrine |
| **AQ** | Amodiaquine |
| **ARPM** | Annual Review and Planning Meeting |
| **BCC** | Behaviour Change Communications |
| **CHA** | Community Health Agent |
| **DDT** | Dichloro-diphenyl-trichloroethane |
| **DHS** | Demographic Health Survey |
| **EARN** | Roll Back Malaria East Africa Regional Network |
| **EMRO** | WHO Regional Office for the Eastern Mediterranean |
| **GFATM** | The Global Fund to Fight AIDS, Tuberculosis and Malaria |
| **GMP** | Global Malaria Programme |
| **HPR** | Health Promotion |
| **IEC** | Information Education Communication |
| **IPT** | Intermittent preventive treatment |
| **IRS** | Indoor Residual Spraying |
| **IST-ESA** | World Health Organization Inter-Country Support Team for East and Southern Africa |
| **ITN** | Insecticide Treated Net |
| **JICA** | Japan International Cooperation Agency |
| **LFA** | Local Funding Agent |
| **LLIN** | Long-lasting insecticidal nets |
| **M&E** | Monitoring and Evaluation |
| **MDG** | Millenium Development Goals |
| **MIS** | Malaria Indicator Survey |
| **MMV** | Medicines for Malaria Venture |
| **MOH** | Ministry of Health |
| **MPR** | Malaria Programme Review |
| **NMCC** | National Malaria Control Centre |
| **NMCP** | National Malaria Control Programme |
| **PMI** | United States of America President Malaria Initiative |
| **PSI** | Population Services International |
| **QA** | Quality Assurance |
| **QC** | Quality Control |
| **RBM** | Roll Back Malaria |
| **RDT** | Rapid Diagnostic Test |
| **SADC** | Southern Africa Development Community |
| **SARN** | Roll Back Malaria Southern Africa Regional Network |
| **SPR** | Slide Positivity Rate |

| | |
|---|---|
| **TWG** | Technical Working Group |
| **UN** | United Nations |
| **UNICEF** | The United Nations Children's Fund |
| **WB** | World Bank |
| **WHO** | World Health Organization |

## Executive Summary

The 2009 Malaria Annual Review and Planning Meeting was held at Safari Hotel in Windhoek, Namibia on 6-10 July 2009. The meeting was attended by 178 participants from 21 countries in the WHO AFRO and EMRO regions and representatives from global and regional partnerships. The main objectives of the meeting were to review country achievements in implementing 2008/9 plans, to identify bottlenecks that slow community uptake of the primary interventions and to develop country roadmaps towards achieving the RBM 2010 targets. The theme of the meeting was **BCC for improved community uptake of malaria interventions**" with the slogan –**"-Promote community malaria control awareness and acceptance**." Presentations and group work that were followed by discussions were the methods of work.

The Deputy Minister of Health in Namibia opened the meeting. Opening remarks were followed by a key presentation by Professor Ki-Zerbo, the AFRO Regional Malaria Manager, who highlighted the WHO/AFRO orientations on malaria elimination and on achievements some countries in the region have made towards the RBM 2010 targets. The IST/MAL presented technical updates on program management, case management and vector control. Highlights in the presentations included the need for countries to conduct malaria program performance reviews, need for parasitological confirmations of all suspected malaria cases before treatment, and combination of IRS and LLINs were possible for optimum impact.

EARN and SARN focal points made presentations on progress countries in their respective sub-regions made in implementing GFATM and the 2008/9 plans. All countries have intensified interventions and some countries especially in SARN reported declining trends in malaria burden. Following two presentations on evidence of disparity between interventions delivery and community utilization and on health promotion interventions required for behaviour change, countries went into group work to identify bottlenecks that hinder intervention absorption by the community. The major challenges identified included low capacity and inadequate resources for IEC/BCC, low country prioritization of IEC/BCC, inadequate involvement of target groups in developing and implementing the messages and inadequate involvement of all stakeholders in IEC/BCC. Proposed solutions to address these challenges included increasing the partner base to assist in implementation, more involvement of stakeholders, use of innovative communication channels and multi-channels of communication in different target groups and engagement of leaders and inter-sectoral collaboration.

During the second group work, countries produced 17 month country roadmaps which contained the main activities by month leading to universal coverage targets by 31/12/2010, summaries of available resources and commodities and schedules of distribution over the next 17 months. Countries also identified technical support needs from WHO/IST/MAL and partners.

The conference achieved all the objectives and made recommendations that were directed to countries to implement their roadmaps and to WHO/IST/MAL and partners to provide assistance in the implementation of the roadmaps.

**REPORT ON THE EAST AND SOUTHERN AFRICA ANNUAL MALARIA REVIEW AND PLANNIG MEETING; 6 - 9 JULY 2009: SAFARI HOTEL, WINDHOEK, NAMIBIA**

## Introduction

The 2009 Annual Review and Planning Meeting (ARPM) was held at Safari Hotel in Windhoek, Namibia on 6-10 July 2009. The annual Malaria review and planning meetings (ARPM) are convened each year. In addition to reviewing program achievements of the previous year and planning for the next year, the meetings also provide an opportunity for countries to jointly discuss cross cutting malaria control challenges. Crucial among the current challenges is the suboptimal uptake of available malaria prevention and treatment interventions. Anecdotal evidence strongly suggests that the observed low uptake of interventions is a result of limited malaria IEC/BCC activities which have not matched the scaling up of interventions. For example, LLIN utilization remains well below the possession rates, few women are able to respond appropriately to fever episodes and IRS coverage remains below acceptable levels in some countries. As a consequence, the 2009 ARPM was convened to identify key bottlenecks to low community uptake of the interventions. The 2009 theme was "**BCC for improved community uptake of malaria interventions**" with the slogan –**"- Promote community malaria control awareness and acceptance"**".

### Objectives of the ARPM

- To provide a forum for review country progress, strategic orientations and technical updates
- To identify major bottlenecks and solutions for achieving 2010 country targets
- To develop a roadmap to achieve 2010 targets
- To provide a forum for partners' contributions to the roadmap

### Expected outcomes of the ARPM

- Country programme implementation progress towards 2010 targets reviewed;
- Current and potential bottlenecks that could impact achievement of the targets identified;
- Solutions (including any technical or other support needs) to overcome bottlenecks that impede achievement of targets identified;
- A roadmap to achieving the 2010 targets developed per country;
- Support needs partners will provide to countries outlined;

### Methodology

Plenary presentations that were followed by interactive discussions formed one method of work. Countries and partners also went into groups with a team of facilitators drawn from the ESA IST and other partners to clarify country level implementation and to identify the major bottlenecks and solutions for implementing health promotion in malaria programmes. Group work was presented and discussed in plenary.

**Participants:**

About 178 participants mainly from 21 countries in the AFRO and EMRO sub-regions attended the meeting. Each country was represented by at least 5 participants who included the Malaria Programme Manager, the IEC/BCC and vector control Focal Points, the GFATM country Principal Recipients and the malaria NPOs. There were also representatives of partners from both the SARN and EARN. The detailed list of participants and the meeting agenda is shown in Annex 3.

