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BEST PRACTICE COLLECTIONS

List of Acronyms

AAVP	African AIDS Vaccine Program
ACSM	Advocacy, Communication and Social Mobilization
ACTs	Artemisinin Based Combination Therapy
ADB	African Development Bank
AIM	African Initiative on Malaria
AL	Artemether-Lumefantrine
ATM	HIV/AIDS, TB and Malaria
ART	Antiretroviral Therapy
Au	African Union
AWA	Africa AIDS Watch
CDC	Centers for Disease Control and Prevention
CBOs	Community-Based Organisations
CHAs	Community Health Agents
CSOs	Civil Society Organisations
DFID	Department for International Development
DOIS	Directly-Observed Treatment, Short-course
	Drug Resources Ennancement against AIDS and Mainutrition
FBUS	Faith-Based Organisations
FDUS	Fixed-Dose Combination drugs
GOE	Global Drug Eacility
GDP	Gross Domestic Product
GEATM	Global Fund to Fight HIV/AIDS, TB and Malaria
GIST	Global Joint Problem-Solving and Implementation Support Team
GLC	Green Light Committee
2GPSTB	Second Global Plan to Stop Tuberculosis
GSC	Global Steering Committee for Universal Access to HIV/AIDS Prevention
GTT	Global Task Team
HIPC	Highly Indebted Poor Countries
HIV	Human Immunodeficiency Virus
IMCI	Integrated Management of Childhood Illness
IMF	International Monetary Fund
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Nets
IVM	Integrated Vector Management
IUATLD	International Union Against Tuberculosis and Lung Disease
KNCV	Royal Netherlands Tuberculosis Foundation
LGAs	Local Government Areas
LLINs	Long-Lasting Insecticide-treated Nets
MACEPA	Malaria Control and Evaluation Partnership in Africa
MAP	World Bank Multi-country AIDS Program
	Millennium Development Goals
MDR-IB	Multi-drug resistant Tuberculosis
NCOC	Medicin Sans Frontiers
	Non-Governmental Organizations
	Norwegian Agency for Development
NSPs	National Strategic Plans
PEPEAR	US President Emergency - Plan for AIDS Relief
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PRSP	Poverty Reduction Strategy Papers
RBM	Roll Back Malaria
RC	WHO/AFRO Regional Committee

STI	Sexually Transmitted Infections
TAP	World Bank Treatment Acceleration Program
ТВ	Tuberculosis
TEHIP	Tanzania Essential Health Interventions Project
THETA	Traditional and Modern Health Practitioners together against AIDS
UNAIDS	Joint United Nations Program on HIV and AIDS
UNDP	United Nations Development Program
UNECA	United Nations Economic Commission for Africa
UNESCO	United Nations Educations, Science and Culture Organization
UNFPA	United Fund for Population Activities
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNSG	United Nations Secretary General
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHA	World Health Assembly
WHO	World Health Organization

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The views expressed in the paper are those of the authors.

1 INTRODUCTION

1. This compilation of examples of best practice aims to highlight key achievements in the prevention and control of HIV/AIDS, Tuberculosis and Malaria. It shows that there is a variety of approaches to prevention and control of the diseases, and can be used to share experience among countries. For each disease, five best practices have been selected from various African countries.

2. In April 2000, African Heads of State and Government from 44 malaria-endemic countries met in Abuja, Nigeria, and signed a Declaration that committed their governments to implement a set of activities to fight malaria within their countries. Subsequently, in April 2001, the African Heads of State and Government held another Summit on HIV/AIDS, Tuberculosis (TB) and other related infectious diseases. The primary goal of the 2001 Declaration was to arrest and reverse the accelerating rate of HIV infection, TB and other related infectious diseases.

3. In spite of the giant strides made since the Summits of 2000 and 2001 towards combating the three diseases, HIV, TB and malaria continue to be the leading causes of morbidity and mortality in sub-Saharan Africa despite the availability of cost-effective large-scale interventions to prevent and control them successfully.

4. The best practice case studies in this document were selected because they showcase effective interventions that can be replicated in other countries. More detailed information on overall progress made between the two summits and the end of 2005 can be found in a report developed by the AU with technical support from WHO and UNAIDS¹.

2 HIV/AIDS BEST PRACTICE CASE STUDIES

2.1 Botswana: Introducing ARV Therapy in the Public Sector

5. Botswana has one of the highest reported HIV-prevalence rates in the world. The annual HIV Sentinel Surveillance, undertaken since 1992 among a representative sample of pregnant women attending antenatal clinics, indicates that the prevalence rate peaked at 38.5% in 2000 and declined to 35.4% in 2002. The average prevalence rate among clients attending one of the 16 free-standing voluntary counselling and testing centres has been reported as 41.4%. The impact on society is reflected by a 62% increase in annual mortality rates in the 2001 census data compared to 1991 and a decrease in estimated life expectancy from one of the highest in Africa at 66.9 years for women in the 1990-1995 period to 30 years expected in the 2005-2010 period.

Point of decision-making / change:

6. Since 2000, the Government of Botswana has demonstrated political leadership by making HIV/AIDS a priority for the country and adopting a compelling, long-term vision to have no new infections from HIV

¹ African Union (2006) Progress Report on the Implementation of the Plans of Action of the Abuja Declarations for Malaria, HIV/AIDS and Tuberculosis

by the year 2016, when Botswana will celebrate 50 years of independence. The President of Botswana, Festus Mogae, has stated publicly, "We are threatened with extinction. People are dying in chillingly high numbers. It is a crisis of the first magnitude".

Strategies and methods used

7. Botswana realized that the epidemic had reached such a magnitude that it could not be faced alone without outside support and innovative ways to address the crisis. This resulted in the establishment of public–private partnerships such as the African Comprehensive HIV/AIDS Partnerships (ACHAP) between the Government of Botswana, the Bill and Melinda Gates Foundation, the Merck Company Foundation and the pharmaceutical company Merck, Sharp & Dohme (MSD). The objectives of this partnership, which started in July 2000, are to support national coordination mechanisms; to build sustainable capacity in health-care structure and systems; to support the development and implementation of a comprehensive HIV/AIDS strategy integrating prevention, care, treatment and support; and the long-term mitigation of the impact of the HIV epidemic.

Results of interventions

8. As of September 2004, there were 21,276 people on antiretroviral therapy in the public sector programme and another 6,900 in the private sector, a total of 28,166 people on treatment in Botswana. The priority of the ARV programme is to save and improve the quality of human lives. In a longer-term perspective, it is important to optimize the chances to make treatment and prevention mutually reinforcing elements of a comprehensive strategy. Several opportunities are being explored in Botswana. They include strengthening the linkages with the mother-to-child transmission programmes because life-long ARV access provides an additional incentive for the mother and her partner.

