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Regional Minimum Standards for the Prevention, Treatment and Management of Malaria in the SADC Region

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ENGLISH

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ACRONYMS & ABBREVIATIONS

ACT	Artemisinin-based combination therapy
AIDS	Acquired Immune-Deficiency Syndrome
DDT	Dichloro-diphenyl-trichloroethane
DHS	Demographic Health Surveys
HIV	Human Immunodeficiency Virus
IEC	Information, education and communication
IMCI	Integrated management of childhood illness
IPT	Intermittent preventive treatment
IPTP	Intermittent preventive treatment in pregnancy
IRS	Indoor residual spraying
IST	In-service training
ITN	Insecticide-treated nets
LLIN	Long-lasting insecticidal nets
M&E	Monitoring and evaluation
MCH	Maternal and child health
MICS	Multiple Indicator Cluster Survey
MIS	Malaria Indicator Survey
NGO	Nongovernmental organisation
NMCP	National Malaria Control Programme
PMI	U.S. President's Malaria Initiative
RBM	Roll Back Malaria [Partnership]
RDT	Rapid diagnostic test
SADC	Southern African Development Community
SARN	Southern African Roll Back Malaria Network
SP	Sulfadoxine-pyrimethamine
UN	United Nations
WHO	World Health Organization

1. BACKGROUND

1.1 Overview of Malaria in the SADC region

Malaria kills more than one million people each year. It has been estimated that most of these victims are children under five years of age, and that almost 90% of the victims live in Africa south of the Sahara. In the Southern African Development Community (SADC) region, Malaria accounts for more than 30% of outpatient visits, 40% of hospitalisations and one in five childhood deaths each year. The World Health Organization (WHO) has estimated that three-quarters of the population residing in southern Africa is at risk of contracting Malaria, with 35 million of these being children under five years of age and approximately 8.5 million being pregnant women.

Malaria transmission varies considerably in the SADC region, which comprises areas with stable and unstable transmission of Malaria, as well as Malaria-free areas. The region includes Member States with some of the highest burdens of Malaria on the continent, as well as others with very low or no Malaria burden. This variation could pose a challenge to developing region-wide programming standards. However, since Member States are moving in the same direction towards Malaria elimination, the theme of region-wide standards should address the necessary steps along the pathway toward elimination.

Botswana, Namibia, South Africa, Swaziland and Zimbabwe have predominantly unstable Malaria transmission and are more prone to epidemics. Lesotho, Seychelles and Mauritius mostly have imported cases of Malaria, and the remaining Member States have mostly stable endemic Malaria.

1.2 Rationale for the development of Regional Minimum Standards

Given the high burden of Malaria cases in the SADC region, SADC in 2007 introduced the Malaria Elimination 8 regional framework for eliminating Malaria.

Botswana, Madagascar, Namibia, South Africa, Swaziland and Zanzibar, which is part of the United Republic of Tanzania, were identified as the six Member States with the highest potential to eliminate Malaria. Botswana, Namibia, South Africa and Swaziland were chosen as first-line Member States for Malaria elimination, and Member States to the north with a relatively higher rate of transmission (Angola, Mozambique, Zambia and Zimbabwe) were considered second-line.

Given that significant proportions of populations are routinely engaged in cross-border movement, strengthening cross-border collaboration and establish additional initiatives between the first- and second-line Member States was emphasised. In response, the SADC Secretariat commissioned the development of Regional Malaria Standards. Once translated into policies and practices, the harmonised regional standards will help ensure that migrants and vulnerable populations receive standardised treatment throughout the region. The guidelines are also aimed at ensuring that similar prevention strategies are employed by each Member State.

The *SADC Protocol on Health* stipulates that cooperation between Member States in dealing with health issues is an essential ingredient for the effective control of both communicable and non-communicable diseases, and for addressing common health concerns in the region. The *Protocol* has prioritised the control of communicable diseases, including Malaria. Article 11 of the *Protocol* deals specifically with Malaria prevention and control and states that:

States Parties shall establish efficient mechanisms for the effective control of Malaria in the Region. States Parties shall co-operate and assist one another in order to reduce the prevalence of Malaria, and with support from stakeholders, ensure:

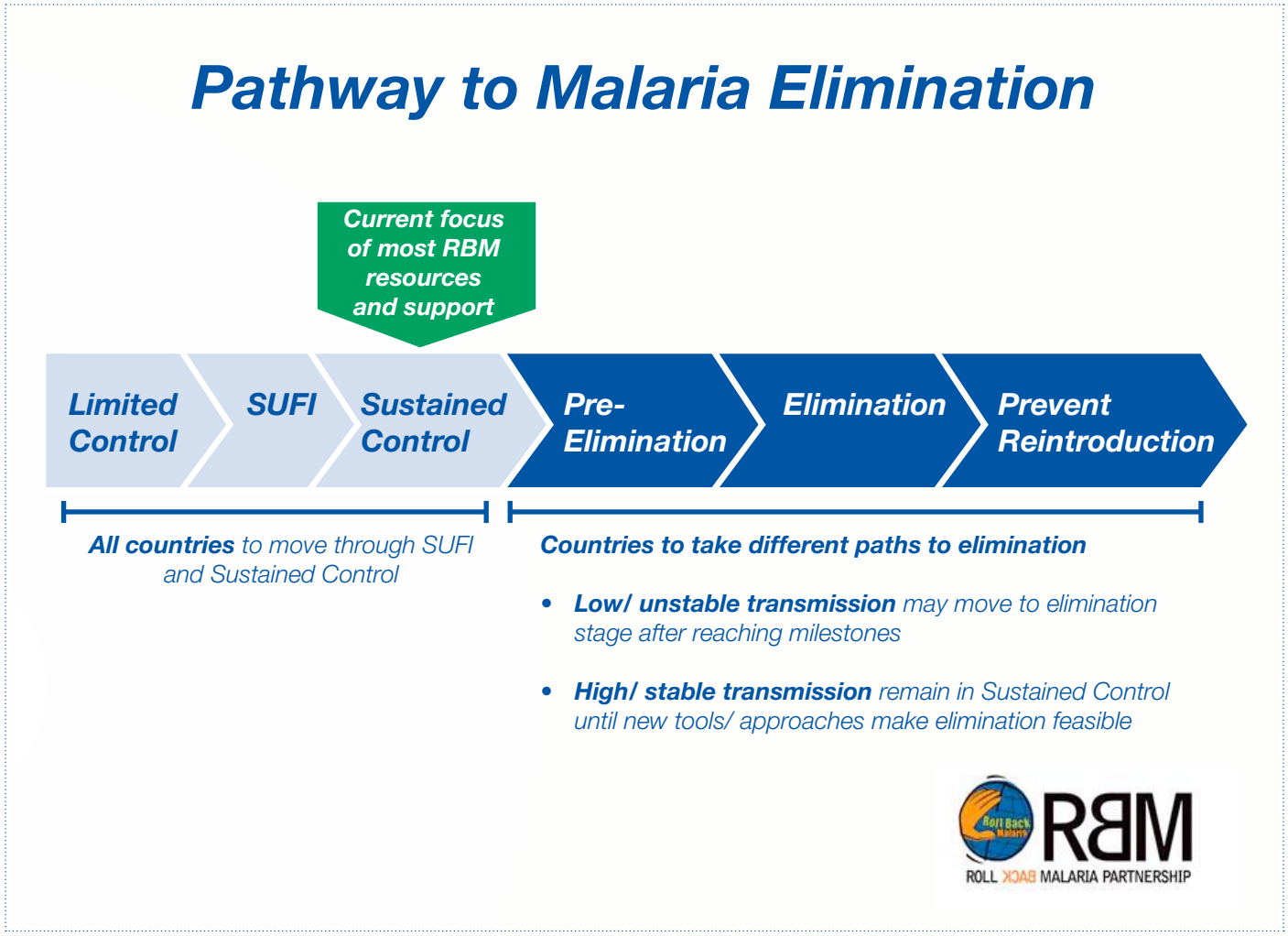
- The optimal use of resources for sharing scarce technical resources and operational research;
- Harmonising goals, policies, guidelines, protocols, interventions and treatment regimens; and
- Integrating Malaria control mechanisms into Primary Health Care Services.

