Additional funding for the President's Malaria Initiative has been allocated under a Continuing Resolution from Congress for the remainder of FY07. USAID Malaria Programs were allotted $248 million ($25 million above the President's 2007 request) to allow the Agency to expand its bilateral global malaria initiative activities from the current 3 countries to 7. Country programs will expand access to long-lasting insecticide treated bed nets and indoor residual spraying, promote and support effective malaria treatment through the use of proven combination therapies; and increase prevention efforts targeted to pregnant women. With the additional funding FY 2007 Malaria Operational Plans (MOPs) will be updated. Revised MOPs will be posted soon.

PRESIDENT'S MALARIA INITIATIVE

FY 2007

Malaria Operational Plan (MOP)
TANZANIA

December 6, 2006

TABLE OF CONTENTS

1. Executive Summary 1
2. Malaria Situation 3
3. Mainland and Zanzibar Malaria Control Programs 4
4. Overview of Existing Partners' Activities and Roles 6
5. Overview of Existing and Recent Activities and Roles of USG 8
6. Goal and Targets of the President's Malaria Initiative 9
7. Expected Results – FY 2007 10
8. Planned Activities and Expenditures 11

8.A Interventions – Prevention 12
- 8.A.1 Intermittent Preventive Treatment – Mainland 12
- 8.A.2 Malaria in Pregnancy – Zanzibar 14
- 8.A.3 Support to Tanzania National Voucher Scheme 15
- 8.A.4 Procurement of LL Insecticide Treatment Kits 19
- 8.A.5 Support to Tanzanian Net Manufacturers 20
- 8.A.6 Routine Distribution of Long Lasting Insecticidal Nets – Zanzibar 22
- 8.A.7 Demand Creation, Behavior Change Communication and Promotion 23
- 8.A.8 Demand Creation, Behavior Change Communication and Promotion 24
- 8.A.9 Urban Malaria Control – Larviciding – Mainland 25
- 8.A.10 Epidemic Surveillance and Response – Mainland 26
- 8.A.11 Indoor Residual Spraying – Zanzibar 27

8.B Interventions – Case Management 28
- 8.B.1 Rapid Diagnostic Tests – Mainland 28
- 8.B.2 Rapid Diagnostic Tests – Zanzibar 28
- 8.B.3 Training and Supervision for ACT Roll Out 29
- 8.B.4 Artemisinin—Combined Treatment for ADDOs 30
- 8.B.5 Artemisinin—Combined Treatment for Refugees 31
- 8.B.6 Management of Severe Malaria 31
- 8.B.7 Technical Assistance and Support to MSD for ACT Implementation 33
- 8.B.8 Promotion and Awareness of Appropriate ACT Use 34

8.C Monitoring and Evaluation Plan 34
- 8.C.1 Entomological Monitoring 35
- 8.C.2 Focused Evaluation of the Infant, Under Five and Equity Vouchers 36
- 8.C.3 Demographic Surveillance System Site Support 39
- 8.C.4 General Monitoring and Evaluation 40

9. Staffing and Administration 43
   CDC Monitoring and Evaluation Advisors 44
10. Communication and Coordination 46
11. Budget and Summary Tables for Interventions 47

TABLES

Table A: Projected Financial Gaps of NMCP Programming 6
Table B: Main Malaria Donors to NMCP and Areas of Support 7
Table C: Targets for Changes in Selected Indicators 10
Table D: Scale Up of FANC Activities by Zone and Region 14
Table E: Target Number of PMI- and GFATM-provided vouchers redeemed 16
Table F: Timeline of Focused Evaluation Activities for ITN Vouchers 39
Table G: General Monitoring and Evaluation..43
Table H: Staffing and Administration Budget 46
Table 1: Timeline for Major Activities 48
Table 2: Planned Obligations 52
Table 3: Targets for Changes in Selected PMI Indicators 54
Table 4: Estimated Budget Breakdown by Intervention 57
Table 5: Budget Breakdown by Implementing Partner..57