Lessons learned / Conclusion

9. Strengthening community-based support groups, enhancing network of people living with HIV/AIDS and mobilizing of local faith-based organizations are critical to creating an enabling environment for adherence to ARV treatment. Partner notification and contact tracing are effective public health interventions in infectious disease control and should be considered and reinforced. Partner protection can be introduced as a driver for behaviour change of enrolled patients, complementing current efforts that concentrate on condom distribution and support. There is some evidence that reduced overall viral load in the community reduces HIV transmission.

2.2 Nigeria: Gender Mainstreaming of HIV/AIDS National Strategic Framework

10. To coordinate, monitor and strengthen the implementation of the multi-sectoral approach to the control of HIV/AIDS, the National Action Committee on AIDS (NACA) in consultation with partners in the National Response to the epidemic spearheaded the review of the National Response to HIV/AIDS that was in use until 2004 with an objective of developing a new National Strategic Framework (NSF) on HIV/AIDS to cover the period 2005-2009.

Point of decision making/change

11. There was a broad consensus among stakeholders for a government-led participatory review of the previous 4 years of HIV/AIDS programming that involved all key stakeholders to review progress to date in order to develop the strategic framework within the context of present priorities and realities. The NSF acts as a platform around which all stakeholders, brought together in the HIV/AIDS partnership, are able to program. The development of the NSF provided an opportunity to influence and shape future HIV/AIDS programming in the country and to ensure that responses recognize the unequal impact that the epidemic has on men and women and that gender equality is an objective of HIV/AIDS programs.

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Strategies and methods used

12. Stakeholders to the Expanded Theme Group on AIDS accepted the NSF development secretariat proposal to infuse five gender/AIDS specialists (funded by UNIFEM, CIDA and UNFPA) to work with a team of 20 consultants recruited to review the National Response and to develop the National Strategic Framework. NACA constituted a Gender Technical Committee (GTC) to facilitate broader support for the gender mainstreaming process in the NSF.



A technical session during a Gender Mainstreaming Workshop for HIV/AIDS programme planners organized with support from UNIFEM

Results of interventions

13. The strategy of having gender specialists as core members of the NSF team has been extremely effective. The NSF has gender equality mainstreamed throughout. The eight key objectives of the NSF have strong gender components, indicators are gender sensitive and key activities of the framework target certain percentages of men, women, girls and boys.

Lessons learned

14. One of the unexpected outcomes of the gender mainstreaming process was the informal advocacy of the gender specialists. Stakeholders and senior program officers within the National Response have reacted positively to the gender mainstreaming process. NACA has designated a senior Manager as the gender focal staff person domiciled in the Monitoring and Evaluation unit of NACA to support other program officers in gender mainstreaming in their programs and for monitoring the implementation of the gender aspects of the NSF. Stakeholders and Partners have also agreed to the continuation of the Gender Technical Committee (GTC), which is now a standing committee of NACA and provides support to the gender focal person at NACA and development partners implementing HIV/AIDS programs. Although there were numerous challenges involved with the process, the strategies adopted have shown positive results and can be used as an example for other countries.

Conclusion

15. The process has been documented and the experience shared with National Commissions (especially those about to start reviewing their national strategies) and CSOs during ICASA 2005.

2.3 Mozambique: An Integrated Faith-Based Initiative to Treat HIV/AIDS

16. Drug Resources Enhancement against AIDS and Malnutrition (DREAM) was created by the Community of Sant'Egidio to fight AIDS in sub-Saharan Africa. The project takes a holistic approach, combining Highly Active Anti- Retroviral Therapy (HAART) with the treatment of malnutrition, tuberculosis, malaria and sexually transmitted diseases. It also strongly emphasizes health education at all levels. DREAM aims to achieve its goals in line with the gold standard for HIV treatment and care.

Point of decision making/change

17. The Sant'Egidio Community, a Christian movement founded in Rome in the late 1960s and has a strong base in Africa, launched DREAM in Mozambique in March 2002 in order to fight the devastating impact of HIV/AIDS. The general objective of the project is delivery of a public health intervention. Within the framework of the national health system, the DREAM project aims to introduce the essential components of an integrated strategy for the prevention and treatment of HIV/AIDS. The project is intended to serve as a model for a wide-ranging scale-up of the response to the epidemic.

Strategies and methods used

18. The DREAM project is fully integrated within the framework of the National Health System. Since August 2003, the DREAM project has been active in nine clinical centres distributed across the country. Another centre is planned to open in 2005. Elements of the DREAM model for a health systems response to HIV include optimal use of personnel, intensive training, scaling-back investment in institutional development and investing instead in a stronger field presence, intensive use of technology and innovative methods in the fields of communication, informatics and diagnostics. Programme acceptability and viability lie in providing free treatment and services, while at the same time ensuring the highest level of quality.

19. The DREAM programme is patient-centred. Staff training focuses on the quality of the relationship with patients and stresses that patients must be welcomed at all times, politely, openly and with respect. The patient–staff relationship develops through direct, regular contact and support for patients and their families.

Results of interventions



20. At the end of September 2004, 13,284 people underwent HIV screening and confirmatory rapid tests in both the Community Care and Home Care and the Mother and Child Prevention Care services operational in the Mozambican DREAM Centres. As a result, more than 6,700 HIV-infected patients have been identified and are currently beneficiaries of the programme.

Lessons Learned

21. A public health programme can offer treatment to people with HIV/AIDS at very contained prices while maintaining high standards, Investment in training is a key strategy in the battle against HIV in these countries; adherence is strongly increased when drugs are free of charge.

Conclusion

22. DREAM is expanding the use of successful approaches. The DREAM project has begun activities in Malawi and will be replicated in Guinea Bissau, Guinea Conakry and the United Republic of Tanzania.

2.4 Uganda: Involving traditional healers in increasing access to HIV/AIDS care and prevention

23. Scaling up HIV/AIDS prevention and control efforts in Africa requires the participation of all social and economic sectors. Traditional healers make a unique contribution that is complementary to other approaches and tend to be the entry point for treatment and care in many African communities. It is therefore imperative and practical to consider traditional healers as partners in the expanded response to HIV/AIDS, and to maximize their contributions.

Aim/Objective:

24. The aim of this best practice is to describe initiatives that have narrowed the gap between the traditional and biomedical health systems in different ways, and to highlight their far-reaching benefits with regard to HIV prevention, treatment access and care for people living with HIV/AIDS (PLHIV), their families, caregivers and communities.

What was the situation before introduction of intervention?

