ROLL BACK MALARIA IN THE TRANS-CAUCASIAN COUNTRIES AND TURKEY

PROJECT DOCUMENTS
2002-2005

December 2001

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ROLL BACK MALARIA

PROJECT DOCUMENT

MINISTRIES OF HEALTH OF AZERBAIJAN, GEORGIA ARMENIA AND TURKEY

WORLD HEALTH ORGANIZATION REGIONAL OFFICE FOR EUROPE

Title:	**The Roll Back Malaria Project**
Duration:	**4 years, January 2002 – December 2005**
Project Sites:	**Selected districts and cities in Azerbaijan, Georgia, Armenia and Turkey**
Intended Beneficiaries:	**About 30.5 million indigenous people and migrants**
Requesting Agency:	**WHO**
Govt. Cooperating Agency:	**Ministries of Health, Azerbaijan, Georgia, Armenia and Turkey**
Estimated Starting Date:	**January 2002**
Estimated Project Budget:	**2002: *USD 4 091 500*** **2003: *USD 3 711 500*** **2004: *USD 3 561 500*** **2005: *USD 3 416 500***
	TOTAL (*2002-2005*): ***USD 14 781 000***

BRIEF DESCRIPTION

In the 1960's-1970's, malaria was eradicated in Armenia and Georgia. The disease was never completely eradicated, however, in some parts of the southern frontiers of the former Soviet Union and Turkey. Throughout the 1970's and the beginning of the 1980's, epidemics of malaria were registered in several districts of Azerbaijan. In the 1970's - 1980's, severe malaria epidemics engulfed the Adana, Ichel, Hatai, Osmani, Sanlurfa, Mardin and other provinces of Turkey. Though epidemics of malaria were contained, it proved impossible to achieve the complete interruption of malaria in the above–mentioned countries. At the beginning of the 1990's, the residual reservoir of malaria infection, aggravated by the political and socio-economic situation, mass population movements, the execution of extensive development projects, and an almost complete cessation of activities for malaria control and prevention combined to constitute conditions favorable for the re-establishment of malaria transmission. As a result, large-scale epidemics and outbreaks of malaria swept through Turkey, Azerbaijan and Armenia. In recent years, the malaria situation in Georgia has also significantly deteriorated. The malaria situation in border areas of the above-mentioned countries remains serious. The National Malaria Control Programmes are at present implemented and supported by WHO and other partners/donors. However, the limited resources invested by the respective governments, WHO and others concerned result in a shortfall of funding sufficient to cope with the malaria problem in these countries.

National RBM Projects will support the countries in building RBM partnerships and working together in the promotion of health-related actions to reduce the incidence of malaria and its burden, containing ongoing outbreaks, and preventing the further spread of malaria. The RBM Projects will focus on addressing malaria–related issues through capacity building, improving capacities for and access to early diagnosis/adequate treatment and timely response to and prevention of malaria outbreaks, reinforcing surveillance mechanisms, and increasing community awareness and involvement in malaria prevention. Implementation of the RBM Projects will be a collaborative effort of the Ministries of Health in cooperation with WHO and other existing/potential partners and donors. The projects are planned for a period of 4 years (2002-2005). The projects will have a strong but flexible management structure, capable of mobilizing the partnership among UN agencies and NGOs, as well as the media and other partners/donors, to implementing cost–effective but technically sound and sustainable malaria control measures adapted to the countries' conditions and responding to local needs.

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I. HISTORICAL CONTEXT

The new Director General of WHO committed herself to an intensive response to the global malaria burden, and in January of 1998, the *Roll Back Malaria Initiative (RBM)* was proposed. A global coalition to Roll Back Malaria, characterized by strategic synergy, coordinated effort, and science-based strategies, was proposed at the World Health Assembly of that same year. The Global Partnership to Roll Back Malaria, consisting of WHO, UNICEF, UNDP, World Bank and a group of national government representatives, heads of bilateral donor organizations, representatives of the private sector, and non-governmental bodies, was formally established in December 1998. Members of the Global RBM Partnership are committed to supporting country-level efforts led by national authorities within the context of their multi-sectoral strategies for development and poverty alleviation.

From 1998 to 2001, a number of meetings to establish Roll Back Malaria partnerships for countries of the Caucasian Region and Turkey were held at country levels, and commitment to the movement was secured. To promote partnerships for RBM in the Caucasian Republics and Turkey, a regional meeting took place in Tbilisi, Georgia in November 2001. It was recommended to draw up RBM Projects which will support the countries in partnership building and working together in the promotion and coordination of health sector actions that reduce the incidence of malaria and its burden, contain ongoing outbreaks, and prevent the further spread of malaria within the Caucasian Sub-Region and Turkey.

The malaria problem may become a major obstacle to developing Trans–Caucasian countries and Turkey, where at present between 50 - 60 million people, or more than 60 per cent of the total population, live in areas at risk of malaria of various levels *(see Annex 1)*. The gravity of the malaria situation in Turkey, where over 15 million people, or 23 per cent of the total population of the country, continue to reside in endemic malaria areas, and a steep rise in the number of malaria cases in Georgia, with the spread of autochthonous malaria cases within the country, are two major malaria-related concerns in the Region. The results achieved in the containment of malaria outbreaks/epidemics in Azerbaijan, Armenia and Turkey must be sustained and further consolidated.

Malaria control and prevention programmes in countries of the Caucasian Region and Turkey are funded by the respective governments, WHO, and other donors and partners. The resources invested for malaria control at present are limited, however, and the countries are in need of additional external assistance to cope with the malaria problem.

II. THE CURRENT MALARIA SITUATION

In the 1960's-1970's, malaria was eradicated in Armenia and Georgia. The disease was never completely eradicated, however, in some parts of the southern frontiers of the former Soviet Union and Turkey. Throughout the 1970's and the beginning of the 1980's, epidemics of malaria were registered in several districts of Azerbaijan. In the 1970's - 1980's, severe malaria epidemics engulfed the Adana, Ichel, Hatai, Osmani, Sanlurfa, Mardin and other provinces of Turkey. Though epidemics of malaria were contained, it proved impossible to achieve the complete interruption of malaria in the above–mentioned countries. At the beginning of the 1990's, the residual reservoir of malaria infection, aggravated by the political and socio-economic situation, mass population movements, the execution of extensive development projects, and an almost complete cessation of activities for malaria control and prevention combined to constitute conditions favorable for the re-establishment of malaria transmission. As a result, large-scale epidemics and outbreaks of malaria swept through Turkey, Azerbaijan and Armenia. In recent years, the malaria situation in Georgia has also significantly deteriorated. The malaria situation in border areas of the above countries remains serious as well *(see Annexes 2, 3, 4, 5, 6, 7, 8, 9, 10 &11)*.

III. HOST COUNTRY STRATEGIES

All the Trans–Caucasian countries and Turkey have committed themselves to malaria control, and in 1999 - 2000, national health authorities, in collaboration with EURO/WHO, developed the National Malaria Prevention and Control Programmes which are presently implemented. The four crucial elements of the Programmes are as follows:

Disease Prevention:	to plan and implement sustainable preventive measures
Disease Management:	to provide early diagnosis and prompt treatment
Epidemic Control:	to detect early outbreaks and prevent the further spread of malaria epidemics
Programme Management:	to strengthen institutional capacities of the National Malaria Control Programmes and surveillance mechanisms.

IV. PROJECT JUSTIFICATION

In face of the grave malaria situation in Turkey, the recent malaria outbreak in Georgia, Azerbaijan's and Armenia's need for further consolidation of the results achieved, and the real threat of a resumption of malaria transmission in areas where malaria had been eradicated many years ago, the projects will attempt to change this unfavourable trend. The practical, technical and operational modalities on dealing with malaria by specialized services and the public health sector, as well as the community itself, are the expected outcomes of the national RBM Projects, funded by a number of international agencies/organizations and implemented by the respective governments. The projects will have a strong but flexible management structure capable of mobilizing the partnership amongst the Ministry of Health, UN agencies, other donor agencies and countries, NGOs, and the media in implementing cost-effective but technically sound and sustainable malaria control measures adapted to country conditions and responding to local needs.

V. PROBLEMS TO BE ADDRESSED

Problem I:

A wide range of malaria–related problems in the Trans–Caucasian countries and Turkey is witnessed, from the ongoing outbreak of malaria in Georgia and its spread across the country, the gravity of the malaria situation in Turkey, to the unstable malaria situations in Azerbaijan and Armenia, which require considerable additional efforts and resources.

Problem II:

Shortages of insecticides and limited use of biological control measures result in a limited impact of vector control operations.

Problem III:

Health facilities which are under–equipped and poorly supplied provide unsatisfactory levels of disease management and prevention.

Problem IV:

There is a lack of malaria surveillance, particularly at peripheral levels.

Problem V:
Communities' lack of knowledge and skills to prevent themselves from malaria results in scant use of personal protective measures.

Problem VI:
Limited resources invested by the government and external donors result in a lack of proper funding to cope with the malaria problem and its spread throughout the territory of the Caucasian Region and Turkey.

VI. TARGET LOCATIONS AND INTENDED BENEFICIARIES

From 2002-2005, assistance will be provided to selected regions and districts in Turkey, Azerbaijan, Georgia and Armenia. Generally speaking, the target beneficiaries will be the 30.5 million indigenous people and migrants entering these areas for various reasons.

VII. SUCCESS IMPACT INDICATORS

A base–line survey conducted in project areas will provide an assessment of malaria–related problems and needs at the onset of the projects, whereas a terminal evaluation at the conclusion of the projects will bring to light improvements in the malaria situation which have occurred as a result of interventions.

In the short and medium term, the projects are likely to contain the outbreak of malaria in Georgia and its spread across the country, reduce the incidence and prevalence of malaria in the Region, and prevent a resumption of malaria transmission in areas where malaria has been eradicated, as well as in parts which are at present free from malaria. Sustaining the project activities beyond 2005 would further consolidate the results achieved in these countries.

VIII. PROJECT STRATEGY AND PRIORITY INTERVENTIONS

The above-mentioned issues will be addressed by actions in specific priority areas, all of which are in line with the following strategic components of the Projects and incorporated into the four elements of the National Action Plans for Malaria Control and Prevention:

Component I *(All Countries)*: STRENGTHENING INSTITUTIONAL CAPACITIES OF THE NATIONAL MALARIA CONTROL PROGRAMME/GENERAL HEALTH SERVICES AND ENHANCING CAPACITY FOR DECISION-MAKING RELATED TO MALARIA AND ITS CONTROL/PREVENTION

To be effective, the national plans of actions for malaria prevention and control should be implemented through properly organized and managed specialized and general health services. To facilitate the execution of the RBM projects in the respective countries, some important aspects in the implementation and management of malaria prevention and control programme, notably responsibility, authority and accountability for work done, resources used and outputs/outcomes produced at all levels, should be reviewed. To provide adequate technical and operational guidance in a satisfactory manner, health staff of specialized health services should be trained in programme management. Technical assistance and back–up will be provided by WHO staff.

Component II *(All Countries)*: BUILDING UP RBM PARTNERSHIPS

RBM will address malaria as a priority health issue within the context of sustainable health sector development in the respective countries. WHO will provide strategic direction, coordination and

technical/financial support for malaria control interventions under RBM. Other partners involved in the RBM Project will mobilize additional funds for RBM interventions.

Component III ***(All Countries)*****: IMPROVING CAPACITIES FOR AND ACCESS TO EARLY DIAGNOSIS AND ADEQUATE TREATMENT OF MALARIA**

An established and properly functioning system for the identification of cases, reliable and early diagnosis, and effective and prompt treatment and follow-up of treatment results comprise fundamental parts of the project. Since the microscopic examination remains the most reliable and least expensive way to diagnose malaria, diagnostic laboratory facilities will be upgraded within project areas.

Component IV ***(All Countries):*** **IMPROVING CAPACITIES FOR THE TIMELY RESPONSE TO AND PREVENTION OF MALARIA EPIDEMICS**

All epidemic-prone areas will be identified and potential situations forecasted within project areas. Emergency preparedness for and mechanisms of response to malaria epidemics will be improved. Contingency plans for epidemic control, including indoor spraying, will be worked out and a reserve of drugs, insecticides and spraying equipment will be maintained for rapid deployment. Basic Health Staff will be trained to recognize epidemic situations and build up community preparedness.

Component V ***(Turkey, Azerbaijan, Armenia):***
PROMOTING COST-EFFECTIVE AND SUSTAINABLE VECTOR CONTROL

To reduce transmission of malaria and its incidence, biological vector control and water management measures and distribution of impregnated mosquito nets will be applied and encouraged through health education in project areas. All the above preventive measures will be guided by consideration of their technical and operational feasibility, effectiveness and sustainability.

Component VI ***(All Countries)*****: CAPACITY BUILDING**

Training is a key component of the projects. In–service training in disease management and prevention will be conducted for all categories of specialized programme and public health personnel within project areas. Laboratory personnel will be trained in malaria microscopy. Basic training will be supplemented by regular supervision and refresher training courses. Training will be practical in nature and directed towards developing skills and competence.

Component VII ***(All Countries):*** **REINFORCING RBM COUNTRY SURVEILLANCE MECHANISMS**

A base–line survey to assess problems and needs related to malaria will be carried out at the beginning of the projects. Mechanisms for the regular collection, processing and analysis of operational, epidemiological and socio-economic data relevant to planning/re-planning, implementation, monitoring and evaluation of the project activities will be built in. The existing reporting and information system will be improved. The survey data will provide a systematic way to determine whether the project approaches and interventions and other inputs are appropriate and sufficient to achieve the stated targets and objectives.

Component VIII ***(All Countries):*** **INCREASING COMMUNITY AWARENESS & PARTICIPATION IN MALARIA CONTROL/PREVENTION**

The involvement of communities and their partnership with the formal and informal health sectors to empower them in their own health development is crucial. People should be educated about malaria and its control/prevention and have access to adequate health care facilities. The existing treatment practices will be improved through development and dissemination of clear messages on malaria and its treatment. Community and family care and preventive practices will be strengthened through

providing IEC materials, skills building, traditional/mass media and community support. KAP assessments will conducted on ways to promote compatibility of practices, customs and beliefs of various social groups and minorities with existing malaria control/prevention options, and develop effective IEC strategies and targeted materials.

Component IX *(All Countries)*: STRENGTHENING RESEARCH CAPABILITIES

Operational research is essential for planning, implementation and evaluation of the project activities and will be an integral part of the project. Such research will address not only the planning and effectiveness of specific interventions, but also cultural, behavioural, social and economic factors that might affect the project interventions and outcomes.

Component X:*(All Countries):* ENHANCING INTERSECTORAL COLLABORATION

Additional resources for malaria control remain severely constrained. The social, economic and environmental problems posed by malaria exceed the jurisdiction and capabilities of the Ministry of Health. There is obviously a need for improved intersectoral collaboration, as well as for planning and information sharing, to ensure that additional funds are earmarked for malaria control. Such collaboration is best developed on the basis of a shared understanding of the underlying problems to be addressed. Information on development activities and the migration of organized and non-organized population groups will be collected and exchanged amongst all parties concerned. The Ministry of Health will stimulate the non-health sectors for active collaboration in malaria control, including the mobilization of additional funds. National multi–sectoral committees will promote coordination and collaboration in malaria control activities amongst all concerned.

Component XI:*(All Countries):* IMPROVING INTER – COUNTRY COORDINATION IN BORDER AREAS

Current malaria situations in border areas have deteriorated in recent years, and there are expectations that the border problems may assume larger dimensions in the near future. All necessary steps should be taken to improve coordination among neigbouring countries for solving common problems in the control and prevention of malaria. Particular emphasis should be placed on conducting a review the current malaria situations and identifications of problems/constraints encountered in border areas, outline of a direction and strategy for increased coordination of malaria control in border areas, discussions of the modalities for regular exchange of relevant information and, finally, development and implementation of joint action plans in order to coordinate and synchronize malaria control and preventive activities in border areas.

IX. PROJECT DEVELOPMENT AND SPECIFIC OBJECTIVES

The development objective **is to prevent malaria outbreaks, to reduce the incidence and prevalence of malaria, to prevent the further spread of malaria to areas where malaria has previously been eradicated, and to minimize the socio–economic losses provoked by the disease** through the progressive strengthening of the capacities and capabilities of health services and mobilizing community actions within the context of the Roll Back Malaria Initiative in countries of the Caucasian Region and Turkey.

Specific objectives at sub-regional level are as follows:

Specific Objective I:
IMPROVED INFORMATION EXCHANGE ON MALARIA SITUATION AND ITS CONTROL/PREVENTION IN BORDER AREAS

Specific Objective II:
INCREASED COORDINATION OF MALARIA CONTROL AND PREVENTIVE ACTIVITIES IN BORDER AREAS

Specific objectives at country level are as follows:

Specific Objective I:
STRENGTHENED INSTITUTIONAL CAPACITIES OF THE NATIONAL MALARIA CONTROL PROGRAMME/GENERAL HEALTH SERVICES AND ENHANCING CAPACITY FOR DECISION-MAKING RELATED TO MALARIA AND ITS CONTROL AND PREVENTION

Specific Objective II:
BUILDING RBM ADVOCACY AND PARTNERSHIPS

Specific Objective III:
IMPROVED CAPACITIES FOR AND ACCESS TO EARLY DIAGNOSIS AND RADICAL TREATMENT OF MALARIA

Specific Objective IV:
IMPROVED CAPACITIES FOR THE TIMELY RESPONSE TO AND PREVENTION OF MALARIA OUTBREAKS

Specific Objective V:
PROMOTING COST-EFFECTIVE AND SUSTAINABLE VECTOR CONTROL MEASURES

Specific Objective VI:
STRENGTHENED RBM COUNTRY SURVEILLANCE MECHANISMS

Specific Objective VIII:
INCREASED COMMUNITY AWARENESS AND PARTICIPATION IN MALARIA CONTROL AND PREVENTION

Specific Objective IX:
STRENGTHENED NATIONAL RESEARCH CAPABILITIES

Specific Objective X:
ENHANCED INTERSECTORAL COLLABORATION

X. PROJECT MANAGEMENT AND TIMEFRAME

The projects will be implemented by Ministries of Health and National Malaria Control and Prevention Programmes/Services, with technical and financial support provided by WHO and other potential donors and partners. The project management structure is as outlined below:

At the inter-country level: Focal points for the projects (Directors/ Project Managers of Malaria Control and Prevention Services from respective countries) will be responsible for the planning, implementation and evaluation of project activities and its coordination with neigbouring countries in border areas.

At the central country level: The National Malaria Control and Prevention Programmes/Services are responsible for the implementation of project activities. Directors/ Project Managers of these structures will work in close consultation with the Ministries of Health. Personnel of the respective programmes/services will undertake field visits to supervise the performance of work done in the field. WHO consultants will be recruited to assist in the planning, implementation and evaluation of project activities. Implementation of some project activities would be sub–contracted to international NGOs.

At the regional/district country levels: Focal points for the projects (Chiefs of Regional/District Malaria Control and Prevention Programmes/Services) will be designated for improved communication and coordination between the central and district levels. Their personnel, along with general health service staff, will be responsible for all project–related activities in their respective areas. Technical advice will be provided by specialized regional/district health personnel dealing with malaria issues.

WHO will provide overall technical backstopping and strategic co-ordination of project activities with UN agencies/NGOs and others concerned. The projects will be implemented in full consultation with all agencies and organizations involved in order to enhance coordination and maximize the impact of assistance. The projects are planned for a period of four years (2002-2005).

XI. PROJECT MONITORING AND EVALUATION

Monitoring and evaluation will be a critical and continuous process of reviewing the project progress, problems and constraints, with the sole purpose of identifying the required areas of action for enhanced effectiveness of the projects. Comprehensive monitoring and evaluation will be carried out by the National Implementing Agency, in collaboration with WHO/EURO, at regular intervals. Impact assessment surveys will be carried out at the end of the projects. Monitoring and evaluation will be based on the participation of all stakeholders.

WHO/EURO will provide technical clearance of all project documents prior to their inception. In every county, project management will prepare a project implementation plan over the first month of the start the project. The projects will be subject to annual reviews and reporting. The project final drafts will be prepared in advance to allow review and technical clearance by WHO. The project management will be responsible for the preparation and submission of project evaluation reports.

XI. RISKS

The implementation of the RBM strategy could entail some risk. The implementation and management of the projects should be reviewed periodically to ensure they remain on track.

A continuous flow of inputs from different UN agencies and other donors is critical to the success of the RBM projects in the region. There is some risk that the funding agencies will not be able to provide and/or sustain the level of inputs required to see visible project impact**. Should the amount of funding provided prove insufficient, the scope of project activities will be limited.**

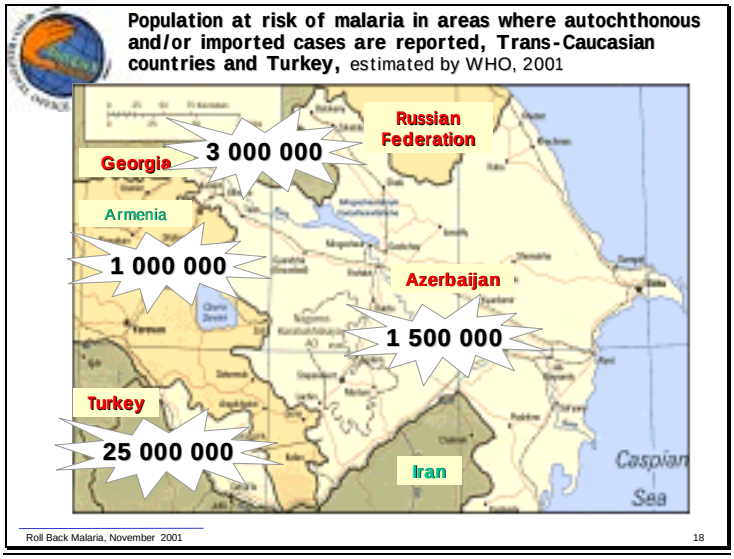
XIII. PROJECT BUDGET

The total project budget is estimated at ***USD 14 781 500***, funds which would be contributed by the Governments, WHO and other potential partners/donors *(see table below)*. Governments will cover operational costs of the existing specialized and public health staff to be involved in implementation of project activities.

