Tanzania Malaria Programme Review 2010

Programme Review Proposal

National Malaria Control Prigramme
Ministry of Health and Social Welfare
Dar es Salaam, Tanzania

May, 2010

ABBREVIATIONS

ACTs	Artemesinin Combination Therapies
ADDO	Acredited Drug Dispensing Outlet

DSS	Demographic Surveillance Sites
HMIS	Health Management Information System
IRS	Indoor Residual Spraying
ITNs	Insecticide Treated Nets
LLINs	Long Lasting Insecticide Treated Nets
MDGs	Millennium Development Goals
MPR	Malaria Programme Review
MUHAS	Muhimbili University of Health and Allied Sciences
NMCP	National Malaria Control Programme
THMIS	Tanzania HIV and Malaria Indicator Survey
WHO	World Health Organization
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
DSS	Demographic Surveillance Sites
IPTp	Intermittent Preventive Therapy in pregnancy
SP	Sulfadoxine-Pyrimethamine
ALu	Artemether-Lumefantrine
PSI	Population Services International
ANC	Antenatal Clinic
NMMTSP	National Malaria Mid-term Strategic Plan
M&E	Monitoring and Evaluation
NPO	National Professional Officer
MUHAS	Muhimbili University of Health and Allied Science
UNICEF	United Nations Children's Fund
IHI	Ifakara Health Institute
PMI	US-Presidential Malaria Initiative
UDSM	University of Dar es Salaam
NEMC	National Environmental Management Council
MPR	Malaria Programme Review
MSD	Medical Store Department
TFDA	Tanzania Food and Drug Authority
MOHSW	Ministry of Health and Social welfare

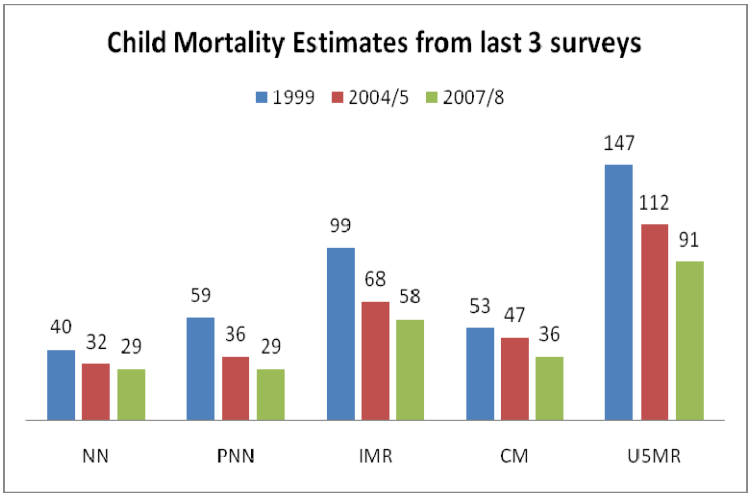
TABLE OF CONTENTS

1. INTRODUCTION

1.1 The Malaria burden

Malaria is the single most significant disease in Tanzania affecting the health and welfare of its 40 million inhabitants (projections from the population census of 2002). The population groups most vulnerable to malaria are children under five years and pregnant women.

It is estimated that 90% of the population in Tanzania is at risk of malaria resulting into 11 million clinical malaria cases per annum (NMCP, 2008). There is increasing evidence in recent years that undoubtedly the scale-up of proven interventions are making an impact. The Tanzania HIV/AIDS and malaria indicator survey (THMIS) 2007/08 demonstrate a significant decline in both infant and under-five mortality over the previous five years.



Legend
NN: Neonatal
PNN:Perineonatal
IMR: Infant Mortality Rate
CM:Child mortality
U5MR:Under-five mortality rate.