ACRONYMS

<5MR	Under-Five Mortality Rate
ACT	Artemisinin-based Combination Therapy
ADDO	Accredited Drug Dispensing Outlet
AED	Academy for Educational Development
ALu	Arthemeter-lumefantrine
AMMP	Adult Morbidity and Mortality Project
ANC	Ante-Natal Care
AO	Acridine Orange
BCC	Behavior Change Communication
CA	Cooperative Agreement
CDC	Centers for Disease Control and Prevention
CEEMI	Centre for Enhancement of Effective Malaria Interventions
CHMT	Council Health Management Team
CORP	Community Resource Person
CSSC	Christian Social Services Commission
DfID	Department for International Development (U.K.)
DFP	District Focal Person
DMO	District Medical Officer
DOT	Directly Observed Treatment
DSS	Demographic Surveillance System
ELISA	Enzme-Linked ImmunoSorbent Assay
FANC	Focused Ante-Natal Care
FBO	Faith-Based Organization
FY	Fiscal Year
GDA	Global Development Alliance
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GOT	Government of Tanzania
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IAMCC	Inter-Agency Malaria Coordinating Committee
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education and Communication
IHRDC	Ifakara Health Research and Development Center
ILS	Integrated Logistic System
IMCI	Integrated Management of Childhood Illness
IMP	Integrated Malaria Project
IMR	Infant Mortality Rate
IPTp	Intermittent Preventive Treatment in Pregnancy
IRS	Indoor Residual Spraying
ITK	Insecticide Treatment Kits
ITN	Insecticide-Treated Net
IVM	Integrated Vector Management
JICA	Japan International Cooperation Agency
JSI	John Snow, Inc.
LLIN	Long Lasting Insecticidal Nets
MEDA	Mennonite Economic Development Associates

MMTSP	Malaria Medium Term Strategic Plan
MOHSW	Ministry of Health and Social Welfare
MOP	Malaria Operational Plan
MSD	Medical Stores Department
MSF	Medecins Sans Frontieres
MVC	Most Vulnerable Children
NATNETS	National Insecticide Treated Nets Programme
NBS	National Bureau of Statistics
NGO	Non-Governmental Organization
NIMR	National Institute for Medical Research
NMAC	National Malaria Advisory Committee
NMCP	National Malaria Control Program
PEPFAR	President's Emergency Plan for AIDS Relief
PHL	Public Health Laboratory
PMI	President's Malaria Initiative
PPP	Public-Private Partnership
RBM	Roll Back Malaria
RCH	Reproductive and Child Health
RDT	Rapid Diagnostic Test
RNE	Royal Netherlands Embassy
RTI	Research Triangle Institute
SDC	Swiss Development Corporation
SES	Socio-Economic Strata
SP	Sulfadoxine-pyrimethamine
SPA	Service Provision Assessment
STI	Swiss Tropical Institute
TaNAAM	Tanzanian NGO Alliance Against Malaria
TASAF	Tanzania Social Action Fund
TBA	Traditional Birth Attendant
TDHS	Tanzania Demographic and Health Survey
THIS	Tanzania HIV Indicator Survey
TNM	Tanzania Net Manufacturer
TWG	Technical Working Group
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Emergency Fund
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization
WVT	World Vision Tanzania
ZAMRUKI	Zanzibar Malaria Research Unit of the Karolinska Institute
ZTC	Zonal Training Center
ZMCP	Zanzibar Malaria Control Program

The United Kingdom's Department for International Development and the Royal Netherlands Embassy have provided funds to purchase insecticide treatment kits (ITKs) which are bundled with all nets sold in the Mainland. However, such funding is set to end in September 2006, at which time a review of the program will clarify whether the support will be extended. Presently, PMI is scheduled to pick up funding for the long lasting insecticide KO TAB 123. Additionally DfID and RNE provide support for the social marketing of bed nets. This support is also set to end by September 2006. The total contribution from the DfID and RNE alliance is US $3.5 million per year for the period 2004 – 2007.

The Swiss Development Corporation and Development Cooperation Ireland support the Mainland's ITN cell within the NMCP by supporting salaries and activities of key staff, plus technical support from the Swiss Tropical Institute (STI)—including one ex-patriate expert. Funding from the SDC will average around $420,000 per year.

The World Bank does not directly fund malaria activities in the country. Rather, its resources are put into basket funding for general support of the MOHSW. Such resources address critical problems that other donors do not fund (e.g. human resources).

In addition to the above, there are several hundred NGOs and faith-based organizations (FBOs) working in different aspects of malaria. Many of these organizations are grouped into two umbrella NGOs—the Tanzanian NGOs Alliance Against Malaria (TaNAAM) and the Christian Social Services Commission (CSSC). Some data suggest that up to 40 % of primary care services are provided by NGO and FBOs.[2] In rural areas this estimate can reach 60 % or more. Given their ubiquity and breadth of capacity, NGOs and FBOs are important partners in rolling back malaria in Tanzania. The Mennonite Economic Development Associates (MEDA) and World Vision International (WVI) are FBO contractors on the voucher scheme.