This document presents the Regional Minimum Standards for the prevention, treatment, and management of Malaria in the SADC region.

2. FRAMEWORK AND PROCESS FOR DEVELOPING THE REGIONAL MINIMUM STANDARDS

A conceptual framework guided the process of learning about Malaria programming experiences, best practices and needs in the region. One key variable in the framework is the wide variety of transmission or epidemiological zones (even within individual Member States) in the SADC region. These zones range from highly-endemic, stable, year-round Malaria, to Malaria epidemics, and the absence of the disease.

Figure 1: Pathway to elimination—Second element of the conceptual framework



The second key variable in the process was the Roll Back Malaria Pathway to Elimination. As shown in Figure 1, the Pathway recognises that Malaria control is not a static process. As Member States scale up and sustain interventions, they can move into a pre-elimination phase and eventually become certified as having eliminated the disease. But even when Member States become certified, programming must continue for as long as Malaria transmission occurs in neighbouring Member States and regions. Interventions and standards therefore vary by location (as noted in the discussion of different transmission zones in the situation and response analysis report), but they also evolve over time as the transmission picture changes due to successful programming.

Two sets of programme standards have been developed based on findings from the country assessments:

- Standards for interventions according to transmission zone; and
- Standards for issues that cut across the different transmission zones.

Standards according to transmission zone include the key intervention standards, such as:

- Vector control measures;
- Malaria case management;
- Intermittent Preventive Treatment for Malaria in Pregnancy; and
- Surveillance, where applicable.

Standards according to crosscutting areas include:

- Policy/strategy formulation and updating;
- Human resources;
- Funding;
- Monitoring and evaluation (M&E) (including surveillance);
- Community participation;
- Procurement and supplies; and
- Coordination.

Cross-border collaboration as well as the need to update intervention planning to reflect progress along the pathway to elimination is a theme woven into most of the proposed standards. These are consistent with the analytical framework that guided collection of Malaria programming practices and experiences in the region.

The process for developing the standards involved a series of key steps, which are described below.

2.1 Desk review

A comprehensive literature review was conducted, including a review of grant proposals, progress reports and information from the Global Fund to Fight AIDS, Tuberculosis and Malaria, Roll Back Malaria Member States, the U.S. President's Malaria Initiative (PMI), Demographic Health Surveys (DHS), the Malaria Information System (MIS) and Multiple Indicator Cluster Survey (MICS). National-level policies, strategies and guidelines were used, when possible. The findings were presented in the form of an Inception Report, which included an overview of Malaria in the SADC region and gaps and recommendations in the prevention, treatment and management of Malaria. The report was accompanied by case studies for 15 Member States as well as assessment tools for site visits.

2.2 Site assessment visits

Technical experts conducted site assessment visits to all the targeted Member States and interviewed key Malaria personnel from the various Ministries, WHO, civil society organisations and other stakeholders, using the standard assessment tools. The findings of the assessment are reported fully in the situation and response analysis report and form the basis for the Regional Minimum Standards.

2.3 Technical expert review

The draft Regional Minimum Standards were presented to technical experts from selected Member States and key partners in the SADC region at the experts meeting, held in June 2011 in Gaborone, Botswana. Comments and changes from the technical expert review team were reviewed and integrated into the draft.

2.4 Consensus-building meeting

The revised Regional Minimum Standards were then presented to technical experts from all but one Member State, as well as key partners. This was followed by group discussion for consensus-building. The resultant comments and changes have shaped the subsequent drafts of the document.

2.5 Review by senior officials of Ministries of Health

The draft Regional Minimum Standards were also reviewed by senior officials from Ministries of Health who made recommendations to their Ministers for approval and adoption.

The draft Regional Minimum Standards follow below. They include some inevitable overlap between the various sets of standards; in programming, as in education, a certain amount of reiteration can be helpful to reinforce action.

3. REGIONAL MINIMUM STANDARDS FOR Malaria

The situation and response analysis report identified a number of exemplary practices which, if emulated, could contribute to the Malaria elimination agenda. On the other hand, there were also major constraints that may hinder progress towards elimination in a number of SADC Member States. The notable practices and constraints informed development of the Regional Minimum Standards.

It is hoped that once the Regional Minimum Standards are translated into policies and practice, they will ensure that populations in SADC Member States draw maximum benefit from efforts to control Malaria, and that Member States are effectively guided towards the goal of Malaria elimination.

This section presents the Minimum Standards for Malaria interventions that are relevant to the three major transmission zones. It also addresses crosscutting programme management issues.

3.1 Minimum Standards for interventions according to transmission zones

The standards related to transmission zones are presented below. It should be noted that while Member States may be in different transmission zones, they also may have different zones within their borders, and thus need to programme accordingly.

3.1.1 Areas with high, stable transmission

High, stable transmission zones constitute those areas in the SADC region where Malaria cases occur throughout the year, with or without seasonal peaks. Eight out of the 15 SADC Member States are in this category.

In these countries, the full WHO intervention package of indoor residual spraying (IRS), insecticide-treated (ITNs) or long-lasting insecticide-treated nets (LLIN), intermittent preventive treatment (IPT), rapid diagnostic tests (RDTs), and Artemisinin-based combination therapies (ACTs) has been adopted. This section presents the recommended Minimum Standards for areas with high, stable transmission.

Vector control measures

- IRS and LLINs need not be mutually exclusive, but must be programmed for maximum impact:

- For remote areas with access issues, LLINs should be prioritised over IRS;

- IRS should be targeted to stable and unstable transmission areas in order to maximise the benefit.