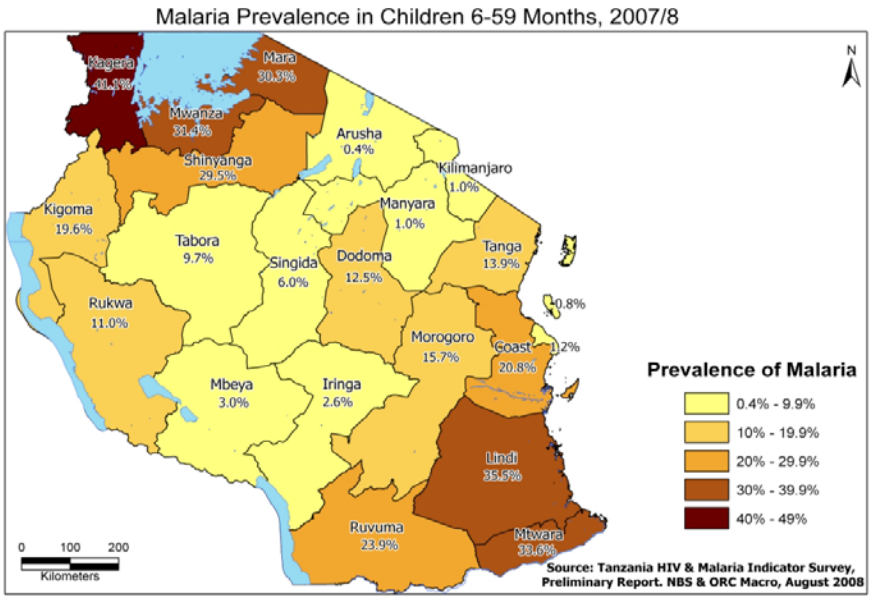
Figure 1: Trends of Neonatal, Perinatal, Infant and Under five mortality in the last 10 years, showing a steady and consistent decrease

Studies carried out in the Demographic Surveillance Sites (DSS) have observed that malaria contributes to about 36% of all deaths in Tanzania in children under five years of age (IHRDC – DSS 2005), therefore it is a huge contributor to child mortality. The scaling up of malaria interventions country wide has significantly contributed to the reduction in infant and child mortality described above. For example the implementation of Intermittent Preventive Therapy in pregnancy (IPTp) since 2001, scaling up of ITNs for the most vulnerable groups since 2004 and the

delivery of free Long Lasting Insecticidal (LLINs) to children under five years of age since 2009, change in malaria treatment policy from Sulfadoxine-Pyrimethamine (SP) to Artemether-Lumefantrine (ALu) in December 2006, and the introduction of Indoor Residual House-spraying (IRS) in epidemic prone areas and most recently the introduction of RDTs which is being phased into all the regions since 2009.

The THMIS (2007/08) observed that the average malaria prevalence had declined from 20% during a similar survey in 2006 to 18%, with anaemia in under five children falling from 10% to 8% over the same period.

In order to show the trends in malaria prevalence in the country; data is available from Rufiji and Ifakara Demographic Surveillance Sites where a signifiant decline has been observed since 2000. These two districts are highly endemic for malaria and are representative of typical intense malaria transmission areas. For example ifakara prevalence in 2000 was 35% and declined to 10% in 2008 which is a reduction of 60% in parasitaemia. This data is used as a proxy for the trends in malaria prevalence in the country as this is not available from previous demograhic health surveys.



Source: THMIS 2007/08

A number of institutions have carried out sub-national surveys in malaria control in recent years. These include;

- Coverage of mosquito nets in selected districts by the National Institute for Medical Research (NIMR) – Feb – March 2008
- Coverage of mosquito nets in selected districts by Population Services International (PSI) – March – May 2008
- Coverage of mosquito nets, IPTp, the prevalence of parasitaemia and anaemia in selected districts by the NMCP – June 2008
- The coverage of mosquito nets, IPTp, the prevalence of parasitaemia and anaemia in selected districts by the Tanzania National Voucher Scheme (TNVS) – July – Sept 2008

The national representative data which are available through DHS and the Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) are quoted by the MOHSW as the most representative data for malaria in Tanzania

1.2 Challenges in malaria control

Malaria diagnosis

Malaria treatment in Tanzania is mainly based on clinical judgement in the majority of health facilities, especially lower level facilities. Most of the health facilities lack laboratory diagnostic capacity for malaria and hence most of the reported malaria cases are clinically diagnosed. According to NMCP, up to early 2009, 83% of health

facilities in Tanzania had no laboratory diagnostic capacity for malaria. In addition, there is a problem of inaccurate malaria microscopic diagnosis and hence misdiagnosis of patients and over use of ACT

Malaria Treatment

ACTs are available in the public health facilities and faith based organizations at no cost for children under the age 5 and pregnant women, and at a minimal cost for adults through cost sharing. ACTs are also available from the private health sector, but at prices that cannot be afforded by the majority of Tanzanians.