5. OVERVIEW OF EXISTING AND RECENT ACTIVITIES AND ROLES OF UNITED STATES GOVERNMENT

Since 2001 the United States Centers for Disease Control and Prevention (CDC) has operated a malaria program in Mainland Tanzania through a cooperative agreement (CA) with the Ifakara Health Research and Development Centre, operating at $800,000 in FY 2007, funded by USAID/ Washington and CDC. A resident epidemiologist (Dr. S. Patrick Kachur) has been seconded to IHRDC since October 2002. The focus of the program is to provide NMCP and its partners with evidence of the effect of current and potential malaria control strategies. The program includes a five year pilot evaluation of artemisinin-based combination therapy for routine treatment of malaria in one district with intense malaria transmission. To date, more than 1,000,000 ACT treatments have been delivered in Rufiji District and a multidisciplinary evaluation is providing evidence for best practices in support of rolling out this intervention nationwide. As was mentioned in the introductory paragraph, early evidence suggests important impact on malaria morbidity and mortality. The evaluation also includes direct support to demographic surveillance systems (DSS) in Kilombero, Ulanga and Rufiji districts covering more than 180,000 people and representing the single largest population under continuous demographic surveillance in sub-Saharan Africa.

[2] Personal communication Christian Social Services Commission

In FY2006, CDC contributed $100,000 to adapt DSSs to better evaluate maternal and perinatal mortality. CDC operates 3 sentinel sites assessing the efficacy of anti-malarial treatment and has funded a longitudinal cohort evaluation of alternative ACT regimens. CDC provided technical support for the MOHSW's Integrated Disease Surveillance and Response (IDSR) program which records facility-based cause-specific morbidity data useful for tracking diseases of epidemic potential (including malaria in epidemic-prone settings).

USAID/Tanzania's recent non-PMI malaria implementing partners include the ACCESS project, managed by JHPIEGO, which focuses on malaria in pregnancy; the T-Marc project managed by Academy for Educational Development (AED) focusing on social marketing and communications; the DELIVER and TASC II projects managed by John Snow Incorporated (JSI) led by a malaria program advisor (Dr. R. Salgado) and drug management and logistics systems; and the Ministry of Health via the Zonal Training Centers (ZTC) in Arusha and Iringa regions. The ACCESS Project includes activities in focused ante-natal care (FANC) which includes IPTp, communications, and collaborative support for the Malaria/IMCI District Focal Persons (DFP) training program of the MOHSW via the Center for Enhancement of Effective Malaria Interventions (CEEMI), as well as support for improved drug management and logistics capacity.

In Zanzibar, CDC Tanzania provided technical guidance to ZMCP in developing interventions to support the roll out of ACT on the islands in 2003. It also supported a baseline survey in sentinel communities prior to the introduction of the new therapy. CDC and IHRDC also provide technical support to the Zanzibar Malaria Research Unit of the Karolinska Institute (ZAMRUKI).

USAID/East Africa and core funding has supported the Academy for Educational Development's NetMark Plus Project to transfer the technology to African bed net manufacturers to produce long lasting insecticide treated bed nets using an insecticide which will last for at least twenty wash cycles. This is vastly superior to the previous insecticide treatment, which required users to re-treat bed nets upon purchase and every three months thereafter. Studies consistently show that while consumers usually treat their nets initially, they usually do not retreat the nets as required to keep them efficient.

Finally, the PMI is closely coordinating with the President's Emergency Plan for AIDS Relief (PEPFAR) on areas of technical overlap such as IPTp for pregnant women, logistics and systems strengthening issues and mechanisms to identify vulnerable children and families.

6. GOAL AND TARGETS OF THE PRESIDENT'S MALARIA INITIATIVE (*by 2010)*

Goal and targets apply for both the Mainland and Zanzibar, except where noted.

Goal

The goal of the PMI is to reduce malaria-associated mortality by 50% compared to pre-initiative levels in all PMI countries.

Target

By the end of 2010, PMI will assist (each country) to achieve the following targets in populations at risk for malaria:

- >90% of households with a pregnant woman and/or children under five will own at least one ITN;
- 85% of children under five will have slept under an ITN the previous night;
- 85% of pregnant women will have slept under an ITN the previous night;
- 85% of houses in geographic areas targeted for IRS will have been sprayed;
- 85% of pregnant women and children under five will have slept under an ITN the previous night or in a house that has been sprayed with IRS in the last 6 months;
- 85% of women who have completed a pregnancy in the last two years will have received two or more doses of IPTp during that pregnancy;
- 85% of government health facilities have ACTs available for treatment of uncomplicated malaria; and
- 85% of children under five with suspected malaria will have received treatment with an anti-malarial drug in accordance with national malaria treatment policies within 24 hours of onset of their symptoms.