Estimated Project Budget, 2002-2005

DESCRIPTION	*2002* *USD*	*2003* *USD*	*2004* *USD*	*2005* *USD*
Technical Expertise:				
International Experts	70 000	70 000	70 000	70 000
Duty Travel	50 000	50 000	50 000	50 000
Sub-Total:	**120 000**	**120 000**	**120 000**	**120 000**
Equipment - Expendable:				
Drugs & Laboratory supplies	150 000	150 000	150 000	150 000
Insecticides/equipment for indoor spraying	1 095 000	1 095 000	1 095 000	1 095 000
Diagnostic kits and supplies	45 000	45 000	45 000	45 000
Equipment for application of antilarval measures	380 000	380 000	380 000	380 000
Mosquito nets and insecticides for impregnation	400 000	200 000	100 000	100 000
Equipment - Non-Expendable:				
Laboratory Equipment	145 000	95 000	70 000	70 000
Transportation	35 000	35 000	35 000	5 000
Office Equipment/Supplies	25 000	5 000	20 000	-
Sub-Total:	**2 275 000**	**2 005 000**	**1 895 000**	**1 845 000**
Quality Assessments/Assurance:				
Quality Care Assessments	35 000	35 000	35 000	35 000
Supervision & Quality Control of Laboratory Services	35 000	35 000	35 000	35 000
Problems & Needs Assessments	25 000	-	-	-
KAP Study/ IEC Service Capacity Development	150 000	115 000	115 000	115 000
RBM Advocacy & Partnership Building	45 000	45 000	45 000	45 000
Impact Assessment	-	-	-	25 000
Training:				
In – Service Training:				
Development & Production of training/learning materials	100 000	90 000	70 000	-
Central and intermediate levels training	130 000	110 000	100 000	90 000
Peripheral level training for public health personnel	330 000	310 000	310 000	300 000
International Training:				
Training in malaria and its control	45 000	45 000	45 000	45 000
Implementation Cost	390 000	390 000	390 000	390 000
Operational Research	50 000	50 000	40 000	10 000
Community Capacity Building	245 000	245 000	245 000	245 000
Monitoring / Evaluation	102 500	102 500	102 500	102 500
Miscellaneous:				
Operation & Maintenance	9 000	9 000	9 000	9 000
Sundries	5 000	5 000	5 000	5 000
TOTAL:	**4 091 500**	**3 711 500**	**3 561 500**	**3 416 500**

Annex 1



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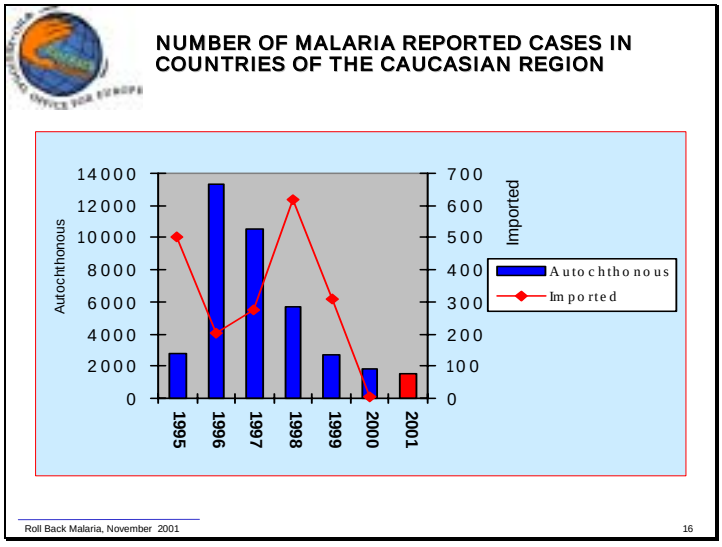

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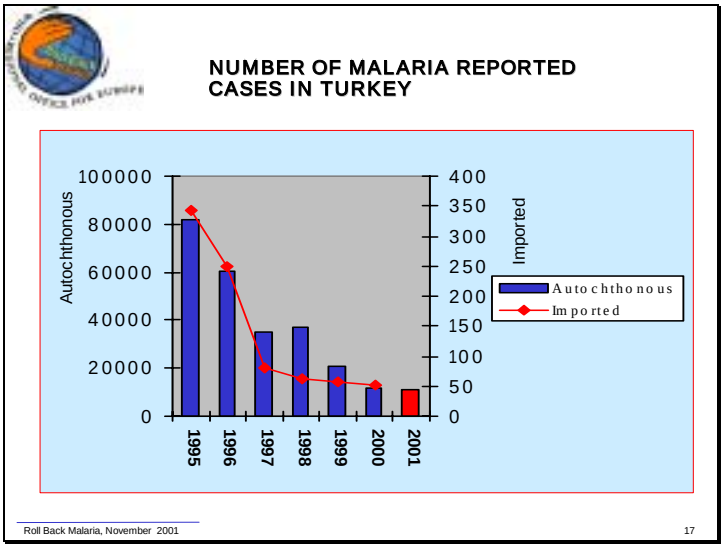

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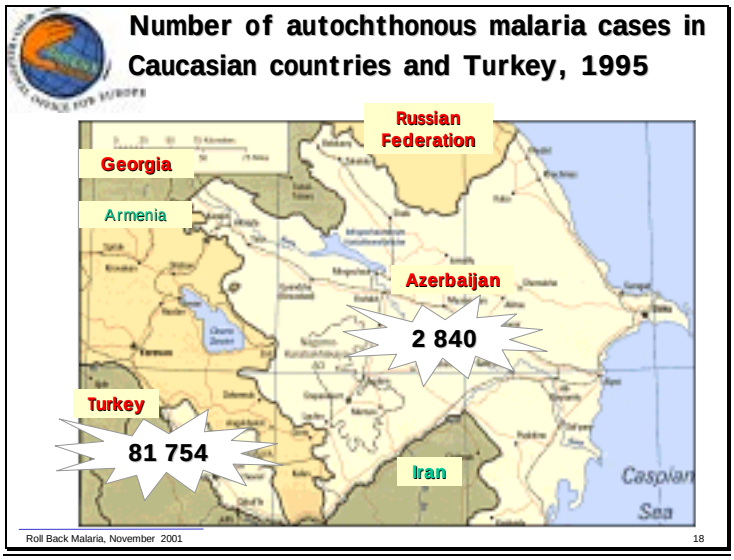

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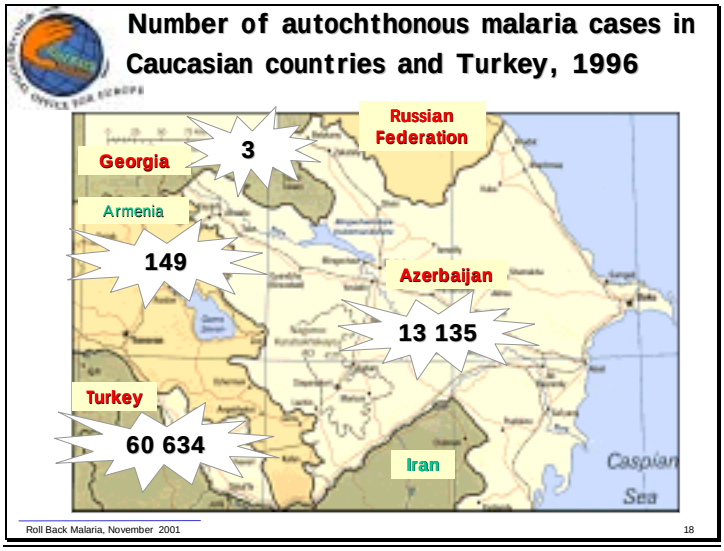

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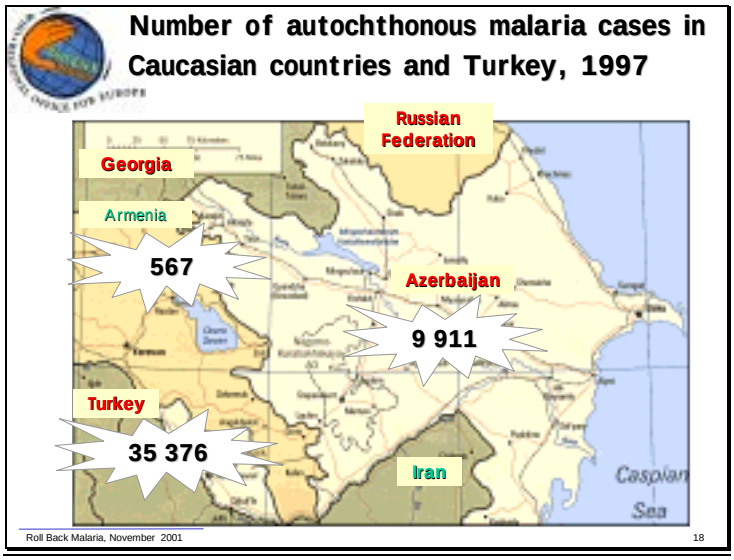

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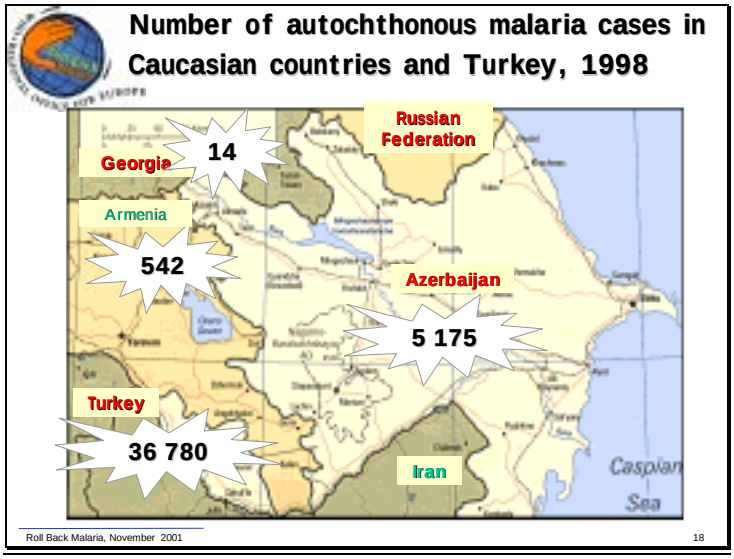

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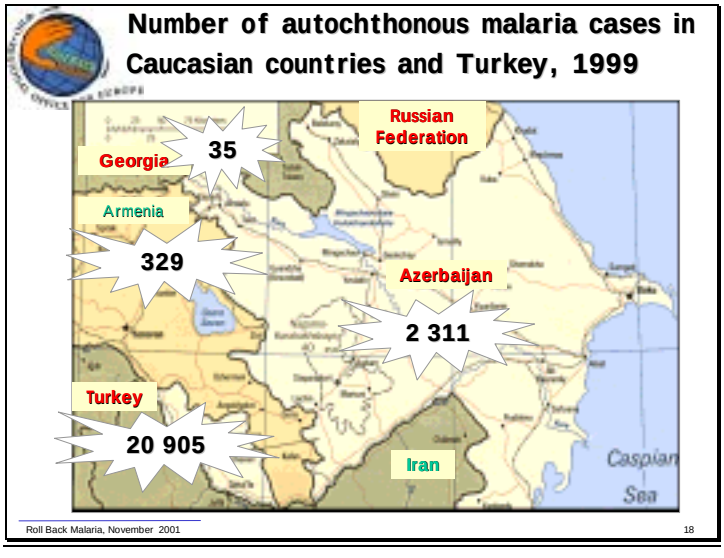

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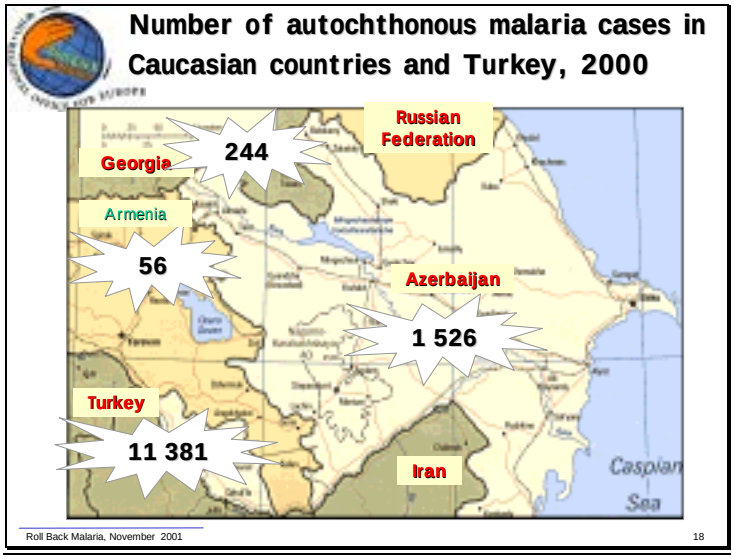

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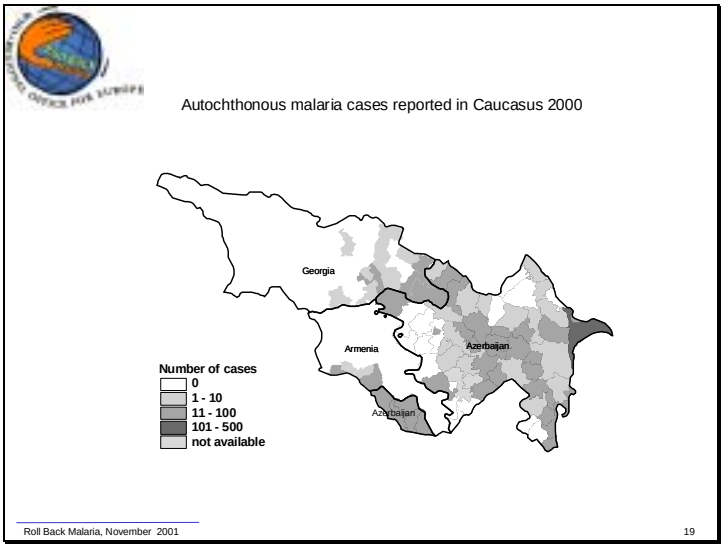

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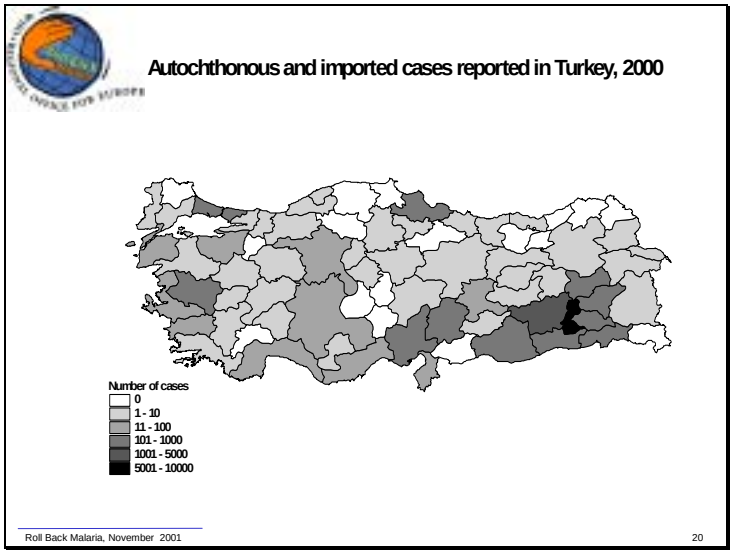
Autochthonous and imported cases reported in Turkey, 2000
Number of cases
0
1 - 10
11 - 100
101 - 1000
1001 - 5000
5001 - 10000
Roll Back Malaria, November 2001
20

ROLL BACK MALARIA
PROJECT DOCUMENT

MINSTRY OF HEALTH
REPUBLIC OF ARMENIA

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

Title:	**The Roll Back Malaria Project**
Duration:	**4 years, January 2002 – December 2005**
Project Sites:	**Selected areas (16): Ararat, Artashat, Vedi, Massis, Armavir, Ejmiadzin, Lori, Vanadzor, Kotayk, Nairi, Gjumri, Goris, Kapan, Shengavit, Erebuni and Khorhurday**
Intended Beneficiaries:	**About 1 million indigenous people and migrants**
Requesting Agency:	**WHO**
Govt. Cooperating Agency:	**Ministry of Health, Armenia**
Estimated Starting Date:	**January 2002**
Estimated Project Budget:	**2002: *USD 358 000*** **2003: *USD 333 000*** **2004: *USD 338 000*** **2005: *USD 293 000*** **TOTAL** (*2002-2005*)**: *USD 1322 000***

BRIEF DESCRIPTION

A total of 1156 cases were reported in 1998 in Armenia, 89% of which were registered in the Masis district, an area in the Ararat valley bordering Turkey. The malaria situation started to improve in 1999, and in 2000, only 141 cases of malaria were reported. At present, the maintenance of the epidemiological well-being and success which has been achieved in the country will require continuous vigilance. The National Malaria Control Programme is at present implemented by the Government with support from WHO, UNICEF, WFP, IFRC and others, and activities consist of disease management and prevention, training, surveillance, health education and integrated vector control. However, the limited resources invested by the Government and external partners result in a lack of funding at levels sufficient to cope with the malaria problem in the country.

The RBM Project will support Armenia in building partnerships and working together in the promotion of health related actions to reduce further the incidence of malaria, prevent malaria outbreaks and finally eradicate the disease in the country. The project will focus on addressing malaria related issues through capacity building, improving capacities for and access to early diagnosis/adequate treatment and timely response to and prevention of malaria outbreaks, reinforcing surveillance mechanisms, and increasing community awareness and involvement in malaria prevention. Implementation of the RBM Project will be a collaborative effort of the Ministry of Health in cooperation with WHO and other potential partners/donors. The project is planned for an initial period of four years (2002-2005). The project will have a strong but flexible management structure capable of mobilizing the partnership among UN agencies and NGOs as well as the media and other partners/donors in implementing cost–effective but technically sound and sustainable malaria control, adapted to the country's conditions and responding to local needs.

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ANNEXES

III. HISTORICAL CONTEXT

The new Director General of WHO committed herself to an intensive response to the global malaria burden, and in January of 1998, the *Roll Back Malaria Initiative (RBM)* was proposed. A global coalition to Roll Back Malaria, characterized by strategic synergy, coordinated effort, and science-based strategies, was proposed at the World Health Assembly of that same year. The Global Partnership to Roll Back Malaria, consisting of WHO, UNICEF, UNDP, World Bank and a group of national government representatives, heads of bilateral donor organizations, representatives of the private sector, and non-governmental bodies, was formally established in December 1998. Members of the Global RBM Partnership are committed to supporting country-level efforts led by national authorities within the context of their multi-sectoral strategies for development and poverty alleviation.

An explosive malaria epidemic has been a result of the disruption of the capacity and capability of both government and community to implement appropriate malaria control. During 1997–1998, the number of reported cases rose, and a total of 1156 cases were reported in 1998. The malaria situation started to improve in 1999, and in 2000, only 141 cases of malaria were reported. Despite a decrease in the reported malaria incidence, the number of active foci of malaria in the country remains high. (*see Annex 1*).

WHO EURO missions to build and promote the Partnership to Roll Back Malaria in Armenia were undertaken during 1998 - 2000. In order to promote RBM partnerships within the Caucasian Republics and Turkey, a regional meeting took place in Tbilisi, Georgia in November 2001. Commitment from all participating countries to build up a Sub–Regional RBM Partnership was the main outcome of this meeting. It was recommended to draw up RBM Project proposals and submit them to existing/potential donors and partners in early 2002. The RBM Sub–Regional and Country Projects will support the countries in partnership building and working together in the promotion and coordination of health sector actions to reduce the incidence of malaria, prevent malaria outbreaks and prevent the further spread of malaria across the countries.

The malaria control programme in Armenia is funded by the government, WHO, UNICEF, IFRC, and WFP. However, the resources invested for malaria control by the government and external donors at present are limited, and the country is in need of additional external assistance to cope with the malaria problem.

II CURRENT MALARIA SITUATION

Following a large – scale malaria eradication campaign, malaria completely disappeared in Armenia in 1963, and a malaria – free situation was maintained until 1994.

In 1994, 196 malaria cases amongst military personnel were reported in the country. In 1995, the number of imported malaria cases increased to 502. In the next year, out of 347 cases, 149 were reported as autochthonous. During 1997 – 1998, the number of reported cases continued to rise, and a total of 1156 cases were reported in 1998. Although 30 out of 81 districts recorded malaria cases, 89% of these were registered in the Masis district, an area in the Ararat valley bordering Turkey. The malaria situation started to improve in 1999, and in 2000, only 141 cases of malaria were reported. There was a futher decrease in the number of reported malaria cases during 2001.