Other challenges with respect to treatment include improvement of access to ACTs in both the public and private sector, improving the awareness of people on the need for prompt treatment of malaria through ACTs, enhancement of the capacity of health workers on current malaria treatment, and inefficient flow of information from health facilities to NMCP related to ACT stock levels as well as ACT consumption.

Malaria in pregnancy

The challenges faced in control of malaria in pregnancy are firstly, to ensure availability of sufficient SP (Sulphadoxine-Pyremithamine) at health facility level. Secondly, advocacy needs to be enhanced to ensure timely attendance to ANC clinics. Thirdly, the quality of services at ANC clinics has to be improved through the provision of appropriate training for service providers.

Use of ITNs/LLINs

The distribution of ITNs has been carried out through a voucher system that target pregnant women and infants. The ITNs coverage to date is estimated to have reached 38% of households with at least one ITN, and 25% and 26% of children under 5 and pregnant women, respectively, using ITNs (2007-08, THMIS). Despite the intensive campaigns on the use of ITNs, the coverage indicators which have only been targeting children under five and pregnant women have not increased significantly. Re-treatment of the existing crop of conventional nets is also low.

Indoor Residual House-spraying

Indoor residual house-spraying (IRS) has been implemented in a high malaria prevalence region in North-western Tanzania with a high significant impact against

the disease. The NMMTSP plans to expand this intervention to cover half of the country where prevalence is still high. The limiting factor is the availability of funds to cover the remaining 53 districts.

Behavioural Change and communication (BCC)

BCC campaigns need to be carried out in a more systematic and co-ordinated manner in order to ensure optimal utilization of resources and enhance their effectiveness. An integrated and comprehensive information and communication strategy for malaria should be developed taking into account current best practices. Thirdly, a large proportion of the rural population have limited access to information about the signs and symptoms of malaria, risk groups, need for immediate malaria treatment, and malaria prevention techniques. Thus there is an urgent need for the intensification of communication on malaria in the rural areas.

Monitoring, evaluation, surveillance and operational research

An M & E plan has been developed which includes operational research for malaria control. However there is a need to operationalize the plan with the NMCP partners. The main weaknesses in the process of monitoring, evaluation, and surveillance include: limited financial support from existing funding mechanisms; partners are not adequately coordinated to collect and report data for M&E purposes; lack of appropriate human resources with the required M & E skills; HMIS staffs at district level have not been trained in malaria M&E; limited capacity of M&E unit at NMCP; inefficient coordinating mechanisms amongst specific sub-recipients; weak M&E network to capture malaria related operational research; lack of appropriate dissemination plan; lack of systematic feedback to sub-reporting entities concerning data quality; and lack of timely malaria data.

1.3 Rationale for the programme review

Over the past ten years, malaria control interventions have been scaled-up at the national level, yet no comprehensive review of the Malaria Programme has been undertaken. The interventions include:

- In the last quarter of 2006, Tanzania introduced a new antimalarial, ACT country wide.

- IRS was introduced in some districts of Kagera region since 2007. By December 2009, the whole Kagera region was covered with IRS, including the islands in Lake Victoria which are part of Kagera region.
- In late 2008, NMCP introduced the under-five catch-up campaign, whereby all children under five years of age were provided with an LLIN free to the end user.
- Since 2006, larviciding has been implemented in some parts of Dar es Salaam region

As Tanzania embarks on the ambitious goal of malaria elimination, it is now necessary to review progress and re-align the Programme as necessary to meet this goal

2. REVIEW OBJECTIVES

2.1 General objective

To conduct a comprehensive Malaria Programme Review to identify achievements, constraints, and best practices to guide future malaria control policies for achieving malaria elimination in Tanzania

2.2 Specific objectives

1. To review the malaria epidemiology in Tanzania
2. To review the NMCP programming framework within the context of the health system (programme structure, management and operation)
3. To assess the progress towards achievement of national, regional and global targets