- With WHO and regional guidance, Member States must develop regional generic guidelines for disposal of used nets, which can be adapted by Member States;

- Member States should develop and use guidelines on integrated vector management;

- Vector control strategies should be implemented at all major ports of entry to SADC Member States to prevent importation of mosquitoes, especially to those Member States that have eliminated the Malaria vector;

- LLINs should be made available as part of routine health services as part of “Top-up” coverage measures. This includes antenatal and child health clinics;

- LLINs should be delivered as close as possible to the points of distribution;

- LLINs must be distributed free of charge at antenatal clinics as a complement to the LLINs that are distributed during campaigns;

- IRS should be implemented in conjunction with other control strategies (where appropriate and in accordance with WHO recommendations). Member States must ensure that IRS corresponds to transmission periods and is preceded by community education and mobilisation. Safety and security issues must be addressed during these preliminary activities;

- SADC Member States should be cognisant of the fact that current evidence suggests that most benefit from IRS is derived from its application in settings of *unstable* Malaria. IRS can still be used in stable transmission areas, but in those conditions it must be applied twice a year, which amounts to a major logistical undertaking;

- Choice of insecticide should be based on local resistance profiles and a goal to prevent resistance from developing by choosing from the available WHO-approved options [http://www.who.int/whopes/en/];

- Insecticide resistance should be monitored for both IRS and LLINs. This requires appropriate national laboratories that can study Malaria vectors;

- Entomological capacity building within Member States should be fully established. This requires capacity building within Member States and collaboration with appropriate national laboratories that can study Malaria vectors;

- Member States should, as is appropriate, develop and deploy environmental control and management to reduce vectors;

- Entomological and epidemiological impact assessments should also be undertaken periodically;

- Larviciding methods appropriate to the country should be used to compliment other vector control measures;

- Environmental safety measures for all insecticides and products used must be developed and enforced;
- Member States must enforce systems to ensure the correct use of nets and to prevent uses that cause environmental risks (such as fishing); and
- Member States must ensure that LLINs are distributed to all members of the community, including minority, migratory and any other underserviced populations.

Malaria in pregnancy

- IPTp should be prioritised in areas of stable Malaria transmission;
- IPTp should be delivered as part of a comprehensive integrated package of antenatal care services;
- As the epidemiological patterns of Malaria and drug sensitivity change, Member States must periodically review the relevance and efficacy of IPTp use to prevent Malaria during pregnancy;
- Since no other drug currently exists for IPTp besides Sulfadoxine-pyrimethamine (SP), in order to combat growing SP resistance, Member States implementing IPTp should introduce and enforce clear policies that SP should be available and used only in antenatal clinics or under the guidance of antenatal clinic staff to ensure appropriate use and to safeguard SP supplies;
- IPTp use should always be complimented with regular use of LLINs, which should be made available routinely as part of a comprehensive package of antenatal care;
- In areas of unstable Malaria transmission, LLINs are the key Malaria preventive tool for pregnant women and must be provided in such a way as to enable women to use them from the start of pregnancy. Universal coverage can be achieved by ensuring that all women of reproductive age use bed nets nightly;
- Community education should be implemented to reach all pregnant women with key messages including: the importance of antenatal clinic attendance, the importance of adherence to IPTp, and the importance of consistent LLIN use from before the 16th week of pregnancy (after fetal movement). These messages may be delivered through community health volunteers, non-governmental organisations (NGOs), or mass media. Early antenatal clinic attendance must be a key message for pregnant women;
- Health services should integrate testing and control of both HIV and Malaria into antenatal care services;
- To achieve the foregoing standards the National Malaria Control Programme (NMCP) and the Reproductive Health Service should develop a protocol of collaboration;
- In countries with high HIV prevalence, pregnant women must be given at least three doses of IPTp in a manner that maintains confidentiality of a client's HIV status.
- Pregnant women who are HIV-positive and on co-trimoxazole prophylactic treatment should not receive IPTp;
- The efficacy of SP must be monitored on a regular basis; and
- Research into alternative drugs for IPTp use must be commissioned.

Malaria case management

- Cases must be confirmed parasitologically by RDT or microscopy. All Member States must have and disseminate to all care-providers national treatment guidelines (including Member States that are designated Malaria-free);
- A clear Malaria treatment policy must be formulated in which provision of Malaria drugs is based on a positive result from either microscopy or RDT;
- Member States should promote basic pre-service, as well as in-service training in differential diagnosis skills, based on integrated disease management such that health staff see clear options for treating patients who have negative Malaria parasitological test results;

- Member States must put in place:

- At least one functional laboratory in each district of each Member State;

- At least one strong national laboratory for each Member State that will also conduct training and supervision of Malaria diagnostic services at sub-national levels; and

- A quality assurance system to monitor the use of both microscopy and RDTs.

- Member States need to commit to training adequate numbers of laboratory technologists, as well as provide training in the use of RDTs for all health staff involved in Malaria case management;

- Although clinical diagnosis of Malaria is not reliable and lacks specificity, national programmes must prepare frontline health staff and community volunteers to undertake rigorous Malaria diagnosis, using tested algorithms in the event that laboratory or RDT services are not available for short periods of time. These algorithms should also aid in the conduct of differential diagnosis;

- Health workers must be trained on other causes of fever so that they explore alternative diagnoses in the event of a negative Malaria test;

- SADC Member States should align their treatment policies with WHO recommendations for ACT;

- Treatment for Malaria during pregnancy must be aligned to WHO-recommended guidelines in SADC Member States;

- Treatment guidelines should be made available at all levels of health services to all levels of cadres;

- Counselling for medicine adherence should be a central part of Malaria treatment guidelines;

- Referral procedures for Malaria treatment need to be specified such that each level knows its responsibilities, has the supplies and resources to carry out those responsibilities, has the knowledge and skills to recognise when referral is required and when necessary, and has the means to ensure referred clients actually get to the next level of care;

- NMCPs should update Malaria case management treatment protocols for health workers based on locally relevant research on Malaria drug efficacy;

- Treatment guidelines for P. vivax must be aligned with WHO guidelines, where indicated;

- Chemoprophylaxis guidelines for non-immune visitors to Malaria endemic areas must be developed;

- Programmes should have in place periodic refresher trainings for health workers on Malaria treatment protocols with special emphasis on the importance of providing treatment only when parasitological tests are positive for Malaria;

- Therapeutic resistance/ treatment failure monitoring should be integrated into case management follow-up guidelines and reported whenever proven cases occur;

- Member states must develop guidelines for implementation of pharmaco-vigilance;

- Malaria treatment and prevention with LLINs should be afforded as a part of care and support for persons living with HIV and for orphans and vulnerable children—there must be strong collaboration between HIV and Malaria programmes; and

- Member States must ensure that caregivers such as mothers and grandmothers have Malaria medications for themselves and the children in their care.

3.1.2 Areas with low, unstable transmission

Low, unstable transmission countries characteristically have low incidence rates of Malaria, which are non-continuous and are prone to epidemics. Four of 15 countries in the SADC region fall in this transmission zone.

All interventions for the high transmission zone (except the IPTp) apply in the low transmission zone, as well. This section lists only those standards that are unique to the low transmission zone.

Surveillance

- Member States in this category must set up strong surveillance systems to enable:

- Early detection of epidemics through early-warning systems;
- Entomological changes in population; and
- Entomological changes in behaviour and adaptation.

Case management

- All patients treated for Malaria must have repeat smears to confirm cure two weeks after commencing treatment;
- As Malaria prevalence decreases, Member States should consider switching to intermittent screening and treatment (IST) of Malaria in pregnant women (where all antenatal clinic attendees are screened for Malaria parasites, using RDTs, and those with positive results are treated with medicines appropriate to their gestational age). IST should be performed at the first antenatal clinic visit and during at least one subsequent visit; and
- As the epidemiological pattern changes and people become less exposed to Malaria, guidelines for travelers to high endemic areas must be developed and adequately disseminated.