III HOST COUNTRY STRATEGY

III.A. NATIONAL STRATEGY

Armenia has committed itself to malaria control and the national health authorities, in collaboration with WHO, have developed a National Malaria Control Programme which is presently being implemented. The four elements of the Programme are as follows:

Disease Prevention: to plan and implement selective and sustainable preventive measures;
Disease Management: to provide early diagnosis and prompt treatment;
Epidemic Control: to detect early outbreaks and prevent the further spread of malaria epidemics;
Programme Management: to strengthen institutional capacities of the National Malaria Control Programme and surveillance mechanisms

III.B. INSTITUTIONAL FRAMEWORK FOR MALARIA CONTROL

The National Malaria Control Programme, as a major component of the National Epidemiological Services, is responsible for technical guidance, planning, monitoring and evaluation of malaria control in the country. NMCP staff is comprised of parasitologists, entomologists, laboratory personnel and administrative staff. Several of these positions are vacant at present, particularly at the peripheral level. The diagnosis and treatment of malaria is considered part of the primary health care system.

Currently, malaria control interventions consist mainly of disease management, training, surveillance and selective vector control.

III.C. PRIOR AND ONGOING ASSISTANCE

WHO assistance focuses on strengthening the National Malaria Control Programme through technical back-up, consultation, training and fellowships, provision of equipment/supplies and transport and insecticides, and equipment for spraying. IFRC has provided antimalarial drugs and laboratory equipment/supplies, while UNICEF has supplied mosquito nets, and WFP has initiated programme Food for Work for voluntary health workers involved in malaria control at the grass–roots level.

IV. PROJECT JUSTIFICATION

To sustain the results which have been achieved in the field of malaria control in Armenia, attempts are being undertaken to prevent malaria outbreaks, to reduce further the incidence of malaria, and finally, to interrupt malaria transmission in the country. The practical technical and operational modalities on dealing with malaria by specialized services and the public health sector, as well as the community itself, are the expected outcomes of the RBM Project, funded and implemented by the Government of Armenia, along with a number of international agencies/organizations. The project will have a strong but flexible management structure capable of mobilizing the partnership amongst the Ministry of Health, UN agencies and other donor agencies and countries and the media in implementing cost-effective but technically sound and sustainable malaria control adapted to the country's conditions and responding to local needs.

IV.A. PROBLEMS TO BE ADDRESSED

Problem I:
The concentration of malaria transmission, particularly in areas bordering Turkey, in areas with poor access to existing health services, could result in underreported malaria morbidity.

Problem II:
Shortages of insecticides and limited use of antilarval operations result in a limited impact on the malaria problem.

Problem III:
Existing health facilities are under-equipped and under–staffed, and public health personnel are underpaid, thus leading to the inadequate quality of disease management and prevention.

Problem IV:
Poor capacities for early diagnosis and prompt treatment of malaria result in inadequate coverage of people at risk of malaria.

Problem V:
A lack of surveillance activities, including inadequate reporting, results in a distorted reflection of the extent of the malaria problem in the country.

Problem VI:
Communities lack of knowledge and skills to prevent themselves from getting malaria results in scant use of personal protective measures.

Problem VII:
Limited resources invested by the government and external donors result in lack of funding at levels sufficient to cope with the malaria problem.

IV.B. TARGET LOCATIONS AND INTENDED BENEFICIARIES

During 2002-2005, assistance is to be provided for selected areas of Ararat, Artashat, Vedi, Massis, Armavir, Ejmiadzin, Lori, Vanadzor, Kotayk, Nairi, Gjumri, Goris, Kapan, Shengavit, Erebuni and Khorhurdayin (*see Annex 2*). Project areas are mainly situated in valleys, foothills and plains, and often have poorly developed health infrastructures and communication systems. In general, the target beneficiaries will be about 1.0 million indigenous people and migrants entering there for various reasons.

IV.C. SUCCESS IMPACT INDICATORS

A base–line survey conducted in project areas will provide an assessment of the malaria–related problems and needs at the beginning of the project, whereas a terminal evaluation at the end of project will bring to light improvements in the malaria situation which have occurred as a result of project interventions.

In the short term, the project is likely to contribute to the prevention of malaria outbreaks and reduction in the number of active foci/cases of malaria and prevent the re–establishment of new foci of malaria transmission in the country. Sustaining the project activities beyond 2002 will reduce the impact of malaria to a low level sufficient to no longer represent a public health problem, and finally interrupt the transmission of malaria in the country.

V. PROJECT STRATEGY AND PRIORITY INTERVENTIONS

The above will be addressed by actions in specific priority areas, all of which are in line with the following strategic components of the project and incorporated into the four elements of the National Action Plan for Malaria Control and Prevention:

Component I: **STRENGTHENING INSTITUTIONAL CAPACITIES OF THE NATIONAL MALARIA CONTROL PROGRAMME AND GENERAL HEALTH SERVICES AND ENHANCING CAPACITY FOR DECISION-MAKING RELATED TO MALARIA AND ITS CONTROL/PREVENTION**

To be effective, the national plan of action for malaria prevention and control should be implemented through properly organized and managed specialized and general health services. To facilitate the execution of the RBM project in Armenia, some important aspects in the implementation and management of malaria prevention and control programme, notably responsibility, authority and accountability for work done, resources used and outputs/outcomes produced at all levels should be reviewed. To provide technical and operational guidance in a satisfactory manner, health staff of specialized health services should be trained in programme management. Technical assistance and back–up will be provided by WHO personnel.

Component II: **BUILDING AND PROMOTING RBM PARTNERSHIPS**

RBM will address malaria as a priority health issue within the context of sustainable health sector development in Armenia. WHO will provide strategic direction, coordination and technical/financial support for malaria control interventions within the framework of RBM. Other partners involved in the RBM Project will mobilize additional funds for RBM interventions.

Component III: **IMPROVING CAPACITIES FOR & ACCESS TO EARLY DIAGNOSIS AND ADEQUATE TREATMENT OF MALARIA**

An established and properly functioning system for the identification of cases, reliable and early diagnosis, effective and prompt treatment, and follow-up of treatment results, all comprise fundamental parts of the project. Since microscopic examination remains the most reliable and least expensive way to diagnose malaria, diagnostic laboratory facilities will be upgraded within project areas. Dip Stick-like technologies with algorithms for simple and labor-saving diagnosis of malaria should be introduced on a pilot basis to make diagnosis of malaria adequate even at the most peripheral levels.

Component IV: **IMPROVING CAPACITIES FOR TIMELY RESPONSE TO AND PREVENTION OF MALARIA EPIDEMICS**

All epidemic-prone areas and situations will be identified and forecasted. Emergency preparedness for and mechanisms of response to malaria epidemics will be improved. Contingency plans for epidemic control, including indoor spraying, will be worked out and the reserve of drugs, insecticides and spraying equipment will be maintained for rapid deployment. To contain an outbreak, selective residual indoor spraying would be applied to the active foci of malaria within project areas. Basic health staff will be trained to recognize epidemic situations and build up community preparedness.

Component V: **PROMOTING COST-EFFECTIVE AND SUSTAINABLE VECTOR CONTROL**

To reduce the transmission of malaria and its incidence, biological vector control measures and water management interventions will be applied in project districts. The use of personal protective measures including impregnated mosquito nets, curtains and repellents will be encouraged through health education. The appropriate approaches to communicate messages on malaria prevention directly to high-risk groups will be developed. All the above preventive measures will be guided by consideration of their technical and operational feasibility, effectiveness and sustainability.

Component VI: **CAPACITY BUILDING**

Training is a key component of the project. In–service training in disease management and prevention will be conducted for all categories of specialized programme and public health personnel within project areas. Laboratory personnel will be trained in malaria microscopy. Basic training will be supplemented by regular supervision and refresher training courses. The training will be practical in nature and directed towards developing skills and competence.

Component VII: **REINFORCING RBM COUNTRY SURVEILLANCE MECHANISMS**

A base–line survey to assess problems and needs related to malaria will be carried out at the beginning of the project. Mechanisms for the regular collection, processing and analysis of operational, epidemiological and socio-economic data relevant to planning/re-planning, implementation, monitoring and evaluation of the project activities will be built in. The existing reporting and information system will be improved. The survey data will provide a systematic way to determine whether the project approaches and interventions and other inputs are appropriate and sufficient to achieve the stated targets and objectives.

Component VIII: **INCREASING COMMUNITY AWARENESS AND PARTICIPATION IN MALARIA CONTROL/PREVENTION**

The involvement of communities and their partnership with the formal and informal health sectors to empower them in their own health development is crucial. People should be educated in malaria and its control/prevention and have access to adequate health care facilities. Existing treatment practices will be improved through the development and dissemination of clear messages on malaria and its treatment. Community and family care and preventive practices will be strengthened through the provision of IEC materials, capacity building, traditional/mass media and community support. KAP assessments will be conducted on ways to promote compatibility of practices, customs and beliefs of various social groups and minorities with existing malaria control/prevention options, and to develop effective IEC strategies and targeted materials.

Component IX: **STRENGTHENING RESEARCH CAPABILITIES**

Operational research is essential for the planning, implementation and evaluation of the project activities, and this will comprise an integral part of the project. Such research will address not only the planning and effectiveness of specific interventions, but also cultural, behavioural, social and economic factors that might affect project interventions and outcomes.

Component X: **ENHANCING INTERSECTORAL COLLABORATION**

Additional resources for malaria control remain severely constrained. The social, economic and environmental problems posed by malaria exceed the jurisdiction and capabilities of the Ministry of Health. There is obviously a need for improved intersectoral collaboration, as well as for planning and information sharing, to see that additional funds are earmarked for malaria control. Such collaboration is best developed from a shared understanding of the underlying problems to be addressed. Information on development activities and the migration of organized and non-organized population groups will be collected and exchanged amongst all parties concerned. The Ministry of Health will stimulate the non-health sectors for active collaboration in malaria control, including the mobilization of additional funds. National multi–sectoral committees will promote coordination and collaboration in malaria control among all concerned.

VI. PROJECT OBJECTIVES, ACTIVITIES AND OUTPUTS

VI.A. DEVELOPMENT OBJECTIVE

The development objective is **to prevent malaria outbreaks, to further reduce the incidence of malaria, and finally, to interrupt the transmission of malaria in the country** through the progressive strengthening of capacities and capabilities of health services and mobilizing community actions within the context of the Roll Back Malaria initiative in Armenia.

VI.B. SPECIFIC OBJECTIVES, ACTIVITIES AND OPERATIONAL OUTPUTS

Specific Objective I:	**STRENGTHENED INSTITUTIONAL CAPACITIES OF THE NATIONAL MALARIA CONTROL PROGRAMME AND GENERAL HEALTH SERVICES, AS WELL AS ENHANCED CAPACITIES FOR DECISION-MAKING RELATED TO MALARIA AND ITS CONTROL AND PREVENTION**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To render technical and managerial expertise and back-up for the RBM Project	WHO short-term consultants recruited and expert advice given wherever required	2002-2005	WHO	USD 60 000
2. To train/retrain Regional/District Health Directors in programme management to improve capacities for planning and implementation of the project activities	Regional/District Health Directors involved in the project trained	2002-2005	MoH/NMCP WHO UN Agencies Others	USD 20 000
3. To train/retrain selected Regional/District Medical Officers in existing approaches to disease management, epidemic control and community mobilization	Regional/District MOs in project areas trained	2002-2005	MoH/NMCP WHO UN agencies Others	USD 40 000
4. To train selected entomologists	Selected entomologists trained	2002-2005	MoH/NMCP WHO Others	USD 10 000
5. To support international training selected NMCP personnel in malaria and its control	Selected NMCP personnel trained abroad	2002-2005	WHO MoH/NMCP	USD 40 000
				TOTAL: USD 170 000

Specific Objective II:	**BUILDING UP RBM ADVOCACY AND PARTNERSHIP**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To identify partners and conduct RBM advocacy through workshops and meetings; message development to obtain broad, inter-sectoral commitment at different levels in the country	Partners identified Targeted RBM advocacy activities conducted among various partners at all levels	2002-2005	MoH/NMCP WHO UN agencies NGOs Informal Sector Media Others	USD 20 000
2. To follow up RBM Partnership actions at country level	RBM Partnership actions followed up	2002-2005	MoH/NMCP WHO UN Agencies NGOs Others	USD 20 000 **TOTAL: USD 40 000**

Specific Objective III:	**IMPROVED CAPACITIES FOR AND ACCESS TO EARLY DIAGNOSIS AND RADICAL TREATMENT OF MALARIA**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To select and train/retrain laboratory staff in malaria microscopy	Laboratory staff trained/retrained	2002-2005	MoH/NMCP WHO UN agencies Others	USD 30 000
2. To upgrade laboratory facilities in selected health centres	Health facilities upgraded	2002-2005	MoH/NMCP WHO NGOs	To be borne by MoH
3. To set up supervision and quality control systems of laboratory services and ensure their functionality	Systems set up and functioning	2002–2005	MoH/NMCP WHO Others	USD 20 000
4. To set up a system for the assessment of quality of care and ensure its functionality	System set up and functioning	2002–2005	MoH/NMCP WHO Others	USD 20 000
5. To develop/modify/produce training/learning materials on disease management and prevention	Materials developed and produced	2002-2005	MoH/NMCP WHO UN agencies Others	USD 40 000
6. To train health personnel in case management	Health personnel trained	2002–2005	MoH/NMCP UN agencies WHO Others	USD 40 000
7. To procure and distribute laboratory equipment/supplies and drugs/other diagnostic items required for disease management	Equipment and supplies procured and distributed	2002-2005	MoH/NMCP UN agencies Others	USD 100 000 **TOTAL: USD 270 000**

Specific Objective IV:	**PROMOTING COST-EFFECTIVE AND SUSTAINABLE VECTOR CONTROL**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
To promote cost-effective vector control measures:				
1. To identify priority target areas and population groups by means of microstratification	Areas and groups identified	2002-2005	MoH/NMCP WHO	To be borne by MoH
2. **To procure and deliver equipment/supplies for vector control**	Equipment and supplies procured and delivered	2002-2005	MoH/NMCP UN Agencies Others	USD 120 000
3. To establish implementation mechanisms and ensure their functionality	Implementation mechanisms established and functioned	2002–2005	MoH/NMCP UN Agencies WHO Others	USD 60 000
4. **To undertake monitoring and evaluation of measures applied**	Monitoring and evaluation undertaken	2002–2005	MoH/NMCP WHO Others	USD 20 000
				TOTAL: USD 200 000

Specific Objective V:	**IMPROVED CAPACITIES FOR TIMELY RESPONSE TO AND PREVENTION OF MALARIA OUTBREAKS**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To develop monitoring mechanisms for the detection/forecasting of epidemic risk factors	Monitoring mechanisms developed	2002-2003	WHO MoH/NMCP	USD 10 000 To be covered by MoH/NMCP together with WHO
2. To update NPS operational guidelines and procedures related to the detection and control of epidemics	Operational guidelines and procedures updated	2002-2003	MoH/NMCP WHO	To be borne by MoH
3. To improve emergency preparedness for and response to malaria epidemics in project areas where outbreaks are a recurring problem	Emergency preparedness for and response to malaria outbreaks improved	2002–2005	MoH/NMCP	To be borne by MoH
4. To procure and deliver insecticides/equipment for spraying and other items	Insecticides/equipment for spraying and other items procured and delivered	2002–2005	MoH/NMCP UN agencies Others	USD 260 000
5. To apply indoor residual spraying in case of emergency	Residual spraying applied	2002-2005	MoH/NMCP	To be borne by MoH
6. To train health personnel in epidemic control with emphasis on vector control	Health personnel trained	2002–2005	MoH/NMCP WHO Others	USD 60 000
				TOTAL: USD 330 000

Specific Objective VI:	**STRENGTHENED RBM COUNTRY SURVEILLANCE MECHANISMS**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To survey to assess needs and problems related to malaria and impact assessment survey	Base–line survey and impact surveys carried out	2002-2005	MoH/NMCP WHO	USD 10 000
2. To identify operational and epidemiological indicators needed for monitoring/evaluation of project activities	Operational and epidemiological indicators identified	2002	MoH/NMCP WHO	To be covered by WHO Consultant
3. To train personnel of NMCPs in data collection, processing and analysis	Personnel of NMCPs trained	2002–2005	MoH/NMCP WHO UN agencies Others	USD 20 000
***4.* To establish and maintain the project operational and epidemiological database**	Operational and epidemiological database established and maintained	2002–2005	MoH/NMCP	To be borne by MoH
5. To improve the existing reporting and information systems	Reporting and information systems improved	2002–2005	MoH/NMCP WHO	To be borne by MoH
***6.* To procure project transport, equipment and supplies to improve supervision and monitoring of project activities at all levels**	Transportation, equipment and supplies procured	2002–2005	MoH/NMCP WHO UN agencies Others	USD 25 000
***7.* To undertake monitoring of project activities**	Monitoring undertaken	2002-2005	MoH/NMCP WHO NGOs	USD 30 000
				TOTAL: USD 85 000

Specific Objective VII:	**INCREASED COMMUNITY AWARENESS AND PARTICIPATION IN MALARIA CONTROL AND PREVENTION**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To strengthen community and family care and prevention practices through providing IEC materials, awareness raising sessions, community support, skills building and mass media	Malaria care and prevention practices strengthened	2002–2005	MoH/NMCP UN agencies WHO Community Others	USD 100 000
2. The rapid assessments on practices of recognition and treatment of malaria and personal protection will be conducted in order to develop effective IEC strategy	KAP designed and conducted	2002	MoH/NMCP UN agencies WHO Community Others	USD 5 000
3. To build IEC service capacity, including development of targeted IEC materials and IEC management and monitoring	Targeted IEC materials developed; IEC campaign implemented and monitored	2002-2005	MoH/NMCP UN agencies WHO Media Others	USD 80 000 **TOTAL: USD 185 000**

Specific Objective VIII:	**STRENGTHENED CAPABILITIES FOR OPERATIONAL RESEARCH**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
To design research protocols, carry out studies and prepare final reports	Protocols designed, studies conducted and final reports prepared	2002-2005	MoH/NMCP WHO Research Institutions Others	USD 30 000 **TOTAL: USD 30 000**

Specific Objective XI:	**ENHANCED INTERSECTORAL COLLABORATION**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To set up a National Multi–Sectoral Committee and ensure its functionality	National Multi–Sectoral Committee established and functioning	2002-2005	MoH/NMCP GOs WHO	To be borne by the Government
2. To define situations where collaboration is needed and establish mechanisms to promote collaboration within the project areas	Situations defined and mechanisms established	2002–2005	MoH/NMCP GOs	To be borne by the Government
3. To coordinate the exchange of information about all development activities relevant to malaria within the project areas	An effective system of communication on malaria between health and non-health sectors established and exchange of information coordinated	2002–2005	MoH/NMCP GOs	To be borne by the Government
4. To identify and mobilize additional resources required for malaria control from non-health sectors	Additional resources identified and mobilized	2002-2005	MoH/NMCP GOs	To be borne by the Government

VII. PROJECT MANAGEMENT AND TIMEFRAME

The project will be implemented by the Ministry of Health and the National Malaria Control Programme, with technical and financial support provided by WHO and other potential donors and partners. The project management structure is as outlined below.

At the inter–country level: The focal point for the project (Director/Project Managers of Malaria Control and Prevention Services) will be responsible for the planning, implementation, and evaluation of project activities and its coordination with neigbouring countries in border areas.

At the central country level: The National Malaria Control Programme will be responsible for the implementation of project activities. The Director of NMCP/Project Manager will work in close consultation with the Ministry of Health. Personnel of NMCP will undertake field visits to supervise the performance of work carried out in the field. WHO consultants will be recruited to assist in the planning and evaluation of project activities. Implementation of some project activities, such as training, health education, community–based activities and other interventions would be sub–contracted.

At the regional/district country levels: Focal points for the project (Chiefs of Regional/District Malaria Control Services) will be designated for better communication and coordination between the central and district levels. Staff of Regional/District malaria control services will be responsible for all project–related activities in their respective areas. Technical advice will be provided by regional/district specialized health personnel dealing with malaria issues.

WHO will provide overall technical backstopping and strategic coordination of project activities with UN agencies and others concerned. The project will be implemented in full consultation with all agencies and organizations involved in order to enhance coordination and maximize the impact of assistance. The project is planned for a period of four years (2002-2005).

VIII. PROJECT MONITORING AND EVALUATION

Monitoring and evaluation will be a critical and continuous process of reviewing the progress of the project and its problems and constraints, with the sole purpose of identifying the required areas of action for enhancing project efficacy. Comprehensive monitoring and evaluation will be carried out by the National Implementing Agency, in collaboration with WHO/EURO, at regular intervals. An impact assessment survey will be carried out at the conclusion of the project. Monitoring and evaluation will be based on the participation of all stakeholders.

WHO/EURO will provide technical clearance of the Project Document prior to the start of the project. Project management will prepare a project implementation plan over the first month of the start the project. The project will be subject to annual reviews and reporting. The project's final draft will be prepared in advance to allow review and technical clearance by WHO. Project management will be responsible for the preparation and submission of the project evaluation reports. Specific monitoring and evaluation methods, schedules and indicators will be developed for the project at the start of the project (s*ee Annex 3)*

IX. RISKS

The implementation of the RBM strategy could entail some risk. The implementation and management of the project should be reviewed periodically to ensure it remains on track.

A continuous flow of inputs from different UN agencies and other donors is critical to the success of the RBM Project in Armenia. There is some risk that the funding agencies would not be able to provide and/or sustain the level of inputs required to ensure a visible project impact. **Should the amount of funding provided prove insufficient, the scope of project activities will be limited.**

X. PROJECT BUDGET

The total project budget, estimated at ***USD 1 322 000*** , would be contributed by the Government, WHO and other potential partners/donors *(See Table 1 below)*. The Government will cover operational costs of the existing NMCP/public health staff to be involved in the implementation of project activities.