25. Uganda, once had the highest HIV prevalence rate in the world, but is now mentioned as the only country in Africa to turn a major epidemic around. In 1985, the Government of Uganda recognized that AIDS affected all strata of the population and posed a serious threat to the socioeconomic development of the country. Today, HIV/AIDS knowledge in Uganda is almost 100% among adults. There has been an overall decline in HIV prevalence rates

Point of decision making/change

26. At the peak of HIV prevalence in Uganda in 1992, the emergency sparked a flood of new ideas in response, including the founding of Traditional and Modern Health Practitioners together against AIDS (THETA). THETA's main goal is to improve and expand access to HIV/AIDS prevention, education and care for disadvantaged populations, such as women and children, through mobilization and the training of traditional healers in Uganda.

Strategies and methods used/Result of intervention

27. THETA's work started in 1992 with two pilot projects based in Kampala. The first project aimed at evaluating traditional herbal treatments for some specific AIDS symptoms. The second project tested the effect of empowering traditional healers as STI/AIDS educators and counsellors through training. Overall, these two projects yielded very encouraging results. THETA's clinical study demonstrated that herpes zoster and chronic diarrhoea, both debilitating conditions affecting PLHIV, could be successfully alleviated by local herbal preparations. In 1995, THETA started a Resource Centre for Traditional Medicine and AIDS, which includes a library and speakers' bureau. The Centre facilitates the exchange of information and networking, both locally and globally. It has also published booklets, training kits, two informational/educational videos and a newsletter with a readership of over 500.

Lessons learned/Conclusion

28. Traditional healers can be enthusiastic and effective community educators and counsellors for STI/AIDS through their ability to deliver preventive messages in unique ways, such as the use of personal testimonies, stories, song, dance, drama and proverbs. They also feel a tremendous responsibility for the health of their communities as they are trusted and called upon for help in a variety of capacities. This sense of responsibility, with added skills and knowledge, has inspired traditional healers to initiate an enormous diversity of health promoting activities in their communities. Through THETA, traditional

healers have opened a very important dialogue to bridge the worlds of traditional and modern medicine. In addition, stigma is significantly reduced when healers, who are highly influential community leaders, become champions of the cause.

2.5 UNHCR and UNAIDS: Strategies to Support the HIV-related Needs of Refugees and Host Populations

Introduction

29. Addressing HIV-related needs in the context of refugee and returnee situations requires changes in the current practice by Governments, donors, UN agencies and non-governmental organisations (NGOs). It is critical that refugees as well as surrounding host populations receive all necessary HIV-related services in an integrated and complementary manner. In this paper, UNHCR and UNAIDS highlight the benefits and discuss strategies that will improve the implementation of HIV-related services for host country populations and refugees as well as returnees.

Objectives

30. The objectives of this best practice collection is to demonstrate the value of and need for the inclusion and integration of refugees into HIV/AIDS national strategic plans (NSPs), policies, programmes and funding, and to promote the effectiveness of sub-regional initiatives when working with displaced populations.

Situation before introduction of intervention

31. Many countries, already overburdened by the impact of AIDS and hosting millions of refugees, are often unable or unwilling to provide refugee populations with the HIV-related services they require. This failure undermines effective HIV prevention, treatment and care efforts for both refugee and host country populations.

Point of decision making/change

32. UNHCR and UNAIDS advocate for the implementation of the best practices described below and trust that these practices will generate more effective, equitable and sustainable frameworks to help countries better address the needs of their own citizens, refugees and returnees.

Strategies and methods used

Best Practice 1: Integrating refugees into national health and HIV programmes

33. This approach improves services and infrastructure both for the displaced and the host population, helps to utilise funds more efficiently, and assists the host country to scale up increased access to HIV prevention and treatment.

Best Practice 2: Implementing sub-regional initiatives

34. These initiatives provide HIV-related services to mobile and displaced persons, provide prevention information and commodities, ensure continuity of treatment and care, and serve to improve programme efficiency and lower costs in HIV prevention, care, support and treatment interventions.

Best practice 3: Combining funding streams

35. This practice improves access to funding for both refugees and local populations. Programmes for both national populations and refugees benefit from access to the two different but complementary funding streams.

Results of interventions

36. Numerous countries have recently included refugees in their revised NSPs and some have begun to provide free antiretroviral therapy. The sub-regional Great Lakes Initiative on AIDS funded by the World Bank has begun and integrated programming for refugees, surrounding host populations and returnees has improved programme efficiency. Uganda and Zambia have integrated host and refugee HIV programmes that have improved infrastructure of district hospitals. The World Bank MAP for the Democratic Republic of Congo has a significant refugee and internally displaced persons component that provides long term HIV funding that is additional to humanitarian funding.

Lessons learned

37. Integrating HIV programmes for refugees, surrounding populations and returnees, sub-regional HIV initiatives, and combining funding streams provide valuable resources for improving local medical services, facilitate the implementation and accessibility of HIV-related interventions, increase resources, and provide more effective HIV programmes for both refugees and the surrounding populations.

Conclusion

38. In the context of conflict and displacement, it is more effective and efficient to deal with the HIVrelated needs of affected populations in an integrated and holistic fashion, preferably under the umbrella of the national aid strategy to ensure that refugees and their host populations receive proper and equitable HIV-related assistance. The integration of humanitarian and development funding benefits all affected populations in terms of improved and more efficient service delivery as well as sustainability of programmes.

3 TUBERCULOSIS BEST PRACTICE CASE STUDIES

3.1 Malawi: Linking TB control with HIV prevention, care and support services

39. The HIV pandemic has massively increased the challenges facing TB control at all levels. TB is one of the most common causes of morbidity and mortality in people living with HIV/AIDS (PLHIV). The World Health Organization's "Two diseases, one patient" strategy for integrated TB and HIV care aims to ensure that all patients with TB are offered HIV testing and counselling and all that HIV patients are tested and treated for TB.



Trends of HIV prevalence in adults (15-49 years) and TB notification rate in MA Malawi, 1980 - 2003

MALAWI

TB Burden in 2004

- Population: 12 608 271
- DOTS Coverage: 100%
- Total number of TB cases: 26 982
- DOTS notification rate (all cases): 214 cases per 100 000 population
- Prevalence of HIV in adult TB patients (15 – 49 years): 52%
- New TB cases multidrug-resistant: 1.4%
- Case Detection Rate (new smearpositive cases): 40%
- Treatment Success (new smearpositive cases, 2003): **73%**
- Global Rank(by estimated number of cases): 26/211

Source: WHO/TME workshop, 2005

Point of decision

40. The Government of Malawi launched its national AIDS strategic plan in 1999. The plan includes a) the provision of an enabling environment, b) a behaviour change intervention and advocacy strategy, c) mainstreaming HIV/AIDS in the public and private sectors, d) an HIV prevention programme and e) a comprehensive HIV/AIDS care and support programme. In acknowledgement of the massive challenges posed by the HIV/AIDS epidemic to TB control, the National TB Control Programme (NTP) inserted a 3-year plan for expanded TB/HIV activities supported and funded by the United States Agency for International Development (USAID), the Centers for Disease Control and Prevention (CDC) and WHO within the National 5-Year TB Control Plan [2002-2006]. This plan was approved and co-funded by the Government of Malawi, the Department for International Development (DFID), the Norwegian Agency for Development (NORAD) and the Royal Netherlands Tuberculosis Foundation (KNCV). The main elements of the TB/HIV plan are HIV testing and counselling for TB patients, provision of isoniazid preventive therapy for PLHIV without active TB, and provision of cotrimoxazole preventive therapy and antiretroviral (ARV) therapy to HIV-positive TB patients.