Vector control

- SADC Member States should make targeted use of LLINs and IRS to achieve maximum control of transmission;
- SADC Member States should ensure epidemic readiness with district or provincial stores of nets and drugs that can be deployed at first sign of an epidemic;
- IRS is most economical in areas with seasonal or unstable transmission. For maximum effect, houses and structures must be sprayed just prior to the transmission period;
- IRS campaigns must be timefocused and should be preceded by intensive community education and mobilisation in order to help people understand that the spray is safe, to improve timely preparation (such as moving personal effects and furniture), and to increase acceptance and trust of the sprayers who will be entering private dwellings; and
- SADC Member States can implement a mixed, IRS-ITN strategy. If needed, a choice between IRS and ITN should be guided by operational feasibility and the availability of local resources.

3.1.3 Areas with no current transmission

These are areas that have eliminated Malaria or never had Malaria. Their goal is to avoid introduction or re-introduction of Malaria. Three countries in the SADC regional fall in this transmission zone.

The major interventions for these countries are surveillance, and case detection and management of imported cases, as well as and health information.

Surveillance

Members must, as part of integrated vector management, monitor vector populations to determine the presence and distribution of anopheles species that are capable of transmitting Malaria.

Case detection and management

- All travelers returning and new arrivals coming from endemic areas must seek prompt treatment should they have Malaria-like symptoms;
- Imported cases of Malaria must be diagnosed and treated in accordance with WHO guidelines;
- All patients treated for Malaria must have a repeat smear to confirm cure two weeks after commencing treatment;
- Systems must be established to facilitate active case investigation for suspected Malaria cases;
- Capacity building and technical expertise in entomology, epidemiology and health statistics must be addressed; and
- SADC should support the establishment of regional reference laboratory for diagnostic quality assurance, and training in specialised techniques related to Malaria control to service the SADC region.

3.2 Crosscutting issues

Crosscutting issues relate to programme management and systems, and are relevant to all SADC Member States.

3.2.1 Policy and strategy standards

- As Member States move on from scale-up to sustaining coverage to pre-elimination, the national Malaria strategy and guiding policies (for example, guidelines and business or action plans) should be informed by annual Malaria programme reviews, mid-term programme evaluation, and end of strategic plan evaluation. Furthermore there should be annual reviews of business or action plans to meet changing intervention, epidemiological and funding situations.

- Thus, the NMCP and Malaria partners must ensure that key documents, such as the business or action plan, clearly reflect the current stage (or stages, depending on regional differences within Member States) of Malaria control and target stages for coming years;

- Such annual amendments to business or action plans, annual programme reviews, programme evaluation and mid-term evaluation strategic plans should be disseminated to all partners, programme managers and programme implementers;

- Partners should work together in the development, updating and support of one national policy, and should ensure unified adoption of the strategy, guidelines and business or action plan by all;

- A mechanism for disseminating the updated strategy, guidelines and business or action plans must be in place to ensure frontline healthcare facilities (public, private and NGO) and training institutions are employing and teaching the most current aspects of Malaria programming in the Member State;

- The national Malaria strategy should also include a dissemination plan for key messages and policies to the general population;

- The Roll Back Malaria process of the Road Map Gap Analysis should become a regular feature of developing annual business or action plans. Even Member States working to prevent re-introduction of the disease should match their plans for surveillance to pledged resources and need; and

- Regular updates of strategies and action plans should be based on M&E data, as well as on cost-effectiveness analysis.

- All SADC Member States should have an evidence-based policy that addresses the current stage of Malaria programme interventions and reflects the different transmission zones within the Member State, whenever feasible.

- This should be accompanied by a sound policy monitoring system; and

- Operations research should support existing interventions and assist in planning for interventions at the next stage of Malaria elimination.

- National technical committees should be formed, as appropriate (for example, case management or vector control committees), to review the evidence and guide policy development and review processes;

- The national Malaria strategy, guidelines and business or action plan must reflect appropriate activities and responsibilities for each tier and sector of the health system to produce integrated implementation.

- Member States therefore should develop a package of essential Malaria interventions that are appropriate for, and are needed at each level and sector of the health system;

- Annual action planning is thus required at sub-national levels, such as regions, provinces, districts and municipalities; and

- Mechanisms for community and civil society input and involvement in sub-national planning should be utilised to guarantee the feasibility and acceptability of plans.

- The national Malaria strategy, guidelines and business or action plan must identify opportunities for synergistic integration of Malaria and related health and development programmes, including HIV, integrated management of childhood illness (IMCI), antenatal or maternal and child health (MCH), agriculture extension, education, health promotion, expanded programme for immunisation, etc.;

- National Malaria strategies should be forward-looking in all Member States, such that preparation is made for the eventual elimination of the disease.

- Member States should prevent re-introduction of Malaria in areas declared Malaria free and should introduce mechanisms to ensure that the policy is well-disseminated and implemented as appropriate in the region; and

- The national Malaria strategy should include provision for active Malaria surveillance as long as any Member State in or neighboring the region is experiencing Malaria transmission.

- Annual joint strategy, planning and updating sessions must be held among Member States that share borders and specific transmission environments to ensure that plans are harmonised plans, coverage of appropriate interventions is adequate and the required funding is available;

- The NMCP should be appropriately situated to access and coordinate the timely use of Malaria funds at all levels;

- The NMCP must relate easily and directly with other key partners whose funding is not under government control in order to ensure that major activities, such as LLIN distribution, occur in a concerted manner;

- National Malaria strategies and policies should reflect the special needs of conflict and post-conflict conditions and natural disasters (such as floods), since these affect infrastructure and access to services;

- Malaria programming should reflect the current and evolving epidemiological situation of the Member State.

- Epidemiological surveillance and monitoring systems for Malaria incidence must be set up in each implementing Member State to monitor Malaria epidemiological patterns. Those patterns should serve as the basis of planning for strategy deployment in each Member State. Interventions deployed must be aligned to the transmission patterns and the WHO Africa Regional Office with their corresponding Member State offices must work with SADC Member States to define appropriate intervention packages for different epidemiological settings;

- At a minimum, highly endemic zones should deploy the full range of currently available evidence-based, efficacious interventions supported by a strong component of behaviour change communication and a robust M&E system;

- Epidemic-prone zones should focus on early epidemic warning systems, rapid response capacity and prompt and correct treatment of cases;

- Malaria-free zones priority focus should be active surveillance, prompt and correct management of cases and prevention of re-entry supported by a strong Information, education and communication (IEC) component;

- As epidemiological patterns change in Member States as a result of intensified implementation of Malaria control activities, Member States must be assisted to institute efficient, active Malaria disease and entomological surveillance systems in areas deemed “Malaria free” For those areas, Malaria should become a notifiable disease.
A resource re-alignment should be made to intensify Malaria control activities in areas where pockets of high transmission still exist in that Member State, while retaining an appropriate annual level of funding to continue monitoring and surveillance.

- Malaria programmes should be integrated with all relevant public health programmes. The following should be provided:

- Malaria-in-pregnancy control through antenatal clinics;

- Malaria case management as part of integrated management of childhood illness and community case management;

- Malaria services to people living with HIV, orphans and vulnerable children;

- Community-based disease control efforts, such as onchocerciasis and neglected tropical diseases control; and

- Uniformed services’ health programmes.

3.2.2 Funding and resource standards

- A five-year strategic plan should be costed and projections should be made for Malaria programme funding based on the expected nature and extent of Malaria interventions.

