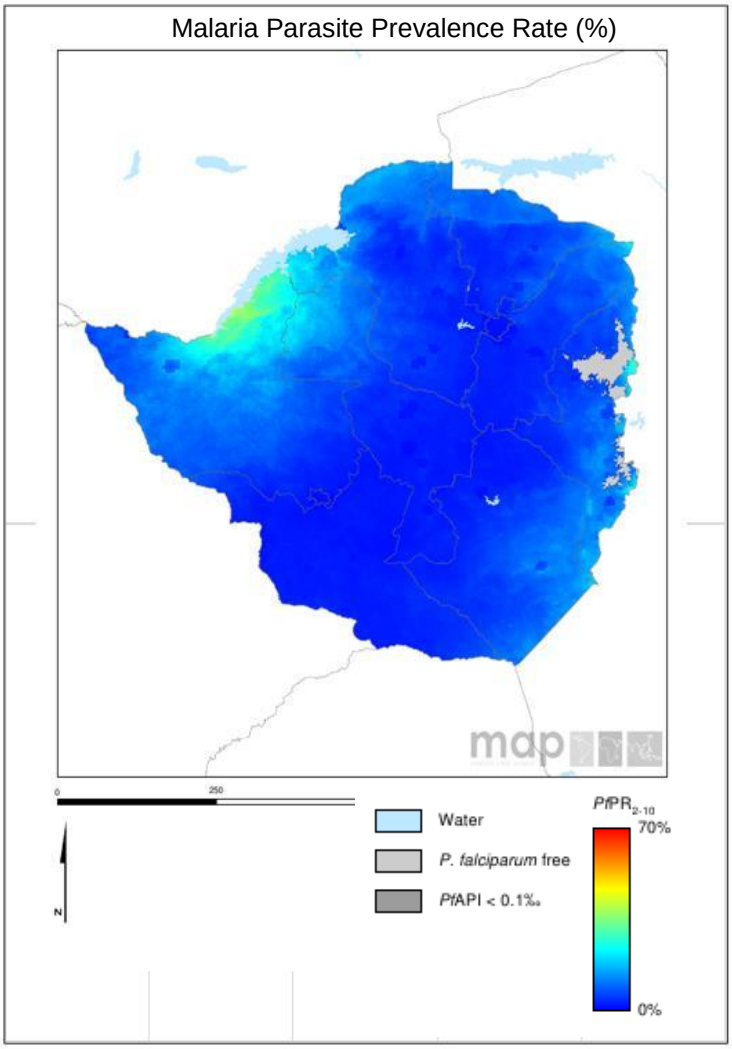
Zimbabwe ALMA Quarterly Report
Quarter One, 2014

AFRICAN LEADERS MALARIA ALLIANCE ALMA

Scorecard for Accountability and Action



Malaria transmission is seasonal in Zimbabwe with about 60% of the population at risk. The annual reported number of malaria cases in 2012 was 276,963 with 351 deaths.

Metrics	
Policy and Financial Control	
Oral Artemisinin Based Monotherapy Ban status (2014)	
Community case management (Pneumonia)	
Community case management (Malaria)	
World Bank rating on public sector mgmt and institutions 2012 (CPIA Cluster D)	2.2
Commodities Financed, Implementation and Malaria Impact	
IRS financing 2014 (% of at-risk population)	75
Public sector RDT financing 2014 projection (% of need)	100
Public sector ACT financing 2014 projection (% of need)	100
IRS Operational Coverage (%)	91
On track in 2012 to Reduce Malaria Incidence by >75% by 2015 (vs 2000)	
Tracer Indicators for Maternal and Child Health	
PMTCT coverage 2012 (% pregnant HIV pts receiving ARVs)	82
% deliveries assisted by skilled birth attendant	66
Exclusive breastfeeding (% children < 6 months)	31
Vitamin A Coverage (2 doses)	56
DPT3 coverage 2011 (vaccination among 12-23 month olds)	99
Postnatal care (within 48 hrs)	27

Key

- Target achieved or on track
- Progress but more effort required
- Not on track
- No data/Not applicable

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Urgent Global Fund Update

The Global Fund has announced that Zimbabwe will receive US$ 477.7 million for HIV, tuberculosis, malaria, and health systems strengthening as the country allocation under the New Funding Model. The total figure includes all existing, unspent funds from previous rounds and the Interim New Funding Model. The Global Fund has determined the total allocation amount based on Zimbabwe's disease burden and income level, as well as several other factors. The malaria component is also allocated a specific proportion of the total, according to a formula developed by the Global Fund that takes into account several factors, including disease burden and previous disbursements. For Zimbabwe this is calculated at US$ 40.2 million, including US$ 29.5 million of new resources. The allocations to the individual disease components are not fixed, and can be adjusted according to decisions made at country level. Zimbabwe is urged to ensure that resources are allocated to malaria control from the overall Global Fund country allocation at a level that is sufficient to sustain the gains made in recent years.

Progress

Zimbabwe has made steady progress in scaling-up malaria control interventions and has been successful in attracting resources through the Global Fund. Zimbabwe has banned oral artemisinin-based monotherapies. The country has introduced a policy on Community Case Management of malaria. The country has secured the majority of the resources required for ACTs, RDTs, and LLINs in 2014. Zimbabwe has achieved high coverage of the tracer MNCH interventions PMTCT and DPT3.

Impact

The annual reported number of malaria cases in 2012 was 276,963 with 351 deaths.

Key Challenge

- Delays and under-reporting of malaria cases and deaths from the National Health Information System, leading to inconsistent reporting on malaria mortality data.

Previous Key Recommended Action

Objective	Action Item	Suggested completion timeframe	Progress	Comments - key activities/accomplishments since last quarterly report
MNCH[1]: Optimise quality of care	Work towards improving postnatal care coverage through increasing availability of skilled care, promoting facility births where women and babies are observed for at least 24 hours before discharge and through home visits by community health workers	Q1 2014		The country has revised the PNC policy to include visits on Day 1,3 and 7. PNC guidelines and a PNC register have been distributed to all health facilities and programme managers have been oriented to enable them to provide technical assistance to health service providers. Low volume health facilities are now keeping mothers and newborns in the health facility for 72 hours to allow the day 1 and 3 postnatal visits. After discharge the mother/baby pair is expected back to the clinic on day 7. All the visits are being captured in the PNC register. The new policy is already increasing PNC coverage especially in the first week of life. Through the community based care programme for mothers and newborns, mothers who are discharged within 24 hours or deliver at home are visited at home by a Village Health Worker on day 1, 3 and 7. All mother/baby pairs are expected to come back for the 6 week PNC visit

New Key Recommended Action

Objective	Action Item	Suggested completion timeframe
Address funding	Ensure the NFM concept note is submitted by Q3 2014 and ensure that resources are allocated to malaria control at a level that is sufficient to sustain the gains made in recent years	Q3 2014

Key

	Action achieved
	Some progress
	No progress
	Deliverable not yet due

[1] MNCH metrics, recommended actions and response tracked through WHO MCA/iERG