



SEVENTH EARN ANNUAL COORDINATION FOR IMPLEMENTATION SUPPORT MEETING

IMPALA HOTEL, ARUSHA, TANZANIA

20-22 November 2007



EARN Annual Coordination for Implementation Support Meeting
On 20th – 22nd November 2007. at Impala Hotel Arusha Tanzania

REPORT

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Executive Summary

The sixth Annual Review and Planning Meeting for Roll Back Malaria in Eastern Africa was attended by more than 80 participants representing 11 national malaria control programmes, as well as global, regional and national partners.

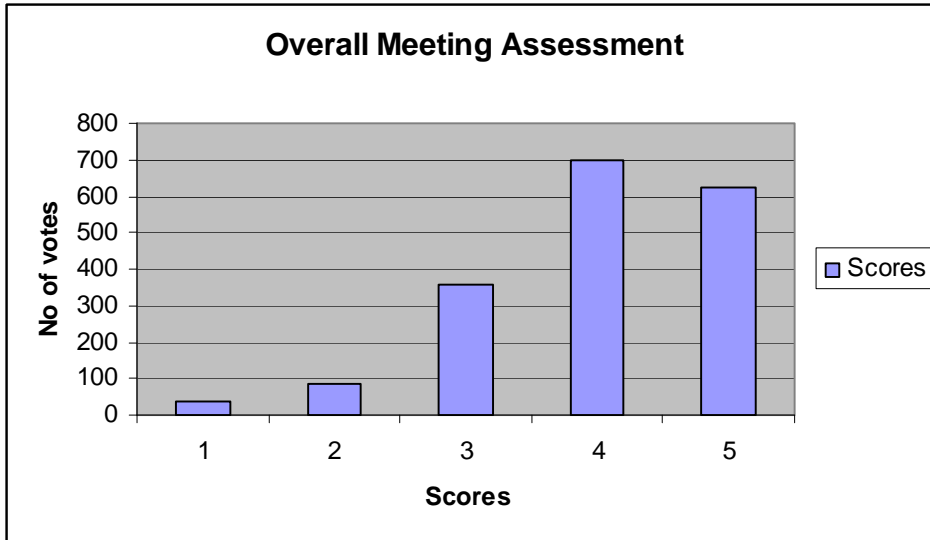
The objectives and outcomes of the meeting were: General Objective was to provide a forum for the programme review, experience sharing and implementation for accelerating access to proven malaria control interventions towards universal access and achievement of Abuja 2010 targets. Specific objectives were: 1) Countries reminded of the essence of the RBM partnership, its vision, mission, components and how it functions in support of countries; 2) Countries share progress in scaling up and challenges for impact (SUFi) to meet 2010 targets; 3) Countries/partners share information on how to overcome specific challenges; and 4) Countries and partners develop joint plan to address challenges and achieve goals/targets. Expected outputs: 1) country and partnership consensus on solutions for identified challenges 2) Country/partner joint work plan to meet country needs.

The meeting was officially opened by the Honourable Minister of Health and Social welfare, Prof. David Mwakyusa. The Honourable Minister was accompanied by; the Principal Secretary of the Ministry of Health, Dr M. Jiddawi; the WHO AFRO Representative, Dr. Josephine Namboze, WHO Tanzania Representative Dr. Rita Njau ; the UNICEF Representative Dr Angus Spiers,; Dr James Banda of the RBM Secretariat, Geneva

The first day of meeting focused on EARN overview and update, RBM partnership overview and Update then sharing of country experiences in scaling up malaria prevention and control. This was followed by half day of presentations and discussions in key technical and implementation support areas, including procurement and supply management, malaria diagnosis, the role of the private sector in ensuring access to effective antimalarials, malaria communication. In addition to presentations and plenary discussions in each of these technical areas, participants undertook gap analysis group work in .Country teams also drafted their technical support requirements for 2007.

Recommendations and action points were formulated in the following 6 key areas: 1)Human resources (Management structures, Management capacity, Decision making, Retention strategies, Training, Supervision, 2)Health information/M&E (Quality of HMIS data, Routine program monitoring, Evaluation of routine program data, Evaluation of the malaria program, Information based decision making, Progress tracking/performance audit 3)Sustainability(Keep up strategies, Net replacement, Moving from control to elimination, Keeping donors and stakeholders interested over the long term, especially when cases are low. 4)PSM(How to speed up procurement of commodities, Monitoring of commodities in country, In-country logistics of commodities, Continuity of supply at both national and sub-national levels, Quantification and forecasting. 5)Quality of Services(Improving diagnostic quality, How to ensure test results are respected when diagnosis is made, Including the private sector in malaria control, how to address and monitor them, Adherence to standard protocols; avoiding drug and insecticide resistance build up. 6)Harmonization(How to include a greater range of partners in malaria planning and implementation, Institutional arrangements between stakeholders and other partners, Integrated service delivery with other programs.