- Member States' financial planning needs to take account of the potential progress in Malaria control in terms of changes in strategic activities in order to reflect new transmission realities;

- Annual Malaria business or action plans that reflect appropriate control activities should be costed;

- Rational costs need to be calculated for interventions, particularly in Member States with poor infrastructure and transportation systems; and

- Annual gap analysis with partners should be conducted to assist in forecasting needs and sourcing of funds. This analysis will ensure that each partner's contributions to specific programming and management areas are recognised and accounted for. Following analysis, Member States need to actively communicate with potential donors about the exact financial needs of their Malaria plans. Additionally, concerted effort should be aimed at eliciting private sector support.

- Member States need to pledge financial support to their own Malaria programmes.

- All Member States should strive to achieve the Abuja target, which requires that 15% of the total national budget be allocated to health spending. The amount of funds from the health budget to be allocated to Malaria control should reflect the Malaria burden on the overall health of the population;

- Member States should be prepared to assume a greater proportion of the Malaria programming budget as they move toward elimination and prevention of re-introduction;

- Member States must develop a specific plan for continued funding while donor support is phased out;

- Member States need to support and strengthen broader health systems components that affect Malaria programming, such as procurement and supply systems, human resource development, health information systems, etc.;

- Sub-national entities such as provinces, districts and municipalities also need to pledge financial support for Malaria programming—especially for logistical support to ensure that planned interventions are actually delivered;

- Financial planning at the sub-national level is needed to ensure that the contributions of all partners (even smaller corporate or civil society donors) are acknowledged and coordinated; and

- Member States should utilise cost-containment principles, using the most cost-effective means for delivering Malaria interventions.

- SADC Member States must develop a framework for accelerated physical infrastructure development specifically related to Malaria control programmes, and set annual targets for the establishment of offices, labs, etc.;

- Cross-border financial planning is needed to ensure that harmonised action plans are fully implemented in Member States that share specific transmission zones;

- Major donor support should include a community systems-strengthening component; and

- Once Member States have reached low transmission or the pre-elimination/elimination phase of Malaria control, annual funding must continue to be set aside for surveillance, monitoring and border control until such time that Malaria is generally eliminated in the region.

3.2.3 Human resource standards

- Member States must conduct human resource planning for Malaria control at all levels of programme implementation.

- All SADC Member States must conduct human resource needs assessments and develop costed human resource development and deployment plans to support the Malaria elimination effort;

- Human resource planning for Malaria prevention and control must be done in concert with overall national human resource planning to ensure equitable distribution of health workers, especially at the primary care service delivery level. In that context, the planning should address recruitment, remuneration/benefits, deployment and retention of staff that can perform Malaria duties at all levels of the health system;

- Task shifting can be used to fill human resource gaps on a short-term basis;

- There should be recognition that human resources for Malaria control at sub-national level often involve staff who multi-task with other disease control responsibilities. Appropriate planning is required to ensure that at least the minimum required staff numbers are available to accomplish programming tasks;

- Job descriptions should be developed for designated Malaria control personnel, and Malaria-relevant content should be integrated into the job descriptions of other employees who have Malaria prevention and control duties at various levels of the health system;

- Member States should ensure that community volunteers are part of human resource planning, where applicable;

- Member States with moderate to high levels of Malaria endemnicity and human resource gaps should train and supervise community members for outreach of Malaria services through a variety of community-based agents, including volunteer community health workers, community ivermectin distributors, traditional birth attendants, patent medicine vendors and others, as appropriate and available;

- Human resource planning for Malaria should be aligned to the various staffing needs based on the Malaria epidemiology/ transmission characteristics of sections of the Member State; and

- Human resource planning should be forward-looking, not only in terms of the numbers and cadres that are needed to carry out the Member State's current Malaria strategy, but in anticipation of changing human resource needs as the Member State progresses along the path to elimination.

- Although Ministries of Health in Member States create the specific structure and establishments within NMCPs, all NMCPs should command a minimum of technical skills and capacity as required in WHO's suggested organogram. * This will vary by transmission zone, in terms of the required skills, structure and location of Malaria expertise in each Ministry of Health;

- Pre-service training programmes should prepare relevant health workers for their appropriate roles in Malaria prevention and control.

- Health worker training institutions should have Malaria prevention and control learning materials and resources that reflect the most recent national Malaria strategy and current scientific evidence for Malaria control;

- Health worker instructors, tutors and lecturers require training to update them on the current national strategies and scientific advances in Malaria prevention and control, as well as support in preparing classroom, community and clinical learning experiences for health trainees that reflect those advances; and

- Intra-regional mechanisms should be established to share basic Malaria learning and training materials, as appropriate to the epidemiological/transmission settings of each Member State.

* *WHO (2009) Malaria Case Management Operations Manual*

- IST programmes are required for all health staff who are involved in Malaria prevention and control that reflects the most recent national Malaria strategy and current scientific evidence. Those programmes include (but are not limited to) clinicians, nurses, midwives, environmental health technicians, laboratory personnel, records staff, and health promotion officers.

- IST sessions should be geared to the Malaria tasks or job description of each cadre who delivers Malaria prevention and control services;

- IST efforts should include health workers in both the private and not-for-profit (NGO) sectors in order to achieve full coverage of correct and up-to-date Malaria control practices. Member States should maintain core teams of Malaria trainers at national and sub-national levels that reflect the key competencies to be included in Malaria IST based on the national Malaria strategic technical emphases and stage along the pathway to elimination;

- IST should be planned in concert with the dissemination of updated national work/action plans;

- Updated supportive learning materials should be distributed as part of IST and should be made available in quantities that can ultimately cover all staff who deliver Malaria prevention and control services;

- While efforts should be made at the sub-national levels to retain staff who are trained for Malaria duties, core training teams need to be prepared to conduct regular IST, as needed, due to staff transfers;

- Opportunities for on-the-job IST need to be developed that take advantage of electronic and mobile technologies, as well as more traditional formats like staff meetings.

- Performance quality improvement standards for health workers must be developed for all cadres who are involved in Malaria programming.

- Existing guidelines for programming areas, such as case management, LLIN distribution, sentinel surveillance, M&E and Malaria-in-pregnancy interventions should be operationalised into basic minimum tasks for health workers that will enable them to monitor their own performance and assist in the supervisory process; and

- These tasks will evolve as progress is made toward elimination. For example, as Malaria prevalence declines in high-burden areas, IPT for pregnant women may be replaced with intermittent screening and treatment.

- Member States must invest in strengthening health systems through capacity building of institutions, facilities and personnel.

- SADC states must develop an organogram that addresses the personnel needs at the various levels of implementation of Malaria control activities in order to support the elimination effort;

- Malaria control programming should be decentralised so that programme staff in government and partner agencies can adapt interventions to the cultural and epidemiological conditions in their areas;

- Supervisory and reporting links need to be established and clearly spelled out from one level of programming to the next: national - regional/provincial - district - facility - community. Supervision should be supportive and educational, not punitive. Funding must be provided to enable supervision to occur.

3.2.4 Procurement and supply standards

- Member States must develop an efficient procurement management system that is based on models that can work in the SADC region. The system should be supported by a strengthened central or regional medical store that is well-funded through core government funds and possibly supplemented by donor funding;

- Member States must develop policies to achieve and sustain high-quality, universal coverage of Malaria commodities and supplies.