7. EXPECTED RESULTS – FY 2007

PMI will measure progress toward achieving these coverage levels through several mechanisms. Mortality impact and intervention coverage can best be measured with representative household surveys like TDHS. Unfortunately TDHS will not be repeated until 2009. However, there will be an opportunity to include questions about malaria indicators in the Tanzania HIV Indicators Survey in mid-2007. Both NMCP and ZMCP also conduct biannual RBM coverage surveys as recommended by WHO –Africa Region (AFRO). These are more rapid and less statistically representative than TDHS or the MERG malaria indicator survey. These surveys will be repeated in 2007 and will be used to help estimate progress toward PMI targets for ITN ownership and use, coverage of IPTp, and prompt effective treatment of childhood fevers. Both NMCP and ZMCP have requested PMI support to complete RBM coverage surveys at household and facility level in 2007. Additionally, there are opportunities that can provide further verification of malaria indicators such as the recent (2006) Service Provision Assessment (SPA) that includes facility-based process indicators.

Key outcomes and their targets to be measured in 2007 surveys are listed in Table C and include:

Table C: Targets for changes in selected indicators for PMI countries*

Country	2 dose IPTp		ITN use(<5's)		ITN use (Pregnant women)		IRS (targeted houses)		Febrile children receiving ACT	
	2005	2007	2005	2007	2005	2007	2005	2007	2005	2007
Tanzania: Mainland	22%	50%	16%	40%	15%	55%	0%	85%	<1%	40%
Zanzibar	14%	40%	22%	80%	26%	80%	0%	85%	36%	70%

ACCESS has identified two important barriers for the scale up of IPTp/ITN/FANC activities, namely—the need for community mobilization around IPTp/ITN/FANC issues and stock outs of SP in ANC services.

Proposed Actions

ACCESS has been requested to extend its facility based intervention nationwide to ensure delivery of quality FANC. This activity will focus on extending the previous ACCESS training of trainers for each district by providing the funds, materials and supervisory support to ensure that the services provided through focused ante-natal services for malaria in pregnancy prevention (IPTp and ITN voucher distribution) are in fact provided efficiently and effectively nationwide. JHPIEGO ACCESS project has been identified to implement this activity as part of its ongoing program of support to the Tanzania MOHSW's focused ante-natal services program.

IPTp – Mainland	
Cost	$1.75 million
% Commodities	--
Level	National/ Regional
Mechanism	ACCESS

The trainers put into place in each district during FY06 will now implement facility-level training with an emphasis on ensuring that quality ANC services for malaria in pregnancy are being provided in rural areas. Facility-based and outreach ANC services will both be specifically addressed in this phase. Special emphasis will be placed on ensuring that all pregnant women attending ANCs receive an ITN voucher, and that steps are taken to promote follow-up visits for ANC services, to encourage 2 doses of IPTp per pregnancy for each pregnant woman.

ACCESS will facilitate the reduction of key ANC supplies stock outs, especially SP. In this regard, ACCESS will analyze, using Standards Based Management (SBM-R), assessment results from facilities trained in Years 1 and 2 to determine the extent and origin of stock outs. Subsequently, ACCESS will work with stakeholders (MSD, RCHS, NMCP, DELIVER-follow on, and others) to improve supply problems by advocating improved supplies, and, where possible, participating directly at the facility level in improving drug management. ACCESS will also coordinate with Prevention of Mother to Child Transmission (PMTCT) programs to ensure that all providers understand and implement the MOHSW guidelines which contraindicate the provision of SP to pregnant women living with AIDS who receive prophylactic cotrimoxazole.

In addition, ACCESS will increase national awareness of IPTp/ITN/FANC by integrating appropriate messages into national mass media campaigns. ACCESS will also collaborate with the MOHSW Health Education Unit to update malaria in pregnancy materials and other safe motherhood IEC materials, including the management of malaria in pregnant women with HIV. Community mobilization will be addressed through the training and support of Community Resource Persons in one region. Given that a significant percentage of health services in Tanzania are provided by faith-based organizations, ACCESS will work with FBOs to integrate FANC into their services. PMI support to ACCESS for FANC will be supplemented by $1.5 million in USAID/Tanzania child survival/maternal health funds to cover non-malaria aspects of FANC. ACCESS will be able to cover 100% of health facilities by the end of 2008.

