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**TECHNICAL MEETINGS:
ZIMBABWE, KENYA,
AND ZAMBIA**

February 22-March 28, 1998

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ACRONYMS

AFRO	Africa regional office (WHO)
AIMI	Africa Integrated Malaria Initiative
AMREF	Africa Medical Research Foundation
AusAid	Australian Agency for International Development
BASICS	Basic Support for Institutionalizing Child Survival Project
BDI	Bungoma District Initiative
CA	Cooperating Agency
CBoH	Central Board of Health, Zambia
CDC	Centers for Disease Control and Prevention, Atlanta
CHSU	Community Health Sciences Unit, Malawi
CHW	Community health worker
DfID	Department of International Development (UK)
DG	Director General (WHO or CBoH)
DHMT	District health management team
DIP	Detailed implementation plan
DPM	Director of Programme Management (WHO/AFRO)
EAN	East Africa Network
EMRO	Eastern Mediterranean Regional Office (WHO)
GOK	Government of Kenya
GRZ	Government of the Republic of Zambia
HMIS	Health management information system
HQ	Headquarters
IEC	Information, education, and communication
IMCI	Integrated management of childhood illness
ITM	Insecticide-treated mosquito net
ITN	Insecticide-treated net
JICA	Japan International Cooperation Agency
Kemri	Kenya Medical Research Institute
MIM	Multi-lateral Initiative for Malaria
NGO	Nongovernmental institution
NHC	Neighborhood health committees
OR	Operations research
PHN	Population, Health, and Nutrition
PHP	Primary health provider
PHR	Partnership for Health Reform
QAP	Quality Assurance Project
SFH	Society for Family Health
SP	Sulfadoxine-pyrimethamine
SWAP	Sector-wide approach
TBA	Traditional birth attendant

TDR	WHO/World Bank/UNDP Special Programme for Research and Training in Tropical Disease
TDRRC	Tropical Disease Research Centre, Ndola
UNESCO	United Nations Economic, Social and Cultural Organization
UNICEF	United Nations Fund for Children
USAID	United States Agency for International Development
VBC	Vector biology and control
WHO	World Health Organization
WR	World Health Organization Representative

SUMMARY

Purpose

The trip comprised three distinct activities which are reported separately here—

- 1) Attendance representing BASICS at the WHO/AFRO Malaria Task Force Meeting, a pre-meeting workshop on operational research, and a donor coordination meeting held in Harare 24-28 February
- 2) Participation in the Bungoma District Initiative Launch meetings and subsequent follow-up meetings with the Malaria Control Unit, AMREF, WHO/AFRO, DfID and the Malaria Consortium
- 3) Consulting with BASICS, USAID, CBoH, TDRC, WHO and UNICEF in Zambia on malaria issues, particularly treatment policy Participation in the Malaria Strategy Workshop in Chipata District

Schedule

2 February	Depart Austin
4-21 February	Bangkok on non-BASICS work
22-28 February	Harare
1-4 March	BDI Launch meetings, Bungoma
5-13 March	Nairobi
14-18 March	Lusaka
19 March	Ndola
20-21 March	Lusaka
22-25 March	Chipata
26-27 March	Lusaka
28 March	Depart Lusaka
29 March	Return to Austin

Primary Persons Contacted

John-Paul Clark, USAID/Africa Bureau
Bernard Nahlen, CDC/Kemri Malaria Field Station, Kisumu
Peter Bloland, CDC
Alastair Robb, WHO/AFRO/DfID, Malaria Unit, Harare
Sylvia Meek, Malaria Consortium
Jenny Hill, Malaria Consortium
Deogratias Barakamfitye, WHO/AFRO, Head Integrated Disease prevention and Control

Yao Kaasankogno, WHO/AFRO, Regional Malaria Advisor
Edwin Afari, WHO/AFRO, Malaria Epidemiologist
Oladapo Walker, WHO/AFRO, Malaria Advisor
A Kondrachine, WHO/Geneva, Head Malaria Unit
Awash Teklehaimanot, WHO/Geneva, Malaria Advisor
Caroline Sergeant, DfID/Nairobi, Regional Health Advisor
Steward Tyson, DfID/Harare, Regional Health Advisor
Alan Macheso, CHSU/Malawi, Malaria Programme Director
Peter Kazembe, Head of Malaria Advisory Committee, Malawi
Jumbe Sebunya, AMREF/Kenya, Country Director
Muthoni Kariuki, AMREF/Kenya
John Nduba, AMREF/Kenya, Deputy Country Director
Hezron Ngugi, AMREF BDI Coordinator
Dennis Carroll, USAID/Global Bureau
Lynette Malianga, Quality Assurance Project
Michael Deming, CDC, Child Survival Unit
Dana Vogel, USAID/Kenya, PHN Officer
Walter North, USAID/Zambia, Country Director
Paul Hartenberger, USAID/Zambia, PHN Officer
Paul Zeitz, USAID/Zambia, Technical Advisor
Remi Sogunro, BASICS/Lusaka, Chief of Party
Elle Burleigh, BASICS/Lusaka, Community Mobilization Advisor
Abdikamal Alisalad, BASICS/Lusaka, Child Survival Advisor
Rodwell Kafula, BASICS/Lusaka, Malaria Coordinator
Vera Mwewa, BASICS/Lusaka, Community Mobilization Coordinator
Mubiana Macwangi, BASICS/Lusaka, Social Scientist
Mary Kaoma, BASICS/Lusaka, Training Coordinator
Mary Segall, Zambia Family Planning Services Project, Training Advisor
Rory Nefdt, TDRC/Lusaka, Malaria Coordinator
Tom Sukwa, TDRC, Director
Brad Lucas, SFH/Zambia
Gavin Silwamba, Acting DG, CBoH/Zambia
Catherine Goodman, London School of Hygiene and Tropical Medicine and PHR, economist
G C Chishumba, South East Regional Health Office
Mary Ngoma, WHO/Lusaka, Child Health Advisor

HARARE MEETING

A Pre-task Force Meeting on Operational Research

Objectives

- 1) Develop mechanisms to strengthen operational research in malaria control programs to enhance the control of the disease in Africa
- 2) Develop mechanisms to establish linkage between MIM, WHO/AFRO Task Force on Malaria Control, and national malaria control programmes

Participants

Peter Bloland and Bernard Nahlen (CDC)

Mary Ettlmg (BASICS)

John-Paul Clark (USAID)

Sylvia Meek (Malaria Consortium/DfID)

Deogratias Barakamfitye, Yao Kassankogno, Edwin Afari, Alastair Robb, Oladapo Walker,

Elizabeth Feller-Dansokho, Lucien Manga (WHO/AFRO)

Awash Teklehaimanot, Charles Delacollette (WHO/HQ)

Thomas Nchinda (Global Forum for Health Research)

Omar Gaye (U Senegal)

Wenceslaus Kilama (African Malaria Vaccine Testing Network)

Proceedings and results

Dr Oladapo Walker, in addition to carrying primary responsibility for drug efficacy monitoring and drug policy development for AFRO (with Dr Alastair Robb), will co-ordinate operational research activities for the regional office from Harare