- Policies need to be in place to guarantee equity: free or subsidised services must be provided, wherever possible;

- Stringent policies and mechanisms should be in place to control over-the-counter purchase of drugs. Member states need to work in close collaboration with national agencies that test and approve drugs for use in their Member States to ensure that approval and registrations of anti-Malarial drugs conform with national case management guidelines;

- Member States should also monitor the sale of drugs and remove counterfeit, inappropriate and substandard medications. Public education on nationally acceptable Malaria medications is a crucial component of this activity;

- Member States should develop appropriate counseling guidelines on all Malaria drugs (both for prophylaxis and treatment) that are to be used by public and private service providers;

• Member States must coordinate with various internal and external stakeholders to ensure that safe, effective and adequate supplies reach the targeted areas.

- Member States need a coordinated planning effort between the Malaria programme, the essential drug programme, the national pharmacy/medical stores and the national drug regulatory agency. Such coordinated planning should devolve to the provincial and regional levels, as well;

- Member states should develop mechanisms to move commodities between them, from Member States that are over-provisioned to Member States that are under-provisioned. The coordination mechanism should engage with the private sector (shop keepers, private medical vendors, etc.) to ensure correct distribution and use of supplies and commodities;

- The coordination mechanism should ensure that medicines purchased for the Member State are consistent with national case management guidelines, and it should facilitate standardised monitoring of the field performance for various different programmes.

• Member States need to invest in building the various institutions, facilities and providers to ensure the provision of safe, effective and high-quality supplies and commodities to the population.

- The Malaria programme must communicate with the national drug regulatory board about accepted Malaria treatment drugs, as per national policy. The national drug regulatory board needs to monitor and test these products to ensure quality and standards dosing, and provide feedback to the NMCP;

- Member States that do not already have such structures should establish a national medicine or drug control authority and quality testing labs;

- Clinic-based performance standards that include the detection and prevention of stock-outs should be developed, disseminated and utilised to help facility staff monitor their drug, RDT and net supplies;

- Provincial and district medical stores personnel and clinic staff should be trained and supervised for monitoring, supply forecasting, and timely and correct procurement processes;

- Private pharmacies should be accredited and regulated by government agencies to ensure that they sell only registered Malaria drugs and related commodities;

- Private outlets/facilities and community-based distributors should be trained, supervised and monitored;

- Multiple controls are needed for the timely ordering of drugs and supplies so that district and provincial levels serve as backups for facility-level ordering; and

- Just as health facilities and districts maintain service delivery statistics, they also need to develop and utilise commodity inventory information systems, including using new technologies.

• A procurement management process should be designed to ensure coverage throughout the continuum of Malaria elimination framework and across different levels of distribution.

- Stocks of appropriate anti-Malarial drugs should be maintained even when MemberStates enter the pre-elimination stage and beyond, in order to respond to imported cases or unanticipated epidemics. Given that Malaria is likely to be imported, stocks should be consistent with current treatment policy guidelines for the region;

- Procurement and supply procedures should take into account the needs for community case management of Malaria through kits at the health facility nearest to community volunteers;

- When conducting net distribution campaigns, Member States should have buffer stocks available (because census population figures are often unreliable);

- Member States should encourage local net manufacturing since community-based net production can serve as a form of income generation and can also avoid gaps in supply. However, Member State-level standards for net development must be adhered to; and

- Member states must make provisions for appropriate storage facilities.

- Member states must select products that have been pre-qualified by WHO. If they wish to use alternatives, they must work closely with WHO to determine efficacy and safety;

- Member States should monitor borders for leakage and smuggling of Malaria commodities—both to prevent loss of those intended for programming in one specific Member State and to stop importation of substandard and inappropriate medicines and materials; and

- Member States should address the security of commodities across the border by reducing the incentive for the cross-border sale of drug at the policy level and also through education of the population on the sale of non-registered drugs.

3.2.5 Monitoring, evaluation and surveillance standards

- SADC Member States must implement the SADC M&E and surveillance framework, develop relevant policies and guidelines, and disseminate them through appropriate channels.

- As SADC's Malaria Strategic Framework notes, Member States are encouraged to adopt WHO's set of core Malaria indicators and report on these;

- Member States should develop their national M&E framework and guidelines, and disseminate them through appropriate channels, such as quarterly reviews;

- Malaria mapping should be an essential part of the framework development to target interventions appropriately, using Geographical Information Systems;

- Malaria case detection skills, equipment and supplies must be available at all entry points of Member States when those Member States enter the pre-elimination phase.

- In order to effectively administer the M&E framework, Member States must ensure capacity building of institutions and providers.

- In high- and low-transmission settings, where the NMCP, exists, it should have at least one M&E staff person who is qualified to track Malaria indicators that are relevant to the level of transmission and progress on the elimination pathway.

- In non-transmission settings where Malaria may fall under a broader infectious disease control division, there should still be an M&E officer who is able to track appropriate Malaria case detection and management indicators;

- All Malaria staff from provincial, district, and frontline facilities need in-service training in M&E, with periodic refreshers and updates;

- Training courses for surveillance and M&E officers need to be offered and maintained;

- Healthcare workers should be encouraged to utilise the data that are collected for decision-making at local level. Furthermore, feedback should be provided on data that are collected and aggregated at higher levels to enable healthcare workers to make decisions and assess their performances in relation to other facilities;

- Innovative use of communication technology, such as cell phones (including the use of toll free numbers), the Internet, satellite links, etc. should be explored to ensure regular and timely reporting of data.

- Member States should invest in effective data collection tools and processes to facilitate decision-making.

- Member States should use DHS, MIS and MICS platforms to conduct bi-annual national documentation to determine progress on intervention coverage, as appropriate;

- Member states must strengthen the Health Management Information Systems to ensure timely availability of high-quality data that programmes can use for management decisions;

- Integrated Malaria data flows should be available at the district, provincial or regional and national levels to ensure that results from primary, secondary and tertiary facilities in a given locality are collated. This should include data from private and NGO/ not-for-profit facilities;

- Regular compilation and analysis of Malaria data needs to be shared with Malaria programme managers and relevant stakeholders at all levels in ways that facilitate decision-making to improve the delivery of Malaria control services;

- Develop mechanisms to ensure that data collection tools meet the current needs of the national Malaria control programme;

- In all Member States where the Malaria burden requires the availability of Malaria treatment at primary healthcare facilities, all client health cards, clinic registers and summary forms that are used as part of national health information systems should contain sections for recording the provision of basic Malaria services;

- Sentinel surveillance sites should be established in the various ecological and transmission zones of Member States for the timely and ongoing documentation of programme implementation and disease prevalence;

- All Member States need to establish systems for entomological monitoring of mosquitoes. This can and should be integrated into larger vector control strategies;

- Pharmacovigillance should be undertaken at all sentinel surveillance sites and should be integrated into Malaria treatment monitoring in primary care facilities, where feasible;

- Member States should ensure epidemic threshold values are in place in healthcare facilities at all levels; and

- Member States should conduct regular knowledge, attitudes and practices, and operational research studies to assess the coverage of Malaria interventions, identify and solve programmatic bottlenecks, and test new approaches.

3.2.6 Community participation and health education standards

- Community participation and involvement, and general health education should be crucial components for delivering any component of Malaria programming, and should be adapted to the programming needs at each stage along the pathway to Malaria elimination;

- Community volunteers should play a central role in the delivery of Malaria control services in order to enhance access and address potential inequities based on gender, ethnicity or economic status.