Table 1 **The estimated project budget for 2002-2005**

DESCRIPTION	*2002* *USD*	*2003* *USD*	*2004* *USD*	*2005* *USD*
Technical Expertise:				
International Experts	15 000	15 000	15 000	15 000
Duty Travel	10 000	10 000	10 000	10 000
Sub-Total:	**25 000**	**25 000**	**25 000**	**25 000**
Equipment - Expendable:				
Drugs & Laboratory supplies	15 000	15 000	15 000	15 000
Diagnostic kit supplies	5 000	5 000	5 000	5 000
Supplies/equipment for vector control	25 000	25 000	25 000	25 000
Insecticides/equipment and other items for epidemic control	60 000	60 000	60 000	60 000
Equipment - Non-Expendable:				
Laboratory Equipment	10 000	10 000	10 000	10 000
Transportation	5 000	5 000	5 000	-
Office Equipment/Supplies	5 000	-	5 000	-
Sub-Total:	**125 000**	**120 000**	**125 000**	**115 000**
Quality Assessments/Assurance:				
Care Quality Assessments	5 000	5 000	5 000	5 000
Supervision and quality control of laboratory service	5 000	5 000	5 000	5 000
Problems And Needs Assessments	5 000			
KAP Study/ IEC Service Capacity Building	25 000	20 000	20 000	20 000
Implementation Cost	15 000	15 000	15 000	15 000
RBM Advocacy & Partnership Building/Foll ow ups	10 000	10 000	10 000	10 000
Impact Assessment				5 000
Training:				
In–service training:				
Development & production of training materials	20 000	10 000	10 000	-
Central and intermediate level training	20 000	20 000	20 000	10 000
Peripheral level training for public health personnel	40 000	40 000	40 000	30 000
International Training:				
Training in malaria and its control	10 000	10 000	10 000	10 000
Operational Research	10 000	10 000	10 000-	-
Community Capacity Building	25 000	25 000	25 000	25 000
Monitoring/Evaluation	15 000	15 000	15 000	15 000
Miscellaneous:				
Operation & Maintenance	2 000	2 000	2 000	2 000
Sundries	1 000	1 000	1 000	1 000
TOTAL:	**358 000**	**333 000**	**338 000**	**293 000**

ANNEXES

Annex 1: **The malaria situation in Armenia, 1995–2000**

	1995	1996	1997	1998	1999	2000
Autochthonous malaria	**0**	**149**	**567**	**542**	**329**	**56**
Imported cases	**502**	**198**	**274**	**614**	**287**	**85**
Plasmodium vivax	**502**	**347**	**841**	**1156**	**612**	**141**
Plasmodium falciparum	**0**	**0**	**0**	**0**	**4**	**0**
Mixed infections	**0**	**0**	**0**	**0**	**0**	**0**
Total number of malaria cases	**502**	**347**	**841**	**1156**	**616**	**141**

Annex 2: **RBM project areas in Armenia, 2002 - 2005**

The project's targeted beneficiaries will be nearly 1 million indigenous people and migrants in Ararat, Artashat, Vedi, Massis, Armavir, Ejmiadzin, Lori, Vanadzor, Kotayk, Nairi, Gjumri, Goris, Kapan, Shengavit, Erebuni and Khorhurday project areas (16).

Annex 3: Monitoring and evaluation indicators

Output (*process*) indicators:

- ***Percentage of project areas with adequate amount of learning and IEC materials***
- ***Percentage of project areas with adequately advocated/trained people***
- ***Percentage of project areas with adequate provision of equipment, drugs, insecticides, mosquito nets and other supplies***
- ***Percentage of project areas under regular supervision of indoor residual spraying/malaria diagnosis and treatment/laboratory services***
- ***Percentage of project areas/population under surveillance***
- ***Type and volume of operational research planned to conduct/conducted***

Outcome indicators:

- ***Percentage of project areas where vector control operations (indoor residual spraying and/or antilarval measures and/or the use of impregnated mosquito nets) have been correctly applied and all active foci are covered by the above–mentioned interventions***
- ***Percentage of project areas in which more than 75 % of patients are diagnosed/treated correctly in the formal and informal sectors***
- ***Percentage of project areas where more than 75 % of formal/informal care providers use updated knowledge and built–up skills in diagnosis and treatment/management of malaria***
- ***Percentage of project areas where more than 75 % of households, families and mothers are knowledgeable about symptoms/diagnosis/treatment/referral and are capable of providing appropriate self–diagnosis***

Impact indicators (*to estimate the effect of large-scale interventions within project areas*):

- ***As a result of improved coverage and quality of vector control (indoor residual spraying, larviciding, and biological control measures):***
  A decrease in the incidence/prevalence of P. vivax infection/disease
  Prevention of malaria outbreaks
  Prevention of re-establishment of transmission of P. vivax malaria
- ***As a result of improved coverage and quality of diagnosis and radical treatment of P. vivax:***
  Prevention of relapses of P. vivax malaria

ROLL BACK MALARIA
PROJECT DOCUMENT

MINSTRY OF HEALTH
REPUBLIC OF AZERBAIJAN

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

Title:	**The Roll Back Malaria Project**
Duration:	**4 years, January 2002 – December 2005**
Project Sites:	**Selected areas : Districts of Agdam, Agdash, Agjabadi, Adjigabul, Agstafa, Apsheron, Astara, Akhsu, Barda, Beylegan, Balaken, Belosuvar, Goychay, Goranboy, Gobustan, Djalilabad, Davachi, Yevlakh, Zagatala, Zardab, Imishli, Ismayilli, Gafgaz, Gakh, Gurdamir, Lachin, Lenkeran, Masalli, Neftechala, Oguz, Saatly, Sabirabad, Salyan, Samukh, Ter-ter, Udjar, Fizuli, Khachmaz, Khizi, Sheki and Shamakhi.**
Intended Beneficiaries:	**Over 1.5 million indigenous people and migrants**
Requesting Agency:	**WHO**
Govt. Cooperating Agency:	**Ministry of Health, Azerbaijan**
Estimated Starting Date:	**January 2002**
Estimated Project Budget:	**2002:** ***USD 508 000*** **2003:** ***USD 473 000*** **2004:** ***USD 478 000*** **2005:** ***USD 448 000*** **TOTAL** (*2002-2005*)**:** ***USD 1 907 000***

BRIEF DESCRIPTION

From 1990, the malaria situation in Azerbaijan began to deteriorate rapidly, and in 1996, the number of malaria cases reached 13 135. The malaria situation started to improve in 1997, and in 2000, only 1 526 cases of malaria were reported. At present, the maintenance of the epidemiologicaél well-being and success which has been achieved in the country will require continuous vigilance. The National Malaria Control Programme is at present implemented by the Government with support from WHO, UNICEF, ENI, IFRC and others, and activities consist of disease management and prevention, training, surveillance, health education, and integrated vector control. However, the limited resources invested by the Government and external partners result in a lack of funding at levels sufficient to cope with the malaria problems in the country.

The RBM Project will support Azerbaijan in building partnerships and working together in the promotion of health related actions that reduce further the incidence of malaria, prevent malaria outbreaks and finally eradicate the disease in the country. The project will focus on addressing malaria related issues through capacity building, improving capacities for and access to early diagnosis/adequate treatment and timely response to and prevention of malaria outbreaks, reinforcing surveillance mechanisms and increasing community awareness and involvement in malaria prevention. Implementation of the RBM Project will be a collaborative effort of the Ministry of Health, in cooperation with WHO and other potential partners/donors. The project is planned for an initial period of four years (2002-2005). The project will have a strong but flexible management structure capable of mobilizing the partnership among UN agencies and NGOs as well as the media and other partners/donors in implementing cost–effective but technically sound and sustainable malaria control adapted to the country's conditions and responding to local needs.

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ANNEXES

I. HISTORICAL CONTEXT

The new Director General of WHO committed herself to an intensive response to the global malaria burden, and in January 1998, the *Roll Back Malaria Initiative (RBM)* was proposed. A global coalition to Roll Back Malaria, characterized by strategic synergy, co-ordinated effort, and science-based strategies, was proposed at the World Health Assembly in 1998. The Global Partnership to RBM, consisting of WHO, UNICEF, UNDP, World Bank and a group of National Government representatives, heads of bilateral donor organizations, representatives of the private sector, and non-governmental bodies, was formally established in December 1998. Members of the Global RBM Partnership are committed to supporting country-level efforts led by national authorities within the context of their multi-sectoral strategies for development and poverty alleviation.

An explosive malaria epidemic has been a result of disruption of the capacity and capability of both government and community to implement appropriate malaria control. The malaria situation started to deteriorate after 1990, and the reported number of cases reached 13 135 in 1996. The malaria situation started to improve in 1997, and in 2000, only 1 526 cases of malaria were reported. Despite a decrease in the reported malaria incidence, the number of active foci of malaria in the country remains high (*see Annex 1*).

WHO EURO missions to build and promote the Partnership to Roll Back Malaria in Azerbaijan were undertaken during 1998 - 2001. To promote partnerships to Roll Back Malaria in the Caucasian Republics and Turkey, a regional meeting was organized in Tbilisi, Georgia in November 2001. Commitment to build up a Sub – Regional RBM Partnership was the main outcome of this meeting. It was recommended to draw up RBM Project proposals and submit them to existing/potential donors and partners in early 2002. The RBM Sub –Regional and Country Projects will support the countries in partnership building and working together in the promotion and coordination of health sector actions to reduce the incidence of malaria, prevent malaria outbreaks and prevent the further spread of malaria across the countries.

The malaria control programme in Azerbaijan is funded by the Government, WHO, ENI, UNICEF, IFRC, and others. However, the resources invested for malaria control by the Government and external donors at present are limited, and the country is in need of additional external assistance to cope with the malaria problem.

II CURRENT MALARIA SITUATION

Following a large–scale malaria eradication campaign, malaria was almost forgotten as a public health problem in Azerbaijan during the 1960s; only 3 autochthonous cases of malaria were reported in 1967.

The malaria situation started to deteriorate after 1990, and in 1996, the number of cases reported rached 13 135. The malaria situation started to improve in 1997, and in 2000, only 1 526 cases of malaria were reported. The major reasons for the large–scale malaria epidemic included a sharp worsening of socio–economic conditions and the displacement of nearly one million people from war–stricken zones. Despite a decrease in the reported malaria incidence, the number of active foci of malaria in the country remains high. There was a futher decrease in the number of reported malaria cases during 2001.

III HOST COUNTRY STRATEGY

III.A. NATIONAL STRATEGY

Azerbaijan has committed itself to malaria control, and national health authorities, in collaboration with WHO, have developed the National Malaria Control Programme which is presently being implemented. The four elements of the Programme are as follows:

Disease Prevention: to plan and implement selective and sustainable preventive measures;
Disease Management: to provide early diagnosis and prompt treatment;
Epidemic Control: to detect early outbreaks and prevent the further spread of malaria epidemics;
Programme Management: to strengthen institutional capacities of the National Malaria Control Programme and surveillance mechanisms

III.B. INSTITUTIONAL FRAMEWORK FOR MALARIA CONTROL

The National Malaria Control Programme, as a major component of National Epidemiological Services, is responsible for technical guidance, planning, monitoring and evaluation of malaria control in the country. NMCP staff is comprised of parasitologists, entomologists, laboratory personnel and administrative staff. Several of these positions are presently vacant, particularly at the peripheral level. The diagnosis and treatment of malaria is considered part of primary health care system.

Currently, malaria control interventions consist mainly of disease management, training, surveillance and selective vector control.

III.C. PRIOR AND ONGOING ASSISTANCE

The WHO assistance focuses on strengthening the National Malaria Control Programme through technical back up, consultations, training and fellowships, provision of equipment/supplies and transport as well. ENI provided insecticides and equipment for spraying, antimalarial drugs and laboratory equipment/supplies, and also supported capacity building and staff recruitment. UNICEF and MSF-Belgium provided assistance for implemention of malaria control interventions during the past few years.

IV. PROJECT JUSTIFICATION

To sustain the results which have been achieved in the field of malaria control in Azerbaijan, the attempts are being undertaken to reduce further the incidence of malaria and prevent malaria outbreaks. The practical technical and operational modalities on dealing with malaria by specialized services and the public health sector as well as the community itself are the expected outcomes of the RBM Project, funded and implemented by the Government of Azerbaijan along with a number of international agencies/organizations. The project will have a strong but flexible management structure capable of mobilizing the partnership among the Ministry of Health, UN agencies and other donor agencies and countries and the media in implementing cost-effective but technically sound and sustainable malaria control adapted to the country's conditions and responding to local needs.

IV.A. PROBLEMS TO BE ADDRESSED

Problem I:
Concentration of malaria transmission particularly in low – land areas with poor access to existing health services could result in underreported malaria morbidity.

Problem II:
Shortages of insecticides and lack of intersectoral collaboration to implement bio – environmental measures for reducing mosquito breeding sites result in a limited impact on the malaria problem.

Problem III:
Under - equipped, under – staffed existing health facilities and under – paid public health personnel lead to the inadequate quality of disease management and prevention.

Problem IV:
Poor capacities for early diagnosis and prompt treatment of malaria result in inadequate coverage of people being at risk of malaria.

Problem V:
Lack of surveillance including inadequate reporting results in a distorted reflection of the extent of malaria problem in the country.

Problem VI:
Communities' lack of knowledge and skills to prevent themselves from getting malaria results in scant use of personal protective measures.

Problem VII:
Limited resources invested by the government and external donors result in lack of proper funding to cope with the malaria problem.

IV.B. TARGET LOCATIONS AND INTENDED BENEFICIARIES

During 2002-2005, assistance is to be provided for districts where malaria cases have been reported in recent years: Agdam, Agdash, Agjabadi, Adjigabul, Agstafa, Apsheron, Astara, Akhsu, Barda, Beylegan, Balaken, Belosuvar, Goychay, Goranboy, Gobustan, Djalilabad, Davachi, Yevlakh, Zagatala, Zardab, Imishli, Ismayilli, Gafgaz, Gakh, Gurdamir, Lachin, Lenkeran, Masalli, Neftechala, Oguz, Saatly, Sabirabad, Salyan, Samukh, Ter-ter, Udjar, Fizuli, Khachmaz, Khizi, Sheki and Shamakhi(*see Annex 2*). Project areas are mostly situated in areas with poorly developed health infrastructure and communication. In general, the target beneficiaries will be about 1.5 million indigenous people and migrants entering there for various reasons.

IV.C. SUCCESS IMPACT INDICATORS

A base–line survey conducted in project areas will provide an assessment of the malaria – related problems and needs at the beginning of the project, whereas a terminal evaluation at the end of project will bring to light improvements in the malaria situation which have occurred as a result of project interventions.

In the short term, the project is likely to contribute to the prevention of malaria outbreaks and a further reduction in the number of active foci/cases of malaria and prevent the re–establishment of new foci of malaria. Sustaining project activities beyond 2005 could reduce the impact of malaria to levels low enough to no longer represent a public health problem.

V. PROJECT STRATEGY AND PRIORITY INTERVENTIONS

The above will be addressed by actions in specific priority areas, all of which are in line with the following strategic components of the project and incorporated into the four elements of the National Action Plan for Malaria Control and Prevention:

Component I: **STRENGTHENING INSTITUTIONAL CAPACITIES OF THE NATIONAL MALARIA CONTROL PROGRAMME AND GENERAL HEALTH SERVICES AND ENHANCING CAPACITY FOR DECISION-MAKING RELATED TO MALARIA AND ITS CONTROL/PREVENTION**

To be effective, the national plan of action for malaria prevention and control should be implemented through properly organized and managed specialized and general health services. To facilitate the execution of the RBM project in Azerbaijan, some important aspects in the implementation and management of malaria prevention and control programme, notably responsibility, authority and accountability for work done, resources used and outputs/outcomes produced at all levels should be reviewed. To provide technical and operational guidance in a satisfactory manner, health staff of specialized health services should be trained in programme management. Technical assistance and back–up will be provided by WHO personnel.

Component II: **BUILDING UP/PROMOTING RBM PARTNERSHIPS**

RBM will address malaria as a priority health issue within the context of sustainable health sector development in Azerbaijan. WHO will provide strategic direction, coordination and technical/financial support for malaria control interventions under RBM. Other partners involved in the RBM Project will mobilize additional funds for RBM interventions.

Component III: **IMPROVING CAPACITIES FOR & ACCESS TO EARLY DIAGNOSIS AND ADEQUATE TREATMENT OF MALARIA**

An established and properly functioning system for the identification of cases, reliable and early diagnosis, effective and prompt treatment, and follow-up of treatment results all comprise fundamental parts of the project. Since microscopic examination remains the most reliable and least expensive way to diagnose malaria, diagnostic laboratory facilities will be upgraded within project areas. Dip Stick-like technologies with algorithms for the simple and labour-saving diagnosis of malaria should be introduced on a pilot basis to make the diagnosis of malaria adequate even at the most peripheral levels.

Component IV: **IMPROVING CAPACITIES FOR TIMELY RESPONSE TO AND PREVENTION OF MALARIA EPIDEMICS**

All epidemic-prone areas and situations will be identified and forecasted. Emergency preparedness for and mechanisms of response to malaria epidemics will be improved. Contingency plans for epidemic control, including indoor spraying, will be worked out and a reserve of drugs, insecticides and spraying equipment will be maintained for rapid deployment. To contain an outbreak, selective residual spraying would be applied to the active foci of malaria within project areas.Basic Health Staff will be trained to recognize epidemic situations and build up community preparedness.

Component V: **PROMOTING COST-EFFECTIVE AND SUSTAINABLE VECTOR CONTROL**

To reduce transmission of malaria and its incidence, biological vector control measures and water management interventions will be applied in project districts. The use of personal protective measures including impregnated mosquito nets, curtains and repellents will be encouraged through health education. The appropriate approaches to communicate messages on malaria prevention directly to high-risk groups will be developed. All the above preventive measures will be guided by consideration of technical and operational feasibility, effectiveness and sustainability.

Component VI: **CAPACITY BUILDING**

Training is a key component of the project. In–service training in disease management and prevention will be conducted for all categories of specialized programme and public health personnel within project areas. Laboratory personnel will be trained in malaria microscopy. Basic training will be supplemented by regular supervision and refresher training courses. The training will be practical in nature and directed towards developing skills and competence.

Component VII: **REINFORCING RBM COUNTRY SURVEILLANCE MECHANISMS**

A base–line survey to assess problems and needs related to malaria will be carried out at the beginning of the project. Mechanisms for the regular collection, processing and analysis of operational, epidemiological and socio-economic data relevant to planning/re-planning, implementation, monitoring and evaluation of the project activities will be built in. The existing reporting and information system will be improved. Survey data will provide a systematic way to determine whether the project approaches and interventions and other inputs are appropriate and sufficient to achieve the stated targets and objectives.

Component VIII: **INCREASING COMMUNITY AWARENESS PARTICIPATION IN MALARIA CONTROL/PREVENTION**

The involvement of communities and their partnership with the formal and informal health sectors to empower them in their own health development is crucial. People should be educated in malaria and its control/prevention and have access to adequate health care facilities. Existing treatment practices will be improved through the development and dissemination of clear messages on malaria and its treatment. Community and family care and preventive practices will be strengthened through the provision of IEC materials, capacity building, traditional/mass media and community support. KAP assessments will be conducted on ways to promote compatibility of practices, customs and beliefs of various social groups and minorities with existing malaria control/prevention options, and to develop effective IEC strategies and targeted materials.

Component IX: **STRENGTHENING RESEARCH CAPABILITIES**

Operational research is essential for the planning, implementation and evaluation of the project activities, and this will comprise an integral part of the project. Such research will address not only the planning and effectiveness of specific interventions, but also the cultural, behavioural, social and economic factors which could affect project interventions and outcomes.

Component X: **ENHANCING INTERSECTORAL COLLABORATION**

Additional resources for malaria control remain severely constrained. The social, economic and environmental problems posed by malaria exceed the jurisdiction and capabilities of the Ministry of Health. There is obviously a need for improved intersectoral collaboration, as well as for planning and information sharing, to see that additional funds are earmarked for malaria control. Such collaboration is best developed from a shared understanding of the underlying problems to be addressed. Information on development activities and the migration of organized and non-organized population groups will be collected and exchanged amongst all parties concerned. The Ministry of Health will stimulate the non-health sectors for active collaboration in malaria control, including the mobilization of additional funds. National multi–sectoral committees will promote coordination and collaboration in malaria control amongst all concerned.

VIII. PROJECT OBJECTIVES, ACTIVITIES AND OUTPUTS

VI.A. DEVELOPMENT OBJECTIVE

The development objective is **to prevent malaria outbreaks, to reduce the incidence of malaria, and to minimize the socio–economic losses provoked by the disease** through the progressive strengthening of capacities and capabilities of health services and mobilizing community actions within the context of the Roll Back Malaria initiative in Azerbaijan.