After a series of presentations on MIM and WHO/AFRO developments in operational research, the meeting broke into two working groups to prepare recommendations for the task force meeting. The complete recommendations are transcribed in Appendix A

In summary, the meeting recommended a strong, proactive role for WHO/AFRO in setting and monitoring the international and regional research agenda for malaria as well as specific actions to strengthen the role of national malaria control programmes in identifying research priorities, carrying out and coordinating operational research, and bringing research findings to programmatic action

Follow-on actions

There are no particular follow-up actions for this pre-task force meeting. Items of interest and possible follow-up that arose during the meeting were—

- 1) A request by Dr Walker for continued assistance as required in development and implementation of operational research projects proposed by national programmes. This is a continuation of Etting's involvement in the operational research workshop in Banjul in 1996. The form of this support will probably be based on the more flexible mechanisms recommended by the meeting for WHO/AFRO to solicit, fund, develop, and support operations research (OR) nationally. In particular, the assistance was requested for projects in social science, economics, and policy.
- 2) Recognizing the importance of operational research and that the schedule of activities for the regional staff is almost too heavy, the Malaria Consortium will request funding from DfID for consultant support for Walker and the rest of the staff for operational research activities.

B Third Meeting of the WHO/AFRO Task Force on Malaria Control in Africa

Objectives

- 1) Identify technical, political, financial, and operational constraints at all levels, especially in relation to community participation in malaria control, as well as the supervision, monitoring, and evaluation of malaria control programmes.
- 2) Appraise the new WHO/World Bank Initiative for long-term vision of sustainable malaria control in Africa.
- 3) Propose a framework of capacity building for research with emphasis on operational research and use of research findings to enhance malaria control in Africa.

Participants

A full list appears in Appendix B.

Proceedings and results

- a Dr Kassankogno reviewed progress in accelerated implementation of malaria control in the African Region in 1997. Emphases of the programme are

- Strengthening national programme management by recruiting regional and national advisors and including Missions from the region in planning, implementing, and evaluating activities
- Improved case management of severe and complicated malaria through training
- Surveillance of drug efficacy with training of national staff and support for efficacy studies in over 20 countries
- Vector control using ITMs

Sub-regional offices for support of malaria control have been established in Lome, Libreville, Entebbe, and Harare, with coordination of epidemic control in Abidjan, Libreville, Entebbe, and Harare. Sub-regional advisors have been hired. Some of them are—

- Lucien Manga, VBC advisor in Harare. Formerly medical entomologist with OCEAC
 - Shiva Murugasampillay, epidemiology advisor for Southern Africa, based in Harare. Formerly chief epidemiologist with Zimbabwe MoH
 - Lyimo, vector control consultant based in Entebbe. Formerly medical entomologist Tanzania MoH
 - Ousmane Faye, entomologist based for now in Libreville
 - Magda Robalo, epidemiology advisor for Portuguese-speaking countries, based for now in Harare
 - Elizabeth Feller-Dansokho, malaria advisor in Lome. Formerly programme director in Senegal
- b Presentations were made by programme managers and national consultants from Ethiopia (case management in the community), Benin (promotion of ITMs), Zimbabwe (epidemic preparedness and response), Zambia (health sector reform), Malawi (planning for 1998), Senegal (planning for 1998), Madagascar (coordination of donor inputs), and Uganda (health sector reform)
- c Walker reported on the results from drug efficacy studies carried out in 1996-97
- d Dr Afari reported on the development of indicators and tools for monitoring and evaluation
- e Dr Teklehaimanot reported on the midterm review of the implementation of activities supported by special funds from WHO/HQ in 1997 and plans for implementation in 1998

- f Partners (USAID, DfID, AusAID, World Bank, UNICEF and the Malaria Consortium) presented summaries of their activities in Africa
- g Dr Kabore presented implementation of IMCI activities in Africa
- h Drs Barakamfitye, Nahlen, Rojas, and Hill reported on the Experts' Meeting on Malaria Control Initiative in Africa (Feb 1997), the Network meeting on Malaria in Pregnancy, the International Conference on Bednets and other Insecticide-treated Materials for the Prevention of Malaria (Oct 1997), and the Study on Global Coordination of Malaria Control (Malaria Consortium for WHO), respectively
- i Caroline Sergeant presented basic concepts of the sector-wide approach (SWAP) to donor support for health
- j Working groups addressed three issues and made recommendations (two of these are given in Appendix C)
 - Community mobilization for case management and ITMs
 - Supervision, monitoring and evaluation of malaria control
 - The WHO/World Bank initiative
- k A closed partners meeting was held at which Barakamfitye and Kassankogno presented the use of resources for malaria control in Africa and the AFRO plan of activities for 1998

C Coordination meeting of AFRO, USAID, and the Malaria Consortium

WHO/AFRO reviewed the plan of action for 1998 with USAID and the Malaria Consortium I was present for only the first two hours of the meeting, during which time several points were made—

- Planning to coordinate various meetings regarding malaria treatment policy for Africa These include a meeting in Geneva in mid-May, following the World Health Assembly of CTD/MAL, AFRO, TDR, USAID, DfID, CDC and others involved in the development of policy for Africa, two meetings called by CDC to explore issues relevant to malaria treatment policy and identify further research and information requirements (tentatively scheduled for late May and July), a meeting called by Wellcome Trust, and the sequence of conferences and training set out in AFRO's plan of action to adopt a framework on drug policy
- Recognition that the task force recommendations on operational research will require some re-programming for 1998

- An expression of concern about the plans to develop training modules for epidemic response and preparedness. The planned training is premature until a better review and summary of the work already accomplished in southern Africa is conducted and until mechanisms are set up to allow sharing of data and strategies between southern and northern Africa epidemic-prone countries. The current AFRO plan is to divide this effort rather than bridge geographic distances in the interests of cross-fertilization of ideas.
- Recognition of the very busy schedule of plans and the need to maintain the quality of activities with adequate preparation, facilitation, and follow up for meetings, conferences, consultations, and trainings. This is a crucial stage for AFRO and the region. Plans for this year include the development of guidelines, training modules, strategies, communication networks and databases, and a policy framework for malaria treatment. Care should be taken to invest the necessary thought, consultation, time, and resources into these vital bases for the future.
- Plans for a consultative meeting to begin framing a WHO/AFRO regional strategy and activities to improve the capacity for community-based malaria control at all levels.
- Concern that the regional malaria effort may be hampered by the establishment of sub-regional offices. For instance, AFRO's IMCI coordination will move to Lome while the malaria unit remains in Harare.

KENYA MEETINGS (Bungoma District Initiative Launch)

A Meeting of BDI CAs, AMREF, and USAID

Participants

Altrena Mukuria, Mary Ettling, and Nicholas Dondi, BASICS
 Michael Deming and Peter Bloland, CDC
 Lynette Mahanga, QAPROject
 Muthoni Kariuki, John Nduba, Rukiya Idarus, and Jumbe Sebunya, AMREF/Kenya
 Hezron Ngugi, AMREF/Bungoma
 Victor Masbayi, USAID/Nairobi
 Dennis Carroll, USAID/Global Bureau

The meeting took place in Webuye after a closed meeting between USAID and AMREF. The purpose of the district meeting was to identify problems in the collaboration between DHMT, AMREF, and the CAs which is necessary for BDI to move forward and to clarify the roles and responsibilities of all partners. Minutes, as prepared by Hezron Ngugi, the AMREF BDI coordinator, are transcribed in Appendix D.