Strategies and methodologies used

41. The DOTS programme was strengthen through the introduction of TB suspect registers and the enrolment of community-based treatment supporters. A national TB/HIV coordination committee was established with focal person in the NTP and the National AIDS Programme. HIV testing and counselling were offered to all patients with TB while people attending HIV services were screened for TB. These interventions were not a new vertical TB/HIV programme but joint national NTP and NAP efforts.

Results

42. In July 2003, 16 hospitals in eleven districts were selected for support for TB/HIV joint care activities and another 19 hospitals were added a month later. By end of 2004, all hospitals in the country were implementing such interventions. Of 26,136 TB patients registered in the public sector in 2004, 6,681 (26%) were HIV tested and 72% of these were HIV-positive. Almost all (97%) HIV-positive TB patients received cotrimoxazole treatment. At 24 sites providing ART, 6,769 new patients were started on therapy during the year but the number of TB patients on ART was limited due to barriers in accessing centralized ART services for TB patients who were managed in a decentralized TB treatment service. According to the Ministry of Health's "Equity to ART" policy, TB patients have a high priority for accessing ART. Evidence is there that the joint approach has modified risky sexual behaviour.

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Right: A mother (seated, front) entertains a group of consultants in rural Malawi. Her daughter (holding the card) is on TB treatment with the support of her mother. Many TB patients are now aware of their HIV status, and can access HIV prevention, treatment, care and support services

Lessons learnt

43. The Malawian response shows that boldness, innovation and above all, action, are essential if the response to the twin scourges of TB and HIV is to be effective. The DOTS strategy is still the mainstay of effective TB control but expansion to address the link between TB and HIV is essential if global control targets are to be met.

Conclusion

44. TB/HIV collaboration calls for enhanced collaboration between the TB and HIV control programmes in providing a continuum of care at service delivery level. This is essential since these are "two diseases – one patient". In most sub-Saharan countries, TB patients constitute the largest single group eligible for ART, and collaboration between TB and HIV care will massively increase the number of people accessing ART. At the very least, all TB patients in high-HIV areas should access an HIV test as the entry point to the most appropriate care and prevention.

3.2 Namibia: Community-based TB Care Improves Delivery of DOTS

45. The steep rise in the TB caseload due to the HIV epidemic has overwhelmed the capacity of many government health services to provide quality TB care. Because of poor access to health care and inadequate human resources for health, there is need to look at other approaches, outside the clinic and hospital setting, e.g. through local health centres, with the contribution of community members. Community participation in health care services is a long-standing key principle of primary health care, and the decentralisation of TB control services into the primary health care system in many countries offers a great opportunity to increase access to care and support services for TB. There is a wide body of evidence on the positive experiences with community-based TB care activities.

What was happening before the intervention?

46. Namibia is a country the size of France and Germany combined that is home to only 2 million people. The country has one of the world's heaviest per capita burdens of TB at 748 cases per 100 000 population. Though the case detection rate of 88% exceeds the global control target, treatment success is still only 63% among new smear-positive patients, far short of the 85% target. DOTS services are available the public sector in each district, and geographical DOTS coverage reached 100% in 2003. However, real access to quality TB diagnostic and care services by many remains poor due to the vastness of the country, difficult terrain and mobile populations.

NAMIBIA

TB Burden, 2004

- Population: 2 009 251
- DOTS Coverage: 100%
- Total number of TB cases: 15 029
- DOTS notification rate (all cases): 748 cases per 100 000 population
- Prevalence of HIV in adult TB patients (15 49 years):
 61%
- New TB cases multidrug-resistant: 1.3%
- Case Detection Rate (new smear-positive cases): 88%
- Treatment Success (new smear-positive cases, 2003): 63%
- Global Rank(by estimated number of cases): 66/211 countries

Source: Global TB Report, 2006 (unpublished)



47. In 1999, Omaheke Region had the country's worst treatment outcomes, with success rates of less than 30%. The challenges facing the Omaheke Region's efforts to control TB included a highly mobile San population in a vast and sparsely populated farming area, making patient follow-up a major challenge.

Point of decision for change

48. In recognition of these challenges, the Omaheke Health and Education Programme (OHEP) was initiated in 1999 with funding from Oxfam Canada.

Strategies and methodologies used

49. The initial intervention was building capacity of hospital staff on case management and introduction of direct observation of treatment (DOT) on the wards. When these measures were found to be insufficient to improve results, the approach was modified to enrol community participation in 2000. TB inpatients were counselled about TB and its treatment and were given the option of treatment under the

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supervision of their nearest clinic or of a community treatment supporter. Community volunteers were trained on treatment observation. Each local clinic had a focal person who was trained to supervise the community treatment supporters. Clinic health committees were formed and were the link between the community, including local San chiefs and the Ministry of Health and Social Services. The programme provides transport and drivers, which are used for primary health care (PHC) outreach activities, including following up defaulters. Treatment supporters were also trained to refer any chronic coughers to clinics for investigation, further increasing case detection rates. The introduction of a "Best managed clinic health committee of the year" competition based on TB control criteria generated great interest and enthusiasm in the region.

Results

50. The results were remarkable. Immediately, hospital wards were decongested. Of an initial 1,200 defaulters in the region's TB register when the programme began, only two were never located. The rest were found and put back on treatment, which they completed. Treatment success increased from less than 30% in 1999 to 89% in 2003 among a cohort of 376 smear-positive patients, while the proportion of patients who defaulted treatment fell to 0.5%. Recent knowledge, attitudes and practice (KAP) surveys have shown that the stigma associated with TB has decreased in the region.

Lessons for other countries

51. Community involvement in Omaheke worked because there was good collaboration between general health services, the TB control programme and the community. The project provided good education to TB patients and their families, and good training for community supporters as well as health workers. A robust system of supervising community supporters by TB programme staff was instituted. The approach was flexible and was adapted to suit the local situation when it became apparent that new adaptations were not having the desired effect.