- Communities need to be trained in planning and delivering Malaria activities that are appropriate to the epidemiological context of the locale and the stage of Malaria elimination;

- In SADC Member States that decide to implement community-based distribution of Malaria commodities, there must be supporting national policies that explicitly permit a role for community volunteers in providing these services. The Malaria commodities can include insecticide-treated nets, ACTs, IRS and SP for IPTp;

- Specific roles for community members/ volunteers, and community-based organisations should be developed in the following areas, depending on national programming at each stage of control/ elimination:

a. *Promotion of antenatal care utilisation for Malaria-in-pregnancy control services;*

b. *Community case management and home-based management of fever;*

c. *Rapid referral for convulsions and signs of severe Malaria;*

d. *Case detection and community-level surveillance;*

e. *General health education and counselling relevant to interventions at the current stage of Malaria control/elimination;*

f. *Promotion of regular LLIN use, especially by vulnerable groups; and*

g. *Encouraging acceptance of IRS, where used.*

- Member States should have guidelines and training materials for participation by community members, volunteers and community-based organisations, as well as appropriate channels for distribution that are culturally appropriate.

• Civil Society should play an active role in Malaria programme promotion.

- Communities, as well as faith-based, civil society and nongovernmental organisations should be engaged as equal partners in the implementation of Malaria interventions, thus promoting their ownership of programme processes and results. Functional and respected community mechanisms (such as committees and coalitions) should exist in all service catchment areas;

- NGOs should be encouraged to participate in national Malaria partnership forums;

- NGOs should be encouraged to develop innovative Malaria service delivery approaches and establish mechanisms for sharing and learning among civil society and public sector programme managers;

- Media outreach to reinforce the behaviour change communication messages from health workers and volunteers should be aligned with media outlets that are preferred in communities;

- School children should be used as conveyers of Malaria messages;

- Community participation efforts should prioritise working with disadvantaged and hard-to-reach populations who are often most deeply-affected by Malaria;

- Community members can take the lead in implementing environmental control measures to reduce mosquito loads, if they receive proper training to differentiate the nature, location and types of breeding sites for anophelene species and mosquito vectors of other diseases; and

- Existing committees, associations and community volunteer programmes should be leveraged to address Malaria control.

• Educate household members to ensure equitable use of Malaria commodities, such as nets, by all household members; and

• Develop behaviour change communication materials to ensure that caregivers have access to resources for seeking care for themselves and their children.

3.2.7 Environmental management for vector control standards

• SADC Member states should actively promote and develop an environmental management plan to reduce breeding places for Malaria vectors;

• Member States should reduce the environmental impact of IRS usage and promote collaborative links between various developmental arms of government to ensure that policies and practices are consistent with the Malaria elimination agenda. Member States can draw important lessons from other regions (such as South-east Asia, where environmental management of vector control has been put in place) (http://www.who.int/water_sanitation_health/publications/whowbMalariacontrol.pdf)

- The NMCP should take the lead in forming linkages between itself (as the lead Malaria control agency) and other sectors (such as agriculture, mining and infrastructure development agencies) whose practices impact on the environment and have the potential to create Malaria vector breeding sites. The aim should be to set environmental standards that are commensurate with the Malaria elimination effort;

- The NMCP should lead the process of developing local community-based environmental control guidelines that facilitate the destruction of breeding sites for mosquitoes that transmit Malaria. Those guidelines must be based on WHO guidelines, and monitoring systems must be introduced to ensure effectiveness;

- SADC Member States should explore environmental modification such as draining and larviciding where this would result in significant reduction of Malaria transmitting vectors and result in decreased transmission of Malaria; and

- Member States should develop sound guidelines for the appropriate procurement, use, storage, and disposal of IRS (such as DDT) to minimise environmental damage. An example from Zambia can be accessed at http://pdf.usaid.gov/pdf_docs/PNADR936.pdf

3.2.8 Cross-border collaboration

SADC Member States, coordinated by the SADC Secretariat, must prioritise and plan for cross- border activities for Malaria control. Members States should:

- Develop regional guidelines for cross-border activities that are modelled around the successful Lubombo Spatial Development Initiative;

- Form a regional coordinating committee/ working group, with representation from Member States and key development partners, to lead and give impetus to cross-border activities. This working group of experts could be additionally tasked with mobilising the financial and human resources that are required for successful cross-border activities; and

- The NMCP should include cross-border activities in both the national strategic and operational plans, and should obtain partner commitment to cross-border activities.

3.2.9 Partner coordination and integration standards

- Member States should replicate the Southern African Roll Back Malaria Network (SARN) model of partnership at Member State level.

- The NMCP should lead Malaria coordination to ensure collaboration with other sectors. A coordinator should be employed, when feasible.

- Partners should support interventions, methods and modalities that have been decided at the national level, and roll them out in a similar and synergistic way within their respective health zones;

- Partners should meet regularly to identify problems, analyse their causes and devise ways of addressing root causes of deficits in Malaria elimination efforts. Many Member State partnership mechanisms should meet at least on a bi-monthly basis to ensure timely coordination of programme implementation;

- The partnership model should be replicated at sub-national levels (regions, provinces, and municipalities, districts) to coordinate programme implementation, and to identify and incorporate locally-available resources;

- SADC plays a central role in regional coordination and should also offer support and guidance for developing coordination mechanisms within and between Member States that develop cross-border interventions;

- SADC should support regional and national Malaria conferences to facilitate the exchange of best practices and challenges nationally and regionally.

- SADC should encourage national and regional corporations to contribute to Malaria control efforts as part of their corporate social responsibility;

- SADC Member States should define an accountability mechanism with various stakeholders;

- Member States must ensure collaboration of the national Malaria programme with other disease programmes such as TB, HIV and AIDS, and reproductive health.

- There should be coordination within public, NGO and private healthcare agencies to ensure full coverage without duplication;

- There should be coordination among Malaria units/programmes and pharmacy/essential drug units, laboratory services, M&E/Health Information System units, health education services and other basic support sections of the health service;

- Malaria programme managers should collaborate with departments and agencies that are planning health systems strengthening efforts to ensure that Malaria interventions become part of a strong and continuous routine health services;

- All Member States should maintain a standardised process for developing technical advisory committees that harnesses the expertise of governments, donors, universities, research institutes and other technical partners.

- Technical committees should be formed around issues that are relevant to the current transmission status of each Member State;

- Technical committees should have clear terms of reference, Secretariat support and opportunities for regular input into national policies and guidelines; and

- Technical committees should serve as both a conduit for national and international research findings to improve programmes, but should also set the Malaria research agenda for the country.

4. IMPLEMENTATION MECHANISMS FOR THE FRAMEWORK

The implementation mechanisms define the key stakeholders and their roles in the implementation of the Framework. It also provides guidance on how the Framework will be financed, and it identifies the critical indicators that should be monitored to ensure that the Framework is fully integrated into the work of Member States. This section proposes a road map for the domestication of the Framework, including how it will be financed and monitored.

4.1 Stakeholder roles and responsibilities

The successful implementation of the Regional Minimum Standards for Malaria requires the involvement of all key stakeholders at national and regional levels. To that end, it is important to provide an outline of their respective roles.