The minutes fail to capture some of the salient points of the discussion

- There is a real difficulty in sustained communication between Bungoma and the US-based partners. Many faxes, e-mails, etc., have been sent with no response. In most cases AMREF denied that attempts to communicate had been made. Frustration was high on both sides. The planned clarification of communication channels may improve this situation.
- There is a lack of clarity about AMREF's coordinating role. The evidence of AMREF's decision with the DHMT to alter the implementation plan which had been agreed upon by all partners in May 1997 is an example of this lack of clarity. US-based partners are eager to follow plans as previously agreed upon and to have some say in alterations to the plan.
- There are misgivings about some financial arrangements, particularly payments of fees to DHMT members participating in BDI activities and the high AMREF daily consultant rates (US\$150-250 plus per diem). Such arrangements raise real questions about the sustainability and/or replicability of district malaria control strategies worked out in Bungoma.

B BDI Project Launch

The launch was an occasion for talks by the representatives of the province, the district, and USAID, and occurred in a very positive atmosphere. Dr. Odongo, the head of the Bungoma DHMT, made an interesting observation. We should change the name of the project to People of Bungoma's Malaria Initiative because the people of Bungoma will consider it the AMREF project, and because, rightly, it is an initiative of the people of Bungoma rather than the DHMT. This seemed a curious observation to make.

C Meeting of DHMT, AMREF, and CAs

On the following day, the group met to review and revise the timing of activities in the plan of action for 1998 in light of initial delays. It was an opportunity to re-clarify some of the roles and responsibilities of the various partners. The revised plan appears in Appendix E.

The key activities for BASICS are the analysis and reporting of the formative research, an IEC assessment, a workshop in June to develop a community case management strategy with the district, and continued back up and support for the development of plans for implementation of ITMs. If the community partnership and assessment activity takes place, it will be later in the year or in 1999, as part of an overall strategy with the DHMT and the communities.

D Meetings with AMREF in Nairobi

Mukuria and Ettlign met with Drs John Nduba and Muthoni Kariuki of AMREF/Kenya, and Mr Hezron Ngugi, the AMREF BDI coordinator, on two occasions to clarify budgetary and administrative procedures. BASICS agreed to present AMREF with outlines of the necessary inputs to the activities planned as soon as possible so that AMREF can prepare budget estimates. Reporting of expenditures was clarified. It was agreed that BASICS will forward funds through AMREF offices in New York as a registered US-based NGO. This will facilitate transfer of funds and reporting. BASICS will, however, plan for the inputs and activities directly with AMREF/Nairobi.

E Meetings with WHO/AFRO and DfID/Malaria Consortium

Ettlign met with Dr Edwin Afari of the WHO/AFRO malaria unit, who was in Kenya on another mission. The important topic discussed was the encouragement of Kenya malaria control unit-BDI communication and coordination. There are USAID and WHO funds specifically for supporting interaction between the two. Afari is aware of the planned activities for 1998 and was invited to attend the community strategy development workshop in June. The strengthening of capacity for community mobilization for malaria control is a high-priority issue for AFRO. Afari reported on an up-coming AFRO conference on community mobilization, to which he invited Ettlign as a representative of BASICS.

In a meeting with the Malaria Consortium/DfID, the main topic of discussion was DfID support of the Kenya malaria control unit, particularly in the area of treatment policy, training, and logistics. As part of the programming activity, a meeting of the Malaria Advisory Committee had been called to assign responsibility to smaller task forces: the current epidemic, case management, training, drug quality and supply, etc. Jenny Hill asked about USAID support for production and distribution of the new treatment guidelines (which will need to be revised as several thousand were printed with significant errors) and for health worker training in their use.

The DfID team was also able to discuss progress with the East Africa Network for monitoring malaria drug resistance.

Hill and Sunil Mehra promised that the final planning document for Kenya and the latest on the EAN will be made available as soon as they are produced.

ZAMBIA MEETINGS

A Interdistrict Planning Meeting, Chipata

This was a follow up to the initial planning meeting held last October for the integrated effort (largely malaria) in Chipata, Lundazi, and Chama districts

Follow-on activities

- 1) The three district draft plans must be reconciled and resolved into a unified plan
- 2) The region and the districts should prepare a detailed request for support in transportation, communication, and drugs and supplies. This request would be used to marshal support from interested donors, chiefly JICA
- 3) BASICS, as the coordinating agency for AIMI activities in Zambia, should communicate to CDC the planned activities which require input from CDC
- 4) Good communication between BASICS/HQ and Lusaka, CDC, the region, TDRC, and the districts must be maintained

B Meetings with TDRC Ndola and Lusaka

I met with Drs Tom Sukwa and Rory Nefdt of TDRC to discuss issues of malaria treatment policy, ITN implementation, research, and coordination of joint activities. Key issues to follow up on—

- 1) The development of a strategy and guidelines for use of malaria microscopy as part of basic laboratory services in health centres. Clearly, all fever cases cannot be screened. What would be the most cost-effective use of microscopy in Zambia?
- 2) Conducting baseline studies of malaria in pregnancy, to begin the policy discussion on possible interventions through ANC. An initial estimation of the impact of malaria in pregnancy was suggested.
- 3) Initial exploratory studies on possible treatment for severe cases in very remote health centres where referral is actually impossible.
- 4) Implementation of treatment efficacy studies in the sentinel sites identified two years ago. Apparently all sites are being studied every year, an unnecessary and costly process. However, it is not clear if the sites originally studied by the CDC/NMCC team are being

revisited at all. Also, the TDRC has some plan for local monitoring of treatment failures. This should be planned together with the new HMIS implementation.

- 5) Clarification of the recommended procedure when a child is given cotrimoxazole and chloroquine and returns as a chloroquine failure.

C Meetings with WHO/Zambia

I met with Dr. Mary Ngoma of WHO/Zambia to brief her on the Chipata planning meeting and to discuss coordination of WHO- and USAID- supported malaria activities. There is a joint planning meeting of TDRC, CBoH, WHO, UNICEF, USAID and others involved in malaria control in Zambia set for 8-9 April. This should be the forum for careful joint planning. I was asked to draft an overall strategy to resolve the differences between the TDRC plans to spend WHO funds, USAID activities in Eastern Province, and CBoH integrated plans and activities.

D Review of Training and IEC Materials

One objective of this trip had been to review the technical malaria content of several training materials under preparation by the CBoH with from BASICS. Luckily, the review of the **primary health provider** was going on when I was in Lusaka. This is training aimed at the polyvalent worker, who is envisioned as the core staff of reformed health centers and health posts. The curriculum aims to refresh, up-date, and fill the gaps of training for nurses, clinical officers and environmental health technicians, so that all three can become polyvalent workers. The training is contained in eight modules: well child, sick child, water and sanitation (an inaccurate name for what has become a general prevention module, including malaria), safe motherhood, and treatment of common medical and surgical conditions in adults. Malaria appears in most of these.