4. To conduct desk review of current status on malaria interventions coverage since 2000
5. To conduct desk review on impact of malaria intervention scale-up in Tanzania since 2000
6. To identify gaps and priority areas for guiding the national, regional, district, facility-level, and community field visits
7. To identify the spectrum of factors that facilitated or hindered the (service) delivery, use and impact of interventions at all levels
8. To define the next steps for improving programme performance or redefining the strategic direction and focus including revisiting the polices and strategic plans
9. To disseminate the MPR outputs and translate findings for realigning malaria control strategy in Tanzania

3. REVIEW PROCESS TASK MANAGEMENT AND COORDINATION

The decision was sought to conduct this review from the MOHSW. The NMCP M&E Technical Working Group has been appointed to move the MPR process forward. The Working Group has obtained consensus from the Ministry of Health and Social Welfare, multiple stakeholders, and donors.

- Appointment of review coordinator and review secretariat

The review coordinator, Ms. Jubilate Minja has been selected by the National Malaria Control Programme Manager. The NMCP has opted to appoint the existing Malaria M&E Technical Working Group to assume the duties of the MPR secretariat

- The Internal review team

Several working groups/committees exist within the NMCP: malaria vector control, BCC working group, case management and M&E. Members from these working groups and representatives from prevention department of the MOHSW will constitute the internal review team, plus subject institutions and partners in malaria control in the country, such as WHO-NPO, MUHAS (senior experts), IHI, NIMR, PMI, UNICEF, Global Fund, World Bank, UDSM, NEMC and Clinton Foundation.

- The external review team

This will consist of invited experts from WHO, international consultant recommended by the WHO and selected NMCP managers invited from experienced countries.

4. REVIEW METHODOLOGY

The MPR process will be manly a desk and field review of all technical and management areas of malaria control in Tanzania. The selected review teams will cover the following technical areas - case management and laboratory, vector control and Entomology, Pharmacology, epidemiology, advocacy and monitoring and evaluation.

The program review will be conducted in four phases; Preparatory and Planning, Internal thematic desk reviews, Joint programme field reviews and lastly report writing, dissemination of results, implementation of recommendations

Phase I: Preparatory and planning

This proposal has been prepared in collaboration with malaria control partners and stakeholders. Review secretariat will be responsible for logistics, secretarial, communication and support. TORs for recruiting internal and external consultants will be prepared.

Eight (8) regions and one district from each region representative of the country have been chosen. These are Magu, Muleba, Kasulu, Lushoto, Dodoma, Rufiji, Tunduru and Mtwara. There will be coordination meetings for consultation throughout the MPR. Field visits including all logistics including; transport, accommodation and support for local teams will be managed by the review secretariat with a designated focal point assigned to coordinate the task.

Phase II: Internal thematic desk review

A review task team (with a minimum of 10 people) will be formed, consisting of the coordinator, the review secretariat, members from the technical working groups and a senior independent internal expert.

Eight thematic areas will be reviewed by a subject internal review team. These are:

- Programme management
- Case management and diagnosis

- Malaria prevention and treatment in pregnancy
- Malaria vector control
- Advocacy, IEC and BCC
- M&E, epidemiology, surveillance and operational research
- Epidemic and emergency preparedness and response
- Malaria commodities procurement and supplies

This phase will involve desk review by thematic areas based on programme data, reports, published/grey literature, plans, proposals and so forth.

Each thematic group will have a consultant who will be responsible for reporting to the secretariat and writing a final thematic review report. The team will amend the checklist to suit the respective context.

Phase III: Joint programme field reviews

In this phase III, field visits in 10 selected regions will be conducted. Members from each internal team will form part of the consolidated field team, which will constitute of both the internal and external members. Before the visit, briefing will be done to familiarise teams with the whole MPR process, field data collection tools and required reports from the field visits as well as final required reports (including press release, press conference, aide-memoire, media events, stakeholder workshops, etc)

The 10 selected regions will be divided in 3 ‘hypothetical’ zones, depending on the geography of the country; therefore, three field teams will be formed. Three of the teams will visit 3 regions each, while one remaining team will visit four regions.

Each group will be responsible for reporting to the secretariat and writing a respective field report.