Conclusion

52. Community participation in TB control does not remove the responsibility for TB control from the TB control programme. It is important to think globally but act locally, and to work through existing community organizations than to create new ones.

3.3 Nigeria: Acceleration of DOTS Expansion

53. Most countries in Africa report DOTS services in more than 85% of their public health facilities, but the quality is often poor and the services not accessible to the majority of the population. Scaling up of DOTS expansion using new initiatives such as community-based TB care and involvement of private sector is still new in most countries.

54. The estimated burden of TB in Nigeria ranks it 4th among the 22 highest TB burdened countries in the world that together contribute 80% of the global burden. An estimated 300,000 new cases of TB occur annually but case detection of new smear-positive cases is low (21% in 2004) and geographical DOTS coverage is only 65%. The HIV seroprevalence rate in TB patients rose from 2.2% in 1991 to 27% in 2004.

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What was happening before the intervention?

55. Before 2002, DOTS implementation was limited to only 19 of Nigeria's 37 states, mainly in the southwest and southeast zones of the country, which were supported by the International Leprosy Organizations (ILEP), the German Leprosy Relief, the Damien Foundation and the Netherlands Leprosy Relief. This limited case detection to 15%, geographical coverage of states to 51%, and population coverage to 45%.

Point of decision for change

56. Beginning in 2002, the country embarked on accelerated DOTS expansion in the 16 states and the FCT in the northern part of the country that were not implementing DOTS for a combination of reasons including a poor laboratory network, lack of supply of good quality anti-TB drugs and a shortage of adequately trained manpower.

Strategies and methodologies used

57. There was intensified training of health care workers, expansion of the microscopy network and empowering the national programme to supervise, monitor and coordinate the DOTS expansion activities. Support was provided by the Global Drug Facility (GDF) through a grant of free anti-TB drugs, financial support from the Canadian International Development Agency (CIDA) and USAID, technical support from the International Union Against Tuberculosis and Lung Disease (IUATLD) and WHO, in collaboration with the national Tuberculosis Inter-Agency Committee.

Results

58. Between 2002 and 2004, 1,300 general health workers and 456 laboratory technicians and microscopists were trained in eight Local Government Areas (LGAs) in each of the remaining non-DOTS states. Commendable progress was made: DOTS expansion reached 100% geographical coverage by states and 60% LGA coverage (549 out of 774 LGAs) by the end of 2004. Smear microscopy became available through a network of 547 microscopy centres compared to 493 at the end of 2002 and the number of primary health care facilities offering DOTS services increased from 1,721 to 1,929 within the same period. Between 2002 and 2004, case detection increased by 33%, case notification by 49%, and treatment success was maintained at 80%.

59. Progress was also made in preparing implementation plans for countrywide TB/HIV collaborative activities. TB/HIV focal persons were appointed in the national TB and HIV programmes, a technical

TB/HIV committee established, and the national TB/HIV coordinating committee inaugurated in 2005. Technical guidelines for implementing joint TB/HIV activities were produced. Preparatory activities to commence implementation of joint TB/HIV plans in six states selected for the initial phase began in 2005, as did the implementation of joint TB/HIV activities, community TB DOTS and Public Private Mix DOTS (PPM). This was accompanied by expansion of DOTS services to more LGAs and health facilities, human resource development and operational research for TB.

Lessons for other countries

60. While DOTS is the *sine qua non* for TB control, an enlarged multisectoral approach is necessary to achieve MDGs by 2015. Such an approach requires adaptation to national settings and engagement of all health sector partners. It is important to conduct stepwise implementation of key operations, using carefully determined priorities and a feasible sequence of applying the expanded framework. Countries should aim for total geographical and total patient coverage in order to make the right of everyone to quality TB care a reality.

3.4 Kenya: Involving Private Practitioners in TB Care

61. After adopting the DOTS strategy in the early 1990s, Kenya achieved nationwide geographical DOTS coverage in 1996. Mainly because of a generalised HIV epidemic, TB notification rates have increased five-fold in the past 10 years. Improved TB control programme performance has also contributed to increasing case detection. TB diagnosis and treatment are integrated into the primary health care system. In collaboration with NGOs, the programme has extended DOTS services to remote areas, nomadic populations and urban slums. However, case detection rates remain low, being 46% in 2004, while treatment success has improved to 80% in new smear-positive TB patients.

62. This case study looks at one of the interventions used by the TB control programme to improve TB control efforts: encouraging private practitioners to provide DOTS services in order to increase case detection.



KENYA

TB Burden in 2004

- Population: 33 467 000
- DOTS Coverage: 100%
- Total number of TB cases: 100 736
- DOTS notification rate (all cases): 301 cases per 100 000 population
- Prevalence of HIV in adult TB patients (15 49 years): 29%
- New TB cases multidrug-resistant: 0.0%
- Case Detection Rate (new smear-positive cases): 46%
- Treatment Success (new smear-positive cases, 2003): 80%
- Global Rank(by estimated number of cases): 10/211 countries

Source: Global TB Report, 2006 (unpublished)

63. Despite the challenging socio-economic conditions common in many African countries, many potential TB patients first approach private practitioners for their management. In most countries, management of TB in the private sector occurs independently of the national TB control programme,

contributing to low case detection and treatment success rates. There is need, therefore, to establish a good relationship between the private and public sectors for better TB control

What was happening before the intervention?

64. All Kenyan district hospitals and some health centres offer smear microscopy services for diagnosis of TB. During the period 1987 to 2004, the number of new cases reported to the NTP annually increased from 10, 000 to more than 100, 000, all reported from the public sector since there was no mechanism for registering TB cases managed in the private sector.

Point of decision for change

65. In response, the Kenyan National TB Control Programme piloted private-public mix in DOTS (PPM-DOTS) in 2002 in Nairobi, Kisumu and Eldoret.

Strategies and methodologies used

66. The project focused on private health care providers, with formal training of health care providers such as doctors, clinical officers, nurses, pharmacists and pharmaceutical technologists at private health facilities such as private hospitals, nursing homes, employer-based clinics and clinics run by health management organizations. The interventions included provision of affordable and quality Fixed-Dose Combination (FDC) anti-TB drugs for TB patients who were willing and able to pay for private care, training, education and supervision of clinicians in the sector to facilitate early diagnosis. The programme promoted smear microscopy, case recording and reporting through the introduction of TB registers and TB treatment cards, and strengthened quality assurance and networking of private laboratories with existing research laboratories.