**Opening Ceremony**

During the official opening remarks were made by Mr Sianga, the Director of SADC Health desk, who emphasized the importance of the meeting in guiding the SADC Member States to attain the set RBM targets, which is key if the economic and development agendas are to be realized. Dr James Banda, RBM Partnership representative, emphasized the need for the meeting to ensure that countries come up with roadmaps for achieving the 2010 targets. Dr Magda Robalo, WHO Representative in Namibia was represented Dr Desta Tiruneh who expressed his appreciation to the host of this meeting and gave a brief description of declining malaria burden in the region and in Namibia.

The Deputy Minister of Health and Social Services, Namibia, Dr Getrina Keigura, opened the meeting. She thanked the organizers of the meeting for choosing Namibia as the venue for the 2009 ARPM. She noted that some countries in the sub-region are achieving malaria control while others are moving towards pre-elimination/ elimination which is now the goal that has been set for the next 10 years in some countries. She also highlighted on the SADC draft plan on elimination that was adopted by the SADC Ministers of Health in Maputo in 2009. This meeting was therefore important in that it sought to identify the bottlenecks and their solutions towards achieving the 2010 RBM targets. She then officially opened the meeting.

**Meeting Proceedings**

The meeting started with presentation of workshop methodology which outlined the organization of the meeting and the days on which each of the objectives will be dealt with. This was followed by a review on the last ARPM 2008 recommendations which showed that most recommendations were achieved.

## Objective 1: To provide a forum for review country progress, strategic orientations and technical updates

The session started with a key note address from Dr Georges Ki-Zerbo, the Programme Manager of Malaria in AFRO, on a presentation entitled: "A**ccelerated malaria control towards elimination in the African region".** This presentation highlighted the burden of malaria in AFRO sub-region, commitments by the Global community towards its' control and /or elimination, description of current anti malaria interventions. He gave some examples of countries in the sub-region where dramatic reductions in burden of malaria are reported where these interventions are well applied and outlined priority actions to be considered for implementation by National Programs. The next presentation was on the Malaria Program Performance Review (MPR) by Mr Gausi who outlined the rationale for conducting an MPR, types and scope, objectives, processes and outputs. He went on to share the main lessons learnt in Kenya were this review was conducted and the future plans to conduct the reviews in both Botswana and South Africa. Dr Charles Paluku presented on **Steps Towards Malaria Elimination.** In his presentation he emphasized on the major stages in the elimination continuum and the major activities in each of these stages. The next presentation was made by Dr John Govere who emphasized on the need for countries to scale up LLINs and / or IRS to achieve universal coverage by 2010. The presentation also gave considerations for combining LLINs and IRS in the context of IVM where and when appropriate for optimal and rapid impact,

On malaria case management, Dr J Namboze, emphasized on Parasitological confirmation (microscopy or RDT) for all cases of suspected malaria before treatment with the Artemisinin-based combination therapies (ACTs) which are the treatments recommended for all cases of uncomplicated falciparum malaria including in infants, people living with HIV/AIDS, pregnant women in the 2nd and 3rd trimesters and for home-based management of malaria. In addition, specific updates on recommendations use of rectal artesunates as part of HMM programmes was also provided. A presentation by Mr S Katikiti on Surveillance, Monitoring and Evaluation highlighted "Recommended Indicators Measured by Routine Information Systems" which include indicators for impact, quality of surveillance, completeness of reporting and logistics.

### Key issues discussed on technical updates

- The denominators of indicators on malaria elimination continuum (<5% slide positivity rate in fever cases, <1 case/1000 population at risk, 0 locally acquired cases) were unclear and the validity of some indicators such as percentage of pregnant women receiving ITNs, and number of ACTs distributed were also unclear.
- There were issues on the proven evidence on added value /effectiveness of combining LLINs and IRS in the context of Integrated Vector Management.
- The steps in elimination continuum are clear but ending point is not clear
- Duration on each process/phases of Malaria Programme review was unclear to some participants

**EARN and SARN Country 2008/2009 Progress:**

**Presentation** was done in two phases, first by the RBM network coordinators (EARN and SARN) and second through a peer review of 3-4 countries together. **RBM networks**:Mrs Lebogang Lebese the acting SARN Partnership Coordinator and Mr Peter Mbabazi the EARN partnership coordinator presented respectively on behalf of represented countries the performance update by network. Their presentation focused on each country briefs on GFATM total grants versus amount disbursed and the ratings of grant by rounds; the number of ITNs distributed versus Universal Coverage, ITN Ownership vs Utilization ,main challenges, solutions and the way forward.

**Key Issues from the EARN and SARN on Country progress**

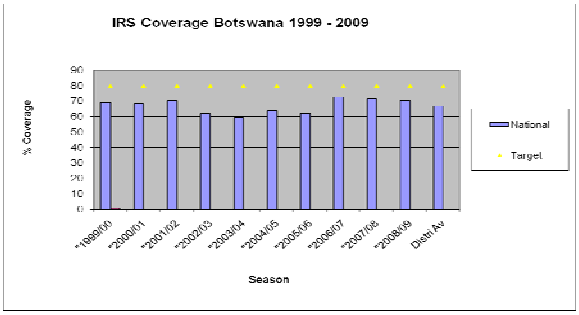
- There are bottlenecks in the disbursements of GFATM grants disrupting program planning and implementation
- There is incomplete data due to weak surveillance systems in some countries
- There is low utilization of some interventions such as LLIns
- Some indicators are unrealistic making it difficulty to achieve them
- There continues to be increased morbidity and mortality trends in some countries

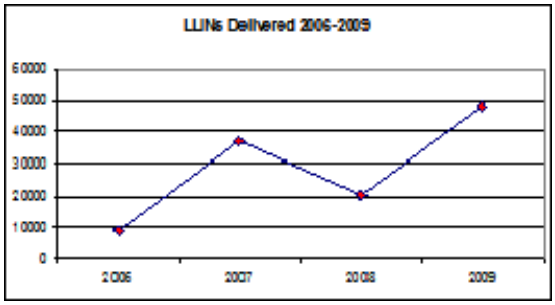
**Peer Group Review**

Peer group review country presentation and discussions focused on trends on IRS coverage, ITN distribution, ACTs and RDTs distribution and morbidity and highlighting main challenges on how to overcome them.

The main achievements by country are described in the figures and comments below:

**Botswana**




There is an observed decline in malaria incidence, deaths and epidemics in all malaria risk zones of Botswana and improving coverage of interventions. The following challenges were identified for achieving 2010 targets: over reliance on clinical diagnosis, lack of baseline data (parasite prevalence ratios etc.); cross border population movement and inadequate resources mainly human at district level. The proposed solutions included: strengthen malaria parasitological diagnosis, conduct malaria parasite prevalence study, retrospective desk review to ascertain slide positivity rate, facilitate cross-border collaboration with Namibia, Zimbabwe and South Africa and advocate for more resources.