The "Safety Net" Program – Ensuring equitable coverage of ITNs

Although the TNVS strategy relies on a targeted subsidy that requires all beneficiaries to provide a top-up amount (depending on the size of the net purchased) this is beyond the reach of the very poor. Therefore the PMI has reached an agreement with the government of Tanzania to establish a new voucher system that provides access to free ITNs for the poorest. Using PMI FY06 funding, an equity/Safety Net voucher (which provides this top up amount making the net free to the user) will be distributed in six districts using existing community based mechanisms. These mechanisms are already working in some districts but will eventually be rolled out nationally. They include Most Vulnerable Children (MVC) Committees and mechanisms for the implementation of the Exemption and Waiver System of the MOHSW, which identifies and exempts the very poor from cost sharing of treatment costs. Also, the Tanzania Social Action Fund (TASAF) is a mechanism that is also being explored. MEDA, in collaboration with NMCP, is responsible for the implementation of this component.

PMI FY07 funds will be used to roll out the Equity Voucher program to seven regions, with particular emphasis on those with high infant and under-five mortality, malaria being the single biggest contributor to this. Careful evaluation of the equity voucher and other elements of the TNVS will be completed to ensure that high levels of coverage are being achieved, particularly among rural poor. If these results are not satisfactory, PMI and NMCP officials will consider alternative approaches to targeting full cost subsidy to those most in need of malaria prevention. Implementation mechanism is the bilateral MEDA cooperative agreement. The costs for this activity are higher than for the regular voucher schemes as it will be considerably more difficult and require more effort logistically to reach the poorest of the poor and the vouchers are fully subsidized.

The monitoring and evaluation of the infant, under five and equity vouchers is discussed in section 8.C.2 below.

8.A.4 Procurement of Longer Lasting Insecticide Treatment Kits for Bundling and Factory Pretreatment

Current Status

The subsidized provision of insecticide treatment kits in Tanzania is a key element of the TNVS and comprises a significant portion of the voucher subsidy. All nets sold nationwide are mandated to be bundled with an insecticide treatment kit (to date funded by DfID and RNE), and uniquely high numbers of nets are sold on the commercial market with significant subsidy (the insecticide kit provided to the manufacturers). Targeted groups under the voucher program are now becoming the primary beneficiaries of the insecticide subsidy. Because the subsidized insecticide is provided through the private sector commercial market, the subsidized cost savings from the insecticide is passed on to all consumers thus lowering the overall retail price of ITNs in Tanzania and increasing accessibility. An essential pre-requisite, however, was that the insecticide would continue to be provided on a free of charge basis (either as kits for bundling or in bulk for factory pre-treatment). Without this support, the price of an ITN/LLIN in Tanzania would effectively double and go beyond the ability to pay off a large proportion of the population.

Funding allocated for the technology transfer in FY06 was used to fill a gap in ITNs and procure insecticide treatment kits for bundling at the request of NMCP.

Proposed Actions

The PMI will support this successful example of competitive free-market economics with technical and material assistance to speed the transition of this manufacturing capacity from the production of bundled ITNs to true LLINs. PMI will collaborate with the NetMark Plus Project to augment the production of LLINs available to the TNVS through factory pre-treatment with a long-lasting insecticide. This transition will directly contribute to the PMI's targets for Tanzanian coverage of ITNs by making long-lasting nets more affordable and available to users. This is a one-time investment with the goal of making all nets produced in Tanzania long lasting. The activity is consistent with the criteria set in the policy memorandum; "Funding and Implementation of Technology Transfer to Increase Supply of Long Lasting Insecticide Treated Nets," March 2006.

Support to TNMs	
Cost	$500,000
% Commodities	---
Level	National
Mechanism	Field Support to NetMark +

While the net manufacturers themselves will finance the costs of the equipment for the pre-treatment of nets, in FY07, the PMI will provide $500,000 to: a) assist the two TNMs supported by NetMark Plus in the acquisition of equipment for quality assurance of their manufactured ITNs; b) support training of TNM personnel in quality assurance methods; c) support the purchase and installation of a QA laboratory within the appropriate governmental entity to provide independent quality verification of locally-produced LLINs, and, finally; d) to encourage the two smaller TNMs to start producing LLINs and remain within the TNVS program. No delays in the distribution of nets are expected as part of this activity. Funding is budgeted to support both remaining TNMs, but will be provided only to ones who chose to participate by investing in capital equipment.

