MAZAMO-mi CROSS-BORDER MEETING REPORT

CHIPATA, ZAMBIA

13th to 14th August, 2012

SARN
Gaborone, Botswana

1.0 BACKGROUND

Malaria Cross-border Initiatives in Southern Africa started in 2003 with the Lubombo Spatial Initiative (LSDI) a collaboration between Mozambique, South Africa and Swaziland. The LSDI resulted in 80 – 90% reduction in incidence of malaria in the three countries. This success over a period of five years demonstrated that a cross-border initiative is an important strategy for accelerating malaria elimination in Southern Africa and hence the need for establishment of other cross-border initiatives in the region. SADC Health Ministers took decisions and endorsed the SADC Malaria Strategic Framework and the Malaria Elimination Strategy in which the strategy of cross-borders was inscribed. The SADC Secretariat with the support of the Southern African Regional Network (SARN) – Roll Back Malaria Partnership in Southern Africa launched the Trans-Zambezi (TZMI), Trans-Limpopo (MOZIZA) and Trans-Kunene (TKMI) cross-border initiatives. Since these initiatives were all south of the Zambezi river, the Health Ministers in their meetings emphasized the need for covering all the countries in the SADC region. In line with the ministers' decisions, SARN facilitated teleconferences with the malaria program managers and partners from Malawi, Mozambique and Zambia during which it was agreed that the three countries will meet to establish a cross-border initiative in the region across the Luangwa river where the three countries converge. Following the teleconferences, SARN developed a draft Concept note which was disseminated to the NMCPs and partners of the region initially called the Trans-Luangwa (TLMI). Following their internal consultations, malaria program managers agreed to include the following districts in MAZAMO-mi: Malawi (Mchinji, Dedza, Lilongwe, Dedza, Mwanza and Mzimba), Mozambique (Chifunde, Macanga, Angonia, Maravia and Moatize) and Zambia (Chipata, Chadiza and Katete).

Group Photo of the MAZAMO-mi Participants

The MAZAMO-mi target districts are at different levels of malaria control with some in which there exists sustained malaria control and others with struggling programs. The burden of malaria in these districts with a total population of about 2 million also differs with some in which malaria is now below100/1000 people while others remain above 950/1000 people while CFR for all age groups is 5 – 45. MAZAMO-mi is an agricultural and tourist region and a major route link between Malawi, Mozambique and Zambia which plays a major economic role in the three countries and the SADC region as a whole. Thus, MAZAMO-mi plan will ensure removal of malaria leading to higher agricultural production, increase in the number of tourists, open more investment opportunities and avenues for employment and economic prosperity. This will boost economic recovery and poverty alleviation among the local communities in the region. The high malaria burden in this region including inadequate service delivery, barriers to service access/delivery due to stringent customs & immigration regulations, highly mobile populations, cross-border infections, uncoordinated surveillance systems, poor partner coordination and collaboration, limited service delivery/access to communities (quantity & quality) and inexistent referral mechanism at cross-border sites provided the justification for convening the meeting and establishment of MAZAMO-mi.

Malawi, Mozambique and Zambia NMCPs and partners met in the eastern district border town of Chipata, Zambia to establish the MAZAMO-mi cross-border initiative. The meeting was jointly supported by the Malawi, Mozambique and Zambia NMCPs and SARN. The Private Sector represented by the Global Business Coalition (GBCHealth), the Malawi and Zambia WHO malaria NPOs supported with facilitation of the meeting proceedings. Participants included representatives of the Malawi and Zambia NMCPs, provincial and district health officials from the MAZAMO-mi districts, WHO malaria NPOs, USAID-Malawi, GBCHealth and SARN. The provincial Medical Director of Eastern Province, Zambia (Dr Kenedy Malama), opened the meeting and emphasized the importance of using malaria as an entry point for a more comprehensive and coordinated health care approach and bringing into play other sectors such as agriculture, mining and tourisms.