The module on **water and sanitation** includes a small section on malaria. This module was field tested last month in Eastern Province. There had been inadequate time scheduled for practical aspects of ITN implementation, e.g., dipping of nets. This has been corrected. I noted three deficiencies with the very well-developed training module. First was the murkiness of the emphasis on techniques for prevention of malaria. There is still a lot in the module about clearing rubbish, cutting grass and making environmental alterations. All of that is fine, but not when the CBoH, WHO, and the USAID/Global priority for prevention of malaria, namely ITNs, get lost in the murk. Secondly, although the module wisely contains the dosage schedules for chloroquine, the schedule is unclear and incomplete (it needs doses in tablets, as well as syrup form for young children) and it needs to be enlarged to include the current guidelines for dosing with sulfadoxine-pyrimethamine (SP). Thirdly, there seems to be no central place, other than this module, for a general training on malaria issues. The module contained a very excellent general review of malaria transmission. I suggest that this module also include a brief description of drug resistance and key implications. Many health workers are struggling with the new treatment.

policy and have many misunderstandings about the drug itself, the importance of complete, adequate and accurate dosing with all anti-malarial drugs, and the nature of resistance (e.g., it is the patient who becomes resistant rather than the parasite, or once a patient has taken SP, they can never take chloroquine again, or once a patient takes SP, they cannot use that drug again for nine months, or SP must be taken daily for three or more days, etc.)

The module on **safe motherhood** is also well-developed. My only suggestion was a clarification of the current chemoprophylaxis recommendations and the need for prompt treatment of fever guidelines, including administration of SP to chloroquine treatment failures. Also the module should specifically mention the importance of ITN use in pregnancy.

The **well and sick-child** modules are very well-developed. The sick child module is essentially the IMCI algorithms.

The **adult treatment** module has not really been begun yet.

The **community health worker** training materials are nearing completion. They also needed 1) clearer training on and greater priority of the implementation of ITNs, including practical work in dipping nets, 2) standard, accurate, and uniform (with other presentations of the schedules) dose schedules for both chloroquine and SP, and 3) clear statements of the key IEC messages regarding case management, i.e., complete dosing with an effective antimalarial, recognition of treatment failure, prompt and appropriate action for treatment failure, and the association of fever and convulsion as a severe form of malaria requiring treatment at a health center.

The training of **neighborhood health committees (NHC)** seems to be forming around a booklet created for the Kitwe Project. This booklet is aimed at urban committees. The training will have to be slightly reoriented, with different emphases. Essentially the booklet shares the same deficiencies as the CHW training: 1) need for clearer priority and practical knowledge of ITNs, 2) clear and accurate dosing schedules for chloroquine and SP, and 3) clear statements of the key IEC messages.

The **IEC materials** being developed comprise posters, flip charts, and information cards to guide group and one-on-one counseling. I suggested, based on the qualitative research, that simple education regarding administration of oral antimalarials be conducted, clear dose schedules, similar to those in the PHP, CHW, and NHC trainings, be developed, and recognition of treatment failure and the seeking of effective second-line treatment at health centers be emphasized.

The **IMCI training** is being revised just now. I was able to suggest several points which the revisors should discuss with TDRC. First, the SP dose is not the same as the national guidelines (hence the schedules being inserted into all of the materials described above), perhaps confusing health worker (Dr. Abdikamal will follow up on this). Second, there is some confusion about the

use of cotrimoxizole when chloroquine fails to reduce fever. Again, I mentioned this to Abdikamal and Sukwa at TDRC.

The **integrated technical guidelines** for health workers have just been printed and will be distributed as part of the revised HMIS training that started in March. There were some minor inaccuracies in SP dosing and in the recommendation of IM chloroquine rather than IM quinine as a pre-referral drug (the national guidelines are clear). Corrections are being made to the booklets. In general, the guidelines for malaria could be better, but CBoH apparently did not allocate space based on the importance of the disease. If there was more space in the booklet, there should be a clear description of the primacy of ITN use for prevention and clear guidelines on how to use them. The guidelines include nothing on recognition and response to outbreaks, key issues in drug resistance, or the key IEC messages that the CBoH is developing for malaria.

APPENDIXES

APPENDIX A

**RECOMMENDATIONS OF THE PRE-TASK FORCE MEETING
ON OPERATIONAL RESEARCH**

Harare, Zimbabwe

Objective 1 Develop mechanisms for strengthening operational research in malaria control programs to enhance the control of the disease in Africa

1 The process for identifying and funding research should be used to close the gap between researchers and control programmes

- The identification of research problems and priorities should involve all stake holders, namely operations staff, researchers, policy/decision makers, main partners and community representatives
- The forum for bringing the group together should be an annual national malaria meeting held in each country It is recommended that this meeting be in the annual plan of action Guidelines on the composition of the malaria advisory group should be drafted by AFRO in relation to the country mission This national meeting should be funded by the national programme
- The annual national meeting should be used as a forum to discuss the annual national action plan, to identify research priorities, to discuss the results of previous research and to determine the need for action to move the results forward

2 The Ministry of Health should bring research institutions and national malaria control programmes closer together and encourage them to collaborate

3 The funding from AFRO should stipulate collaboration between the research community and the control programme

4 WHO/AFRO should develop guidelines and protocols for applications for research grants and prototype protocols for common research problems All protocols should show the desired collaboration between the researchers and control staff

5 WHO should facilitate the programming of WHO malaria country budgets to include small funds for local operational research All malaria operational research projects should be coordinated by the programme manager

6 A review process should be instituted at all levels of the project from protocol development to results dissemination

7 Training and capacity building should be enhanced at all levels Epidemiology training for all programme managers is very important The training of programme managers should be at least at the masters level

Objective 2 Develop mechanisms to establish linkage between MIM, WHO/AFRO Task Force and malaria control programmes

WHO/AFRO

- 1 One role for WHO/AFRO is to establishing and maintaining linkages between the research community, policy makers and public health bodies to ensure rapid dissemination and use of research findings and an operational research agenda which responds to the priority policy and programme needs of the countries in Africa

- 2 AFRO should develop a proposal for its role in the MIM for more effective research in malaria. The proposal should be written to create interest and support within MIM funding agencies. This would give AFRO an active role in leading the initiative

- 3 WHO should maintain databases on the following (note some of these are being developed by other agencies participating in MIM, and AFRO should ensure access to them)
 - Research institutions in the region and their capacity for research,
 - Research projects carried out in the region,
 - International research institutes and what they are doing,
 - Partners funding malaria control

- 4 WHO should establish an effective process for communication and advocacy in operational research, including a network to disseminate the information from the databases to countries

- 5 WHO country offices should be strengthened
 - to facilitate national networks for collection and dissemination of research findings within the country
 - to disseminate research findings from outside the country through WHO and its linkages with MIM, TDR, etc
 - to facilitate and support the dissemination of research results through widely publicized research seminars and symposia

- 6 AFRO should be involved in decision making, for example, by participation in proposal review and selection in major initiatives such as the MIM Task Force/ TDR, and should influence funding for research. AFRO should be represented at the MIM Secretariat and Task Force meetings

- 7 AFRO should consider hosting a future MIM meeting as a mark of its commitment

8 AFRO should ensure that the agenda of MIM is balanced and that research continues to respond to the needs of programmes at the country level

9 AFRO should encourage funding agencies and countries to build the capacity for research and the use of research findings into all research projects. Training should aim at building a critical mass of field epidemiologists, policy analysts, behavioral scientists and health economists. Where appropriate, AFRO could develop and strengthen institutions for operational research.