## Comoros

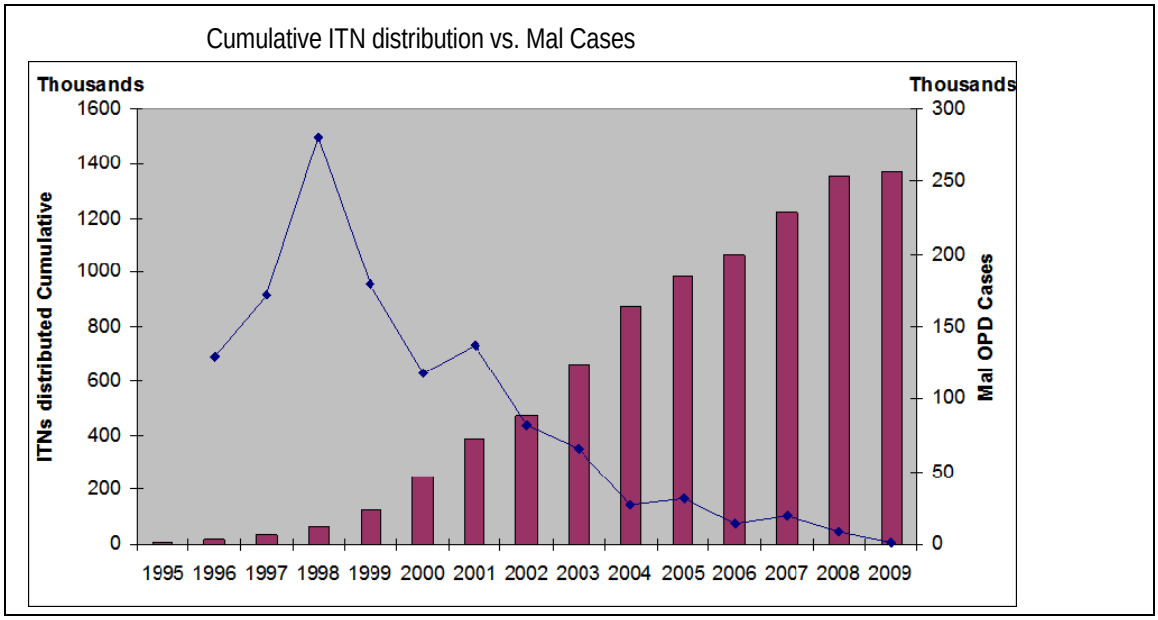
| | 2008 | | 2009 | | 2010 | |
|---|---|---|---|---|---|---|
| | TARGET | ACHIEVED | TARGET | ACHIEVED | TARGET | POSSIBLE |
| LLIN | 0 | 0 | [illegible] | 22% ([illegible]) | 100% (2733992/2733997) | 100% (2733992/2733997) |
| IRS | 0 | 0 | [illegible] | [illegible] | 7% | 7% |
| ACT | 60% | 39% | [illegible] | [illegible] | 100% | 100% |
| DIAGNOSTICS | 80% | 20% | [illegible] | [illegible] | 80% | 60% |
| IEC | 80% | 30% | [illegible] | [illegible] | 90% | 80% |

**Gestion des cas**

| | 2006 | 2007 | 2008 |
|---|---|---|---|
| Cas | 74422 | 73096 | 66396 |
| ACT | 76000 | 104640 | 193050 |

There is a progressive scaling up of interventions in Comoros with a slight declining trend in malaria ceases and deaths. Challenges identified for achieving 2010 targets are: the slow pace on scaling up interventions , inadequate resources and non performing malaria surveillance system. The country is envisaging to expand free services delivery as one of the solutions for scaling up.

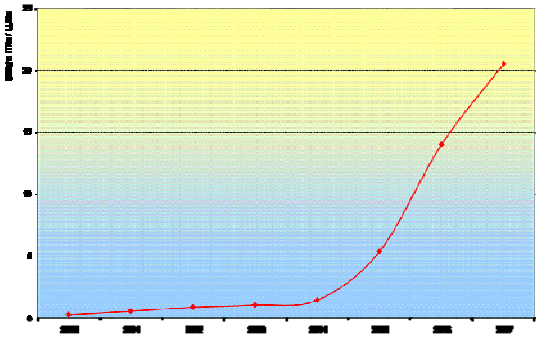
## Eritrea




Malaria morbidity and mortality In Eritrea has gone significantly down due to high IRS and ITNs coverage, and introduction of ACTs as first line drug, improvement in early diagnosis and timely case management and high levels of community awareness and participation for environmental vector control. The following challenges were identified for achieving 2010 targets. The challenges related to sustainability of the achievements and of community based interventions and support for CHAs and cross-border malaria concerns.

## Ethiopia

Rapid Scale-up of LLINs



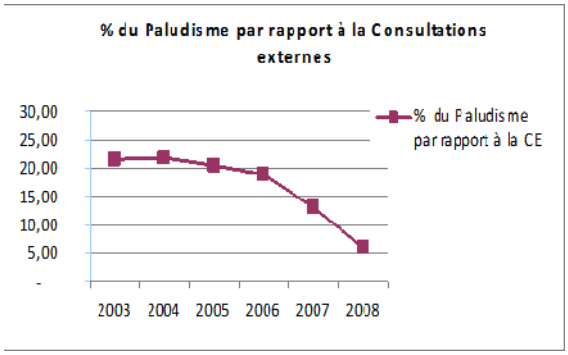
Trends in Malaria Morbidty and Mortality

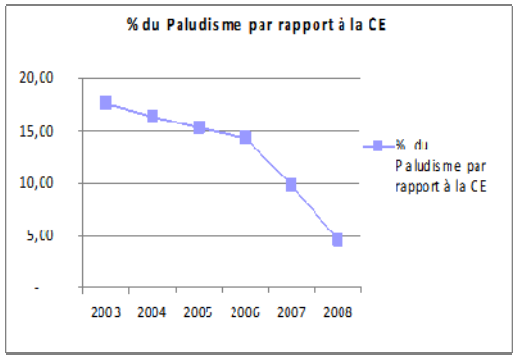
| Age | admission | Death | OPD malaria | OPD malaria -confirmed | Slide positivity rate |
|---|---|---|---|---|---|
| ≥ 5 years | -55% | -34% | -48% | -70% | --- |
| < 5 years | -52% | -56% | -47% | -61% | --- |
| **All ages** | **-54%** | **-55%** | **-48%** | **-67%** | **-38%** |

Compared: Mean 2001 –2004 as baseline Vs 2007 data

The burden of malaria morbidity and mortality decreased significantly over the last three years in Ethiopia and number of malaria epidemic affected villages / epidemic dropped down to zero. The health extension program has accelerated expansion of primary health service coverage towards universal health service coverage. 21.5 million LLINs have been distributed to beneficiaries since 2005, 65.5 % coverage at least one ITN per household. Only 30% of household were sprayed from the targeted areas. More than 6 million doses of coartem were procured and distributed annually for the last 2 years. The following challenges were identified for achieving 2010 targets: sustaining the distribution and coverage of the ITNs, high price of coartem in the Private Sector, low IEC/BCC at Community level and logistic and supply issues and inadequate human resources.