It is expected that significant incentives will be provided for early adopters and increasing penalties (e.g. non participation in the voucher scheme) over time for laggard manufacturers. This incentive structure is needed as it is highly likely that significant savings can be achieved in per-net costs with the factory level bulk treatment. These funds will then be freed-up for increased voucher provision to the consumers. In addition, the memorandum of understanding with the net manufacturers for the next phase will explicitly lay out a timetable for the phased withdrawal of donor subsidies for the insecticide treatment process, so that as the costs per net decrease, the savings can be passed directly to the unsubsidized Tanzanian consumer via increased price competition.

The implementing mechanism will be field support to NetMark Plus.

will be used to complement other BCC resources from other donors. Among potential activities that may be carried out are community-based approaches to promote ITNs and IPTp, promotion of IRS, collaboration with NGOs, development of malaria radio programs, etc. Equipment and materials for the development and printing of BCC materials will be procured.

Behavior Change – Zanzibar	
Cost	$70,000
% Commodities	--
Level	Zanzibar
Mechanism	Competed

The implementing mechanism will be a competitively awarded cooperative agreement.

8.A.9 Urban Malaria Control – Larviciding Mainland

Current Status – Mainland

PMI has provided $200,000 in FY 2006 support to the Dar-es-Salaam Urban Malaria Control Programme through the global Integrated Vector Management (IVM) implemented by Research Triangle Institute (RTI). This is a collaborative effort between the City Medical Office and IHRDC. Field workers have successfully mapped mosquito breeding sites within the municipality and conducted regular inspections to identify which are active, as well as to conduct reconnaissance for new breeding sites. The teams also conduct regular sampling for mosquito vectors including nighttime human landing catches. Since April 2006, field teams have treated active breeding sites with a biological larvicide (*Bacillus thuringiensius israelensis* and *Bacillus sphaericus*).

Urban Malaria Control	Mainland
Cost	$400,000
% Commodities	25%
Level	District
Mechanism	Competed

Data from other larviciding programs suggest that it is a feasible and effective means for reducing malaria transmission, particularly in urban areas where mosquito breeding sites are identifiable. Since larviciding began, routine monitoring of mosquito densities has shown a 50% reduction in vector populations and in human-mosquito contacts. Community and health facility-based data on malaria infection and illness rates are currently being collected. Through the activities of the Dar-es-Salaam Urban Malaria Control Programme, more than 200,000 urban residents have been protected from mosquitoes carrying malaria and other diseases. The program also provides a scaleable model for rolling out larval control in other urban settings.

Proposed Actions

In PMI FY07, $400,000 will be used to move the program to direct implementation and expansion of the Dar-es-Salaam work. An additional 3 wards will be added, effectively doubling the population covered. The total population covered by the end of calendar year 2007 will be 370,000 and will be doubled in calendar year 2008.

The implementing mechanism will be competed as the Integrated Vector Management agreement is ending in March 2007.

Proposed Actions

IRS Zanzibar	
Cost	$1,850,000
% Commodities	43%
Level	National
Mechanism	Competed

ZMCP is requesting $1,850,000 for a second round of spraying to complement the first IRS campaign. The physical and human infrastructure as well as the logistics systems built during the first campaign will be used for the second round. ZMCP officers and the contractor (i.e. RTI) have assessed their performance and have identified ways of improving this second round of spraying. Such lessons will also be incorporated into the mainland's IRS program. The second round of spraying in Zanzibar will take place before the start of the long rains toward late January 2007. Close entomological monitoring (See 8.C.1) is part and parcel of this activity.

The implementing mechanism will be competed as the Integrated Vector Management Project ends in March 2007.

8.B INTERVENTIONS – CASE MANAGEMENT

8.B.1 and 8.B.2 Rapid Diagnostic Tests for Mainland and Zanzibar

Current Status – Mainland and Zanzibar

PMI awarded a total of $500,000 for procurement of rapid diagnostic tests (RDTs) for malaria in FY06. $65,000 was used to procure 100,000 Paracheck® tests on behalf of ZMCP so that RDTs could be provided for three districts where they had been introduced for routine use. The additional $435,000 will be used to procure RDTs for Mainland Tanzania. In January 2006, NMCP convened a Task Force to advise the program manager on issues related to improved malaria diagnosis, especially the use of RDTs. The group has developed technical specifications and recommended two equivalent products (Paracheck® and Parahit®) that the NMCP will use.