10 AFRO should be strengthened by employing permanent staff to ensure that the long-term vision of AFRO is sustained.

Country level

1 Countries should be encouraged to establish effective research coordinating systems through which all research activities will be registered, and through which research findings would be disseminated, especially to policy makers and managers.

2 Countries should build the capacity to organize workshops, manage small grants and develop linkages between research institutions, policy makers and public health bodies.

3 Country programmes should be represented at major MIM fora.

4 The principal investigators of the projects funded through the Task Force for Research Capability Strengthening, coordinated by TDR, should invite the malaria control manager of their respective countries to the initial meeting of the scientists participating in the project. It will enable the malaria control manager to become fully acquainted with the proposal and facilitate his participation where needed.

Role of WHO/AFRO in MIM

Research initiatives	Work groups/ networks	Fora	Research institutions	National health staff responsible for malaria control
WHO/TDR, NIH, EC, WTRO, etc	Malaria in pregnancy Drug efficacy Communications	Meetings/secretariat WHO Task Force		
<ul style="list-style-type: none"> • Participate in solicitation, review of proposals • Proactive role in advocacy for OR • Promote training emphasis on epidemiology, behavioral science, policy and economics 	<ul style="list-style-type: none"> • Participate in routine meetings of networks and working groups • Disseminate proceedings of networks and working groups 	<ul style="list-style-type: none"> • Host MIM meeting in Africa with secretariat • Sponsor malaria control programme representation in MIM fora • Increase participation of research groups in Task Force • Use Task Force to disseminate research findings • Use Task Force to solicit research priorities from African control programmes • Present control programme research priorities at MIM meetings 	<ul style="list-style-type: none"> • Identify research institutions and their capacity for OR • Strengthen capacity of institutions • Strengthen linkage with national policy makers 	<ul style="list-style-type: none"> • Strengthen capacity • Disseminate research findings • Routinely assess the priority research agenda • Strengthen linkage with local research institutions

APPENDIX B

**PARTICIPANTS IN MEETING OF WHO/AFRO TASK FORCE
ON MALARIA CONTROL IN AFRICA**

February 25-27, 1998

Harare, Zimbabwe

PARTICIPANTS IN MEETING OF WHO/AFRO TASK FORCE
ON MALARIA CONTROL IN AFRICA

February 25-27, 1998

Harare, Zimbabwe

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E Afarai, WHO/AFRO (Malaria Advisor)
D Barakamfitye, WHO/AFRO (Director, Div Integrated Disease Prevention and Control)
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Malayah Harper, World Bank
Jenny Hill, Malaria Consortium
Antoine Kabore, WHO/AFRO (IMCI Coordinator)
Richard Kamwi, Program Manager, Namibia
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Peter Kazembe, Malaria Committee Chair, Malawi
Ian Kershaw, AusAID
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W Kílama, African Malaria Vaccine Testing Network
A Kondrachine, WHO/HQ
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Batsirai Makundike, Program Manager, Zimbabwe
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Bernard Nahlen, CDC
Thomas Nchinda, Global Forum for Health Research
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Hope Phillips, World Bank Harare
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Alastair Robb, WHO/AFRO and DfID
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Lateef Salako, Nigerian Institute of Medical Research
Bakary Sambou, Program Manager Senegal
Caroline Sergeant, DfID Nairobi
Awash Teklehaimanot, WHO/HQ
Stephane Tohon, National Malaria Consultant Benin
Steward Tyson, DfID Harare
Iyorlumun Uhaa, UNICEF Uganda
Oladapo Walker, WHO/AFRO
S Wessels, MoH Namibia

APPENDIX C

**RECOMMENDATIONS FROM WHO/AFRO TASK FORCE WORKING
GROUPS**

Harare, Zimbabwe

Working Group 1 Community Mobilization

The 2nd Meeting of the Task Force in June 1996 made several recommendations regarding community mobilization. The working group of the 3rd Task Force Meeting recognizes that several of the recommendations they make this year repeat those of the last Task Force. However, the continued gaps in capacity for community mobilization within malaria control programs compel us to reiterate these recommendations and make additional recommendations.

To ministries of health

- 1) IEC or health education units of the ministry should be strengthened and encouraged to develop new approaches to IEC, including social marketing of ITMs and community mobilization.
- 2) A strong central capacity for IEC should support the work of focal persons for IEC at regional and district levels.
- 3) Development of IEC and community mobilization skills should be a central part of pre-service training for health workers in addition to exposure to national case management and prevention policies.
- 4) Strong intersectoral cooperation and collaboration, including activities of NGOs, should be created by the ministry.

To malaria control programmes

- 1) Programmes should form a national malaria committee with diverse representation from communities and other sectors, including the private sector.
- 2) Programmes should liaise well with the IEC unit of the Ministry of Health, to ensure adequate programme representation in planning for training, developing IEC materials and messages.
- 3) Training carried out by the programme, both in case management and other activities, should include strong and adequate training in counseling and community mobilization.
- 4) Programme monitoring and evaluation indicators should include indicators of IEC and community mobilization activities.
- 5) Programmes should produce and distribute standardized IEC materials for management of simple malaria, which can be adapted to local needs.
- 6) Programmes should support districts in the recruitment, training, support, supervision and motivation of community agents. This must include an adequate supply of necessary drugs.
- 7) District health workers should give feedback to the community health committee on malaria impact. The committee should prioritize families or persons in need of bednets, insecticides, funds or other material and report back to the community worker. This person should then be the co-ordinator between DHW and the community to provide the necessary material for the appropriate people.

- 8) Coordination should be in accordance with existing structures in the community DHW should be the final technical coordinator of all participating groups in the different communities
- 9) The minimum package at the community level should be the diagnosis and treatment of simple cases, the recognition and referral of severe disease, the supply of drugs and chemoprophylaxis for pregnant women, ITMs (recognition of their utility, purchase, treatment and re-treatment, and proper use) and IEC
- 10) Programmes should encourage and co-ordinate relevant operational research on community case management and use of ITMs and utilize the results of the research to strengthen community-based activities
- 11) There are different structures in communities and the programme should recognize each particular structure and use it for sustainability

To WHO/AFRO

- 1) AFRO should identify a focal person to provide technical support for community-based activities and IEC for malaria control
- 2) AFRO should support national programmes in the mobilization of resources for IEC in order to facilitate new approaches
- 3) Because of identified gaps in health worker communication and community mobilization skills, AFRO should identify existing or develop new short courses in these skills for national staff An example is the UNICEF training in communication strategies held last year in Eritrea
- 4) AFRO should develop linkages with organizations having greater experience in community mobilization (a particular example is UNICEF)

Working Group 2 An Africa Malaria Initiative for the 21st Century Statement from the WHO/Afro Task Force on Malaria