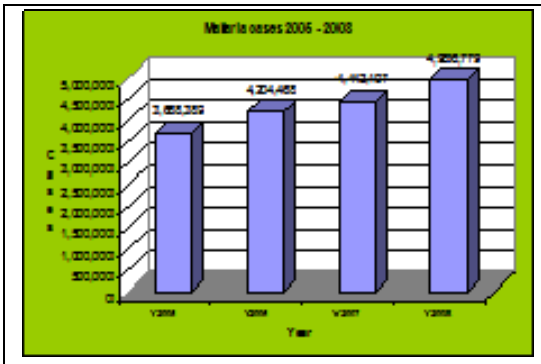
## Madagascar

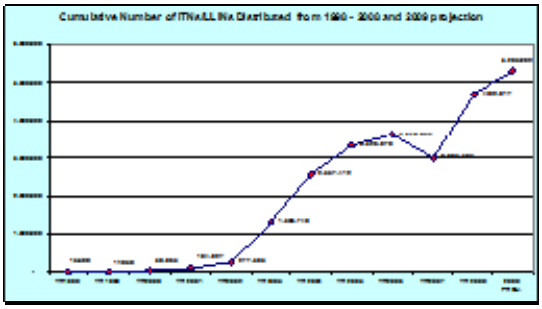



Madagascar has observed a decline in malaria cases and deaths over the years and a good coverage of interventions. The following challenges were identified for achieving 2010 targets: inadequate affordable and good quality ACTs, inadequate scaling up of malaria home management, inadequate expansion service delivery of free nets distribution and inadequate health system strengthening.

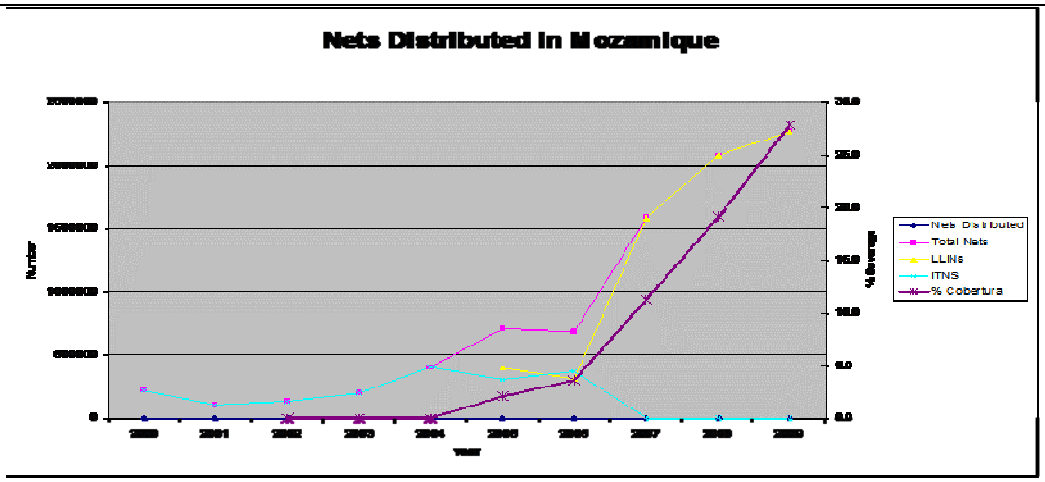
**Malawi**




There are no significant changes in the malaria cases and deaths trend in Malawi. The process of scaling up malaria interventions is on going. The following challenges were identified for achieving 2010 targets: non availability of AL at community level, low utilization rate of ITNs, limited capacity for malaria diagnosis and low coverage of second dose of IPTp.

**Mozambique**

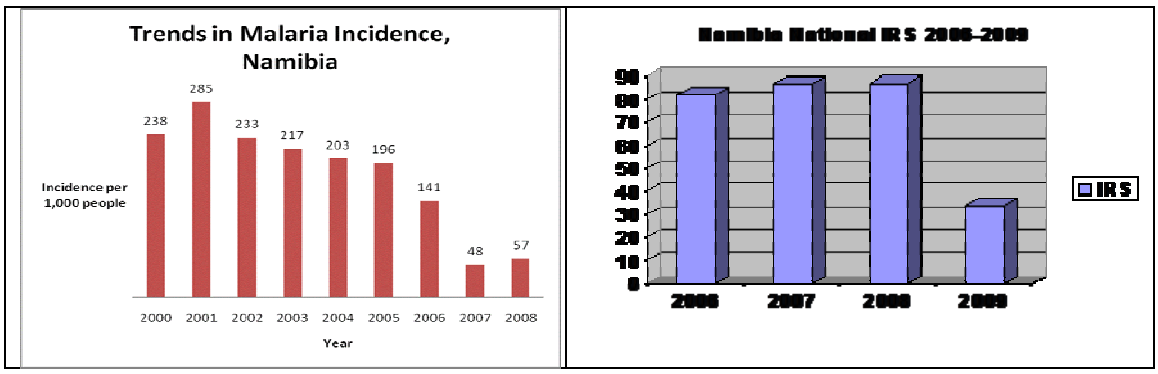



**Target**

| 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|
| 2,800,000 | 3,600,000 | 2,260,750 | 7,539,764 |

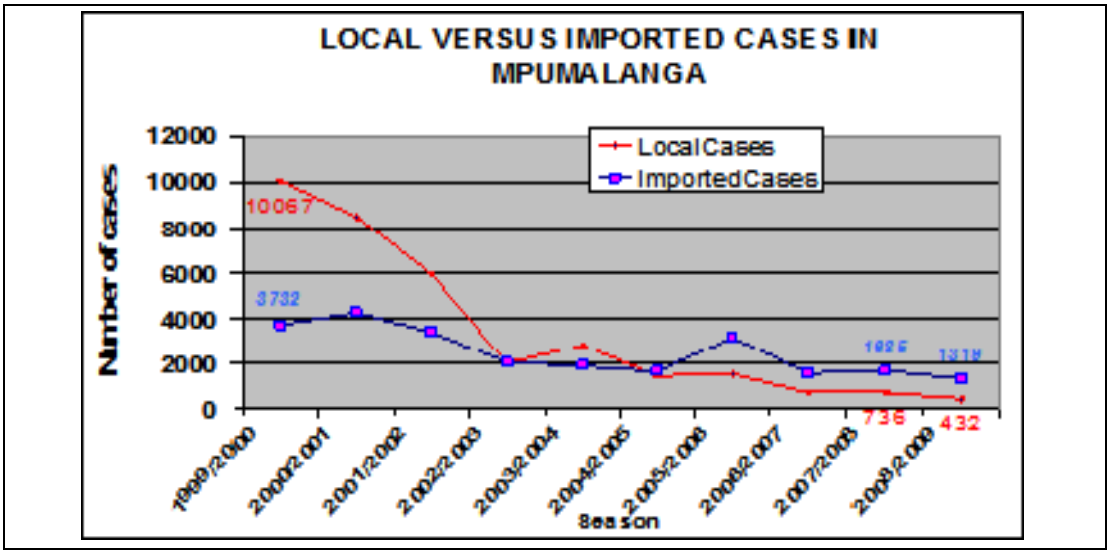
2008 has shown a slight drop on malaria cases and deaths in Mozambique as the coverage of interventions are improving over the years.