LEVEL	INTERVIEWS/MEETINGS
NATIONAL	Minister for Health and Social Welfare, Permanent Secretary, Chief Medical Officer, All Directors and Assistant Directors, Commissioner of Social Welfare, Vector-borne diseases officer, Environmental Health unit, NMCP manager, Heads of cells, DG of MSD, NIMR, TFDA, NEMC, Minister/representative from Ministry of Water and Irrigation; Minister/representative of Lands, Houses and Development of Human Settlement, WR, country representative UNICEF, PMI, and private sector representatives
REGIONAL	RMO and RHMT, HIMS, RMFP, Heads of related Departments, Environmental Health, some NGOs at regional level.
DISTRICT	DMO and CHMT, HIMS, DMFP, Heads of related Departments, Environmental Health, some NGOs.
HEALTH FACILITIES	In-charge of Health facilities, heads of departments, HIMS, Nurses, Environmental Health Practitioners;
COMMUNITY	12 people from the community per FGD, 2 FGD per district.

***Phase IV*:**

In this phase, teams will finalise their reports and prepare a single MPR report. The aide memoire will also be prepared. Depending on the recommendations given, strategic plan, annual operational plans, guidelines and project proposals will be updated; a re-design of programme will be done if required. Articles for publication in peer reviewed journal will be prepared.

The results will be disseminated to the MOHSW administration, stakeholders and publications will be done.

4.1. Review Tools

WHO review check lists and tools will be adapted to address the Tanzanian context. Each internal team will build consensus on the tools and the final tools will be pre-tested in one of the districts.

4.2. Data management

The data collected will be captured in excel spreadsheets and tables and will be analysed with the assistance of biostatisticians. Both qualitative and quantitative statistics will be used to analyse the data.

5. EXPECTED MPR OUTPUTS

The MPR expected outputs of are:

- Programme thematic areas and sub-national reports of the review
- Programme Review Aide Memoire
- Programme Review Report
- Updated Medium Term Strategic Plan (2008-13), Malaria M&E Plan
- Peer-reviewed journal publications of program review articles
- Feedback to the Malaria Technical Working Groups and member of Malaria advocacy Committee

The dissemination of the review report will include all partners and stakeholders who will be engaged in updating the strategic plans for malaria program.

Follow-Up of MPR Recommendations

The NMCP in collaboration with partners will implement the recommendations from the programme review.

6. MPR TIMELINE

The MPR is expected to run from May 2010 to September 2011 detailed timeline is shown in Gantt chart below:

Review time line (Gantt chart)

		2010											2011								
Phase	**Steps**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**
Phase 1. Planning the malaria programme review	Step 1. Identify the need for a review																				
	Step 2. Build consensus to conduct a review with NMCP, MOHSW, partners and stakeholders																				
	Step 3. Appoint a review coordinator and establish internal review secretariat and internal review task team																				
	Step 4. Define the objectives and outputs of the review																				
	Step 5. Develop review proposal with budget and identify funding sources.																				
	Step 6. Identify and agree on terms of reference for internal and external review teams.																				
	Step 7. Make official request to WHO for technical support.																				
	Step 8. Select central, regional and district field sites for interviews and observations.																				
	Step 9. Plan administration and logistics.																				
	Step.10 Develop review checklist of activities																				

Phase	**Steps**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**

Phase.2 Internal thematic desk review	Step 1. Assemble information from available documents and reports																				
	Step 2. Conduct a technical desk review.																				
	Step 3. Compile the thematic desk review report.																				
	Step 4. Select and adapt data collection tools for field review.																				
	Step 5. Meet with RMOs and DMOs and familiarise with them the MPR. Give them the profile templates																				
Phase	**Steps**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**
Phase.3. Joint programme field review	Step 1. Briefing of and team-building between internal and external review teams																				
	Step 2. Consensus-building on findings of thematic internal desk review																				
	Step 3. Familiarization with data collection tools for field visits																				
	Step 4. Briefing and formation of field teams for field review																				
	Step 5. Central visits to national institutions and organizations																				
	Step 6. Regional, state, district and community field visits to malaria service delivery points																				
	Step 7. Sharing of reports and presentations from field review and consensus on key findings.																				
	Step 8. Preparation of field reports																				
	Step 9. Preparation of executive summary, aide-memoire and slide presentation of key findings and recommendations. Share aide memoir with partners before goes to CMO for signing																				
Phase	**Steps**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**