The Task force recognizes

- the continuing problems of malaria morbidity and mortality in Africa and the associated social and economic implications,
- the limited impact of various attempts to control malaria and the variety of reasons for it lack of political will and resources, weak health care systems, inadequate implementation of existing control techniques, poor leadership among key agencies working in malaria control and fragmentation of their efforts,
- that there are reasons for optimism with new techniques available ITMs, new treatments, candidate vaccines, new therapies being developed, new attention being given to environmental issues and to improving access to preventive and treatment services,
- global and international commitments the Amsterdam 1992 conference, the MIM, the G8, increased bilateral interest in and commitment to malaria control,
- the regional political commitment through the Harare Declaration of 1997, the preliminary work by the World Bank and AFRO on an African initiative, the work of the Expert Committee and the results and experience of the DG's Africa initiative for the intensification of malaria control in Africa,
- the work of AFRO in building on the growing global, international and regional commitment to malaria, particularly in Africa through the establishment of an Expert Committee to examine the possibility of an Africa malaria initiative

The Task force recommends to the Regional Director that

- he approach the DG and other partners to ensure that the issue of an Africa-wide long-term initiative for malaria control is included on the agenda at the World Health Assembly in May 1998 and at the G8 summit in May 1998,
- he establish a working group to take forward the development and key elements of the initiative, making recommendations on
 - establishing the process of consultation with key partners at all levels with a focus on country-level consultation to ensure political commitment and ownership, including an analysis of key players and their comparative advantage in contributing to the process,
 - the development of a communication strategy for the initiative across Africa in order to galvanize political support and inform the populace at a country level towards malaria prevention and control activities,
 - working with EMRO to cover the whole of Africa,
 - ensuring synergy with global developments,
 - clarifying the objectives and targets of the initiative and developing strategies through a review of existing policies and strategies taking into account opportunities and constraints,

- exploring possible financial and institutional mechanisms for the initiative,
- providing a likely time table and implementation schedule

The outcome of the working group will also include a preliminary statement which will be made to the next World Health Assembly and Organization of African Unity (OAU) conference

The Task Force strongly recommends that during the initiative development and deliberations the following be taken into consideration

- the initiative should be African led and built on African institutions, including representation by all major bilateral partners and driven by WHO,
- this is likely to be a long-term initiative over 20-30 years with an evolving strategy, therefore making it essential to invest time and energy into getting it right,
- interim strategies will be necessary to tackle the problems of malaria morbidity and mortality and to build the capacity to effectively utilize the substantial additional resources likely to be available,
- development of this initiative will be beneficial and enhance wider health sector developments in Africa

APPENDIX D

MINUTES OF THE AMREF, USAID, CDC, BASICS, QAP MEETING

March 2, 1998

Webuye, Kenya

MINUTES OF MEETING HELD ON 2/3/98 BETWEEN USAID AND COLLABORATING AGENCIES

The meeting took place at Park Villa Hotel (Webuye) from 5 10 pm Victor Masbayi formally welcomed the participants and requested them to introduce themselves

He then stated the purpose of the meeting, which was building a team of collaborating agencies He gave the following as the issues which required discussion

- 1 Roles and responsibilities of collaborating agencies
- 2 Implementation plan
- 3 Communication
- 4 Budgeting
- 5 Any other business

1 Roles and responsibilities

Victor pointed out that the role of AMREF is clearly stated in the five year strategic plan document These include

- 1 Coordination of all USAID input financial, logistics, and supplies into BDI project
- 2 Management and liaison duties of the project
- 3 Technical input

From the discussions, it emerged that this role was not clearly understood by other CAs, who in other countries have their own offices and personnel on the ground

On operational research it was agreed that the other CAs should consult AMREF when they set consultancy rates and other budgetary allocation to line items to avoid inconveniences and misunderstanding It was further agreed that AMREF rates will apply in the district during BDI implementation AMREF was requested to provide its field rates and consultancy rates to other collaborating agencies in writing This will enable them to prepare realistic budget estimates for their local costs (ACTION AMREF)

2 Implementation plan

The current detailed implementation plan (DIP) was produced in May 1997 and due to long delay in contract signing, activities could not be started as planned The DHMT/Coordinating unit produced a new DIP for this year, which was distributed to other CAs The CAs also had produced their own DIP and reconciling these two documents was not easy

Dennis pointed out however that the original DIP sequence/timing of activities will be followed, unless there is very significant reason for changing the sequence

It was agreed that there was a need to give written feedback on the DHMT/AMREF DIP by the CAs and also the DHMT/AMREF should have provided some explanation why there were changes on activities timing

It was further agreed that in the future AMREF will be included in the conference calls of other CAs when BDI is discussed

The BASICS team pointed out that its contract with USAID expires on 30th September this year and there is need therefore for it to complete all its planned activities by August

Dennis stated that this issue is being looked into by USAID and he re-affirmed the USAID stand that the 1997 DIP sequence of activities should remain as it is and only the timing of activities implementation altered January this year will be taken as the first month instead of July last year

3 Communication

It was pointed out that there have been some communication problems due to a lack of appropriate equipment for the project (computers, fax machines) and due to the unclear channels of communication between DHMT and CAs

The meeting agreed that all communication to the DHMT should be through AMREF and mechanisms for communication between all CAs should be developed In the meantime, urgent communication should be e-mailed to either Dr John Nduba or Dr Muthoni Kariuki in AMREF Kenya Country Office, Nairobi

It was further agreed that a lead time of six to eight weeks be given to AMREF by other CAs before their arrival in Kenya or start of any field study The CAs should also specify qualifications and experience of researchers they require for the field studies This will enable AMREF search for the right researchers A recruitment cost budget line should be included to meet travel costs (Action all CAs)

4 Budgeting

Dennis explained that a transparent budget where DHMT members will know how much money has been allocated per CA will be worked out without specifics

He also explained that local costs of all CAs will be met by AMREF, as USAID will provide extra funds to AMREF to meet this cost The CAs were therefore asked to work out their local costs using the AMREF rates and provide this to AMREF as soon as possible AMREF will then prepare a budget for all local costs and submit it to USAID for funding consideration Dennis also asked the participants to ignore the budget indicated per activity in the current implementation plan (Action other CAs, AMREF)

Dennis further explained that a budget line item will be included in the document to meet local training costs for DHMT members. The relevant short course organized by AMREF, WHO or other recognized bodies within Kenya and the region will be met by this budget line item. This budget line item will also meet the costs of attending relevant malaria and IMCI conferences/seminars/workshops to be attended by AMREF staff providing technical back-stopping to the BDI project. (Action: Victor, Dennis)

There was not any other AOB and the meeting ended at 10:15 pm. Victor thanked all participants for their active participation.