## Namibia



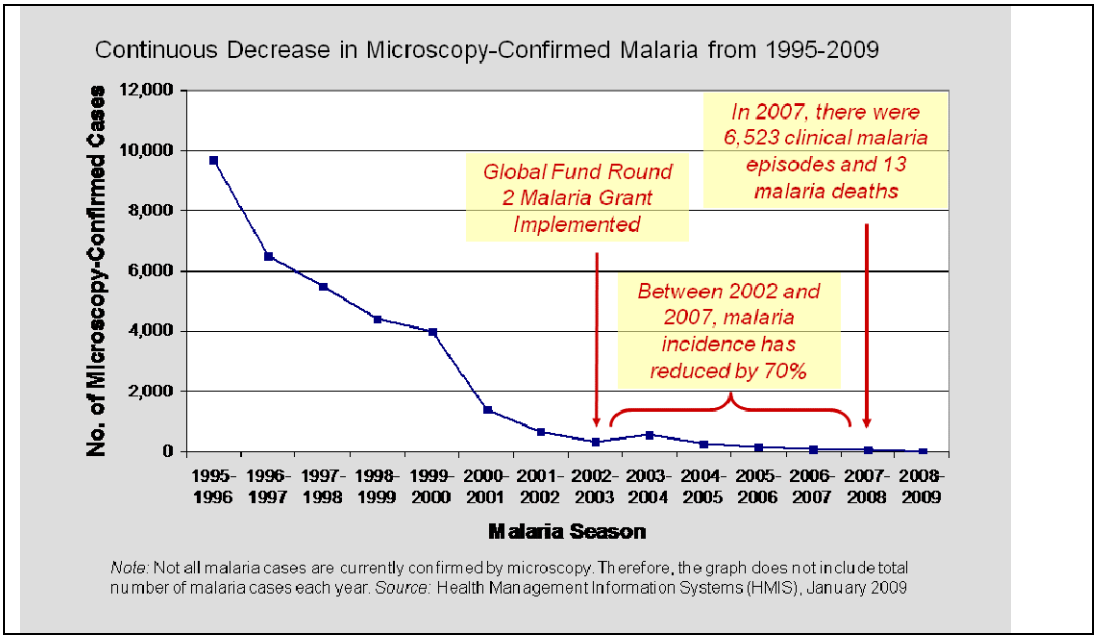

There is a consistent decline in malaria morbidity and mortality in Namibia and a consistent high coverage of IRS and an improvement on LLINs coverage. All health facilities have available ACTs and RDTs. The following challenges were identified for achieving 2010 targets: unavailability of funds to support the regions (buffer stock), lack of transport at regional and districts level hampering the malaria activities, shortage of skilled human resources at regional and districts levels, few partners to support malaria control in the country, inadequate reporting of confirmed cases and statistic of malaria cases from private HF.

## South Africa



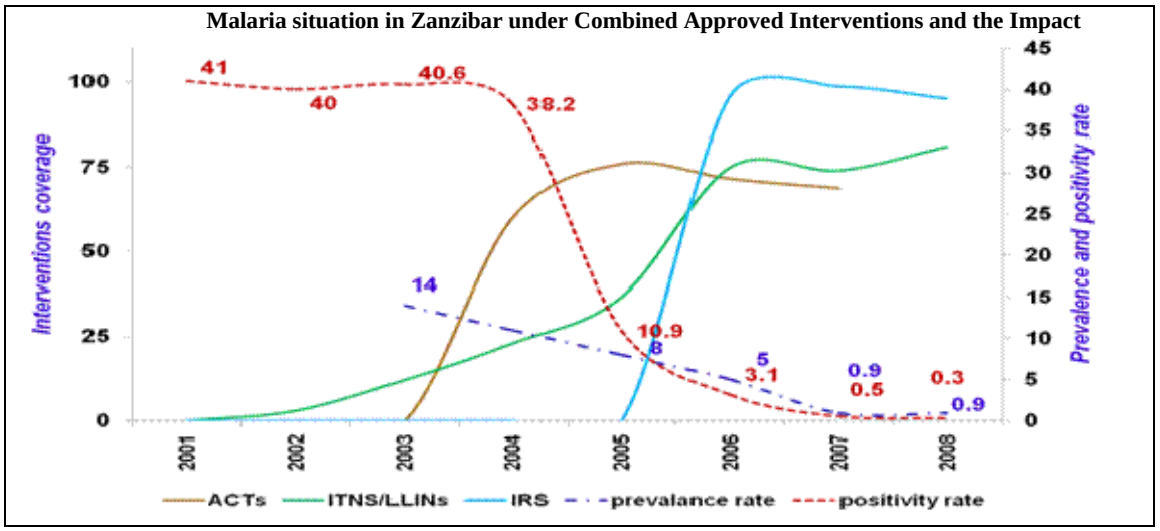

Between 2000 & 2008, mortality has been reduced by 96% and morbidity by 88% in South Africa. The coverage for IRS has been sustained at more than 85% for the past few years Malaria diagnosis and treatment is free of charge at all levels of public health care facilities in malaria areas. Malaria diagnosis in South Africa is definite by either RDT or microscopy before treatment is administered.

**Swaziland**




The trend of malaria cases and deaths is declining in Swaziland over the years. The coverage for IRS has been sustained at more than 90% for the past few years and LLINs are been introduced as a supplementary vector control intervention. Swaziland has just adopted the use of ACT for malaria treatment.

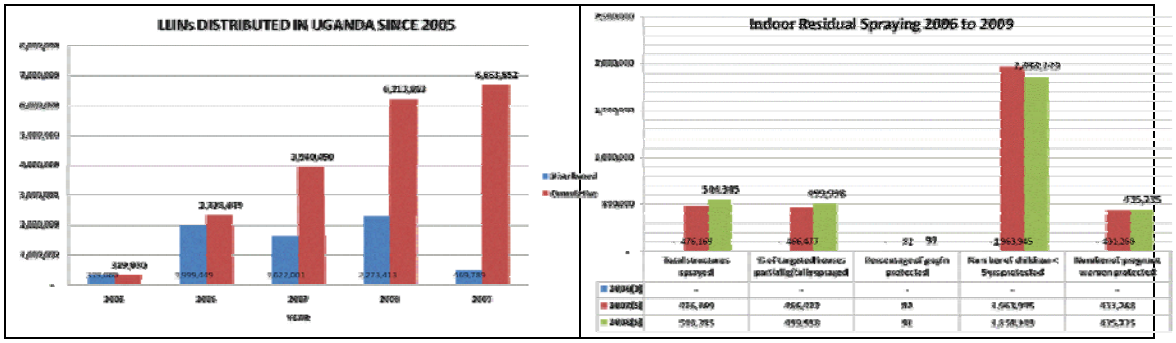
**Tanzania Zanzibar**




Since scaling up of combined approved interventions malaria prevalence and SPR have gone drastically down in Zanzibar. Meanwhile some challenges remained such as inconsistence prescription of antimalaria, mono-therapy is still being used for confirmed and suspected malaria cases mainly at private health facilities, shortage of Laboratory

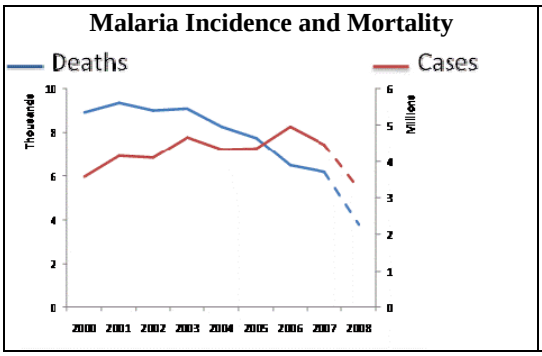
Technicians in some of the public health facilities, LLINs distribution: remaining with 4 districts, IRS sustainability to continue with universal spraying, Behavioral change of the community and health workers, clinical treatment and delaying of funds

**Uganda**




Uganda is experiencing a lot of challenges such as irregular funding to support procurement of malaria commodities such as ACTs and RDTs, suspension and delayed resumption of the GF funding disrupting implementation of key interventions and achievement of the MDGs, Abuja targets and GMP of elimination by 2015 as shown on the table above, weak health systems, weak HMIS including facility and community surveillance, unexpected litigations by environmentalists on DDT use for malaria control and fragmented implementation of key interventions. Amidst all these challenges, Uganda as a country has registered some successes in malaria control. The country has also learnt some lessons that integrated strategies can eliminate malaria. Therefore, with a revised National Malaria Control Policy, continued support from government (investment in local factory for manufacture of ACTs) and partners (RBM,WHO, PMI, JICA, UNICEF, JUMP,UMSP,Malaria Consortium, PACE (PSI), Malaria No More, stop Malaria Project, Pilgrim and others) the country looks forward to ultimate elimination of malaria from its midst.