VI.B. SPECIFIC OBJECTIVES, ACTIVITIES AND OPERATIONAL OUTPUTS

Specific Objective I:	**STRENGTHENED INSTITUTIONAL CAPACITIES OF THE NATIONAL MALARIA CONTROL PROGRAMME AND GENERAL HEALTH SERVICES, AS WELL AS ENHANCED CAPACITY FOR DECISION-MAKING RELATED TO MALARIA AND ITS CONTROL AND PREVENTION**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To render technical and managerial expertise and back-up for the RBM Project	WHO short-term consultants recruited and expert advice given wherever required	2002-2005	WHO	USD 60 000
2. To train/retrain Regional/District Health Directors in programme management to improve capacities for planning and implementation of the project activities	Regional/District Health Directors involved in the project trained	2002-2005	MoH/NMCP WHO UN Agencies Others	USD 20 000
3. To train/retrain selected Regional/District Medical Officers in existing approaches to disease management, epidemic control and community mobilization	Regional/District MOs in project areas trained	2002-2005	MoH/NMCP WHO UN agencies Others	USD 60 000
	Selected entomologists trained	2002-2005	MoH/NMCP WHO Others	USD 10 000
4. To train selected entomologists	Selected NMCP personnel trained abroad	2002-2005	WHO MoH/NMCP	USD 40 000
5. To support international training selected NMCP personnel in malaria and its control				**TOTAL: USD 190 000**

Specific Objective II:	**BUILDING RBM ADVOCACY AND PARTNERSHIP**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To identify partners and conduct RBM advocacy through workshops and meetings; message development to obtain broad, inter-sectoral commitment at different levels in the country **2. To follow up RBM Partnership actions at country level**	Partners identified Targeted RBM advocacy activities conducted among various partners at all levels RBM Partnership actions followed up	2002-2005 2002-2005	MoH/NMCP WHO UN agencies NGOs Informal Sector Media Others MoH/NMCP WHO UN Agencies NGOs Others	USD 20 000 USD 20 000 **TOTAL: USD 40 000**

Specific Objective III:	**IMPROVED CAPACITIES FOR AND ACCESS TO EARLY DIAGNOSIS AND RADICAL TREATMENT OF MALARIA**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. **To select and train/retrain laboratory staff in malaria microscopy**	Laboratory staff trained/retrained	2002-2005	MoH/NMCP WHO UN agencies Others	USD 40 000
2. To upgrade laboratory facilities in selected health centres	Health facilities upgraded	2002-2005	MoH/NMCP WHO NGOs	To be borne by MoH
3. **To set up supervision and quality control systems of laboratory services and ensure their functionality**	Systems set up and functioning	2002–2005	MoH/NMCP WHO Others	USD 30 000
4. To set up a system for the assessment of the quality of care and ensure its functionality	System set up and functioning	2002–2005	MoH/NMCP WHO Others	USD 30 000
5. **To develop/modify/produce training/learning materials on disease management and prevention**	Materials developed and produced	2002-2005	MoH/NMCP WHO UN agencies Others	USD 60 000
6. **To train health personnel in case management**	Health personnel trained	2002–2005	MoH/NMCP UN agencies WHO Others	USD 40 000
7. To procure and distribute laboratory equipment/supplies and drugs/otherdiagnostic items required for disease management	Equipment and supplies procured and distributed	2002-2005	MoH/NMCP UN agencies Others	USD 160 000 **TOTAL: USD 360 000**

Specific Objective IV:	**PROMOTING COST-EFFECTIVE AND SUSTAINABLE VECTOR CONTROL**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
To promote cost-effective vector control measures:				
1. To identify priority target areas and population groups by means of microstratification	Areas and groups identified	2002-2005	MoH/NMCP WHO	To be borne by MoH
2. **To procure and deliver equipment/supplies for vector control**	Equipment and supplies procured and delivered	2002-2005	MoH/NMCP UN Agencies Others	USD 280 000
3. To establish implementation mechanisms and ensure their functionality	Implementation mechanisms established and functioning	2002–2005	MoH/NMCP UN Agencies WHO Others	USD 100 000
4. **To undertake monitoring and evaluation of measures applied**	Monitoring and evaluation undertaken	2002–2005	MoH/NMCP WHO Others	USD 20 000
				TOTAL: USD 400 000

Specific Objective V:	**IMPROVED CAPACITIES FOR TIMELY RESPONSE TO AND PREVENTION OF MALARIA OUTBREAKS**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. **To develop monitoring mechanisms for the detection/forecasting of epidemic risk factors**	Monitoring mechanisms developed	2002-2003	WHO MoH/NMCP	USD 10 000 To be covered by MoH/NMCP together with WHO
2. To update NPS operational guidelines and procedures related to the detection and control of epidemics	Operational guidelines and procedures updated	2002-2003	MoH/NMCP WHO	To be borne by MoH
3. **To improve emergency preparedness for and response to malaria epidemics in project areas where outbreaks are a recurring problem**	Emergency preparedness for and response to malaria outbreaks improved	2002–2005	MoH/NMCP	To be borne by MoH
4. To procure and deliver insecticides/equipment for spraying and other items	Insecticides/equipment for spraying and other items procured and delivered	2002–2005	MoH/NMCP UN agencies Others	USD 400 000
5. **To apply indoor residual spraying in cases of emergency**	Residual spraying applied	2002-2005	MoH/NMCP	To be borne by MoH
6. **To train health personnel in epidemic control with emphasis on vector control**	Health personnel trained	2002–2005	MoH/NMCP WHO Others	USD 60 000
				TOTAL: USD 470 000

Specific Objective VI:	**STRENGTHENED RBM COUNTRY SURVEILLANCE MECHANISMS**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To survey to assess needs and problems related to malaria and impact assessment survey	Base–line survey and impact surveys carried out	2002-2005	MoH/NMCP WHO	USD 10 000
2. To identify operational and epidemiological indicators needed for monitoring/evaluation of project activities	Operational and epidemiological indicators identified	2002	MoH/NMCP WHO	To be covered by WHO Consultant
3. To train personnel of NMCPs in data collection, processing and analysis	Personnel of NMCPs trained	2002–2005	MoH/NMCP WHO UN agencies Others	USD 30 000
***4.* To establish and maintain the project operational and epidemiological database**	Operational and epidemiological database established and maintained	2002–2005	MoH/NMCP	To be borne by MoH
	Reporting and information systems improved	2002–2005	MoH/NMCP WHO	To be borne by MoH
5. To improve the existing reporting and information systems	Transportation, equipment and supplies procured	2002–2005	MoH/NMCP WHO UN agencies Others	USD 30 000
***6.* To procure project transport, equipment and supplies to improve supervision and monitoring of project activities at all levels**	Monitoring undertaken	2002-2005	MoH/NMCP WHO NGOs	USD 30 000
***7.* To undertake monitoring of project activities**				**TOTAL: USD 100 000**

Specific Objective VII:	**INCREASED COMMUNITY AWARENESS AND PARTICIPATION IN MALARIA CONTROL AND PREVENTION**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To strengthen community and family care and prevention practices through providing IEC materials, awareness raising sessions, community support, skills building and mass media	Malaria care and prevention practices strengthened	2002–2005	MoH/NMCP UN agencies WHO Community Others	USD 160 000
2. Rapid assessments on practices of recognition and treatment of malaria and personal protection conducted in order to develop effective IEC strategy	KAP designed and conducted	2002	MoH/NMCP UN agencies WHO Community Others	USD 5 000
3. To build IEC service capacity, including development of targeted IEC materials and IEC management and monitoring	Targeted IEC materials developed; IEC campaign implemented and monitored	2002-2005	MoH/NMCP UN agencies WHO Media Others	USD 100 000 **TOTAL: USD 265 000**

Specific Objective VIII:	**STRENGTHENED CAPABILITIES FOR OPERATIONAL RESEARCH**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To design research protocols, carry out studies and prepare final reports	Protocols designed, studies conducted and final reports prepared	2002-2005	MoH/NMCP WHO Research Institutions Others	USD 30 000 **TOTAL: USD 30 000**

Specific Objective XI:	**ENHANCED INTERSECTORAL COLLABORATION**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To set up a National Multi–Sectoral Committee and ensure its functionality	National Multi–Sectoral Committee established and functioning	2002-2005	MoH/NMCP GOs WHO	To be borne by the Government
2. To define situations where collaboration is needed and establish mechanisms to promote collaboration within the project areas	Situations defined and mechanisms established	2002–2005	MoH/NMCP GOs	To be borne by the Government
3. To coordinate the exchange of information about all development activities relevant to malaria within the project areas	An effective system of communication on malaria between health and non-health sectors established and exchange of information coordinated	2002–2005	MoH/NMCP GOs	To be borne by the Government
4. To identify and mobilize additional resources required for malaria control from non-health sectors	Additional resources identified and mobilized	2002-2005	MoH/NMCP GOs	To be borne by the Government

IX. PROJECT MANAGEMENT AND TIMEFRAME

The project will be implemented by the Ministry of Health and the National Malaria Control Programme, with technical and financial provided by WHO and other potential donors and partners. The project management structure is as outlined below.

At the inter–country level: The focal point for the project (Director/Project Manager of Malaria Control and Prevention Services) will be responsible for the planning, implementation and evaluation of project activities and its coordination with neigbouring countries in border areas.

At the central country level: The National Malaria Control Programme will be responsible for the implementation of project activities. The Director of NMCP/Project Manager will work in close consultation with the Ministry of Health. Personnel of NMCP will undertake field visits to supervise the performance of work carried out in the field. WHO consultants will be recruited to assist in the planning and evaluation of project activities. Implementation of some project activities, such as training, health education, community–based activities and other interventions would be sub–contracted.

At the regional/district country levels: Focal points for the project (Chiefs of Regional/District Malaria Control Services) will be designated for better communication and coordination between the central and district levels. Staff of Regional/District malaria control services will be responsible for all project–related activities in their respective areas. Technical advice will be provided by specialized regional/district health personnel dealing with malaria issues.

WHO will provide overall technical backstopping and strategic coordination of project activities with UN agencies and others concerned. The project will be implemented in full consultation with all agencies and organizations involved in order to enhance coordination and maximize the impact of assistance. The project is planned for a period of four years (2002-2005).

VIII. PROJECT MONITORING AND EVALUATION

Monitoring and evaluation will be a critical and continuous process of reviewing the progress of the project and its problems and constraints, with the sole purpose of identifying the required areas of action for enhanced effectiveness of the project. Comprehensive monitoring and evaluation will be carried out by the National Implementing Agency, in collaboration with WHO/EURO, at regular intervals. An impact assessment survey will be carried out at the conclusion of the project. Monitoring and evaluation will be based on the participation of all stakeholders.

WHO/EURO will provide technical clearance of the Project Document prior to the start of the project. Project management will prepare a project implementation plan during the first month of the start the project. The project will be subject to annual reviews and reporting. The project's final draft will be prepared in advance to allow review and technical clearance by WHO. Project management will be responsible for the preparation and submission of the project evaluation reports. Specific monitoring and evaluation methods, schedules and indicators will be developed for the project at the time of its inception (s*ee Annex 3.)*

IX. RISKS

The implementation of the RBM strategy in Azerbaijan could entail some risk. The implementation and management of the project should be reviewed periodically to ensure that it remains on track.

A continuous flow of inputs from different UN agencies and other donors is critical to the success of the RBM Project in Azerbaijan. There is some risk that the funding agencies would not be able to provide and/or sustain the level of inputs required to ensure a visible project impact. **Should the amount of funding provided prove insufficient, the scope of project activities will be limited.**

X. PROJECT BUDGET

The total project budget, estimated at ***USD 1 987 000*** , would be contributed by the government, WHO and other potential partners/donors *(See Table 1 below)*. The government will cover operational costs of the existing NMCP/public health staff to be involved in the implementation of project activities.

Table 1 **Estimated project budget for 2002-2005**

DESCRIPTION	*2002* *USD*	*2003* *USD*	*2004* *USD*	*2005* *USD*
Technical Expertise:				
International Experts	15 000	15 000	15 000	15 000
Duty Travel	10 000	10 000	10 000	10 000
Sub-Total:	**25 000**	**25 000**	**25 000**	**25 000**
Equipment - Expendable:				
Drugs & Laboratory supplies	20 000	20 000	20 000	20 000
Diagnostic kit supplies	10 000	10 000	10 000	10 000
Supplies/equipment for vector control	70 000	70 000	70 000	70 000
Insecticides/equipment and other items for epidemic control	90 000	90 000	90 000	90 000
Equipment - Non-Expendable:				
Laboratory Equipment	20 000	20 000	20 000	20 000
Transportation	5 000	5 000	5 000	5 000
Office Equipment/Supplies	5 000	-	5 000	-
Sub-Total:	**220 000**	**215 000**	**220 000**	**215 000**
Quality Assessments/Assurance:				
Care Quality Assessments	7 500	7 500	7 500	7 500
Supervision and quality control of laboratory service	7 500	7 500	7 500	7 500
Problems And Needs Assessments	5 000			
KAP Study/ IEC Service Capacity Building	30 000	25 000	25 000	25 000
Implementation Cost	25 000	25 000	25 000	25 000
RBM Advocacy & Partnership Building/Foll ow ups	10 000	10 000	10 000	10 000
Impact Assessment				5 000
Training:				
In–service training:				
Development & production of training materials	20 000	20 000	20 000	-
Central and intermediate level training	30 000	20 000	20 000	20 000
Peripheral level training for public health personnel	50 000	40 000	40 000	40 000
International Training:				
Training in malaria and its control	10 000	10 000	10 000	10 000
Operational Research	10 000	10 000	10 000-	-
Community Capacity Building	40 000	40 000	40 000	40 000
Monitoring/Evaluation	15 000	15 000	15 000	15 000
Miscellaneous:				
Operation & Maintenance	2 000	2 000	2 000	2 000
Sundries	1 000	1 000	1 000	1 000
TOTAL:	**508 000**	**473 000**	**478 000**	**448 000**

ANNEXES

Annex 1: **The malaria situation in Azerbaijan, 1995–2000**

	1995	1996	1997	1998	1999	2000
Autochthonous malaria	**2 840**	**13 135**	**9 911**	**5 175**	**2 312**	**1526**
Imported cases	**0**	**0**	**0**	**0**	**4**	**0**
Plasmodium vivax	**2 840**	**13 135**	**9 911**	**5 175**	**2 312**	**1526**
Plasmodium falciparum	**0**	**0**	**0**	**0**	**3**	**0**
Mixed infections	**0**	**0**	**0**	**0**	**0**	**0**
Total number of malaria cases	**2 840**	**13 135**	**9 911**	**5 175**	**2 312**	**1 526**

Annex 2: **RBM project areas in Azerbaijan, 2002 - 2005**

The project's targeted beneficiaries will be nearly 1.5 million indigenous people and migrants entering the districts of Agdam, Agdash, Agjabadi, Adjigabul, Agstafa, Apsheron, Astara, Akhsu, Barda, Beylegan, Balaken, Belosuvar, Goychay, Goranboy, Gobustan, Djalilabad, Davachi, Yevlakh, Zagatala, Zardab, Imishli, Ismayilli, Gafgaz, Gakh, Gurdamir, Lachin, Lenkeran, Masalli, Neftechala, Oguz, Saatly, Sabirabad, Salyan, Samukh, Ter-ter, Udjar, Fizuli, Khachmaz, Khizi, Sheki and Shamakhi.

Annex 3: **Monitoring and evaluation indicators**

Output (*process*) indicators:

- ***Percentage of project areas with an adequate amount of learning and IEC materials***
- ***Percentage of project areas with adequately advocated/trained people***
- ***Percentage of project areas provided with adequate quantities of equipment, drugs, insecticides, mosquito nets and other supplies***
- ***Percentage of project areas under regular supervision of indoor residual spraying/malaria diagnosis and treatment/laboratory services***
- ***Percentage of project areas/population under surveillance***
- ***Type and volume of operational research planned and conducted***

Outcome indicators:

- ***Percentage of project areas where vector control operations (indoor residual spraying and/or antilarval measures and/or the use of impregnated mosquito nets) have been correctly applied and all active foci are covered by the above – mentioned interventions***
- ***Percentage of project areas where more than 75 % of patients are diagnosed/treated correctly in the formal and informal sectors***
- ***Percentage of project areas where more than 75 % of formal/informal care providers use updated knowledge and built–up skills in diagnosis and treatment/management of malaria***
- ***Percentage of project areas where more than 75 % of households, families and mothers are knowledgeable about symptoms/diagnosis/treatment/referral and are capable of providing appropriate self–diagnosis***

Impact indicators (*to estimate the effect of large-scale interventions within project areas*):

- ***As a result of improved coverage and quality of vector control (indoor residual spraying, larviciding, and biological control measures):***
  A decrease in the incidence/prevalence of P. vivax infection/disease
  Prevention of malaria outbreaks
  Prevention of re-establishment of transmission of P. vivax malaria
- ***As a result of improved coverage and quality of diagnosis and radical treatment of P. vivax:***
  Prevention of relapses of P. vivax malaria

ROLL BACK MALARIA
PROJECT DOCUMENT

MINSTRY OF HEALTH
REPUBLIC OF GEORGIA

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

Title:	**The Roll Back Malaria Project**
Duration:	**4 years, January 2002 – December 2005**
Project Sites:	**Selected areas: Shida, Kvemo Kartli, Kakheti, Tskhinvali and Samtskhe – Javakheti in the eastern part of the country and Guria, Adjara, Abkhzeti, Samagrelo, Imereti and Racha – Lechkhumi in the western part of Georgia**
Intended Beneficiaries:	**About 3.0 million indigenous people and migrants**
Requesting Agency:	**WHO**
Govt. Cooperating Agency:	**Ministry of Health, Georgia**
Estimated Starting Date:	**January 2002**
Estimated Project Budget:	**2002:** ***USD 378 000*** **2003:** ***USD 343 000*** **2004:** ***USD 348 000*** **2005:** ***USD 313 000*** **TOTAL** (*2002-2005*)**:** ***USD 1 382 000***

BRIEF DESCRIPTION

From 1998, the malaria situation in Georgia began to deteriorate rapidly, and by 2001, the number of malaria cases had reached nearly 500. The malaria situation is now assuming epidemic dimensions in the country. The National Malaria Control Programme is at present implemented by the government, with technical and financial support provided by WHO. Activities consist mostly of disease management and prevention, training and surveillance. The limited resources invested by the government and external partners results in a lack of funding at levels sufficient to cope with the malaria problem in the country.

The RBM Project will support Georgia in building partnerships and working together in the promotion of health related actions to contain ongoing outbreaks of malaria and reduce the incidence of malaria in the country. The project will focus on addressing malaria related issues through capacity building, improving capacities for and access to early diagnosis/adequate treatment and timely response to and prevention of malaria outbreaks, reinforcing surveillance mechanisms, and increasing community awareness and involvement in malaria prevention. Implementation of the RBM Project will be a collaborative effort of the Ministry of Health in cooperation with WHO and other potential partners/donors. The project is planned for an initial period of four years (2002-2005). The project will have a strong but flexible management structure capable of mobilizing the partnership among UN agencies and NGOs, as well as the media and other partners/donors in implementing cost–effective but technically sound and sustainable malaria control adapted to the country's conditions and responding to local needs.

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IV. HISTORICAL CONTEXT

The new Director General of WHO committed herself to an intensive response to the global malaria burden, and in January 1998, the *Roll Back Malaria Initiative (RBM)* was proposed. A global coalition to Roll Back Malaria, characterized by strategic synergy, co-ordinated efforts, and science-based strategies, was proposed at the World Health Assembly in 1998. The Global Partnership to RBM, consisting of WHO, UNICEF, UNDP, World Bank and a group of national government representatives, heads of bilateral donor organizations, representatives of the private sector, and non-governmental bodies was formally established in December 1998. Members of the Global RBM Partnership are committed to supporting country-level efforts led by national authorities within the context of their multi-sectoral strategies for development and poverty alleviation.

An explosive malaria epidemic has been the result of a disruption of the capacity and capability of both government and community to implement appropriate malaria control. The malaria situation started to deteriorate after 1998, and the reported number of cases reached nearly 500 in 2001. The malaria situation is at present assuming epidemic dimensions in the country (*see Annex 1*).

A WHO mission to build the Partnership for Roll Back Malaria in Georgia was undertaken in November 1999. However, neither adequate response nor sufficient financial assistance from partners/donors to cope with the malaria problem has been forthcoming. As a result of this, the number of malaria cases has risen and there are clear signs that the malaria situation has already begun to deteriorate. With the goal of eliciting financial assistance to tackle the growing malaria problem, an emergency RBM meeting was organized by WHO, along with the Ministry of Health, in December 2000. To promote partnerships for Roll Back Malaria in the Caucasian Republics and Turkey, a regional meeting was organized in Tbilisi, Georgia in November 2001. Commitment to build up a Sub–Regional RBM Partnership was the main outcome of this meeting. It was recommended to draw up RBM project proposals and submit them to potential donors and partners for consideration in early 2002. The RBM Sub–Regional and Country Projects will support the countries in partnership building and working together in the promotion and coordination of health sector actions to reduce the incidence of malaria, to prevent malaria outbreaks, and to prevent the further spread of malaria across the countries.

The malaria control programme in Georgia is funded by the Government and WHO. However, at present, the resources invested for malaria control by the Government and external donors are limited, and the country is in need of additional external assistance to cope with the malaria problem.

II CURRENT MALARIA SITUATION

Following a large–scale malaria eradication campaign, malaria completely disappeared in Georgia in 1970. Between 1970 and 1995, 139 cases of *P. vivax* malaria were reported among residents in the border region with Azerbaijan. Since then, the number of autochthonous cases of malaria has continued to rise, and 245 cases were reported in 2000. In 2001, the malaria situation continued to deteriorate, and almost 500 cases were reported in the country. The re–introduction of malaria transmission and the occurrence of autochthonous cases in the western part of the country were additional aggravating factors of the malaria situation in Georgia in 2001.