Minutes taken by Hezron Ngugi

APPENDIX E

BDI REVISED IMPLEMENTATION PLAN

March 3, 1998

Operations Research	Input	Key Persons District	Key persons USAID partners	Quarter	Expected outputs
#1 Further assess performance and the skills knowledge and managerial factors that affect quality of care at NGO health facilities facility based health workers clinical supervisors in-patient** and out patient management interpersonal communications skills	1 1	DCO PHN	CDC* Med Epd & Beh Scientist QAP ^(R) AMREF ^(R)	May/June,98	FACTORS AFFECTING HEALTH WORKER PERFORMANCE ASSESSED BOTH IN GOK AND NON-GOK FACILITIES
#2 Assessment of barriers to supervision (other than technical skills and knowledge) at district facility and community levels	1 2	MOH*	AMREF * Management specialist CDC ^(R)	April/May,98	NON-TECHNICAL BARRIERS TO SUPERVISION IDENTIFIED (e g transport)
#3 Assessment of current laboratory procedures (e g quality and availability of microscopy and	1 7	Lab Tech *	CDC* Malariaologist Malaria Unit ^(R) AMREF ^(R)	May/June, 98	APPROPRIATE ROLE OF LABORATORY PROCEDURES IN BDI ELABORATED

*-Refers to Officer/Partner with key responsibility for activity

^R -Refers to backup resource for activity

**** Timing for in-patient management assessment will be revisited at a later date**

OPERATIONS RESEARCH	INPUT	Key Person District	Key Person USAID Partners		Quarter	Expected Outputs
<p>#4 Further assess and characterize health seeking pathways of caretakers (understand decisions made and why) including</p> <ul style="list-style-type: none"> - mother s compliance with referrals and barriers to compliance - drug purchase behavior - expectations experience acceptability and affordability of various treatment options - traditional treatments - proximity to health facility (GOK and non GOK) - IEC channels recognition of signs symptoms - terminologies of illness related to malaria 		DHEO PHN Nutritionist	BASICS* Social Scientist		Feb\April 98	HEALTH SEEKING PATHWAYS OF CARETAKERS CHARACTERIZED IN DETAIL
<p>#5 Assessment of community distribution outlets for drug supply (current and potential)</p> <ul style="list-style-type: none"> - women s groups - self-help groups - shops (business people) - NGOs - BDI sites - VHC/HCDC - youth groups - church groups - market vendors 		DHMT* Pharmacist or Phrm Tech	DHMT* EDP Pharmacist KEMRI ^(R) Social Scientist AMREF ^(R) BASICS ^(R)		April\May	INVENTORY OF COMMUNITY OUTLETS FOR ANTI MALARIAL DRUGS COMPLETED

OPERATIONS RESEARCH	INPUT	Key Persons District	Key Persons USAID Partners		QUARTER	EXPECTED OUTPUTS
#6 Further assess and characterize health seeking pathways of pregnant women (understand decisions made and why) <ul style="list-style-type: none"> - compliance with referrals - compliance with treatment - drug purchase behavior - expectations experience acceptability and affordability of various treatments <ul style="list-style-type: none"> - traditional treatment - proximity to HF (GOK/non GOK) - community knowledge attitudes and practices on Malaria in Pregnancy - ANC - malaria retreatment and prevention including ITM - role of husband/community - TBAs - barriers to use - IEC channels 	3 3	DPHN DSDO Nursing Officer	CDC* Social Scientist + BASICS Social Scientist		Oct Nov 98	HEALTH SEEKING PATHWAYS FOR PREGNANT WOMEN CHARACTERIZED
#7 Further assess community knowledge attitudes and practices on ITMs (ability/willingness to buy acceptability seasonality related to availability of funds ITM and insecticide distribution outlets IEC channels and barriers to use)	4 3 4 4	DHMT DPHO* DHEO DPHN DSDO	AMREF* DFID ^(R) CDC ^(R)		July August, 98	COMMUNITY ISSUES RELATING TO ITMs CHARACTERIZED

POLICY DIALOGUE		INPUT	KEY PERSONS	QUARTER				EXPECTED OUTPUTS
#1	Drug policy review with national policy makers and manufacturers - use of effective firstline drug such as Fansidar - community based drug distribution (to include BDI sites) - drug efficacy - drug side effects - antenatal use (prevention/treatment) - responsible drug marketing (manufacturers) - packaging with anti pyretic - formulation (pediatric/adult) - pricing - availability in kits/EDP	1 3 2 3 3 1	All Policy Dialogue should be resp of MoH PHCP and USAID staff	xxx	xxx	xxx	xxx	NEW FRONT LINE DRUG POLICY FOR MALARIA TREATMENT AND CHEMOPROPHYLAXIS IN PLACE
#2	Dialogue with national policy makers and other donors on IMCI - standards - role of laboratory - indicators - implications for HIS (including revision and replication of CHMIS) - provision for adequate supervisory logistic support	1 4		xxx	xxx	xxx	xxx	COORDINATING BODY FOR IMCI AT THE NATIONAL LEVEL FUNCTIONING
#3	Dialogue with HCFS (Health Care Finance Secretariat) regarding community financing schemes for drug and ITM and insecticide procurement	1 11 2 4 3 1 4 2					xxx	FORUM FOR ROUTINE DISCUSSION WITH HCFS ESTABLISHED AND INITIAL DISCUSSIONS HELD

ALL policy dialogue to involve the MOH (Odongo) and Western Province PHCP with USAID

POLICY DIALOGUE		INPUT	KEY PERSONS	QUARTER			EXPECTED OUTPUTS
#4	Request for gazetteement of Rural Health Facility Committees (HCDC) and linkage to the DHMB	1 12				xxx	INITIAL DISCUSSIONS ON GAZETEMENT OF HCDC AND LINKAGE TO DHMB HELD
#5	Dialogue with national policy makers on ITM strategy - insecticide choice - tax exemption on materials and insecticide	4 1				xxx	FORUM FOR NATIONAL DIALOGUE FOR ITM ESTABLISHED INITIAL DISCUSSION
#6	Dialogue with District policy makers and planners on the development of a plan to provide equitable and adequate health services coverage	1 13				xxx	DIALOGUE BEGUN

IMPLEMENTATION ACTIVITIES	INPUT	Key Persons District	Key Person USAID Partner		EXPECTED OUTPUTS
<p>Objective 1 CASE MANAGEMENT OF FEVER AND ANEMIA AT THE HEALTH FACILITY</p> <p>1 1 Expanded training of clinical health workers and supervisors in IMCI (based on current IMCI activities)</p>	<p>1 5</p>	<p>DCO Med Sup</p>	<p>CDC* IMCI Specialist +</p>	<p>February 98 Continuous</p>	<p>TRAINING OF CLINICAL AND SUPERVISORY HEALTH WORKERS IN IMCI CONTINUED AND EXPANDED TO INCLUDE NON-GOK FACILITIES</p>
<p>1 2** Develop and field test a modified IMCI plan for improved case management at health facilities (GOK and non GOK)</p> <ul style="list-style-type: none"> - in patient - supervision - IEC - Policy - Training - laboratory aspects - supplies - OR - basic standards for admission and referral 	<p>1 9 1 10 1 16</p>	<p>DMOH</p>	<p>BASICS Training Specialist</p>	<p>ACTIVITY 1 2 POST PONED TO JAN FEB 99</p>	<p>A PLAN FOR IMCI INCLUDING CURRICULA, TRAINING MATERIALS AND METHODS DEVELOPED FOR TRAINING CLINICAL AND SUPERVISORY HEALTH WORKERS, INCLUDING</p> <ul style="list-style-type: none"> guidelines for clinical diagnosis -standards for proper treatment protocols for health worker counseling of caretakers on proper management of illness guidelines for patient referral standards for supervision