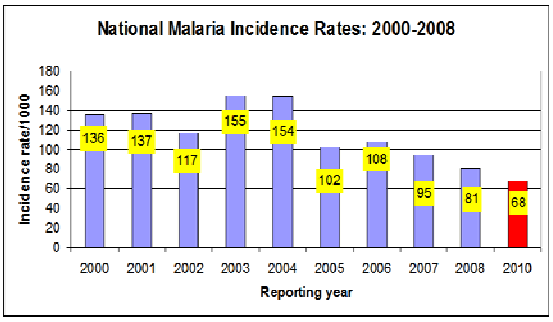
**Zambia**




| | 2008 | | 2009 | | 2010 | |
|---|---|---|---|---|---|---|
| | Target | Achieved | Target | Achieved | Target | Possible |
| LLIN – D | 2,303,823 | 1,188,443 | 4,592,039 | 3,244,082 | 2,686,462 | 1,608,000 |
| IRS | 1,149,599 | 1,093,682 | 1,650,000 | 1,640,000 | 1,800,000 | 1,799,000 |
| ACT | 4,000,000 | 3,142,405 | 3,800,000 | 3,800,000 | 3,700,000 | 3,500,000 |
| Diagnostic | 3,000,000 | 2,015,500 | 2,500,000 | 3,000,000 | 4,000,000 | 4,000,000 |
| MIP | 80% | 66% | 80% | 70% | 80% | 80% |

Rapid increase of coverage of interventions, coordinated partnership buying into one plan and a strong IEC/BCC using various channels has contributed to current observed impact in Zambia (30% reduction in mortality over one year). But challenges for achieving 2010 targets include limited access to health care and delayed disbursement of funds.

## Zimbabwe




Target and Progress

| | 2008 | | 2009 | | 2010 | |
|---|---|---|---|---|---|---|
| | Target | Achieved | Target | Achieved | Target | Possible |
| LLIN | 920,587 | 220,000 | 1,371,248 | 300,657 | 1,909,575 | Yes/If |
| IRS | 325,962 | 322,618 | 958,682 | 429,921 | 974,664 | Yes/If |
| ACT | 1,094,167 | 1,000,000 | 1,132,457 | | 792,247 | |
| Diagnostics | 2,125,336 | | 4,609,947 | | 3,391,995 | |
| IEC | | | | | | |

Zimbabwe has sustained IRS coverage at more than 80% for the past few years. The trend on malaria morbidity and mortality is going down. Extremely high staff attrition, delays in disbursements of funds from GF, inadequate transport at implementation level and poor communication system remain challenges for achieving 2010 targets in Zimbabwe.

## Objective 2: To identify major bottlenecks and solutions for achieving 2010 country targets

As a way of introduction, two presentations by Ms Labese Lebong and Mr P Mbabazi on behalf of the SARN and EARN countries, respectively, were made. The two presentations focused on status on GF grants, each country's performance on the key interventions and the malaria burden. The country profiles are shown in Annex 2. After discussing the presentations countries were divided into groups with countries sharing similar burden for malaria grouped together to identify bottlenecks that will need to be addressed if RBM 2010 targets are to be achieved.

The above presentations were followed by brief presentations on the key malaria interventions (case management and vector control) highlighting the evidence of low utilization of these interventions in some countries. The low uptake was attributed to inadequate IEC/BCC programs. Since this was the focus of the ARPM, a key presentation by Dr Cossa **"community-based health promotion interventions for malaria prevention and control"** was made. The presentation was intended to assist countries to identify in group work bottlenecks that need to be addressed if RBM 2010 targets are to be achieved. The presentation outlined principles for an effective IEC/BCC strategy. The main principles included participation of stakeholders, empowering individuals and communities, use of a variety of IEC/BCC approaches and stakeholders.

The presentation also gave the key health promotion **(**HPR) interventions used to achieve the required behaviour change. These included the following:.

a) Develop Individual/Family/Community knowledge on malaria prevention and control. Main methods used is health education, IEC campaigns, participatory methods
b) Develop Individual/Family/Community skills by using BCC, participatory methods
c) Develop Health Workers skills using technical capacity building
d) Promote the use of ITN/LLIN by using community social mobilization campaigns
e) Promote Intermittent preventive treatment in Pregnancy by using interpersonal communication, door-to-door campaign
f) Promote Motivation for Behaviour Change by values clarification, participatory methods
g) Advocacy by lobbying, negotiation
h) Promote IRS by lobbying, negotiation, community social mobilization campaigns
i) Promote ACT by community social mobilization campaigns, particiaptory methods

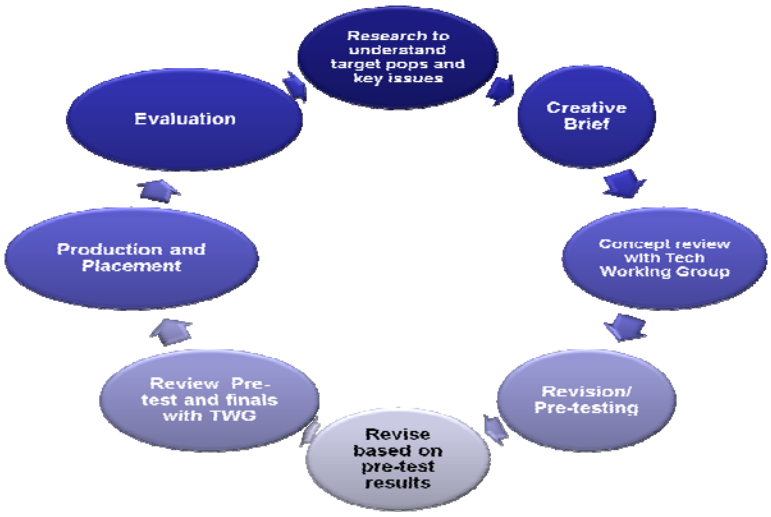
Dr Cossa then gave steps in Planning and Implementing Malaria Community-Based HPR Interventions as follows:

- 1. Advocacy with community leaders
- 2. Community engagement
- 3. Agreement on methods of operation
- 4. Community needs assessment/situation analysis
- 5. Consensus building and development of intervention action plan
- 6. Implementation of malaria intervention action plan at community level
- 7. Monitoring & evaluation of malaria intervention at community level
- 8. Documentation of best practices of malaria intervention at community level
- 9. Scaling-up of malaria intervention

