Malaria Case Management in Zimbabwe
Successes and Challenges

CMWG Annual meeting
Annecy 05/03/13
Staneford Mashaire
Rationale for E8; Southern Africa is adopting a spatially progressive model of elimination, moving from south to north.

...setting the stage for the disease to pushed up the continent.

With the help of cross-border initiatives, malaria will be rolled back from the southernmost countries.
Malaria profile

National Malaria incidence rate per 1000 population

<table>
<thead>
<tr>
<th>Years</th>
<th>Incidence Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>155</td>
</tr>
<tr>
<td>2004</td>
<td>153</td>
</tr>
<tr>
<td>2005</td>
<td>125</td>
</tr>
<tr>
<td>2006</td>
<td>109</td>
</tr>
<tr>
<td>2007</td>
<td>99</td>
</tr>
<tr>
<td>2008</td>
<td>94</td>
</tr>
<tr>
<td>2009</td>
<td>58</td>
</tr>
<tr>
<td>2010</td>
<td>49</td>
</tr>
<tr>
<td>2011</td>
<td>25</td>
</tr>
<tr>
<td>2012</td>
<td>22</td>
</tr>
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</table>
Disease burden in relation to neighbouring countries

• Disease burden still more pronounced along the borders
• Eastern province borders with Mozambique has biggest burden, it is >740km long. Moza still in control phase
• Western province borders with Botswana, it is a low rainfall area & Botswana is in pre-elimination phase
• Southern province borders with South Africa (in pre-elimination phase)
• Northern province borders Zambia (in control phase)
Background

• Prior to the change of the malaria treatment policy in Zimbabwe HMM was the major strategy used for prompt delivery of effective malaria treatment in the rural areas.

• But no accurate documentation was carried out on the burden of malaria case management that was shouldered by these CBHWs.
• Introduction of ACTs meant that every case of malaria that received treatment had to be a confirmed case.

• NMCP embarked on a nation-wide training of HW in malaria case management using the ACTs.

• However training of CBHWs in carrying out RDTs met with some stiff resistance from some quarters of the policy makers.
From 2008 to 2010, burden of malaria case management shifted from mainly community based management to health centre based management programme.

“Atypical” malaria outbreaks country wide, with a prolonged nature despite adequate intervention measures being put into place were witnessed.
Introduction

• We carried out a study in the 4\textsuperscript{th} high burdened (2011 data) malaria district in the country

• Access to health facilities is very poor

• Hence community based management of malaria was piloted in the district
What the study intended to answer

- Can the CHBWVs be trained to be competent enough to carry out RDTs and dispense ACTs?
- What are the training needs for such training of these CBHWs?
- How significant is the role of CBHWs in malaria case management in the rural settings?
- What is the burden of malaria case management that is borne by the CBHWs in rural settings of the high burdened malaria districts in Zimbabwe vis-a-vie the rural health centres?
Methodology

• Health centres where major challenges had been encountered during the 2009/2010 malaria season were purposively selected, due to limited funding.
• Three phased intervention study was carried out in three rural health centres in the district.
  1. Training of CBHWs in Dec 2010 around 3 clinics
  2. Assessment of performance of the trained CBHWs in CCM carried out in March 2011
  3. Collection of data from the clinics on malaria cases managed by CBHWs and by HWs from Jan. to June 2011
Distribution of suspected cases between HWs & CBHWs for the 3 clinics (Jan –June 2011)
Successes

- Health Workers trained 7478 against a target of 12 000+
- Community Based Health Workers = 2983, against 6 600 for 55/63 districts
- Cross-boarder malaria initiatives
  - Malaria is a disease without borders,
  - Control efforts restricted by borders.
  - Innovative solutions are required to improve access to isolated communities
  - Need for coordinated, harmonized and synchronised malaria control and elimination interventions
- TZMI/ZamZim
- TLMI/MoZiZA
Challenges

• Mobilizing enough resources for the community based management of malaria
• Community factors including late presentation and poor compliance
• ? Low community awareness and motivation.
• Inadequate supportive supervision
• Keep the community health workers motivated
• Delays in disbursement of funds - malaria seasonal
• Limited corporate/private sector support-for sustainability of programme
• Staff attrition
• Protecting the ACTs from emergence of resistance
Table 2. Outcome of Antimalarial Drug Efficacy Studies conducted from 2000 to 2010

<table>
<thead>
<tr>
<th>Year</th>
<th>Antimalarial used (sites)</th>
<th>Treatment failure (%)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>CQ (8)</td>
<td>43.2</td>
<td>Recorded at Lukunguni</td>
</tr>
<tr>
<td>2001</td>
<td>CQ (5) / CQ+SP (3)</td>
<td>36.3 / 4.5</td>
<td>Recorded at Chibuwe / Chirundu</td>
</tr>
<tr>
<td>2002</td>
<td>CQ (3)/CQ+SP</td>
<td>11.5 / 3.3</td>
<td>Recorded at Hauna / Chirundu</td>
</tr>
<tr>
<td>2003</td>
<td>CQ+SP (12)</td>
<td>5.0</td>
<td>Total all sites</td>
</tr>
<tr>
<td>2004</td>
<td>CQ+SP (11)</td>
<td>7.0</td>
<td>Total all sites</td>
</tr>
<tr>
<td>2005</td>
<td>CQ+SP (8) – inadequate numbers recruited to give valid results</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>CQ+SP (6)</td>
<td>26.0</td>
<td>Recorded at Kariba</td>
</tr>
<tr>
<td>2007</td>
<td>CQ+SP (3) / AL (5)</td>
<td>43.0 / 1</td>
<td>Recorded at Hauna / Total all sites</td>
</tr>
<tr>
<td>2008</td>
<td></td>
<td></td>
<td><em>No studies done due to lack of funding</em></td>
</tr>
<tr>
<td>2009</td>
<td>AL (6)</td>
<td>5.0</td>
<td>Total all sites (Hauna – 8% TF)</td>
</tr>
<tr>
<td>2010</td>
<td>AL (8)</td>
<td>3.4</td>
<td>Total all sites (Chitulipasi -9% TF)</td>
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</table>
Thank you!!

• Muchas gracias
• Merci beacoup!!
• Obrigado
• Siyabonga!!
• Tatenda!!