Results

67. By mid-2004, the private sector in Nairobi alone had registered more than 3,000 patients. Other large towns continue to embrace the private sector TB management programs. Treatment success rates continue to improve as supervision and monitoring intensify, being 74% of the 3,603 cases registered in Nairobi during the first half of 2003, a very auspicious start for a sector that was not reporting at all. Scaling up of the project is underway to other major towns such as Mombasa, Kisumu, Nakuru, Eldoret, Kericho and Nyeri, with plans to expand the project even to the smaller areas. Some of the challenges faced by the project include securing the necessary funds for training, supervision, recruitment of key health personnel to strengthen monitoring and evaluation, development of IEC materials and communication strategy interventions to assist in the rolling out of the initiative

Lessons for other countries

68. There should be active communication and information gathering to establish links with the private health sector at all levels. It is vital for the NTP to be aware of the extent and nature of private sector involvement in TB care and to exploit the opportunities afforded by the private health sector for improving TB control efforts. TB care in the private sector must be according to national guidelines. The NTP should exercise flexibility without compromising TB control principles.

Conclusions

69. Countries should obtain more information on the issue of private health sector involvement in TB control. The extent and details of private-public collaboration in TB control will depend on country-specific and intra-country situations and should be designed to suit local settings.

3.5 Togo: Community Mobilisation for Better TB Control



Above: Community mobilisation is a crucial element in implementing any community-based intervention. Here, Chief Danyi Dafo in the Plateau Region of Togo addresses his community, educating them about TB and encouraging early detection and full adherence to treatment

What was happening before the intervention?

70. All TB patients used to be admitted for at least 2 months, and hospital staff supervised in-patient treatment. Access to hospitals is difficult due to the terrain and other constraining factors such as costs, and patients were often lost to follow up. In the Plateau region, the distance that some TB patients travel to get to Kpalime Hospital can be as much as 70 km away.

Point of decision for change

71. The turning point came when a medical officer working in the region, recognising the challenges facing the community, decided to improve care and manage by personally administering treatment to TB patients in their own homes. The idea gained momentum and was discussed by the national TB control programme with the WHO country office, leading to the launching of community-based TB care on World TB Day 2002 in three zones in the Plateau Region: Danyi, Tchaoudjo and Tone.

Strategies and methodologies used

72. The TB control programme sensitised the communities in the Plateau region through the local leadership structures. One local chief was particularly supportive because his nephew had recently successfully completed TB treatment. This chief became the main advocate for introducing community DOTS in the area and galvanised his people to accept the intervention. Health personnel at Apeyeme Hospital were trained on TB management, particularly on early diagnosis and ambulatory treatment. Community volunteers from the surrounding area were also trained as treatment supporters (called community based agents). The treatment supporters included family members of TB patients. The community was sensitised on early case detection, and anyone with a chronic cough is referred to the nearest health post for further investigation. Sputum specimens were collection and submitted by the community-based agent to the health post, instead of patients travelling to the facility for investigation.



Above: A group passes on messages about TB diagnosis and treatment through song and dance

Results

73. TB management has become patient-centred without compromising control principles. Sputum results turn-around time was reduced to above 48 hours, and ambulatory treatment decongested hospitals. The community has been sensitised about TB diagnosis and treatment. The community-based agents are supported and supervised by nurses during weekly visits. Records of treatment compliance are maintained, and this system has virtually eliminated defaulting and the need for transfers. The regional officer visits the districts monthly and there are quarterly national level meeting for regional officers where all district TB registers are inspected.

Lessons for other countries

74. Community DOTS is feasible and patients prefer to receive treatment within their own community, which is more convenient and more affordable. The enthusiastic involvement of key stakeholders and should be sought at the earliest stage, especially in the planning and sensitization stage, as well as at implementation. Despite the general willingness of communities to participate in community-based actions on a voluntary basis, innovative measures to motivate volunteers are need.

4 MALARIA BEST PRACTICE CASE STUDIES

4.1 Niger, Togo, Mali, Malawi and Tanzania: Rapid Increase of Insecticide Treated Net Coverage

75. The great majority of deaths due to malaria in Africa occur in very young children, and the risk is especially high in the first year of life. Insecticide-treated nets (ITNs) are a simple but very powerful way of preventing malaria. The lives of several hundred thousand children could be saved every year by complete ITN coverage of all under-fives. For this reason, the Abuja summit in 2000 set ambitious ITN coverage targets for young children and pregnant women.

76. In 2000, much debate centred around two key questions: how to increase ITN coverage rapidly and how to sustain it at high levels over the long term. Several strategies had been proposed, each with its own advantages and impressive success stories. One approach is to combine delivery of ITNs with other services. For example, in most African countries, with some important exceptions, immunisation and antenatal services achieve remarkably high levels of coverage. These channels therefore offer good opportunities for the timely and targeted delivery of ITNs to pregnant woman and infants.

77. In **Malawi**, for example, a nationwide programme has been operating through antenatal services since 2002. ITNs are sold to pregnant women at a very low token price and more than 100,000 nets have been delivered every month since the programme began. Net coverage of under-five children was 8% in 2000, reached 38% in February 2004 and is rising rapidly. Similar trends were seen in coverage of pregnant women. This has probably contributed to the observed decline in infant mortality rates in Malawi over recent years, although of course, it is not possible to distinguish the effects of ITNs from those of other interventions including the switch to more effective anti-malarial drugs.

78. Even more rapid scaling-up of ITN coverage has recently been achieved in **Togo** and **Niger**, by combining ITN distribution with measles vaccination, in intensive nationwide "catch-up" campaigns. In both case, high and equitable levels of coverage were achieved very rapidly. The Togo campaign, for example, delivered ITNs to more than 90% of eligible children, and a follow-up survey one month after the campaign showed that 43.5% of under-five children had slept under an ITN the previous night.

79. Although campaigns are clearly beneficial for rapidly increasing coverage, it is less clear how effective they are at covering the children born in the long intervals between campaigns. This is a critical issue because the risk of malaria is so strongly concentrated in the first year or two of life. There might therefore be significant advantages, especially in terms of timing, to delivery of ITNs in conjunction with routine immunisation activities. Surprisingly, however, there has not yet been any attempt to use this delivery mode on a national scale. This may be partly because donors are more willing to give one-off contributions for occasional campaigns, and are less willing to fund routine services.

80. No other programmes can match the Togo and Niger campaigns for the speed with which scaling up of ITN coverage was achieved. However, some alternative approaches do seem to offer better prospects for long-term sustainability, together with the advantages of integration with local systems.

81. At the time of the 2000 Abuja summit, it was generally assumed that commercial net markets existed only to serve the urban rich and that, with a few exceptions, net coverage was generally very low. We have since realised that commercial net markets are much more pervasive, dynamic and equitable than we previously thought. For example, in one series of surveys carried out in 2000-2001, seven out of 26 surveyed countries reported more than 30% of under-five children sleeping under untreated nets. The highest rates were found in **Mali**: more than 50% of Malian households reported owning one or more commercially purchased nets, and more than 90% did so in the famously remote region of Timbuktu.