In conclusion, it was noted that behavior change is a long-term process, hence the need for continuity of interventions. The BCC component in Malaria Prevention and Control needs to be refocused to take into account Community-Based approaches to achieve the desired behaviour Change. However, it was noted that engaging communities in development, implementation & evaluation of any BCC activity is cost-effective and critical. HPR provides a broader scope for implementation of Community-based interventions

**Country examples on IEC/BCC**

The first country example presentation was made by Kenya and it was on "Evidence Based Communication: The Kenya Experience – Promoting Public Sector ACT". Simple steps used in the design of the IEC/BCC strategy are summarized in the diagram below:




The example presented sought to address the following situation in Kenya:
Although 90% of caregivers took some action to treat a child's fever within 48 hours of symptom onset, the proportion of febrile children under 5 who received recommended AL within 48 hours was only 10.2%. The vast majority of AL (95%) was dispensed from public health facilities. Some nurses had been trained—less than ideal provider practice and the training was extremely inconsistent. Job aids existed, but spotty use. Some informational spots about AL, but messages were very mixed, recall not good

This emphasized the research that needs to take place before IEC/BCC messages are developed. Building a Communication Plan considered the following from the research:

Positioning:

- For self-sacrificing parents, treating a child with ACT/AL as soon as you notice signs of fever and finishing all 3 days of the dose is the behavior that gives you peace of mind because it's the only sure way to keep your child from dying of malaria.
- For responsible health workers, adhering to the policy of presumptive treatment of fever with AL for Children <5 is the behavior that gives you peace of mind because it's the safest and most effective malaria treatment available.

- Kenya went ahead to develop materials with all the various target groups with clear objectives against which the programme will finally be evaluated that were pre-tested and then refined. The whole process involved the target groups. The take home message was that it is important in the development process of any IEC/BCC materials to identify the specific BEHAVIOR you want to change, Know your targets INTIMATELY, Never assume you are representative of your target audience, Analyze, Synthesize, Prioritize and Stay Positive

The second presentation was on Zambia's Steps in the development of a National IEC / BCC Strategy and Implementation for Malaria prevention and control. The presentation highlighted the major steps taken in producing a communication strategy. For example,:
Step 1: Formed broad-based Technical Group, developed TOR to guide steps…….
Step2: Technical Group developed clear IEC/BCC Objectives and selected the "writing Team", which developed Strategy Matrix – this defined strategies in the matrix and also had what each strategy contained.

NMCC served as secretariat and provided logistical support to TWG, availed Key Reference IEC learning materials and coordinated IEC-TWG multi-discipline *"writing team".* The IEC Specialist in the NMCP collaborated with MOH partners . The IEC/BCC strategy contribution to impact on malaria, increased awareness on malaria using multiple channels and ensuring consistency of messages. Malaria IEC/BCC Programme has now become the path finder for other programmes, utilizing every opportunity for advocacy - popular sports-cycling, soccer and have seen to increased resources and number of partners.

Once challenges in each intervention were identified, specific strategies to address these challenges were implemented. This included Training in Behaviour Change Communication e.g. Health Workers, Engaging the Media, Working with various Leaders, Involve decision-makers – RDTs. Apart from that, there were other IEC/BCC Innovations that included identifying opportune events to promote malaria interventions, rider on other child health initiatives, training of Community Radio Stations, vigil Night, Inter-denominational prayer night and publications in relevant newsletters and bulletins and exhibitions during Agriculture shows and Trade Fairs. A malaria musical CD has also been produced.

Some enabling factors to the STEPS were availability of IEC Specialist by NMCP, with Backstop from Inter-Country and Partners, leadership and secretariat by NMCC, partner interest and functional Technical IEC/BCC Working Group, with clear TORs and national mandate.

**Group work**

As stated above, the group work was preceded by two short presentations on the evidence on low utilization of malaria control interventions after which, countries were divided into groups along major interventions to try and identify the major challenges and solutions that will need to be addressed for better uptake on these interventions.

The common bottlenecks from the working groups were the following:

- There is both low capacity and resources for IEC/BCC
- IEC/BCC continues to receive very low prioritization;
- There is limited use of evidence based planning and development of IEC/BCC materials
- Channels of communication especially those accessible to target populations are not adequately used
- There is inadequate involvement of target groups in developing and implementing the messages; leading to messages not appropriate for the target group;
- There is also noted top-down development of strategies and low utilization of communication specialists and social scientists to study behaviors;
- Inadequate identification of all stakeholders involved in each intervention so that when messages are delivered, they are fragmented and lack continuity at all levels;
- Little is done on use of local systems and local languages to deliver messages
- Inappropriate distribution challenges for the print materials

Efforts to address these challenges were proposed that included increasing the partner base to assist in implementation and more efforts in involving stakeholders. The use of innovative communication channels and multi-channels of communication in different target groups was also proposed. Engagement of leaders was emphasized and intersectoral collaboration.

Another thematic group made up of mainly the principle recipients of the various malaria grants looked at the financing of malaria interventions and identified the major bottlenecks related to the release of GFATM funds that may prevent countries from achieving their targets.

The major challenges identified by the group were the following;
- Conditions precedent to disbursement is too many and requires too much time.
- Delayed response from GF(LFA)
- One way obligation, no clarity on GF timelines
- GF delayed disbursement
- There is normally inadequate capacity when PR is government
- Inadequate implementation and absorption capacity
- LFA insensitivity of the program

**Solutions**

- PR should take seriously programme assessment and conditions precedent
- Agreement should outline disbursement schedule
- Strengthen PR Capacity
- Strengthen Programme capacity
- Need to separate PR and programme implementation roles
- Joint(PR/GF) review of LFA performance

## Objective 3: To develop a roadmap to achieve 2010 targets

A special session on development of 17 month country roadmaps describing what the main activities would be by month, to achieve the universal coverage targets by 31/12/2010 was conducted through the guidance of the UN Secretary General special envoy bureau. The roadmap contained the following:

- Summary of resources (and what they will be used for) that are currently available in country to achieve the 2010 targets
- LLIN ordering and distribution schedule over the next 17 months
- ACT ordering and delivery schedule over the next 17 month
- IRS schedule over the next 17 months
- Other core interventions to be delivered over the next 17 months

The Roadmaps are expected to be used by countries and will be submitted to donors, for funding and to technical agencies. A summary of the roadmaps will be presented by Governments to the UN Secretary General in September 2009. The detailed country technical support needs is shown in Annex 2.

**Special Partners' presentation**

A representative from MMV made a presentation on the upcoming new medicines for malaria treatment. In addition to new ACTs that are coming out, there are other medicines that are coming out but are not ACTs. Compliance is also one of the key issues to make sure the current generation stays as long as possible.

Another presentation was made by UN Special Envoy who acknowledged the achievements especially in malaria control and reminded countries to identify alternative strategy if there is a gap in order to achieve the target on time.

Common themes from the above presentations were to recommend Global Fund to finalize procedures, countries and partners assess why signatures are not done as soon as possible, issues relating to supply chain management planning and distribution systems.