The conditions favorable for malaria transmission exist in nearly 52% of the entire territory of the country, in which approximately 93% of the total population resides. Thus, almost the entire population of the country lives in areas at risk of malaria.

III HOST COUNTRY STRATEGY

III.A. NATIONAL STRATEGY

Georgia has committed itself to malaria control and the national health authorities, in collaboration with WHO, developed the National Malaria Control Programme which is presently being implemented. The four elements of the Programme are as follows:

Disease Prevention: to plan and implement selective and sustainable preventive measures;
Disease Management: to provide early diagnosis and prompt treatment;
Epidemic Control: to detect early outbreaks and prevent the further spread of malaria epidemics;
Programme Management: to strengthen institutional capacities of the National Malaria Control Programme and surveillance mechanisms

III.B. INSTITUTIONAL FRAMEWORK FOR MALARIA CONTROL

The National Malaria Control Programme, as a major component of the National Centre for Disease Control, is responsible for technical guidance, planning, monitoring and evaluation of malaria control in the country. NMCP staff is comprised of parasitologists, entomologists, laboratory personnel and administrative staff. Several of these positions are presently vacant, particularly at peripheral levels. The diagnosis and treatment of malaria are considered part of primary health care system.

Currently, malaria control interventions consist mainly of disease management and prevention, training and surveillance.

III.C. PRIOR AND ONGOING ASSISTANCE

WHO assistance focuses on strengthening the National Malaria Control Programme through technical back-up, consultation, training and fellowships, and the establishment of mobile RBM teams, along with the provision of insecticides, equipment for indoor residual spraying, antimalarial drugs, laboratory equipment and supplies, office equipment and transport.

IV. PROJECT JUSTIFICATION

To cope with the growing problem of malaria, the attempts are being undertaken to contain the ongoing outbreak of malaria and its spread across the country. The practical technical and operational modalities on dealing with malaria by specialized services and the public health sector, as well as the community itself, are the expected outcomes of the RBM Project, funded and implemented by the Government of Georgia along with a number of international agencies/organizations. The project will have a strong but flexible management structure capable of mobilizing the partnership amongst the Ministry of Health, UN agencies and other donor agencies and countries and the media in implementing cost-effective but technically sound and sustainable malaria control adapted to the country's conditions and responding to local needs.

IV.A. PROBLEMS TO BE ADDRESSED

Problem I:
The concentration of malaria transmission in areas bordering Azerbaijan, with poor access to existing health services, and its further spread across the country could result in underreported morbidity.

Problem II:

Shortages of insecticides and lack of intersectoral collaboration to implement bio–environmental measures for reducing mosquito breeding sites result in a limited impact on the malaria problem.

Problem III:
Existing health facilities are under-equipped and under–staffed, and public health personnel are often underpaid, thus leading to an inadequate quality of disease management and prevention.

Problem IV:
Poor capacities for early diagnosis and prompt treatment of malaria result in inadequate coverage of people at risk of malaria.

Problem V:
A lack of surveillance activities, including inadequate reporting, results in a distorted reflection of the extent of the malaria problem in the country.

Problem VI:
Communities' lack of knowledge and skills to prevent themselves from getting malaria result in scant use of personal protective measures.

Problem VII:
Limited resources invested by the government and external donors result in lack of funding at levels sufficient to cope with the malaria problem.

IV.B. TARGET LOCATIONS AND INTENDED BENEFICIARIES

During 2002-2005, assistance should be provided for selected areas of Shida, Kvemo Kartli, Kakheti, Tskhinvali and Samtskhe – Javakheti in the eastern part of the country, as well as Guria, Adjara, Abkhzeti, Samagrelo, Imereti and Racha – Lechkhumi in the western part of Georgia(*see Annex 2*). Project areas are mostly situated in the valleys, foothills and plains, and often have poorly developed health infrastructure and communication systems. In general, the target beneficiaries will be 3.0 million indigenous people and migrants entering there for various reasons.

IV.C. SUCCESS IMPACT INDICATORS

A base–line survey conducted in project areas will provide an assessment of the malaria–related problems and needs at the beginning of the project whereas a terminal evaluation at the end of project will bring to light improvements in the malaria situation which have occurred as a result of project interventions.

In the short term, the project is likely to contain ongoing outbreaks of malaria, reduce the number of active foci/cases of malaria, and prevent the re–establishment of new foci of malaria. Sustaining the project activities beyond 2005 could reduce the impact of malaria to a low level sufficient to no longer represent a public health problem.

X. PROJECT STRATEGY AND PRIORITY INTERVENTIONS

The above will be addressed by actions in specific priority areas, all of which are in line with the following strategic components of the project and incorporated into the four elements of the National Action Plan for Malaria Control and Prevention:

Component I: **STRENGTHENING INSTITUTIONAL CAPACITIES OF THE NATIONAL MALARIA CONTROL PROGRAMME AND GENERAL HEALTH SERVICES AND ENHANCING CAPACITY FOR DECISION-MAKING RELATED TO MALARIA AND ITS CONTROL/PREVENTION**

To be effective, the national plan of action for malaria prevention and control should be implemented through properly organized and managed specialized and general health services. To facilitate the execution of the RBM project in Georgia, some important aspects in the implementation and management of the malaria prevention and control programme, notably responsibility, authority and accountability for work done, resources used and outputs/outcomes produced at all levels, should be reviewed. To provide technical and operational guidance in a satisfactory manner, health staff of specialized health services should be trained in programme management. Technical assistance and back–up will be provided by WHO personnel.

Component II: **BUILDING UP RBM PARTNERSHIPS**

RBM will address malaria as a priority health issue within the context of sustainable health sector development in Georgia. WHO will provide strategic direction, coordination and technical/financial support for malaria control interventions under RBM. Other partners involved in the RBM Project will mobilize additional funds for RBM interventions.

Component III: **IMPROVING CAPACITIES FOR & ACCESS TO EARLY DIAGNOSIS AND ADEQUATE TREATMENT OF MALARIA**

An established and properly functioning system for the identification of cases, reliable and early diagnosis, effective and prompt treatment, and follow-up of treatment results, all comprise fundamental parts of the project. Since microscopic examination remains the most reliable and least expensive way to diagnose malaria, diagnostic laboratory facilities will be upgraded within project areas. Dip Stick-like technologies with algorithms for the simple and labor-saving diagnosis of malaria should be introduced on a pilot basis to make diagnosis of malaria adequate even at the most peripheral levels.

Component IV: **IMPROVING CAPACITIES FOR TIMELY RESPONSE TO AND PREVENTION OF MALARIA EPIDEMICS**

All epidemic-prone areas and situations will be identified and forecasted. Emergency preparedness for and mechanisms of response to malaria epidemics will be improved. Contingency plans for epidemic control, including indoor spraying, will be worked out and a reserve of drugs, insecticides and spraying equipment will be maintained for rapid deployment. To contain an outbreak, selective residual spraying will be applied to the active foci of malaria within project areas. Basic Health Staff will be trained to recognize epidemic situations and build up community preparedness.

Component V: **CAPACITY BUILDING**

Training is a key component of the project. In–service training in disease management and prevention will be conducted for all categories of specialized programme and public health personnel within project areas. Laboratory personnel will be trained in malaria microscopy. Basic training will be supplemented by regular supervision and refresher training courses. The training will be practical in nature and directed towards developing skills and competence.

Component VI: **REINFORCING RBM COUNTRY SURVEILLANCE MECHANISM**

A base–line survey to assess problems and needs related to malaria will be carried out at the beginning of the project. Mechanisms for the regular collection, processing and analysis of operational, epidemiological and socio-economic data relevant to planning/re-planning, implementation, monitoring and evaluation of the project activities will be built in. The existing reporting and information system will be improved. The survey data will provide a systematic way to determine whether the project approaches and interventions and other inputs are appropriate and sufficient to achieve the stated targets and objectives.

Component VII: **INCREASING COMMUNITY AWARENESS AND PARTICIPATION IN MALARIA CONTROL/PREVENTION**

The involvement of communities and their partnership with the formal and informal health sectors to empower them in their own health development is crucial. People should be educated in malaria and its control/prevention and have access to adequate health care facilities. Existing treatment practices will be improved through the development and dissemination of clear messages on malaria and its treatment. Community and family care and preventive practices will be strengthened through the provision of IEC materials, capacity building, traditional/mass media and community support. KAP assessments will be conducted on ways to promote compatibility of practices, customs and beliefs of various social groups and minorities with existing malaria control/prevention options, and to develop effective IEC strategies and targeted IEC materials.

Component VIII: STRENGTHENING RESEARCH CAPABILITIES

Operational research is essential for the planning, implementation and evaluation of the project activities, and this will comprise an integral part of the project. Such research will address not only the planning and effectiveness of specific interventions, but also cultural, behavioural, social and economic factors that might affect project interventions and outcomes.

Component IX: ENHANCING INTERSECTORAL COLLABORATION

Additional resources for malaria control remain severely constrained. The social, economic and environmental problems posed by malaria exceed the jurisdiction and capabilities of the Ministry of Health. There is obviously a need for improved intersectoral collaboration, as well as for planning and information sharing, to ensure that additional funds are earmarked for malaria control. Such collaboration is best developed from a shared understanding of the underlying problems to be addressed. Information on development activities and the migration of organized and non-organized population groups will be collected and exchanged amongst all parties concerned. The Ministry of Health will stimulate the non-health sectors for active collaboration in malaria control, including the mobilization of additional funds. National multi–sectoral committees will promote coordination and collaboration in malaria control among all concerned.

XI. PROJECT OBJECTIVES, ACTIVITIES AND OUTPUTS

VI.A. DEVELOPMENT OBJECTIVE

The development objective **is to contain ongoing outbreaks of malaria, to reduce the incidence of malaria, and to minimize socio–economic losses provoked by the disease** through the progressive strengthening of capacities and capabilities of health services and mobilizing community actions within the context of the Roll Back Malaria initiative in Georgia.

VI.B. SPECIFIC OBJECTIVES, ACTIVITIES AND OPERATIONAL OUTPUTS

Specific Objective I:	**STRENGTHENED INSTITUTIONAL CAPACITIES OF THE NATIONAL MALARIA CONTROL PROGRAMME AND GENERAL HEALTH SERVICES, AS WELL AS ENHANCED CAPACITY FOR DECISION-MAKING RELATED TO MALARIA AND ITS CONTROL AND PREVENTION**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To render technical and managerial expertise and back-up for the RBM Project	WHO short-term consultants recruited and expert advice given wherever required	2002-2005	WHO	USD 80 000
2. To train/retrain Regional/District Health Directors in programme management to improve capacities for planning and implementation of the project activities	Regional/District Health Directors involved in the project trained	2002-2005	MoH/NMCP WHO UN Agencies Others	USD 20 000
3. To train/retrain selected Regional/District Medical Officers in existing approaches to disease management, epidemic control and community mobilization	Regional/District MOs in project areas trained	2002-2005	MoH/NMCP WHO UN agencies Others	USD 60 000
4. To train selected entomologists	Selected entomologists trained	2002-2005	MoH/NMCP WHO Others	USD 10 000
5. To provide international training for selected NMCP personnel in malaria and its control	Selected NMCP personnel trained abroad	2002-2005	WHO MoH/NMCP	USD 40 000
				TOTAL: USD 210 000

Specific Objective II:	**BUILDING UP RBM ADVOCACY AND PARTNERSHIP**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To identify partners and conduct RBM advocacy through workshops and meetings; message development to obtain broad, inter-sectoral commitment at different levels in the country	Partners identified Targeted RBM advocacy activities conducted among various partners at all levels	2002-2005	MoH/NMCP WHO UN agencies NGOs Informal Sector Media Others	USD 20 000
2. To follow up RBM Partnership actions at country level	RBM Partnership actions followed up	2002-2005	MoH/NMCP WHO UN Agencies NGOs Others	USD 20 000
				TOTAL: USD 40 000

Specific Objective III:	**IMPROVED CAPACITIES FOR AND ACCESS TO EARLY DIAGNOSIS AND RADICAL TREATMENT OF MALARIA**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To select and train/retrain laboratory staff in malaria microscopy	Laboratory staff trained/retrained	2002-2005	MoH/NMCP WHO UN agencies Others	USD 40 000
2. To upgrade laboratory facilities in selected health centres	Health facilities upgraded	2002-2005	MoH/NMCP WHO NGOs	To be borne by MoH
3. To set up supervision and quality control systems of laboratory services and ensure their functionality	Systems set up and functioning	2002–2005	MoH/NMCP WHO Others	USD 30 000
4 To set up a system for the assessment of quality of care and ensure its functionality	System set up and functioning	2002–2005	MoH/NMCP WHO Others	USD 30 000
5. To develop/modify/produce training/learning materials on disease management and prevention	Materials developed and produced	2002-2005	MoH/NMCP WHO UN agencies Others	USD 60 000
6. To train health personnel in case management	Health personnel trained	2002–2005	MoH/NMCP UN agencies WHO Others	USD 40 000
7. To procure and distribute laboratory equipment/supplies and drugs/otherdiagnostic items required for disease management	Equipment and supplies procured and distributed	2002-2005	MoH/NMCP UN agencies Others	USD 120 000
				TOTAL: USD 320 000

Specific Objective IV:	**IMPROVED CAPACITIES FOR TIMELY RESPONSE TO AND PREVENTION OF MALARIA OUTBREAKS**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To develop monitoring mechanisms for the detection/forecasting of epidemic risk factors	Monitoring mechanisms developed	2002-2003	WHO MoH/NMCP	USD 10 000 To be covered by MoH/NMCP together with WHO
2. To update NPS operational guidelines and procedures related to the detection and control of epidemics	Operational guidelines and procedures updated	2002-2003	MoH/NMCP WHO	To be borne by MoH
3. To improve emergency preparedness for and response to malaria epidemics in project areas where outbreaks are a recurring problem	Emergency preparedness for and response to malaria outbreaks improved	2002–2005	MoH/NMCP	To be borne by MoH
4. To procure and deliver insecticides/equipment for spraying and other items	Insecticides/equipment for spraying and other items procured and delivered	2002–2005	MoH/NMCP UN agencies Others	USD 340 000
5. To apply indoor residual spraying in cases of emergency	Residual spraying applied	2002-2005	MoH/NMCP	To be borne by MoH
6. To train health personnel in epidemic control with emphasis on vector control	Health personnel trained	2002–2005	MoH/NMCP WHO Others	USD 60 000
				TOTAL: USD 410 000

Specific Objective V:	**STRENGTHENED RBM COUNTRY SURVEILLANCE MECHANISMS**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To survey to assess needs and problems related to malaria and impact assessment survey	Base–line survey and impact surveys carried out	2002-2005	MoH/NMCP WHO	USD 10 000
2. To identify operational and epidemiological indicators needed for monitoring/ evaluation of project activities	Operational and epidemiological indicators identified	2002	MoH/NMCP WHO	To be covered by WHO Consultant
3. To train personnel of NMCPs in data collection, processing and analysis	Personnel of NMCPs trained	2002–2005	MoH/NMCP WHO UN agencies Others	USD 30 000
4. To establish and maintain an operational and epidemiological database for the project	Operational and epidemiological database established and maintained	2002–2005	MoH/NMCP	To be borne by MoH
5. To improve existing reporting and information systems	Reporting and information systems improved	2002–2005	MoH/NMCP WHO	To be borne by MoH
6. To procure project transport, equipment and supplies to improve supervision and monitoring of project activities at all levels	Transportation, equipment and supplies procured	2002–2005	MoH/NMCP WHO UN agencies Others	USD 25 000
7. To undertake monitoring of project activities	Monitoring undertaken	2002-2005	MoH/NMCP WHO NGOs	USD 30 000
				TOTAL: USD 95 000

Specific Objective VI:	**INCREASED COMMUNITY AWARENESS AND PARTICIPATION IN MALARIA CONTROL AND PREVENTION**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To strengthen community and family care and prevention practices through the provision of IEC materials, awareness raising sessions, community support, skills building and mass media	Malaria care and prevention practices strengthened	2002–2005	MoH/NMCP UN agencies WHO Community Others	USD 120 000
2. To conduct rapid assessments on practices of recognition and treatment of malaria and personal protection in order to develop effective IEC strategy	KAP designed and conducted	2002	MoH/NMCP UN agencies WHO Community Others	USD 5 000
3. To build IEC service capacity, including development of targeted IEC materials and IEC management and monitoring	Targeted IEC materials developed; IEC campaign implemented and monitored	2002-2005	MoH/NMCP UN agencies WHO Media Others	USD 80 000
				TOTAL: USD 205 000

Specific Objective VII:	**STRENGTHENED CAPABILITIES FOR OPERATIONAL RESEARCH**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To design research protocols, carry out studies and prepare final reports	Protocols designed, studies conducted and final reports prepared	2002-2005	MoH/NMCP WHO Research Institutions Others	USD 30 000
				TOTAL: USD 30 000

Specific Objective VIII:	**ENHANCED INTERSECTORAL COLLABORATION**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To set up a National Multi–Sectoral Committee and ensure its functionality	National Multi–Sectoral Committee established and functioning	2002-2005	MoH/NMCP GOs WHO	To be borne by the Government
2. To define situations where collaboration is needed and establish mechanisms to promote collaboration within the project areas	Situations defined and mechanisms established	2002–2005	MoH/NMCP GOs	To be borne by the Government
3. To coordinate the exchange of information about all development activities relevant to malaria within the project areas	An effective system of communication on malaria between health and non-health sectors established and exchange of information coordinated	2002–2005	MoH/NMCP GOs	To be borne by the Government
4. To identify and mobilize additional resources required for malaria control from non-health sectors	Additional resources identified and mobilized	2002-2005	MoH/NMCP GOs	To be borne by the Government

XII. PROJECT MANAGEMENT AND TIMEFRAME

The project will be implemented by the Ministry of Health, National Malaria Control Programme with technical and financial support from WHO and other potential donors and partners. The project management structure is as outlined below.

At the inter-country level: The focal point for the project (Director/ Project Manager of Malaria Control and Prevention Services) will be responsible for the planning, implementation, and evaluation of project activities and its coordination with neigbouring countries in border areas.

At the central country level: The National Malaria Control Programme will be responsible for the implementation of project activities. The Director of NMCP/Project Manager will work in close consultation with the Ministry of Health. Personnel of NMCP will undertake field visits to supervise the performance of work carried out in the field. WHO consultants will be recruited to assist in the planning and evaluation of project activities. Implementation of some project activities, such as training, health education, community–based activities, and other interventions would be sub–contracted.

At the regional/district country levels: Focal points for the project (Chiefs of Regional/District Malaria Control Services) will be designated to ensure better communication and coordination between the central and district levels. Staff of Regional/District malaria control services will be responsible for all project–related activities in their respective areas. Technical advice will be provided by regional/district specialized health personnel dealing with malaria issues.

WHO will provide overall technical backstopping and strategic coordination of project activities with UN agencies and others concerned. The project will be implemented in full consultation with all agencies and organizations involved in order to enhance coordination and maximize the impact of assistance. The project is planned for a period of four years (2002-2005).

VIII. PROJECT MONITORING AND EVALUATION

Monitoring and evaluation will be a critical and continuous process of reviewing the progress of the project and its problems and constraints, with the sole purpose of identifying the required areas of action for enhanced effectiveness of the project. Comprehensive monitoring and evaluation will be carried out by the National Implementing Agency, in collaboration with WHO/EURO, at regular intervals. An impact assessment survey will be carried out at the conclusion of the project. Monitoring and evaluation will be based on the participation of all stakeholders.

WHO/EURO will provide technical clearance of the Project Document before the start of the project. Project management will prepare a project implementation plan over the first month of the start the project. The project will be subject to annual reviews and reporting. The project's final draft will be prepared in advance to allow review and technical clearance by WHO. Project management will be responsible for the preparation and submission of project evaluation reports. Specific monitoring and evaluation methods, schedules and indicators will be developed for the project at the the time of its inception (s*ee Annex 3).*

IX. RISKS

The RBM Project in Georgia is a new initiative. The implementation of the RBM strategy could entail some risk. The implementation and management of the project should be reviewed periodically to ensure it remains on track.

A continuous flow of inputs from different UN agencies and other donors is critical to the success of the RBM Project in Georgia. There is some risk that the funding agencies would not be able to provide and/or sustain the level of inputs required to see a visible project impact. **Should the amount of funding provided prove insufficient, the scope of project activities will be limited.**

X. PROJECT BUDGET

The total project budget, estimated at ***USD 1 382 000*** , would be contributed by the Government, WHO and other potential partners/donors *(See Table 1 below)*. The Government will cover operational costs of the existing NMCP/public health staff to be involved in the implementation of project activities.