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Moreover, in West and Central Africa, Southern Sudan and Madagascar, untreated commercial nets were surprisingly evenly distributed across socioeconomic groups. By contrast, treated nets from projects were strongly concentrated in the richer households. Assuming that untreated nets are half as effective as treated nets, and there is good evidence to support this, then we must infer that the untreated (commercial) nets in these surveys were preventing about twice as many child deaths as the treated nets from projects, most of all in the poorest households. For this reason, and because it is home-grown fully integrated and 100% sustainable, this commercial coverage perhaps deserves some recognition as a modest success story in its own right.

82. There is a long tradition of net-use in Mali, and in many other parts of West Africa. The story of Tanzania, however, shows that net use is not a fixed cultural attribute, but a habit that can be quickly learned. In the 1980s, nets were a rare sight in Tanzania. In 1994, a private textile company started to sell branded nets, and two competing brands entered the market soon afterwards. Over the next eight years, there was a sustained commercial boom, with sales and coverage growing by about 20% per year, helped by a social marketing programme. Competition brought rapid improvements in quality, choice and rural penetration. The Tanzanian "ITN cell", which involves the Ministry of Health and other stakeholders, rejected the idea of a new social marketing brand. Instead, it decided to work with the existing net producers, strengthening their brands, rationalising taxes and tariffs and promoting demand and competition. Free insecticide was provided to the manufacturers, so that all the nets sold in Tanzania were ITNs. By 2004, more than half of Tanzania's households owned at least one net, and net use is now well established as a social norm. Best of all, there has been a substantial decline in infant mortality rates, from approximately 100 per 1000 live births in 1995-99 to about 68 in 2000-04. Of course, ITNs are just one contributing factor, but this is nevertheless encouraging. Now, Tanzania is in the process of rolling out its national ITN voucher scheme, which will allow all pregnant women to buy commercial ITNs at very low prices. It is expected that this will quickly complete the process of bringing coverage rates up to target levels, both in pregnancy and in very young children.

83. Together, these examples show that by employing a carefully chosen complementary mix of strategies, it is possible to scale-up ITN coverage rapidly, and at the same time to build longer-term distribution systems that offer greater integration with the local economy and better prospects for sustainability.

84. When the Heads of State met in Abuja in the year 2000, they defined some clear ITN coverage goals, but it was not yet clear how these goals could be achieved. Now we have a range of effective strategies to choose from, and we are finding out how to combine them most effectively at national level. We are on the way....

4.2 Burundi: Treatment Policy Change In The Midst of a Complex Emergency

85. In September 2000, the north-eastern part of Burundi experienced one of the deadliest malaria epidemics in recent times in Africa, affecting more than half the country's population and resulting in about 10 000 deaths. As the death toll mounted, speculation rose about the effectiveness of the two drugs used to treat malaria, chloroquine and sulfadoxine–pyrimethamine. With support from WHO, Medicin Sans Frontiers (MSF) and the United Nations Children's' Fund (UNICEF), the government of Burundi assessed the efficacy of chloroquine and sulfadoxine-pyrimethamine in four sites across the country to be from 9 % to 49% for sulfadoxine-pyrimethamine. The MoH therefore removed chloroquine from its antimalarial treatment guidelines.

86. Subsequent studies demonstrated the safety and effectiveness of two alternative therapies: The ACTs artesunate + amodiaquine and artemether-lumefantrine (Coartem).Based on cost and simplicity to administer, the artesunate + amodiaquine combination was chosen replace sulfadoxine-pyrimethamine as the first-line national treatment policy. Because no coamodiaquine combination was available form a pre-qualified supplier, interim guidelines were established to ensure that available medicines met WHO manufacturing and quality standards. A national commission, including officials from the Ministry of Health (MoH), MSF, WHO and UNICEF, was established to guide and monitor implementation of the new policy.

87. Initially, the cost of the combination therapy (US\$2.80 per adult treatment course) was higher than estimated during the planning stage, created a problem. Subsequently, the European Commission's Humanitarian Aid Office and the USAID Office of Foreign Disaster Assistance committed funding for an initial supply. To cover procurements for an initial 6 months, La Cooperation Belge and the USAID Regional Economic Development Services Office for East and Southern Africa bridged the remaining gap.

88. A national drug stock was created, stored and managed by UNICEF. All provincial health centres were provided with an initial 2-month supply of drugs. Before the launch, clinicians, nurses and community health workers in the public sector and those working for NGOs in all provinces were trained in the use of the new treatment. To ensure equitable access at health facilities, the government developed a scaled pricing scheme, including free distribution to the very poor. Finally, the Health Promotion Service of the MoH launched a national communication strategy several months before introduction of the new drug to inform the population and practitioners about the new protocol.

89. The new treatment policy was successfully launched in November 2003. A rapid initial evaluation in six provinces suggested that the incidence of malaria had decreased over the first 9 months of 2004. A grant of US\$ 13 million from the GFATM will ensure the continued supply of drugs through 2006. Half of the grant is earmarked for the purchase of ACT, the cost of which had dropped to US\$1.24 by November 2004.

4.3 Tanzania: Strengthening Health Systems Reduces Child Malaria Mortality

90. Proven efficacious tools are now available to control malaria, but these are of little use unless they reach the people in need. Achieving, sustaining, and exceeding the Abuja coverage targets is absolutely dependent on strengthening health systems. In addition to strengthening facilities, capability of health workers, supply systems and data use, there are added benefits to provision of integrated packages of essential health interventions as opposed to single disease interventions, in terms of cost, efficiency and addressing multiple diseases which together increase a child's vulnerability. The Tanzania Essential Health Interventions Project (TEHIP) began in 1997 as an integrated research and development project in two districts.

Point of decision-making

91. The decision to undertake the project followed from the World Bank's call in "Better Heath for Africa" that essential health packages could have a major impact on disease burden, but needed increased financial investment.

Strategies and methods

92. The project, which was managed by the Tanzanian Ministry of Health with support from the Canadian International Development Research Centre (IDRC), provided health system investments and strengthening including decentralised health basket funding (less than US\$1 increment per person per year), district health management team capacity building, an integrated management cascade and community ownership of health facilities. It developed evidence-based tools for planning and management (community sentinel surveillance, district health service profiles and district health accounts. The project used annual inputs from sentinel Demographic Surveillance Systems (DSS) to develop these. Health intervention profiles derived from the DSS and showing the share of burden by each disease where specific interventions could be applied, were produced annually to assist priority setting. Key interventions for malaria given highest priority by district health teams were Integrated Management of Childhood Illness (IMCI) and provision of insecticide-treated nets. The impact of the project was thoroughly evaluated and documented and the results energetically disseminated.