2.0 Objectives

The objectives of the meeting were to:

a. Agree on coordination structure/mechanisms and hosting arrangements.
b. Establish the demographic and epidemiological profiles of the MAZAMO-mi region.
c. Develop district budgeted action plans.
d. Finalize MAZAMO-mi Concept note.
e. Develop a draft MAZAMO-mi Business Plan.
f. Agree on the name, vision and goal of the initiative.
g. Develop a MAZAMO-mi follow-up roadmap (next steps), gaps and TA Plan.

3.0 Achievements

At the end of the two day meeting, the following had been achieved:

A. **Project ownership:**
   a. The three NMCPs adopted the name: **MAZAMO-mi,** thus the working name trans-Luangwa (TLMI) was discarded.
   b. Agreed on the **Vision: –** "Malaria/parasite free MAZAMO-mi communities with social and economic prosperity- by 2025".
   c. Agreed on the **Goal: – "**Near zero transmission in MAZAMO-mi by 2020".
   d. Agreed to form coordinating committee and technical sub-committees
   e. NMCPs paid for their participants' accommodation and per-diems and SARN was responsible for conferencing costs only. In the past, all costs were the responsibility of SARN and the fact that the three countries supported their teams demonstrates their commitment to the MAZAMO-mi project.

Reaching agreement on the above, signaled the beginning of ownership of the project by the NMCPs.

B. MAZAMO-mi Concept note was finalized – the demographic, epidemiological and programmatic data presented by the districts was used for filling the gaps in the concept note. The concept note has now been integrated into the draft Business Plan.
C. A draft MAZAMO-mi Business Plan was developed using the concept note and draft districts action plans.
D. Draft districts budgeted action plans – the plans have activities, time lines and budget. Once finalized and printed, it will form the basis for resource mobilization.
E. TA plan and roadmap for the launch and operationalization of MAZAMO-mi – district presentations showed gaps in program management and capacity building (case management, CCM, diagnosis, PSM especially lack of storage facilities and on-going ACTs ad RDTs stock outs).
F. The participants also agreed on establishment of a 15 member Technical Coordinating Committee made up of 5 people from each country.
G. Establishment of technical advisory sub-committees for various thematic areas such as vector control, case management and diagnostics, Research (including Insecticide and drug resistance monitoring), BCC/IEC and M/E.
H. **Sharing of information and best practices:** districts presentations showed that malaria burden was high in all districts, there exists a high risk of cross-border movement of parasites, barriers (language, poor road infrastructure, difficult terrain and no formal cross-border linkages) to follow up of cases and on-going stock outs of malaria commodities. All three NMCPs are now aware of districts with the highest burden in MAZAMO-mi and also the districts that have the highest burden of dealing with imported cases **(20% of cases)** and also from which districts these cases come from. Presentations also provided a database to be used as the MAZAMO-mi baseline and for update of regional database – these data would not have been available if the meeting had not taken place. With this data, gaps (epidemiological and demographic, programmatic) in the concept note were filled and the data will now be used to inform decisions/planning and what needs to be done in the next steps.
I. All districts agreed that the role of community based workers was critical in strengthening surveillance/M&E at community and district levels. Community based workers are in all districts, but they are not adequate and they require on-going training to ensure they remain up to date with current developments and technology.
J. **Impact of current interventions** – IRS, LLINs, ACTs, RDTs, IPTp, Larviciding and BCC/IEC was demonstrated in the observed decreases in cases, deaths and CFR. The

rising number of confirmed cases using RDTs and in some cases microscopy and the number of pregnant women receiving IPTp-2 serve as other indicators that all districts are to a certain extent using them.