Table 1 **Estimated project budget for 2002-2005**

DESCRIPTION	*2002* *USD*	*2003* *USD*	*2004* *USD*	*2005* *USD*
Technical Expertise:				
International Experts	20 000	20 000	20 000	20 000
Duty Travel	15 000	15 000	15 000	15 000
Sub-Total:	**35 000**	**35 000**	**35 000**	**35 000**
Equipment - Expendable:				
Drugs & Laboratory supplies	15 000	15 000	15 000	15 000
Diagnostic kit supplies	5 000	5 000	5 000	5 000
Insecticides/equipment and other items for epidemic control	80 000	80 000	80 000	80 000
Equipment - Non-Expendable:				
Laboratory Equipment	15 000	15 000	15 000	15 000
Transportation	5 000	5 000	5 000	-
Office Equipment/Supplies	5 000	-	5 000	-
Sub-Total:	**125 000**	**120 000**	**125 000**	**115 000**
Quality Assessments/Assurance:				
Care Quality Assessments	7 500	7 500	7 500	7 500
Supervision and quality control of laboratory services	7 500	7 500	7 500	7 500
Problems And Needs Assessments	5 000			
KAP Study/ IEC Service Capacity Building	25 000	20 000	20 000	20 000
RBM Advocacy & Partnership Building/Foll ow ups	10 000	10 000	10 000	10 000
Impact Assessment				5 000
Training:				
In–service training:				
Development & production of training materials	20 000	20 000	20 000	-
Central and intermediate level training	30 000	20 000	20 000	20 000
Peripheral level training for public health personnel	50 000	40 000	40 000	40 000
International Training:				
Training in malaria and its control	10 000	10 000	10 000	10 000
Operational Research	10 000	10 000	10 000-	-
Community Capacity Building	30 000	30 000	30 000	30 000
Monitoring/Evaluation	10 000	10 000	10 000	10 000
Miscellaneous:				
Operation & Maintenance	2 000	2 000	2 000	2 000
Sundries	1 000	1 000	1 000	1 000
TOTAL:	**378 000**	**343 000**	**348 000**	**313 000**

ANNEXES

Annex 1: **The malaria situation in Georgia, 1995–2000**

	1995	1996	1997	1998	1999	2000
Autochthonous malaria	**0**	**3**	**0**	**14**	**35**	**164**
Imported cases	**0**	**0**	**0**	**2**	**16**	**6**
Plasmodium vivax	**0**	**3**	**0**	**16**	**51**	**169**
Plasmodium falciparum	**0**	**0**	**0**	**0**	**0**	**1**
Mixed infections	**0**	**0**	**0**	**0**	**0**	**0**
Total number of malaria cases	**0**	**3**	**0**	**16**	**51**	**170**

Annex 2: **RBM project areas in Georgia, 2002 - 2005**

- *selected areas of Shida, Kvemo Kartli, Kakheti, Tskhinvali and Samtskhe – Javakheti in the eastern part of Geogia*
- *selected areas of Guria, Adjara, Abkhzeti, Samagrelo, Imereti and Racha – Lechkhumi in the western part of Georgia*

The project's targeted beneficiaries will be nearly 3.0 million indigenous people and migrants.

Annex 3: Monitoring and evaluation indicators

Output (*process*) indicators:

- ***Percentage of project areas with adequate quantities of learning and IEC materials***
- ***Percentage of project areas with adequately advocated/trained people***
- ***Percentage of project areas with adequate provision of equipment, drugs, insecticides, mosquito nets and other supplies***
- ***Percentage of project areas under regular supervision of indoor residual spraying/malaria diagnosis and treatment/laboratory services***
- ***Percentage of project areas/population under surveillance***
- ***Type and quantity of operational research planned /conducted***

Outcome indicators:

- ***Percentage of project areas where vector control operations (indoor residual spraying and/or antilarval measures and/or the use of impregnated mosquito nets) have been correctly applied and all active foci are covered by the above – mentioned interventions***
- ***Percentage of project areas where more than 75 % of patients are diagnosed/treated correctly in the formal and informal sectors***
- ***Percentage of project areas where more than 75 % of formal/informal care providers use updated knowledge and built–up skills in diagnosis and treatment/management of malaria***
- ***Percentage of project areas where more than 75 % of households, families and mothers are knowledgeable about symptoms/diagnosis/treatment/referral and are capable of providing appropriate self – diagnosis***

Impact indicators (*to estimate the effect of large-scale interventions within project areas*):

- ***As a result of improved coverage and quality of vector control (indoor residual spraying, larviciding, and biological control measures):***
  A decrease in the incidence/prevalence of P. vivax infection/disease
  Containment of malaria outbreaks
  Prevention of malaria outbreaks
  Prevention of re-establishment of transmission of P. vivax malaria
- ***As a result of improved coverage and quality of diagnosis and radical treatment of P. vivax:***
  Prevention of relapses of P. vivax malaria

ROLL BACK MALARIA
PROJECT DOCUMENT

MINSTRY OF HEALTH
REPUBLIC OF TURKEY

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

Title:	**The Roll Back Malaria Project**
Duration:	**4 years, January 2002–December 2005**
Project Sites:	**Selected provinces (28) in the southeastern, northwestern and western parts of the country**
Intended Beneficiaries:	**Approximately 25 million indigenous people and migrants**
Requesting Agency:	**WHO**
Govt. Cooperating Agency:	**Ministry of Health, Turkey**
Estimated Starting Date:	**January 2002**
Estimated Project Budget:	**2002:** ***USD 2 847 500*** **2003:** ***USD 2 562 500*** **2004:** ***USD 2 397 500*** **2005:** ***USD 2 362 500*** **TOTAL** (*2002-2005*)**:** ***USD 10 170 000***

BRIEF DESCRIPTION

The malaria situation in Turkey remains serious. Despite a significant reduction in the reported incidence of malaria cases from 1996–2001, the magnitude of malaria in the country is thought to be much greater than official statistics indicate and cannot be reliably assessed on the basis of data available. At present over 15 million people,or 23% of the total population of Turkey, live in areas where malaria is endemic. A rather large proportion of the total population (nearly 44%) resides in areas where the risk of the explosive resumption of malaria transmission, leading to a full scale outbreak, remains high.. The National Malaria Control Programme is at present implemented and supported by WHO, and activities consist of disease management and prevention, training, surveillance, and vector control. However, the limited resources invested by the Government, GAP Administration and WHO result in a lack of funding at levels sufficient to cope with the malaria problem in the country.

The RBM Project will support Turkey in building partnerships and working together in the promotion of health related actions to reduce the incidence of malaria and prevent malaria outbreaks in the country. The Project will focus on addressing malaria related issues through capacity building, improving capacities for and access to early diagnosis/adequate treatment and timely response to and prevention of malaria outbreaks, reinforcing surveillance mechanisms, and increasing community awareness and involvement in malaria prevention. Implementation of the RBM Project will be a collaborative effort of the Ministry of Health in cooperation with WHO, the GAP Administration and other potential partners/donors. The project is planned for an initial period of four years (2002-2005). The project will have a strong but flexible management structure capable of mobilizing the partnership among UN agencies and NGOs, as well as the media and other partners/donors, in implementing cost–effective but technically sound and sustainable malaria control measures adapted to the country's conditions and responding to local needs.

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HISTORICAL CONTEXT

The new Director General of WHO committed herself to an intensive response to the global malaria burden, and in January 1998, the *Roll Back Malaria Initiative (RBM)* was proposed. A global coalition to Roll Back Malaria, characterized by strategic synergy, co-ordinated effort, and science-based strategies, was proposed at the World Health Assembly in 1998. The Global Partnership to RBM, consisting of WHO, UNICEF, UNDP, World Bank and a group of national government representatives, heads of bilateral donor organizations, representatives of the private sector, and non-governmental bodies was formally established in December 1998. Members of the Global RBM Partnership are committed to supporting country-level efforts led by national authorities within the context of their multi-sectoral strategies for development and poverty alleviation.

A meeting to establish a partnership for Roll Back Malaria Initiative with representatives of the Ministry of Health and a number of UN Organizations, including WHO, was held in March 2000 in Turkey. Commitment to build up a Country RBM Partnership was the main outcome of this meeting. To promote partnerships for Roll Back Malaria in the Caucasian Republics and Turkey, a regional meeting was organized in Tbilisi, Georgia in November 2001. It was recommended to draw up RBM Project proposals and submit them to existing/potential donors and partners in early 2002. The RBM Sub–Regional and Country Projects will support the countries in partnership building and working together in the promotion and coordination of health sector actions to reduce the incidence of malaria, prevent malaria outbreaks, and prevent the further spread of malaria across the countries.

The malaria situation in Turkey continues to be serious in terms of its impact on the health of the population, development and tourism. In 1994, there were 84 345 malaria cases, the highest rate of malaria morbidity to be reported in the country over the past 15 years (*See Annex 1*). The massive malaria epidemic in the middle of the 1990's has occurred as a result of development activities including the construction of a dam and the expansion of the irrigation network, population movements, including an influx of infected temporary migrants driven by social and economic reasons to epidemic–prone areas, and lack of and poor access to diagnostic and treatment facilities, particularly in the GAP project area in southeastern Anatolia and the Cukurova and Amirova plains. The malaria situation has also been aggravated by shortages of man–power at the periphery, poor perception and inadequate use of malaria preventive measures by communities, cultural and linguistic differences of high–risk segments of the population, and security problems in some areas. Children and pregnant women are threatened by malaria, which is one of the biggest impediments to child growth and development in the country.

At present, over 15 million people, or 23 per cent of the total population of the country, continue to reside in areas where malaria is endemic. A rather large proportion of the total population (nearly 44%) lives in areas where the risk of the explosive resumption of malaria transmission, leading to an outbreak, remains high.

The malaria control programme in Turkey is funded by the Government, the GAP Administration and WHO. However, at present, the resources invested in malaria control by the Government, GAP Administration and WHO are limited, and the country is in need of additional external assistance to cope with the malaria problem.

V. CURRENT MALARIA SITUATION

A malaria control programme was launched in Turkey in 1925. In 1945, one third of the population of the country, or 2 542 272 malaria patients, received treatment. In 1946, a countrywide survey indicated a spleen rate of 25%. During the same year, residual spraying of houses using DDT was introduced. Following the introduction of a national malaria eradication programme in 1957, malaria had almost disappeared by 1968. By 1970, 1293 cases of malaria were reported, mainly from the south–eastern part of Anatolia. Prior to the introduction of control activities, *Plasmodium falciparum* was the predominant parasite, but since the early 70's, only *Plasmodium vivax* malaria has been found in indigenous patients.

From 1971 onwards, the number of malaria cases in Cukurova and Amikova plains, areas which form the Provinces of Adana, Hatay and Icel, continued to increase, reaching alarming proportions during a *Plasmodium vivax* epidemic in 1976, as well as 1977, when 30 852 and 115 512 cases were reported respectively. Many factors contributed to the deterioration of the epidemiological picture; including the rapid agricultural development of the Cukurova plain and the subsequent increased industrial expansion. This led to a substantial migration of workers from areas of Turkey where malaria at that time was more prevalent and a sharp increase in the density of *An. Sachorovi.* Insufficient coverage by the surveillance system during the period between 1970–1975 also played a major role. Through concentrated efforts and at considerable cost, the incidence of the disease began to recede in this area in 1978, following the re–introduction of large–scale control operations. By 1979, the reported total for the country had dropped to 29 323 cases, and the epidemic was contained. However, by 1980, the situation had once again deteriorated, and the number of malaria cases reached over 56 000. This tendency remained unchanged, with 66 681 cases reported in 1983. Major reasons behind this included the occurrence and spread of insecticide resistance in *An. sacharovi* populations to the organochlororine compounds and, soon after, to several of the organophosphorus compounds that replaced them. At the same time, the rate of refusals to accept house spraying increased among the inhabitants due to their objections to the odour of the insecticides.

During the epidemic in 1977, the country was divided into four epidemiological strata based on the distribution of reported malaria cases and transmission patterns as follows:

- STRATUM I is divided into sub – strata. *STRATUM Ia* compromises the provinces of Adana, Hatay and Icel which includes the Cukurova area, where the major epidemic occurred in 1977, and *STATATUM Ib* which is the whole of South Eastern Anatolia. Thi is the site of two major irrigation projects, that of the Seyhan and Ceyhan rivers in the Cukorova plain which was completed in the 1970's, as well as the South Eastern Anatolia (GAP) project initiated the 1980's. Malaria transmission occurs in many provinces of STRATUM I.
- STRATUM II includes the whole of the Western part of Turkey, plus the province of Nigde, Nersehir and Kayseri. The area contains major tourist centres. Malaria is considered a risk and focal transmission may occur.
- STRATUM III is composed mainly of the high plateau of Central Anatolia. The risk of malaria is very low.
- STRATUM IV includes North Eastern Turkey and the provinces of Zonguldak, Kastamonu, and Sinop on the Black Sea cost. The risk of malaria is very low.

Since 1990, when only 8 680 malaria cases were reported nationally, there has been a marked deterioration in the malaria situation in the country, with a steady increase in the number of cases, from 12 218 to 84 345 during 1991 - 1994. This increase in the incidence of malarial disease was mainly observed in areas which belong to Stratum Ib in which the GAP project is being implemented. In contrast to the previous epidemic of the mid 1970's that occurred in the Cukurova and Amikova plains, the epidemic in the 1990's within the area of GAP project, with its concomonant changes in the environment and agricultural practices, cannot be attributed solely to the impact of the expansion of the irrigation network, inasmuch as malaria outbreaks have occurred in areas where construction has not yeet begun. A rise in the number of malaria cases reported in all other strata was most probably a result of importation of malaria by migrant workers. Despite a significant reduction in the reported incidence of malaria cases from 81 754 to 11 432 during 1995–2000, the magnitude of malaria in the country is thought to be much greater and cannot be reliably assessed on the basis of data available.

VI. HOST COUNTRY STRATEGY

III.A. NATIONAL STRATEGY

Turkey has committed itself to malaria control and the national health authorities, in collaboration with WHO, developed the National Malaria Control Programme which is being implemented. The four elements of the Programme are as follows:

Disease Prevention: to plan and implement selective and sustainable preventive measures;
Disease Management: to provide early diagnosis and prompt treatment;
Epidemic Control: to detect early outbreaks and prevent the further spread of malaria epidemics;
Programme Management: to strengthen institutional capacities of the National Malaria Control Programme and surveillance mechanisms

III.B. INSTITUTIONAL FRAMEWORK FOR MALARIA CONTROL

The National Malaria Control Programme is responsible for technical guidance, planning, monitoring and evaluation of malaria control in the country. The National Malaria Control Programme is headed by the Director. NMCP staff is comprised of medical officers, biologists, medical technicians and administrative staff. At the provincial level, the head of the communicable disease department has overall responsibility for all malaria-related activities in his or her respective province. At the district level, the head of the malaria control team is responsible for malaria control activities. The team includes laboratory technicians and malaria workers. Diagnosis and treatment of malaria are considered, in principle, part of the primary health care system, and disease management activities related to malaria should be integrated and carried out by general health services. However, in practice, this integration is still lacking. Although the health centers have laboratory facilities, many of them are in need of upgrading.

Currently, malaria control interventions consist mainly of disease management, vector control, capacity building, surveillance, and community–based activities including health education.

III.C. PRIOR AND ONGOING ASSISTANCE

WHO assistance focuses on strengthening the National Malaria Control Programme through technical back up, consultation, training and fellowships. The GAP Administration supports community–based activities in the southeastern part of the country. UNDP has provided valuable assistance in the form of funding to allow for the hiring of international and local personnel, capacity building and the procurement of essential supplies and equipment.

IV. PROJECT JUSTIFICATION

In face of the magnitude of the malaria situation in Turkey, attempts are being undertaken to change unfavourable trends in the southeast, northwest and western areas of the country where local transmission of *Plasmodium vivax* malaria is reported, incidence remains high, and there is an underreporting of cases. The practical, technical and operational modalities on dealing with malaria by specialized services and the public health sector, as well as the community itself, are the expected outcomes of the RBM Project, funded and implemented by the Government of Turkey, along with a number of international agencies/organizations. The project will have a strong but flexible management structure capable of mobilizing the partnership among the Ministry of Health, UN agencies, other donor agencies and countries, and the media in implementing cost-effective but technically sound and sustainable malaria control adapted to the country's conditions and responding to local needs.

IV.A. PROBLEMS TO BE ADDRESSED

Problem I:
There is a concentration of intense transmission of malaria in the southeastern part of the country, an area with poor access to existing health services. This results in high and underreported morbidity. The complexity of principal and secondary malaria vectors and their behavioural characteristics (*An. sacharovi*, *An. maculipennis* complex*, An hircanus, An. superpictus* etc.), along with environmental modifications for agricultural development, have resulted in a sudden increase in the vectorial capacity and degree of transmission of malaria. Massive population movements within the country and an influx of migrants, including infected persons, to development project sites is one of the major reasons behind both the re–introduction of malaria into areas which were previously free from the disease and malaria outbreaks among vulnerable non-immune people.

Problem II:
The insecticide resistance of *An. sacharovi*, the principal malaria vector, shortages of insecticides and spraying equipment, limited use of antilarval operations, and a low rate in the utilization of community –based preventive measures, including insecticide-treated mosquito nets, result in a limited impact of vector control operations.

Problem III:
Existing health facilities are under–equipped and poorly supplied, and public health personnel are often underpaid, particularly at peripheral levels. This leads to the inadequate quality of disease management and prevention.

Problem IV:
Poor capacities for early diagnosis and prompt treatment of malaria result in inadequate coverage of people at risk of malaria. Some malaria patients are never seen within the public health sector, and/or are self-treated, and these cases are not reported to NMCP. An additional factor to be considered is that malaria patients are usually treated on an out–patient basis, and many of them do not complete the full course of anti–relapse treatment.

Problem V:
A lack of surveillance, including inadequate malaria reporting, results in a distorted reflection of the true extent of the malaria problem in the country.

Problem VI:
Communities' lack of knowledge and skills to prevent themselves from getting malaria result in scant use of personal protective measures. The majority of people retain numerous misconceptions about malaria and are unaware of preventive measures which may be taken.

Problem VII:
Limited resources invested by the Government, GAP Administration and external donors (UNDP and WHO) result in lack of funding at levels sufficient to cope with the malaria problem.

IV.B. TARGET LOCATIONS AND INTENDED BENEFICIARIES

During 2002-2005, assistance is to be provided for 28 selected provinces in the southeastern, northwestern and western parts of the country (*see Annex 2*). Project areas are mostly situated on the coast, in the foothills, and in hilly areas with poorly developed health infrastructures and communication systems. In general, the target beneficiaries will be nearly 25 million indigenous people and migrants entering there for various reasons. Due to their vulnerable status, particular attention will be given to young children and pregnant women.

IV.C. SUCCESS IMPACT INDICATORS

The project aims at promoting health sector actions with a particular emphasis on building the capacities of communities to enable them to actively participate in malaria control/prevention that reduce suffering from malaria. A base–line survey conducted in project areas will provide an assessment of the malaria–related problems and needs at the beginning of the project, whereas a terminal evaluation at the end of the project will bring to light improvements in the malaria situation which have occurred as a result of project interventions.

In the short and medium term, the project is likely to contribute to the prevention of malaria outbreaks and reduction in the incidence and prevalence of malaria and prevent a resumption of malaria transmission in areas where malaria has been eradicated in the past. Sustaining the project activities beyond 2005 reduce the impact of malaria to a sufficiently low level so that it no longer represent a public health problem.

XIII. PROJECT STRATEGY AND PRIORITY INTERVENTIONS

The above will be addressed by actions in specific priority areas, all of which are in line with the following strategic components of the project and incorporated into the four elements of the National Action Plan for Malaria Control and Prevention:

Component I: **STRENGTHENING INSTITUTIONAL CAPACITIES OF THE NATIONAL MALARIA CONTROL PROGRAMME AND GENERAL HEALTH SERVICES AND ENHANCING CAPACITY FOR DECISION-MAKING RELATED TO MALARIA AND ITS CONTROL/PREVENTION**

To be effective, the national plan of action for malaria prevention and control should be implemented through properly organized and managed specialized and general health services. To facilitate the execution of the RBM project in Turkey, some important aspects in the implementation and management of malaria prevention and control programme, notably responsibility, authority and accountability for work done, resources used and outputs/outcomes produced at all levels should be reviewed. To provide technical and operational guidance in a satisfactory manner, health staff of specialized health services should be trained in programme management. Technical assistance and back–up will be provided by WHO staff.

Component II: **BUILDING UP/PROMOTING RBM PARTNERSHIP**

RBM will address malaria as a priority health issue within the context of sustainable health sector development in Turkey. WHO will provide strategic direction, coordination and technical/financial support for malaria control interventions under RBM. The government, along with other partners involved in the RBM Project, will mobilize additional funds for RBM interventions.

Component III: **IMPROVING CAPACITIES FOR & ACCESS TO EARLY DIAGNOSIS AND ADEQUATE TREATMENT OF MALARIA WITHIN THE PRIMARY HEALTH CARE SYSTEM**

An established and properly functioning system for the identification of cases, reliable and early diagnosis, effective and prompt treatment, and follow-up of treatment results, all comprise fundamental parts of the project. Since microscopic examination remains the most reliable and least expensive way to diagnose malaria, diagnostic laboratory facilities will be upgraded within project areas. Dip Stick-like technologies with algorithms for simple and labor-saving diagnosis of malaria should be introduced on a pilot basis to make diagnosis of malaria adequate even at the most peripheral levels.

Component IV: **IMPROVING CAPACITIES FOR TIMELY RESPONSE TO AND PREVENTION OF MALARIA EPIDEMICS**

All epidemic-prone areas and situations will be identified and forecasted. Emergency preparedness for and mechanisms of response to malaria epidemics will be improved. Contingency plans for epidemic control including indoor spraying will be worked out and the reserve of drugs, insecticides and spraying equipment will be maintained for rapid deployment. To contain an outbreak, indoor residual spraying would be applied within project areas. Basic Health Staff will be trained to recognize epidemic situations and build up community preparedness.