IMPLEMENTATION ACTIVITIES	INPUT	Key Persons District	Key Persons USAID Partners		EXPECTED OUTPUTS
<p>Objective 1 CASE MANAGEMENT OF FEVER AND ANEMIA AT THE HEALTH FACILITY (cont)</p> <p>1 3** Develop and field test a training program for IPD and OPD including materials and methodology for clinical health workers (GOK/non GOK) and supervisors</p> <ul style="list-style-type: none"> - IMCI - pregnant women with fever - technical skills - communication (IEC and IPC) <p>1 4 Develop and implement a logistics plan for supervision of the above activities</p>	<p>1 15</p> <p>1 6 1 14</p>	<p>DCO DHEO DPHN Lab Tech</p> <p>DHAO AMREF As above</p>		<p>ACTIVITY 1 3 POSTPONED TO JAN FEB 99</p> <p>Follow</p>	<p>TRAINING PROGRAM FOR IPD AND OPD DEVELOPED AND READY FOR FIELD TESTING</p> <p>LOGISTIC PLAN TO SUPPORT SUPERVISION DEVELOPED AND UNDER IMPLEMENTATION</p>

** Activities 1 2 and 1 3 are dependant on assessment 6 scheduled for October/November There is need to dis aggregate and allow for proper sequence of these activities

IMPLEMENTATION ACTIVITIES	INPUT	Key Persons District	Key Persons USAID Partners	QUARTER	EXPECTED OUTPUTS
Objective 2 HOUSEHOLD MANAGEMENT OF FEVER					
2.1 Assessment of existing IEC in the district - supervision - IEC - Policy, - Training - supplies - OR - SP availability and guidelines at community level	2.5	DCO* DHEO DPHN Lab In Charge	BASICS IEC Specialist* CDC ^(R) AMREF ^R	March 98 March 98	PLAN FOR COMMUNITY MANAGEMENT OF FEVER AND ANEMIA DEVELOPED AND FIELD TESTED
2.2 Develop a training program for provision of malaria treatment and IEC in the community - TBAs - CHWs - Chemists/Pharmacists - Shopkeepers - Traditional Medicine Practitioners - supervisors	2.6	DCO* DHEO DPHN LAB in charge Pharmacist	BASICS* CDC ^(R) AMREF ^R	Moved to Jan 99	PLAN FOR IEC TRAINING PROGRAM TO SUPPORT COMMUNITY/HOUSEHOLD LEVEL MANAGEMENT OF FEVER AND ANEMIA DEVELOPED AND FIELD TESTED

40

IMPLEMENTATION ACTIVITIES	INPUT	Key Parsons District	Key Persons USAID Partners	QUARTER	EXPECTED OUTPUTS
<p>Objective 2 HOUSEHOLD MANAGEMENT OF FEVER (cont)</p> <p>2.3 Develop Field test and begin to implement an IEC program for appropriate management of malaria with SP (at the household and facility level)</p> <ul style="list-style-type: none"> - How to recognize signs symptoms - When what, where to get appropriate treatment - Differences between SP and CQ - Need to use anti pyretic with SP - Benefits of SP - appropriate use of drugs - side-effects/safety 	2.7	DHEO* DCO DN Pharmacist	BASICS* AMREF ^(R)	June/July 98	AN IEC PLAN TO SUPPORT APPROPRIATE MANAGEMENT OF MALARIA DEVELOPED AND FIELD TESTED

CASE Management at Household level The Health Center Management Team (HCMT) would be trained to work with DHMT to carry out these activities

IMPLEMENTATION ACTIVITIES		INPUT	Key Persons District	Key Persons USAID Partners	QUARTER	EXPECTED OUTPUTS
	Objective 3 PREVENTION OF MALARIA IN PREGNANT WOMEN					
3 1	Develop and field test a plan for improved ANC prevention of malaria in pregnancy - supervision - IEC, - Policy - Training, - supplies, - OR	3 4 3 5 3 6	DPHN* CNS DN	CDC Mothercare ^(R)	ACTIVITY 3 1 POSTPONED TO JAN 99	A PLAN TO SUPPORT ANC PREVENTION OF MALARIA IN PREGNANCY DEVELOPED AND READY FOR FIELD TESTING

IMPLEMENTATION ACTIVITIES		INPUT	Key Persons District	Key Persons USAID Partners	QUARTER	EXPECTED OUTPUTS
	Objective 4 INSECTICIDE TREATED MATERIALS					
4 1	Develop a plan for implementation of ITM program - source - distribution, - IEC - policy - financing, - supervision, - sustainability - treatment and retreatment, - monitoring of effective use of nets, - social marketing, - coordinate with other NGOs/donors on supply and distribution of the ITMs and production of IEC materials	4 5 4 6 4 7	DHEO DPHO*	AMREF* BASICS ^R DFID ^R	October/Nov 98	A PLAN FOR IMPLEMENTATION OF A COMPREHENSIVE ITM PROGRAM DEVELOPED AND READY FOR FIELD TESTING

SPECIAL SURVEYS	INPUT	Key Persons District	Key Persons USAID Partners	QUARTER	EXPECTED OUTPUTS
#1 Develop plan for special studies to monitor and evaluate impact outcome and process indicators for <i>BDI</i> . For each of the special studies the plan should include: <ul style="list-style-type: none"> - complete protocols, - description of data sources and study methodology, - sample size calculations and sampling frame - timing of baseline data collection and analysis, - timing of follow-up data collection and analysis, - selection of study and comparison sites - appropriate plans for logistics, supplies and supervision Protocol for Mortality Baseline Survey Referral Study		MOH* Coordinator HIS	CDC*- Malariaologist CDC-Trainer BASICS- Community Specialist	August 98	A PLAN FOR MONITORING AND EVALUATION DEVELOPED AND READY FOR FIELD TESTING
#2 Implementation of M/E plan **		AS ABOVE	CDC*	March 99	DISTRICT HEALTH PERSONNEL TRAINED IN M/E METHODOLOGY DATA COLLECTION AND ANALYSIS DATA COLLECTION UNDERWAY
#3 Data collection and analysis** underway Follow-up visit to assess progress and assist with analysis			CDC*	March 99	ANALYSIS BEGUN BY DISTRICT HEALTH PERSONNEL
#4 Baseline finalized**				March 99	BASELINE SET

Activities 2 3 and 4 postponed until further discussion

BASICS

BASIC SUPPORT FOR INSTITUTIONALIZING CHILD SURVIVAL

TD 000 ZA 58 012/000 KN 01 012/000 AF 58 011

May 28 1998

Dear Colleague

A copy of the report entitled "Technical Meetings Zimbabwe, Kenya, and Zambia" by Mary Ettling is attached. This report details the author's activities during the above mentioned meetings held during February 22-March 28, 1998.

Please contact the Information Center at BASICS/Washington by mail or fax if you would like additional copies of this report.

Sincerely,



Patricia Bandy

Director of the Information Center

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