Results

93. Outputs were: 1) better health plans, prioritisation and resource allocation, 2) higher investments in cost-effective packages for high burden problems and 3) increased quality and utilisation of essential health services.

94. Associated outcomes are significantly reduced all-cause under-five mortality (see figure below), mostly from reduced infant mortality and most of which was from reduced malaria (54% reduction in Rufiji District), pneumonia, and perinatal causes. Reductions were also seen in per capita Years of Life Lost and adult mortality.



Child mortality nationwide reduced by 24% from 1999 and more than 50% in intervention districts

95. Nationwide rollout started slowly, but gathered momentum in late 2005. The Ministry of Health created and funded a project to accelerate scale up of the TEHIP experience nationwide. District basket

funding at US\$0.50, IMCI and ITN programming have now reached all districts. The main TEHIP planning tools have already reached about half of the districts since 2002. Together this probably contributed to the national child survival gains. The Ministry of Local Government has now embedded the District Health Accounts Tool in the national budget and expenditure software that all districts must use.

Lessons learned

- Systematically collected data on preventable disease burden can be used to set priorities and allocate budgets to focus on the most important problems and to apply cost-effective interventions, when the data collection is combined with district capacity development and response to community priorities.
- Nationwide scale-up of effective approaches can be slow when finances and human resources are limited, but full buy-in by government can lead to raising resources.
- Even modest increments in funding at district level can lead to significant health impact if these increments are well managed.
- Clear presentation of evidence to key decision makers can persuade them to adopt nationwide scaleup of effective approaches. This highlights the importance of investing in stronger monitoring, surveillance and information systems.
- Development of capacity in district health systems is a key motivator of health staff

Conclusion

96. Tanzania is now on track to achieve MDG 4 (two-thirds reduction in child mortality). The lessons from this project could apply to many countries. Increased investment in health system strengthening is needed to achieve better disease control.

4.4 Eritrea: National leadership promotes comprehensive packages and exceeds Abuja targets

97. The Ministry of Health endorsed the Roll Back Malaria (RBM) initiative, and a five-year malaria control strategic plan (2000-2004) was prepared in consultation with partners and stakeholders. The main objective of the strategic plan was to reduce morbidity and mortality due to malaria by 80% from the 1999 level. It also aimed to reduce incidence of malaria by 90% in epidemic-prone areas.

Strategies and methods

98. The National Malaria Control Programme of the Ministry of Health in collaboration with partners identified and pursued the following strategies for tackling malaria on all fronts:

- Early diagnosis, prompt treatment, and appropriate management of malaria;
- Malaria prevention through Integrated Vector Management (IVM) including personal protection and the use of ITNs, Long-lasting Insecticide-treated Nets (LLINs), Indoor Residual Spraying (IRS) and larviciding;
- Epidemic forecasting, early warning and response (prevention and control);
- Operational research
- Health promotion, community education and involvement;
- Programme management, including capacity building, integration, building partnership, logistic and financial management;
- Supervision, monitoring and evaluation; and
- Capacity building (training, workshops and study tours).

Results

99. The choice of strategies and their positioning in consistency with RBM and Abuja declarations led to great achievements. These includes exceeding the 80% target for reduction in mortality and mortality (reduction in malaria cases by 84% and malaria deaths by 84% from the 1999 level) and surpassing the

60% objective of households owning ITNs (increase in net treatment from 17.2% in 1999 to 83.5% in 2004).

100. Vector control performed well with various methods: use of ITNs was higher for children under five years and pregnant women than for the rest of population indicating appreciation of the vulnerability of the target groups. Community health agents (CHAs) treated more cases than in health facilities, emphasizing the need for the CHAs to be well trained and up-dated on malaria information.





Lessons learned

101. Eritrea has demonstrated that it is possible to control malaria even in a resource poor country through active implementation of a comprehensive strategy, with strong national leadership and reduced donor dependency.

4.5 South Africa: Combined approaches and timely information reduce morbidity and mortality

102. Using combined interventions, South Africa has significantly reduced malaria morbidity and mortality from 1999 to 2004 (Figure). From 1995 to 2000, *Plasmodium falciparum* malaria increased markedly in KwaZulu–Natal province. Information systems detected the increase, and found resistance to the pyrethroid insecticides and resistance to sulfadoxine-pyrimethamine, the first-line drug for treatment.

Strategies and methods

103. The Ministry of Health responded rapidly by intensifying vector control mainly with IRS, achieving up to 90% coverage and by changing first line treatment to an effective artemisinin-based combination therapy (artemether-lumefantrine, AL). Malaria is diagnosed definitively, and treatment is provided free of charge in public-sector health care facilities, which are reasonably accessible to most people. A Geographic Information System (GIS) was introduced for good malaria mapping. An early detection system for malaria epidemics was set up based on good surveillance.

Results

104. In the year following improved vector control and AL treatment, malaria-related admissions and deaths both declined by 89%, and outpatient visits decreased by 85% at sentinel facilities. By 2003, malaria-related outpatient cases and admissions had fallen by 99%, and malaria-related deaths had decreased by 97%. There was also a marked and sustained decline in notified malaria throughout the province.



Malaria morbidity reduction in South Africa by season of transmission

105. Cross border collaboration was a key element for the success in malaria control in South Africa under the Lubombo Spatial Development Initiative (between Mozambique, South Africa, and Swaziland); and Trans-Limpopo initiative (between Zimbabwe and South Africa).

Lessons learned

106. This story demonstrates the value of collecting and using evidence to update policy and responding quickly and thoroughly. It also highlights the importance of systems ensuring access, which require adequate investment. The combined response makes it difficult to know how much of the success could be attributed to a single intervention, but enough examples indicate that combined approaches provide reliable and sustainable control.

5 CONCLUSION

107. These success stories from a range of countries in Africa show that with determination, impact can be achieved. A few years ago, it was difficult to find examples of success in Africa that covered more than a small part of any country. Today countrywide examples are starting to appear. However, there are still major challenges in long-term development of systems that can deliver high quality services nationwide. In general, these best practice case studies show that with commitment and innovative approaches involving diverse partners, scaling up universal access to HIV, TB and malaria prevention, treatment care and support is possible.

108. Ultimately, strong leadership and the willingness to take bold action backed by evidence of the effectiveness of the approaches are necessary towards achieving the targets for 2010 and 2015. Approaches that integrate disease control programmes will make the expansion task more feasible. Good documentation of progress will be essential both to assess the appropriateness of implementation of strategies and to advocate for long-term predictable political and financial support.