Working on districts action plans/budgets and during plenary sessions

4.0 Challenges

1. **Language barrier and non-disclosure of nationality** – while cross-border communities in both Malawi and Zambia understand each other to a certain extent, communication with Mozambique is difficult because of the Portuguese language. In communities where the same dialect is spoken, very often they mask their nationality and this makes it difficult to quantify both local and imported cases.
2. **Some health facilities/posts are manned by non-qualified staff -** this HR shortage limits both the quality and quantity of services available hence the need for more trained health workers.
3. **Limited access to health care in some districts –** difficult terrain (geographical barriers poor road infrastructure, inadequate health facilities/posts (patients walk >40 km), shortage of HR and on-going stock outs pause serious challenges to achievement of universal access to ACTs, RDTs, IRS, LLINs, Larviciding and IPTp (SP).
4. **Low coverage rates -** although some reports showed that high coverage rates (80 – 90%) were achieved in IRS and other interventions, these are not covering the entire district (due to in-adequate commodities).
5. **Operations/campaigns are not synchronized -** synchronization of spraying and Larviciding operations and LLINs distribution campaigns in the MAZAMO-mi region would result in a greater dent on malaria and is also cost-effective in terms of sharing pooled resources (commodities), equipment, human resource and technical support.
6. **Lack of formalized cross-border outreaches and referral systems –** there are no referral systems or joint outreaches at cross-borders as a result communities that would normally access a health facility within less that 8 km have to walk further as they require documentation to cross the border and

get treatment at the nearest centre in another country. Joint outreaches along the border would serve communities on both sides of the border.

7. **Following mass distribution campaign in Malawi,** their districts achieved universal access to LLINs – the campaign would have been even more effective if districts in Mozambique and Zambia had also distributed during the same period.
8. **Absence of resistance monitoring systems –** there are no systems for monitoring both drugs and insecticides.
9. **Discrepancy in the treatment protocols** among the three countries.
10. **Low adherence to LLINs use –** this is being observed in several districts and does require new BCC/IEC strategies because as the districts move towards low transmission, the problems will become magnified.
11. **Low capacity for Case Management/Community Case Management (CCM) and Diagnosis** – all districts emphasized the need for on-going training especially in latest developments, techniques and technologies in both case management and diagnosis. Because some communities are isolated and difficult to reach, there is need for strengthening CCM through increasing the number of Community Based Health Workers (CBWs or VHWs). CBWs will act as the first line of health care, facilitate contact tracing, ensure compliance with treatment, strengthen surveillance/M&E/data collection/SMS systems and are a key link for operationalization of the T_3 strategy (Test, Treat and Trace).

Mozambique showed the latest in nets hanging/use

5.0 Next Steps

1. NMCPs will provide names of the members of the Coordinating Committee and sub-committees by 30 August 2012.
2. All budgeted district action plans will be submitted by 30 September 2012.
3. Business Plan will be ready for dissemination to all stakeholders for final inputs by 30 October 2012.
4. An Aide Memoire with a budgeted Action Plan will be signed by the Health Ministers of Malawi, Mozambique and Zambia at a venue and date to be announced by 30 September 2012.
5. Inter-district Information and best practice sharing would start immediately.
6. Malawi NMCP will host the next meeting in Mwanza while Mozambique will host the 3rd meeting in Tete (dates and venues for both meetings to be determined by the MAZAMO-mi Coordinating Committee).

MAZAMO-mi Participants

6.0 Recommendations

1. There is need for reviewing the cross-border strategy with regard to achieving access to health care.
2. Provincial and district health officials have to ensure that sharing of information/best practices and joint contact tracing has started.
3. Harmonize treatment protocols/guidelines and synchronize preventive activities/operations in the MAZAMO-mi region.
4. Program managers to speed up formation and operationalization of the technical committees.

List of Participants

REGISTRATION FORM – Rolling out cross-border regional malaria control initiatives

Date : ***13 August 2012***

Venue : ***Crossroads Lodge, Chipata***

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ROLL BACK MALARIA

REGISTRATION FORM – Rolling out cross-border regional malaria control initiatives (Cont'd page 3)

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