Component V: **PROMOTING COST-EFFECTIVE AND SUSTAINABLE VECTOR CONTROL**

To reduce transmission and the incidence of malaria, selective residual spraying will be applied to all the active foci of malaria including those found on the territory of labor camps and settlements of migrant workers within project areas. Larviciding and other biological control measures will also be applied in project areas. The use of personal protective measures including impregnated mosquito nets, curtains and repellents will be encouraged through their social marketing and health education. Most appropriate approaches for the communication of messages regarding malaria prevention directly to high-risk groups will be developed. All of the above preventive measures will be guided by consideration of their technical and operational feasibility, effectiveness and sustainability.

Component VI: **CAPACITY BUILDING**

Training is a key component of the project. In–service training in disease management and prevention will be conducted for all categories of specialized programme and public health personnel within project areas. Laboratory personnel will be trained in malaria microscopy. Basic training will be supplemented by regular supervision and refresher training courses. Training will be practical in nature and directed towards developing skills and competence.

Component VII: **REINFORCING RBM COUNTRY SURVEILLANCE MECHANISMS**

A base–line survey to assess problems and needs related to malaria will be carried out at the beginning of the project. Mechanisms for the regular collection, processing and analysis of operational, epidemiological and socio-economic data relevant to planning/re-planning, implementation, monitoring and evaluation of project activities will be built in. The existing reporting and information system will be improved. Survey data will provide a systematic way to determine whether the project approaches and interventions and other inputs are appropriate and sufficient to achieve the stated targets and objectives.

Component VIII: **INCREASING COMMUNITY AWARENESS AND PARTICIPATION IN MALARIA CONTROL/PREVENTION**

The involvement of communities and their partnership with the formal and informal health sectors to empower them in their own health development is crucial. People should be educated in malaria and its control/prevention and have access to adequate health care facilities. Existing treatment practices will be improved through the development and dissemination of clear messages on malaria and its treatment. Community and family care and preventive practices will be strengthened through the provision of IEC materials, capacity building, traditional/mass media and community support. KAP assessments will be conducted on ways to promote the compatibility of practices, customs and beliefs of various social groups and minorities with existing malaria control/prevention options, and to develop effective IEC strategies and targeted materials.

Component IX: **STRENGTHENING RESEARCH CAPABILITIES**

Operational research is essential for the planning, implementation and evaluation of the project activities, and this will comprise an integral part of the project. Such research will address not only the planning and effectiveness of specific interventions, but also cultural, behavioural, social and economic factors that might affect project interventions and outcomes.

Component X: **ENHANCING INTERSECTORAL COLLABORATION**

Additional resources for malaria control remain severely constrained. The social, economic and environmental problems posed by malaria exceed the jurisdiction and capabilities of the Ministry of Health. There is obviously a need for improved intersectoral collaboration, as well as for planning and information sharing, to ensure that additional funds are earmarked for malaria control. Such collaboration is best developed from a shared understanding of the underlying problems to be addressed. Information on development activities and the migration of organized and non-organized population groups will be collected and exchanged amongst all parties concerned. The Ministry of Health will stimulate the non-health sectors for active collaboration in malaria control, including the mobilization of additional funds. National multi–sectoral committees will promote coordination and collaboration in malaria control among all concerned.

XIV. PROJECT OBJECTIVES, ACTIVITIES AND OUTPUTS

VI.A. DEVELOPMENT OBJECTIVE

The development objective is **to prevent malaria outbreaks, reduce the incidence and prevalence of malaria, prevent its spread across the country and minimize socio–economic losses provoked by the disease** through the progressive strengthening of capacities and capabilities of health services and mobilizing community actions within the context of the Roll Back Malaria initiative in Turkey.

VI.B. SPECIFIC OBJECTIVES, ACTIVITIES AND OPERATIONAL OUTPUTS

Specific Objective I:	**STRENGTHENED INSTITUTIONAL CAPACITIES OF THE NATIONAL MALARIA CONTROL PROGRAMME AND GENERAL HEALTH SERVICES, AS WELL AS ENHANCED CAPACITY FOR DECISION-MAKING RELATED TO MALARIA AND ITS CONTROL AND PREVENTION**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To render technical and managerial expertise and back-up for the RBM Project	WHO short-term consultants recruited and expert advice given wherever required	2002-2005	WHO	USD 80 000
2. To train Regional/District Health Directors in programme management to improve capacities for planning and implementation of the project activities	Regional/District Health Directors involved in the project trained	2002-2005	MoH/NMCP WHO UN Agencies Others	USD 60 000
3. To train selected Regional/District Medical Officers in existing approaches to disease management, epidemic control and community mobilization	Regional/District MOs in project areas trained	2002-2005	MoH/NMCP WHO UN agencies Others	USD 120 000
4. To support international training selected NPS personnel in malaria and its control as well as entomology	Selected NPS personnel trained abroad	2002-2005	WHO MoH/NMCP Others	USD 60 000 **TOTAL: USD 320 000**

Specific Objective II:	**BUILDING UP RBM ADVOCACY AND PARTNERSHIP**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To identify partners and conduct RBM advocacy through workshops and meetings; message development to obtain broad, inter-sectoral commitment at different levels in the country	Partners identified Targeted RBM advocacy activities conducted among various partners at all levels	2002-2005	MoH/NMCP WHO UN agencies Informal Sector Media Others	USD 40 000
2. To follow up RBM Partnership actions at country level	RBM Partnership actions followed up	2002-2005	MoH/NMCP WHO Others	USD 20 000
				TOTAL: USD 60 000

Specific Objective III:	**IMPROVED CAPACITIES FOR AND ACCESS TO EARLY DIAGNOSIS AND RADICAL TREATMENT OF MALARIA**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. **To select and train/retrain laboratory staff in malaria microscopy**	Laboratory staff trained/retrained	2002-2005	MoH/NMCP WHO UN agencies Others	USD 200 000
2. To upgrade laboratory facilities in selected health centres	Health facilities upgraded	2002-2005	MoH/NMCP WHO NGOs	To be borne by MoH
3. **To set up supervision and quality control systems of laboratory services and ensure their functionality**	Systems set up and functioning	2002–2005	MoH/NMCP WHO Others	USD 60 000
4. To set up a system for the assessment of quality of care and ensure its functionality	System set up and functioning	2002–2005	MoH/NMCP WHO Others	USD 60 000
5. **To develop/modify/produce training/learning materials on disease management and prevention**	Materials developed and produced	2002-2005	MoH/NMCP WHO UN agencies Others	USD 100 000
6. **To train health personnel in case management**	Health personnel trained	2002–2005	MoH/NMCP UN agencies WHO Others	USD 300 000
7. To procure and distribute laboratory equipment/supplies and drugs/other diagnostic items required for disease manage-ment	Equipment and supplies procured and distributed	2002-2005	MoH/NMCP UN agencies Others	USD 500 000 **TOTAL: USD 1 220 000**

Specific Objective IV:	**PROMOTING COST-EFFECTIVE AND SUSTAINABLE VECTOR CONTROL**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
To apply vector control measures:				
1. To identify priority target areas and population groups by means of microstrati-fication	Areas and groups identified	2002-2005	MoH/NMCP WHO	To be borne by MoH
2. **To procure and deliver equipment/supplies for vector control**	Equipment and supplies procured and delivered	2002-2005	MoH/NMCP UN Agencies Others	USD 4 000 000[1]
3. To establish implementation mechanisms and ensure their functionality	Implementation mechanisms established and functioned	2002–2005	MoH/NMCP WHO Others	USD 800 000[1]
4. **To undertake monitoring and evaluation of measures applied**	Monitoring and evaluation undertaken	2002–2005	MoH/NMCP WHO Others	USD 100 000
To promote measures aimed at reduction of human/vector contact with special emphasis on ITMNs:				
5. To define priority areas and population groups by means of microstratification	Areas and groups identified	2002-2005	MoH/NMCP WHO	To be borne by MoH
6. To establish distribution system for ITMNs and make its functional	Distribution system established	2002–2005	MoH/NMCP WHO Others	USD 200 000
7. To procure and deliver mosquito nets and insecticides	Equipment nd supplies procured and delivered	2002-2005	UN Agencies Others MoH/NMCP	USD 800 000
8. To establish and make functional communal re-impregnation services on cost-sharing basis and supervision of re-impregnation	Re-impregnation services established and supervised	2002-2005	MoH/NMCP Others Community-based organizations Communities	USD 400 000
9. To undertake community-based monitoring and evaluation	Monitoring and evaluation undertaken	2002-2005	MoH/NMCP UN Agencies WHO Others	USD 100 000
				TOTAL: USD 6 400 000

[1] - *all related procurement and delivery of vector control items and implementation of vector control operations will be made and covered by MoH*

Specific Objective V:	**IMPROVED CAPACITIES FOR TIMELY RESPONSE TO AND PREVENTION OF MALARIA OUTBREAKS**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. **To develop monitoring mechanisms for the detection/forecasting of epidemic risk factors**	Monitoring mechanisms developed	2002-2003	WHO MoH/NMCP	USD 10 000 To be covered by MoH/NMCP together with WHO
2. To update NPS operational guidelines and procedures related to the detection and control of epidemics	Operational guidelines and procedures updated	2002-2003	MoH/NMCP WHO	To be borne by MoH
3. **To improve emergency preparedness for and response to malaria epidemics in project areas where outbreaks are a recurring problem**	Emergency preparedness for and response to malaria outbreaks improved	2002–2005	MoH/NMCP	To be borne by MoH
4. To procure and deliver insecticides/equipment for spraying and other items	Insecticides/equipment for spraying and other items procured and delivered	2002–2005	MoH/NMCP UN agencies Others	USD 800 000
5. **To apply indoor residual spraying in case of emergency**	Residual spraying applied	2002-2005	MoH/NMCP	To be borne by MoH
6. **To train health personnel in epidemic control, with emphasis on vector control**	Health personnel trained	2002–2005	MoH/NMCP WHO Others	USD 200 000
				TOTAL: USD 1 010 000

Specific Objective VI:	**STRENGTHENED RBM COUNTRY SURVEILLANCE MECHANISMS**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To conduct surveys to assess needs and problems related to malaria and impact assessment survey	Base–line survey and impact surveys carried out	2002-2005	MoH/NMCP WHO	USD 20 000
2. To identify operational and epidemiological indicators needed for monitoring/ evaluation of project activities	Operational and epidemiological indicators identified	2002	MoH/NMCP WHO	To be covered by WHO Consultant
3. To train personnel of NMCPs in data collection, processing and analysis	Personnel of NMCPs trained	2002–2005	MoH/NMCP WHO UN agencies Others	USD 60 000
***4.* To establish and maintain an operational and epidemiological database for the project**	Operational and epidemiological database established and maintained	2002–2005	MoH/NMCP	To be borne by MoH
5. To improve the existing reporting and information systems	Reporting and information systems improved	2002–2005	MoH/NMCP WHO	To be borne by MoH
***6.* To procure project transport, equipment and supplies to improve supervision and monitoring of project activities at all levels**	Transportation, equipment and supplies procured	2002–2005	MoH/NMCP WHO UN agencies Others	USD 80 000
***7.* To undertake monitoring of project activities**	Monitoring undertaken	2002-2005	MoH/NMCP WHO NGOs	USD 40 000
				TOTAL: USD 200 000

Specific Objective VII:	**INCREASED COMMUNITY AWARENESS AND PARTICIPATION IN MALARIA CONTROL AND PREVENTION**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To strengthen community and family care and prevention practices through providing IEC materials, awareness raising sessions, community support, skills building and mass media	Malaria care and prevention practices strengthened	2002–2005	MoH/NMCP UN agencies WHO Community Others	USD 600 000
2. The rapid assessments on practices of recognition and treatment of malaria and personal protection will be conducted in order to develop effective IEC strategy	KAP designed and conducted	2002	MoH/NMCP UN agencies WHO Community Others	USD 20 000
3. To build IEC service capacity, including development of targeted IEC materials and IEC management and monitoring	Targeted IEC materials developed; IEC campaign implemented and monitored	2002-2005	MoH/NMCP UN agencies WHO Media Others	USD 200 000
				TOTAL: USD 820 000

Specific Objective VIII:	**STRENGTHENED CAPABILITIES FOR OPERATIONAL RESEARCH**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
1. To design research protocols, carry out studies and prepare final reports	Protocols designed, studies conducted and final reports prepared	2002-2005	MoH/NMCP WHO Research Institutions Others	USD 60 000
				TOTAL: USD 60 000

Specific Objective XI:	**ENHANCED INTERSECTORAL COLLABORATION**			
ACTIVITIES	OPERATIONAL OUTPUTS	TIMEFRAME	POSSIBLE PARTNERS	ESTIMATED COST
5. To set up a National Multi–Sectoral Committee and ensure its functionality	National Multi–Sectoral Committee established and functioning	2002-2005	MoH/NMCP GOs WHO	To be borne by the Government
6. To define situations where collaboration is needed and establish mechanisms to promote collaboration within the project areas	Situations defined and mechanisms established	2002–2005	MoH/NMCP GOs	To be borne by the Government
7. To coordinate the exchange of information about all development activities relevant to malaria within the project areas	An effective system of communication on malaria between health and non-health sectors established and exchange of information coordinated	2002–2005	MoH/NMCP GOs	To be borne by the Government
8. To identify and mobilize additional resources required for malaria control from non-health sectors	Additional resources identified and mobilized	2002-2005	MoH/NMCP GOs	To be borne by the Government

XV. PROJECT MANAGEMENT AND TIMEFRAME

The project will be implemented by the Ministry of Health, the National Malaria Control Programme, and the GAP Administration, with technical and financial support provided by WHO and other potential donors and partners. The project management structure is as outlined below.

At the inter–country level: The focal point for the project (Director/ Project Manager of Malaria Control and Prevention Services) will be responsible for the planning, implementation and evaluation of project activities and coordination with neigbouring countries in border areas.

At the central country level: The National Malaria Control Programme will be responsible for the implementation of project activities. The Director of NMCP/Project Manager will work in close consultation with the Ministry of Health. Personnel of NMCP will undertake field visits to supervise the performance of work carried out in the field. WHO consultants will be recruited to assist in the planning and evaluation of project activities. Implementation of some project activities, such as training, health education, community–based activities and other interventions, will be sub–contracted.

At the regional/district country levels: Focal points for the project (Chiefs of Regional/District Malaria Control Services) will be designated for better communication and coordination between the central and district levels. Staff of Regional/District malaria control services will be responsible for all project–related activities in their respective areas. Technical advice will be provided by specialized regional/district health personnel dealing with malaria issues.

WHO will provide overall technical backstopping and strategic coordination of project activities with UN agencies and others concerned. The project will be implemented in full consultation with all agencies and organizations involved in order to enhance coordination and maximize the impact of assistance. The project is planned for a period of four years (2002-2005).

VIII. PROJECT MONITORING AND EVALUATION

Monitoring and evaluation will be a critical and continuous process of reviewing the progress of the project and its problems and constraints, with the sole purpose of identifying the required areas of action for enhanced effectiveness of the project. Comprehensive monitoring and evaluation will be carried out by the National Implementing Agency, in collaboration with WHO/EURO, at regular intervals. An impact assessment survey will be carried out at the conclusion of the project. Monitoring and evaluation will be based on the participation of all stakeholders.

WHO/EURO will provide technical clearance of the Project Document before the start of the project. Project management will prepare a project implementation plan over the first month of the start the project. The project will be subject to annual reviews and reporting. The project's final draft will be prepared in advance to allow review and technical clearance by WHO. Project management will be responsible for the preparation and submission of the project evaluation reports. Specific monitoring and evaluation methods, schedules and indicators will be developed for the project at the start of the project (s*ee Annex 3)*

IX. RISKS

The implementation of the RBM strategy could entail some risk. The implementation and management of the Project should be reviewed periodically to ensure it remains on track.

A continuous flow of inputs from different UN agencies and other donors is critical to the success of the RBM Project in Turkey. There is some risk that the funding agencies would not be able to provide and/or sustain the level of inputs required to see a visible project impact. **Should the amount of funding provided prove insufficient, the scope of project activities will be limited.**

X. PROJECT BUDGET

The total project budget, estimated at ***USD 10 170 000***, would be contributed by the government, Gap Administration, WHO and other potential partners/donors *(See Table 1 below)*. The government will also cover operational costs of the existing NMCP/public health staff are to be involved in the implementation of project activities.

Table 1 **Estimated project budget for 2002-2005**

DESCRIPTION	*2002* *USD*	*2003* *USD*	*2004* *USD*	*2005* *USD*
Technical Expertise:				
International Experts	20 000	20 000	20 000	20 000
Duty Travel	15 000	15 000	15 000	15 000
Sub-Total:	**35 000**	**35 000**	**35 000**	**35 000**
Equipment - Expendable:				
Drugs & laboratory supplies	100 000	100 000	100 000	100 000
Diagnostic kit supplies	25 000	25 000	25 000	25 000
Insecticides/equipment for vector control	1 000 000	1 000 000	1 000 000	1 000 000
Insecticides/equipment and other items for epidemic control	150 000	150 000	150 000	150 000
Mosquito nets and insecticides for impregnation/re-impregnation	400 000	200 000	100 000	100 000
Equipment - Non-Expendable:				
Laboratory Equipment	100 000	50 000	25 000	25 000
Transportation	20 000	20 000	20 000	-
Office Equipment/Supplies	10 000	5 000	5 000	-
Sub-Total:	**1 805 000**	**1 550 000**	**1 425 000**	**1 400 000**
Quality Assessments/Assurance:				
Care Quality Assessments	15 000	15 000	15 000	15 000
Supervision and quality control of laboratory service	15 000	15 000	15 000	15 000
Problems And Needs Assessments	10 000			
KAP Study/ IEC Service Capacity Building	70 000	50 000	50 000	50 000
Implementation Cost	350 000	350 000	350 000	350 000
RBM Advocacy & Partnership Building/Follow ups	15 000	15 000	15 000	15 000
Impact Assessment				10 000
Training:				
In–service training:				
Development & production of training materials	40 000	40 000	20 000	-
Central and intermediate level training	50 000	50 000	40 000	40 000
Peripheral level training for public health personnel	190 000	190 000	190 000	190 000
International Training:				
Training in malaria and its control	15 000	15 000	15 000	15 000
Operational Research	20 000	20 000	10 000-	10 000
Community Capacity Building	150 000	150 000	150 000	150 000
Monitoring/Evaluation	62 500	62 500	62 500	62 500
Miscellaneous:				
Operation & Maintenance	3 000	3 000	3 000	3 000
Sundries	2 000	2 000	2 000	2 000
TOTAL:	**2 847 500**	**2 562 500**	**2 397 500**	**2 362 500**

ANNEXES

Annex 1: **The malaria situation in Turkey, 1995–2000**

	1995	1996	1997	1998	1999	2000
Autochthonous malaria	**81 754**	**60 634**	**35 376**	**36 780**	**20 905**	**11381**
Imported cases	**342**	**250**	**80**	**62**	**58**	**51**
Plasmodium vivax	**82 076**	**60 863**	**35 443**	**36 824**	**20 950**	**11424**
Plasmodium falciparum	**13**	**20**	**10**	**14**	**13**	**7**
Mixed infections	**7**	**1**	**3**	**4**	**0**	**1**
Total number of malaria cases	**82 096**	**88**	**35 456**	**36 842**	**20 963**	**11 432**

Annex 2: **RBM project areas in Turkey, 2002 - 2005**

- *ADANA, OSMANIYE, ICEL, HATAY, K.MARAS, G.ANTEP, KILIS, ADIYAMAN, S.URFA, MARDIN, D.BAKIR, SIIRT, BATMAN, SIRNAK, MUS, BITLIS, ELAZIG, BINGOL, VAN, HAKKARI PROVINCES (20) IN* ***STRATUM I***
- *YALOVA, KOCAELI, SAKARYA, IZMIR, MANISA, AYDIN PROVINCES (6) IN* ***STRATUM II***
- *BOLU AND SAMSUN PROVINCES (2) IN* ***STRATUM III***

The project's targeted beneficiaries will be nearly 25 million indigenous people and migrants in 28 provinces.

Annex 3: Monitoring and evaluation indicators

Output (*process*) indicators:

- ***Percentage of project provinces with adequate amount of learning and IEC materials***
- ***Percentage of project provinces with adequately advocated/trained people***
- ***Percentage of project provinces with adequate provision of equipment, drugs, insecticides, mosquito nets and other supplies***
- ***Percentage of project provinces under regular supervision of indoor residual spraying/malaria diagnosis and treatment/laboratory services***
- ***Percentage of project provinces/population under surveillance***
- ***Type and volume of operational research planned to conduct/conducted***

Outcome indicators:

- ***Percentage of project provinces where vector control operations (indoor residual spraying and/or antilarval measures and/or the use of impregnated mosquito nets) have been correctly applied and all active foci are covered by the above – mentioned interventions***
- ***Percentage of project provinces where more than 75 % of patients being diagnosed/treated correctly in the formal and informal sectors***
- ***Percentage of project provinces where more than 75 % of formal/informal care providers used updated knowledge and built – up skills in diagnosis and treatment/management of malaria***
- ***Percentage of project provinces where more than 75 % of households, families and mothers are knowledgeable about symptoms/diagnosis/treatment/referral and are capable of providing appropriate self – diagnosis***

Impact indicators (*to estimate the effect of large-scale interventions within project areas*):

- ***As a result of improved coverage and quality of vector control (indoor residual spraying, larviciding, biological control and impregnated mosquito nets):***
  A decrease in the incidence/prevalence of P. vivax infections/diseases
  Prevention of malaria outbreaks
  Prevention of re-establishment of transmission of P. vivax malaria
- ***As a result of improved coverage and quality of diagnosis and radical treatment of P. vivax:***
  Prevention of relapses of P. vivax malaria