Current guidelines published by NMCP call for diagnostic confirmation of suspected malaria infection, either by blood slide or RDT, where available. Children under five years who test negative should be carefully evaluated and treated for other conditions, but also offered first line treatment for malaria. For older children and adults NMCP recommends that negative test clients be evaluated and treated for other conditions but not offered malaria-specific treatment.

Proposed Actions – Mainland

RDTs – Mainland	
Cost	$600,000
% Commodities	83%
Level	District
Mechanism	
Commodities	UNICEF
Non-commodities	CDC

Although PMI funds were available only to procure the test kits, NMCP has an interest in making sure their use is evaluated carefully, so that it can develop future recommendations about the wider use of RDTs for malaria. In particular, understanding how prescribers use the results to guide the delivery of ACT will be critical. The Malaria Diagnostic Task Force has identified sites of varying transmission where the first

seeking behaviors. The FY07 MOP includes $100,000 to contribute to this effort which can be allocated to Johns Hopkins University (JHU) through field support to the Global Research Activity. ZMCP and their research partners have also prioritized an additional mortality follow-back survey that would estimate
mortality on Unguja. To date, no PMI resources have been programmed for this purpose.

A necessary first step will be to assess the DSS data available throughout the country that can serve as a baseline for assessing the impact of PMI interventions, which will be available in November of 2006. CDC has included a preliminary data analysis workshop in its FY 2007 cooperative agreement with IHRDC. This will include site managers from active DSS's including IHRDC and Johns Hopkins/PHL as well as other sites where data collection is not currently active but baseline information may be. DSS sites collect data and complete verbal autopsies 3 times per year. It is usually possible to make stable estimates of child mortality at intervals of six months. After the initial workshop to establish baseline estimates, data analysis and reporting will be completed at least once per year.

DDS Site Support	
Cost Mainland	$200,000
Zanzibar	$100,000
% Commodities	--
Level	National/ Regional
Mechanism Mainland	CDC
Zanzibar	JHU/GRA

This aspect of monitoring and evaluation will include longitudinal surveillance within the DSS areas for coverage indicators, population demographic and rainfall factors, and all-cause and malaria-attributed morbidity and mortality, including verbal autopsy as an attempt to estimate malaria-specific mortality. This activity will be accomplished by supporting 40% of the operating costs of the DSS under the Ifakara cooperative agreement and technical supervision by CDC. Partial funds for this activity became available at CDC June 2006 and will be awarded to IHRDC pending approval of their cooperative agreement renewal application, anticipated by September 30, 2006. Also in September 2006, IHRDC and CDC will convene a data analysis workshop for DSS data managers from IHRDC and other institutions operating demographic surveillance in other parts of the country. The objective of this workshop will be to establish baseline mortality indicators for PMI and establish a plan for ongoing evaluation. This activity will be implemented in Tanzania prior to developing a common approach for all PMI countries.

8.C.4 General M&E

Current Status – Mainland and Zanzibar

Small monitoring and evaluation units are functional in both the NMCP and ZMCP and each program maintains a database of malaria cases diagnosed and treated at health facilities, conducts regular RBM coverage surveys, and provides occasional supportive supervision to endemic districts to help monitor the delivery of national strategies for malaria control. In practice, however, these basic monitoring and evaluation activities are poorly staffed and under funded. Resources and fuel are scarcely available to complete more than a fraction of proposed supervision visits, routine health facility data are often incomplete or missing requiring extensive follow-up visits, and routine coverage surveys frequently suffer from insufficient sample sizes and poorly representative sampling strategies demanded by the limited funding available. Both ZMCP and NMCP prioritized additional support for monitoring and evaluation activities in their requests for FY06 and FY07 PMI funding.

Table H: Staffing and Administration Budget ($)			
Staff/ Consultants	**FY2006**	**FY2007**	
M&E Advisor		30,000	
CDC Advisor	333,000	400,000	
CDC Administrator		60,000	
JSI – TASC II	200,000	350,000	
PMI – FSN		60,000	
Zanzibar Advisor		75,000	
TOTAL	533,000	975,000	

10. COMMUNICATION AND COORDINATION

Key to the success of PMI will be how it fits, complements and coordinates activities with government, development partners and with USAID and CDC headquarters. All PMI technical activities will be undertaken in close coordination with the NMCP and other national and international partners, including the WHO, UNICEF, the GFATM, World Bank and the private sector.