	Step 10. Preparation of Summary reports of Abuja targets																			
	Step 11. Presentation of review findings and recommendations to MOHSW																			
	Step 12. Presentation of review findings and recommendations to partners																			
	Step 13. Completion of final of review report																			
	Step 14. Prepare Articles for publication in peer reviewed Journals																			

Phase	Steps	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		S
Phase 4. Final report and follow-up on Recommendations	Step 1. Finalize and publish report																				
	Step 2: Printing the report 2000 copies																				
	Step 3. Disseminate and distribute report to regions, stakeholders, press release																				
	Step 4. Implement recommendations through: updating strategic plan, guidelines, implementation plan and proposals.																				
	Step 5. Monitor implementation of the recommendations.																				

7. BUDGET

Phase	Steps	Item	Total Costs
Phase 1. Planning the malaria programme review	Step 1: Identify the need for a review	0	-

	Step 2: Build consensus to conduct a review with partners and stakeholders	1 meeting	17,272,000
	Step 3: Appoint a review coordinator and establish internal review secretariat and internal review task team	meeting of review team	-
	Step 4: Define the objectives and outputs of the review	meeting/bworkshop	4,494,000
	Step 6: Make official request to WHO for technical support.	0	-
	Orientation of MPR to Ministriy's officials	meeting	3,942,999
	Training to NMCP staffs on MPR	workshop	16, 443,000
	Orientation of MPR to partners		17,272,000
	Step 7: Select central, provincial and district field sites for interviews and observations.	0	-
	Step 5. Identify and agree on terms of reference for internal and external review teams.	meeting	569,974
	Step 8: Administrative plan and logistics.		122,837,354
	Step 9: Develop review checklist of activities		16,556,425
	Step 10: Develop review proposal with budget and identify funding sources.	meetings	1,709,922
Phase.2 Internal thematic desk review	Step 1. Assemble information from available documents and reports	Photocopying	2,279,896
	Step 2: Conduct a technical desk review.	Meeting of sub-groups and local consultants support	35,900,000

	Step 3: Compile the thematic desk review report.	Meeting of sub-groups and local consultants' support	39,531,400
	Step 4: Select and adapt data collection tools for field review.	Meeting of sub-groups and local consultants support	2,279,896
	Step 5. Training to zonal teams	training	53,446,000
Phase 3. Joint programme field review	Step 1: Briefing of and team-building between internal and external review teams	Internal and External consultants travel and per diem	8,988,000
	Step 2: Consensus-building on findings of thematic internal desk review	Meeting of sub-groups and local consultants support	4,494,000
	Step 3: Familiarization with data collection tools for field visits	Meeting of sub-groups and local consultants support	38,755,500
	Step 4: Briefing and formation of field teams for field review		2,279,896
	Step 5: Central visits to national institutions and organizations Step 6: Provincial, state, district and community field visits to malaria service delivery points, and prepare zonal reports	Meeting Travel and per diem for internal and external consultants	113816000
	Step 7. Sharing of reports and presentations from field review and consensus on key findings, and compile field reports	Meeting	18986000
	Step 9. Preparation of executive summary, aide-memoire and slide presentation of key findings and recommendations	Workshop-	9119583.667
	Step 10. Presentation of review findings and recommendations	meeting	4494000
	Step 11. Completion of final draft of review report	workshop	35446000

Phase 4. Final report and follow-up on Recommendations	Step 1. Finalize and publish report	Formatting and publishing report	9119583.667
	Step 2. Disseminate report to government officials		7124000
	Disseminate report to implementing all partners		10,752, 000
	Step 3. Implement recommendations as part of updating policies, guidelines and plans.	meetings	20800000
	Step 4. Monitor implementation of the recommendations.	0	0
	Step 6. Update malaria policies and strategic and annual operational plans, and redesign programme, if necessary.	Meeting of sub-groups and stakeholder meetings	17, 436,750
Grand total			**591,514,429**

7. REFERENCES

1. Demographic Surveillance Sites (DSS 2005) report
2. National Malaria Medium Term Strategic Plan 2008-2013
3. NIMR, (2008) Coverage of mosquito nets in selected districts by the National Institute for Medical Research (unpublished)
4. NMCP (2008) Coverage of mosquito nets, IPTp, the prevalence of parasitaemia and anaemia in selected districts.
5. THMIS 2007/08