**SADC Military support for elimination**

A presentation by Dr Mudambo highlighted the participation of military malaria coordinators in national, regional and global malaria elimination committees

**Universal access in Mozambique** on distribution strategy

A presentation by Tim Freeman, UNICEF/Mozambique described a strategy to equitably distribute LLINs to target populations. The strategy showed that the strategy scales up distribution towards Universal Access, that it is equitable, practicable, relatively cheap and can be carried out by Ministry of Health staff with little difficulty.Because the distribution is based on lists, the strategy is not dependent on weather. For example, if there is rain one day you can always go to the same village a few days later.

## Conclusions

It was clear from group work discussions that there is limited use of evidence based planning and development of IEC/BCC materials and inadequate allocation of funds to IEC/BCC. Comprehensive national malaria program performance reviews is the way for NMCP to determine the needs for program re-designing towards universal access, pre-elimination and elimination.

## Recommendations

**Program management**

- As part of the malaria strategy countries should develop an evidence based malaria BCC strategy which ensures participation and adoption by all stakeholders and is allocated at least 5-10% of the malaria budget.
- Countries should strengthen routine surveillance and logistics systems including database establishment and data validation.
- Countries should plan to conduct comprehensive malaria program reviews to inform the development of strategic plans and policies in line with universal access/pre-elimination
- Countries should strengthen cross border activities to ensure pre-elimination is achieved;
- Countries should finalize their Road maps in the next two weeks and submit them to the focal points of the sub-regional networks;
- Countries to plan and budget for TA and capacity building in GFATM, AMFm, WBB, UNITAID and other funding proposals

**Vector control**

- Governments and their partners should emphasize operations research to ensure evidence based scaling up of malaria control /elimination interventions.
- Countries should conduct vector surveillance including annual vector resistance monitoring;
- Countries should be supported and guided in the scaling up of the LLINs and IRS in a supplementary manner in cognizant of intra- and inter-country epidemiological differences in line with the guidelines of WHO on the combination of two interventions ;

**Case management**

- Countries should rapidly improve capacity for malaria case management especially parasite based diagnosis (including quality control and assurance) in order to increase the proportion of suspected malaria cases that are confirmed by microscopy/RDTs

## Annex. 1: Country Technical Support Needs

| Country | Technical Support Needs |
|---|---|
| Botswana | • Capacity building to strengthen malaria diagnosis<br>• Development of an M&E Plan<br>• IEC/BCC material development<br>• Social marketing of vector control interventions<br>• MPR and Strategic plan<br>• MIS |
| Burundi | Assistante technique pour le TPI, PECADOM,<br>Assistance Technique pour la mise en place d'une base de données<br>Assistance technique pour l'élaboration des directives pour la PID<br>MIS |
| Comoros | • Elaboration du plan de communication (dec 2009)<br>• Formation sur la Gestion de données (janvier 2010)<br>• Enquêtes MIS (Echantillonnage dec 2009), Formation (octobre – novemre 2010), Analyse et interprétation des données = Elaboration du rapport (janvier 2011))<br>• Elaboration du plan de lutte contre les épidémie (mars 2010)<br>• Etablissement de la cartographie (mai 2010)<br>• Formation des agents sur le PID (novembre 2010)<br>• Etudes d'efficacité thérapeutique (dec 2009)<br>• Evaluation du PNLP (dec 2010) |
| Eritrea | • Assessment of vector control activities<br>• Strengthen insectaries and sentinel sites with experts and equipment<br>• Strengthening of Malaria Early Warning System<br>• Resident epidemiologist for strengthening malaria surveillance system<br>• QC/QA of microscopy and RDT diagnosis<br>• Initiation of malaria cross-border collaboration with the Sudan<br>• Support study tour to countries practicing malaria elimination<br>• Support local production of co-formulated ACTs (AS + AQ) |
| Ethiopia | • Malaria Indicator Survey 2010<br>• Resource mobilization to fill gap<br>• Malaria communication guideline<br>• Health Facility Survey 2009 |
| Madagascar | • |
| Malawi | • IRS<br>• MPR<br>• MIS<br>• Pharmacovigilance |
| Mozambique | • Procurement of LLINs<br>• Logistics<br>• Quality control/assurance of RDTs<br>• DHS in 2010<br>• MIS in 2010 |
| Namibia | • National RBM five years Strategic Plan review and development, January-March 2010 |

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|---|---|
| | • National Vector Control guidelines finalization, November 2009-January 2010<br>• MIS report writing and finalized, October 2009<br>• National Programme re-view and re-orientation towards elimination imitative, February 2010 |
| South Africa | • Programme review- Aug-Sept-09<br>• Database implementation July-Aug-09<br>• Cross border initiative-Oct -09- Dec 2010<br>• Development of elimination strategy and implementation Jan 2010-July 2010 |
| Swaziland | • Technical support on training guidelines and ensure protocols for RDT – (Aug – Sept 2009)<br>• Development of M&E plan- LLIN delivery and record-keeping August 2009 |
| Uganda | • Evaluation of the Current NMCP Strategic Plan and Programme Review (MPR)<br>• Update the malaria Strategic Plan<br>• Updating the Malaria Communication Strategy<br>• LLINs Distribution Plan<br>• Update the M & E plan and operationalize the Malaria Database<br>• Establish an insectary and field entomological insecticide susceptibility monitoring sentinel sites |
| Zambia | • Comprehensive malaria programmatic<br>• review<br>• Development of Malaria Control Strategic Plan; 2011-2015<br>• National Malaria Surveillance, Data base<br>• Management Systems (Routine, surveys) |
| Zanzibar | • Establishment of ITNs distribution data base<br>• Establishment and strengthening of QA/QC system/guidelines for microscopy and RDT<br>• Development of guidelines on efficacy trials<br>• Monitoring of efficacy and durability of LLINs<br>• IPT implementation in low malaria endemicity |
| Zimbabwe | • Malaria Programme Review<br>• Revision of communication strategy<br>• Cross Border Initiatives (development of concept note and proposal)<br>• Needs Assessment for BCC<br>• HMM guidelines<br>• Establishment of sentinel sites (vector bionomics)<br>• Programme reorientation for pre-elimination<br>• Strengthening Malaria data base |

## Annex 2: Agenda of the meeting

| | Morning | Afternoon |
|---|---|---|
| **MON** | ▪ Official opening<br>▪ Strategic Orientations and Technical Updates | ▪ Country Progress Updates – Peer Review |
| **TUE** | Objective 2: To Identify Major Bottlenecks And Solutions for Achieving 2010 Country Targets<br>▪ Access and utilization of interventions (plenary then group work) | Objective 3: To Develop a Roadmap to Achieve 2010 Targets<br>▪ Country peer review of plans |
| **WED** | ▪ Country peer review of progress and plans<br>▪ Identification of support needs including TA | Objective 4: To Provide a Forum for Partners' Contributions to the Roadmap<br>▪ Mapping of partner response to country needs |
| **THUR** | ▪ EARN and SARN Network meetings | ▪ EARN and SARN Network meetings |

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| | 178. | Ms C Garapo | Secretary | WHO | P O Box CY348<br>Causeway<br>Harare<br>Zimbabwe | 263-4-253724 – 30 | 263-4-253731/2 | garapoc@zw.afro.who.int |
| | 179. | Mrs E Imbayarwo | Secretary | WHO | P O Box CY348<br>Causeway<br>Harare<br>Zimbabwe | 263-4-253724 – 30 | 263-4-253731/2 | imbayarwoe@zw.afro.who.int |