PMI – Tanzania understands that communication and coordination will require constant vigilance and that there might be a steep time cost for ensuring that stakeholders are informed and participating in PMI. In Tanzania, PMI made sure that a transparent consultative process was followed in the development of the PMI strategy and work plan for years one and two. As a result, all stakeholders strongly buy into the current PMI strategy and year 2 work plan. This process will continue to guide our efforts in Tanzania. However, it must be made clear that in the case of Tanzania a double effort in communication and coordination will be required as we are essentially dealing with two programs—Mainland and Zanzibar.
At the country level, PMI will coordinate through mechanisms already existing in the Mainland and Zanzibar. Such mechanisms include the National Malaria Advisory Committee (NMAC), the various sub-committees (e.g. case management, vector control, IEC, etc.) and the Inter Agency Malaria Coordinating Committee (IAMCC). PMI has already been invited to participate in the National Insecticide Treated Net Programme (NATNETS) as a way to coordinate efforts with partners already involved with ITNs. Additionally, PMI will also work through the Development Partners – Health (DPH) group to ensure that all are informed and on board with PMI work plans.

PMI has been allocated office space in both the NMCP and the ZMCP. This will facilitate communications between technical staff and will ensure that PMI works closely with the respective programs. PMI has instituted monthly and quarterly coordinating meetings with the NMCP. To ensure that PMI contractors are clear that NMCP is the ultimate leader of their activities, contractors have been invited to participate in the monthly meetings and report on their activities and plans. Initially, only a few contractors were invited, but during this second year, all contractors will be invited and required to participate.

Communication with USAID and CDC headquarters is already effective through e-mail, phone and fax. Visits from HQ staff will be encouraged to enhance already efficient communications.

11. BUDGET AND SUMMARY TABLES FOR INTERVENTIONS

Table 1

President's Malaria Initiative – Tanzania
Year 2 (FY07) Timeline of Major Activities

ACTIVITY	2006	2007											
	OCT-DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
MALARIA PREVENTION A.1 INTERMITTENT PREVENTIVE TREATMENT (IPT) – MAINLAND													
In-service training of ANC providers on IPT/ITN/FANC													
Supportive follow-up of providers in offering FANC services, including IPT, using SBM-R approach													
Pre-service Education for Diploma and Higher level Nurse/Midwifery schools in FANC													
Increase national awareness/ community mobilization of IPT/ITN/FANC													
Facilitate reduction of key ANC supplies stock outs													
Improve enabling environment for Safe Motherhood													
A.2 MALARIA IN PREGNANCY – ZANZIBAR													
Update/disseminate Malaria in Pregnancy Guidelines													
Refresher training for IPT with new guidelines													
Conduct supervisory visits to facilities implementing IPT													
Introduce IPT to private sector													
A.3 EXPANSION OF TNVS													
Ongoing Implementation of Pregnant Women vouchers													
Expansion to Children <5 – Mainland in 4 regions													
Ongoing Implementation of the Infant voucher													

ACTIVITY	2006	2007											
	OCT-DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
program													
Implementation of Safety Net Voucher Program													
A.4 PROCUREMENT OF INSECTICIDE TREATMENT KITS FOR BUNDLING AND FACTORY RETREATMENT													
Purchase kits and distribute to TNMs													
Bundled and factory treatment of LLINs begins													
A.5 Support to TNMs													
Procure and installation of new equipment to two													
Train TNM on use of QA equipment and protocols													
Initiate production by equipped factories													
TNMs Begin independent QA monitoring of factory-treated LLINs.													
Work with the two smaller TNMs to help them introduce factory pre-treatment of LLINs													
A.6 LLINs FOR ROUTINE DISTRIBUTION													
Distribution of LLINs through ZMCP-determined distribution points.													
A.7 DEMAND CREATION & BCC MAINLAND													
Create awareness on malaria prevention through ITN use –mass media and community													
A.8 DEMAND CREATION & BCC – ZANZIBAR													
Create awareness on malaria prevention through ITN use –mass media and community													
A.9 URBAN MALARIA CONTROL MAINLAND													
Continue activities in Burunguri, Mikocheni and Kurasini													
Add Vingunguti, Ilala, Mwananyamala, Magomeni, Keko and Mtoni to plan and begin implementation													
A.10 EPIDEMIC SURVEILLANCE AND IRS MAINLAND													
Develop PERSUAP for Muleba													
Procure IRS materials													
Start training supervisors, sprayers, procure													