4.1.1 Member States

- The SADC Health Ministers will oversee and monitor the implementation of this Framework;

- Member States shall take a lead role in ensuring that the Minimum Standards are integrated into the annual work plans of national Malaria programmes;

- Member States shall ensure that national Malaria programmes involve various departments in the Ministries of Health (for example, laboratories, HIV and AIDS, and pharmacy) and key stakeholders in the public and private sectors (for example, donors, WHO, partners, community-based organisations and training institutions) to identify their roles in the implementation of the various activities articulated in the Minimum Standards;

- Member States shall identify the challenges to implementation of each standard, identify the specific shortcomings that prevent the standards from being met, and identify the barriers and opportunities for each standard; and

- Member States shall develop detailed financial plans and make resources available for supporting the implementation of the harmonised Minimum Standards.

4.1.2 SADC Secretariat

- The SADC Secretariat will coordinate the overall implementation and monitoring of these Minimum Standards on behalf of the Ministers of Health. Specific responsibilities will include:

- Advocating for implementation of effective Malaria prevention and control programmes in the region in relation to the commitments made by Member States (such as the *SADC Protocol on Health, and the Maputo Declaration);*

- Facilitating the harmonisation of policy guidelines and protocols for the prevention and control of Malaria;
- Facilitating skills transfers and sharing of good/innovative practices, benchmarking of Member States relative to one each other, and providing a platform for sharing of good practices;
- Coordinating partners for resources mobilisation and technical support in the region;
- Facilitating the establishment of a rapid response system for the Malaria epidemic and for dealing with Malaria endemic areas in the region;
- Facilitating inter-country and cross-border Malaria prevention and control; and
- Coordinating regional training programmes on Malaria.

4.1.3 Other stakeholders

Other stakeholders include United Nations (UN) Agencies, bilateral donors and development partners, local and international NGOs, community-based organisations and communities, the private sector, and research and training institutions. All are essential for the successful implementation of the Framework.

UN Agencies and other development partners

- Their roles will vary, but shall include:
- Identifying the Malaria burden in each Member State;
- Assisting in updating and developing new programmatic/clinical guidelines;
- Linking Member States with new technologies and tools for diagnostics;
- Supporting resource mobilisation to assist in implementing Malaria control activities;
- Assisting with inputs for harmonising the management protocols to support implementation, including routine reporting and recording of Malaria data;
- Assisting Member States and the Secretariat to coordinate Malaria cross-border issues; and
- Assisting in ensuring access to Malaria services for mobile populations, women and other vulnerable populations.

- Local and international donors and NGOs shall:
- Assist in implementation of agreed-on Minimum Standards;
- Advocate for strengthening Malaria control;
- Augment resources to ensure implementation of the Minimum Standards;
- Assist in disseminating best practices within the region;
- Provide additional human resources as needed to support implementation of the Minimum Standards;
- Work with Member States to establish formal cross-border Malaria control mechanisms; and
- Provide feedback to Member States on progress or otherwise in the implementation of the Minimum Standards.

4.2 Financing mechanisms

Implementation of these Minimum Standards may require additional financial resource allocation by each Member State. Funding for the activities that are required to meet the Minimum Standards will be allocated within the national budget of each Member State, if these activities are not currently provided for in Malaria control budgets.

- Member States shall ensure that:
- Areas that need additional financial resources are identified, with the participation of all relevant stakeholders (including UN agencies, donors, development partners, and NGOs);
- Each area that needs improvement is costed. Examples could include the cost of implementing the advocacy, communications and social mobilisation strategy, expansion of the laboratory network, and the procurement of necessary drugs; and
- National Malaria programmes receive endorsement from their Ministries of Health where additional finances are required.

4.3 Monitoring implementation

4.3.1 Role of monitoring and evaluation in the implementation of Minimum Standards

These Minimum Standards for the prevention, treatment and management of Malaria need to be monitored in order to enable both Member States and the SADC Secretariat to objectively assess progress in implementation.

Monitoring is an important management tool that helps to indentify implementation progress, challenges and bottlenecks that should be addressed for enhanced impact. Effective monitoring shows programme managers the extent to which they are making progress in institutionalising the Minimum Standards in the national health programme. Furthermore, results from such monitoring will inform management decisions that are aimed at fine-tuning the response at the Member State level. At the same time, results from monitoring will reveal the progress the region is making in implementing the SADC Protocol on Health as it relates to prevention, treatment and management of Malaria.

4.3.2 Monitoring and evaluation at Member State level

There are broad areas that are articulated in the Minimum Standards which, once fully implemented, will lead to the realisation of the commitments and harmonisation of Malaria responses across Member States. Member States are expected to collect data on each of those areas in order to systematically assess progress in them. Those areas are:

- Adherence to diagnosis procedures for Malaria;
- Coverage rates for specific interventions (for example, ITNs and IRS);
- Achievement and maintenance of elimination status;
- Systems for monitoring the import and export of Malaria;
- Adherence to Malaria treatment;
- Adherence to paediatric care, in line with the procedures articulated in the Minimum Standards;
- Development of policies and guidelines, for example, updating guidelines, in line with regional standards;
- Human resource capacity development;
- Development and implementation of quality control mechanisms for laboratory services;
- Development and implementation of mechanisms for donor coordination;
- Allocation of financial resources; and
- Information management systems.

Member States will collect this information on an annual basis and prepare an annual report. The detailed variables on the information that is collected are presented in a separate document, the “Framework for Monitoring Implementation of Regional Policies and Frameworks”.

4.3.3 Monitoring and evaluation at the SADC regional level

At the SADC regional level, tracking implementation progress for the Minimum Standards shall focus on issues that pertain to that level. The focus will be to establish the number of Member States that have implemented each of the following steps:

- Adherence to Malaria diagnosis and treatment guidelines;
- Development of Malaria policies and guidelines, in line with the regional and international standards;
- Development and implementation of plans to strengthen human capacity to implement Minimum Standards; and
- Domestication of Minimum Standards into national M&E systems.

Specific details on the information to be collected are contained in the “Framework for Monitoring Implementation of Regional Policies and Frameworks” document.

4.4 Reporting mechanisms

- Member States will prepare national reports on the implementation of Minimum Standards, based on the information collected on the various areas that are to be monitored at Member State level;
- Those *national* reports will be submitted to the SADC Secretariat annually by 30 April;

- The reports will also describe challenges that Member States are experiencing in the implementation of the Minimum Standards;
- On the basis of the Member State reports, the SADC Secretariat will compile an annual *regional* report that details progress in the implementation of the Minimum Standards;
- That report will be a section in the overall annual regional Malaria report;
- Thus, the submission timelines for Member State reports on the implementation of the Minimum Standards will be in line with the submission of national Malaria annual reports, as detailed in the "SADC Harmonised Surveillance Framework for HIV and AIDS, TB and Malaria";
- The SADC Secretariat will share the report with Malaria managers and the laboratory experts from SADC Member States for review and comments by end-June every year;
- Member States will share their comments with the SADC Secretariat by mid-July every year, after which the report will be presented to senior officials from Ministries of Health and Ministries of HIV and AIDS for review and recommendation to Ministers; and
- Finally, the draft report will be presented at the annual joint Ministerial meeting of SADC Ministers of Health and Ministers responsible for HIV and AIDS, for further review and approval.

The annual regional Malaria report will be analysed to identify implementation challenges and recommend concrete solutions to the identified bottlenecks. Thus, the Malaria report will be used for decision- making and policy reviews at both the national and regional levels.

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