The meeting was evaluated and the overall assessment was as follows in the chart below



It can be seen from the chart that 2.0% voted 1, 4.8% voted 2, 19.9% voted 3, 38.7% voted 4 and 34.7% voted 5. This showed that overall the participants were satisfied with the way the meeting was conducted and that facilitators were generally good.

Acknowledgements

The sixth Annual Review and Planning Meeting for Roll Back Malaria in Eastern Africa was attended by more than 140 participants representing 11 national malaria control programmes, as well as global, regional and national partners. The success of a meeting of this kind depends on the dedication and commitment of many individuals and organisations, but EARN would like to thank the following in particular for their support:

- National Malaria Control Programme, Ministry of Health, Tanzania
- The RBM Secretariat for financial support
- WHO Tanzania office
- WHO-AFRO for key technical presentations
- A-to Z Simutomo and Vestergaard for supporting the evening social functions
- Sophie Smith and Nadia for Secretariat support, and the rapporteurs Drs Kaggwa Mugagga, and Ambechew Yohanes and Peter Mbabazi Kwehangana for preparing this report
- Country representatives, members of EARN and the RBM partnership for their enthusiastic support

Lastly, we would like to thank all of the National Malaria Control Programmes and manufactures for their enthusiastic participation and engagement.

Peter Mbabazi Kwehangana, James Banda, Angus Spiers, Halima Mwenesi, Josephine Namboze, Gladys Tetteh, Alison Mamvist, Kate Kolenzest (EARN Co-ordination Team)

Acronyms

ACT	Artemisinin-based Combination Therapy
ADDO	Accredited Drug Distribution Outlet
AFRO	Africa Regional Office (WHO)
ANC	Antenatal Care
AQ	Amodiaquine
ART	Artesunate
BCC	Behaviour Change Communication
CBO	Community Based Organisation
CCM	Country Co-ordinating Mechanism (GFATM)
CHA	Community Health Agent
CHW	Community Health Worker
CQ	Chloroquine
DLDB	Duka La Dawa Baridi (non-accredited drug shop, Tanzania)
DHS	Demographic and Health Survey
EARN	Eastern Africa RBM Regional Network
GF	Global Fund (GFATM)
GFATM	Global Fund against HIV/AIDS, TB and Malaria
HBMF	Home Based Management of Fever
HFS	Health Facility Survey
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
IPT	Intermittent Preventive Treatment
IPTp	Intermittent Preventive Treatment for pregnant women
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Net
LLIN	Long-Lasting Insecticidal Net
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MIS	Malaria Indicator Survey
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
NMCP	National Malaria Control Programme
PMI	US President's Malaria Initiative
PSI	Population Services International
PSM	Procurement and Supply Management
RBM	Roll Back Malaria
RDT	Rapid Diagnostic Test
REAPING	Roll Back Malaria Essential Actions Products Investment Gaps
SP	Sulphadoxine-pyrimethamine
UNICEF	United Nations Children's Fund
WG	Working Group (RBM)
WHO	World Health Organization
WHOPES	World Health Organization Pesticide Evaluation Scheme

Introduction

The Arusha meeting was the seventh Eastern Africa RBM Network Annual Coordination for Implementation Support Meeting, and builds on the successes of the previous meetings held in Tanzania in 2000, Kenya in 2001, Uganda in 2003, Rwanda in 2004, Kenya in 2005, and Zanzibar 2006.

Purpose of Meeting

To provide a forum for the programme review, experience sharing and implementation for accelerating access to proven malaria control interventions towards universal access and achievement of Abuja 2010 targets.

Objectives and Expected Outcomes of Meeting

Objectives

- Countries reminded of the essence of the RBM partnership, its vision, mission, components and how it functions in support of countries;
- Countries share progress in scaling up and challenges for impact (SUFI) to meet 2010 targets;
- Countries/partners share information on how to overcome specific challenges; and
- Countries and partners develop joint plan to address challenges and achieve goals/targets.

Expected Outcomes

- Country and partnership consensus on solutions for identified challenges
- Country/partner joint work plan to meet country needs

Key Issues and Recommendations

Human resources

Management structures

- Decentralization will help in decision affecting HR, such that district will identify their needs.
- Advocate for more donor funding to increase the ceiling of staff costs
- Advocacy for establishment of advancement of all health personnel
- Advocacy for staffing norms to address both physical structure and workload

Management capacity

- Advocate for creation of additional posts to cater the administrative functions
- Develop skills of available staff to bridge the gap

Decision making

- Set up a regulatory council for the nurses and allied health personnel
- Clarify roles of different centres of influence

Retention strategies

- Uganda, ZNZ- those deployed in rural areas stand better chances of recommendation for further training and set a bonding agreement
- Pay top up-eg. The case of Tanzania (BM Foundation)
- Performance –based incentives
- To work it in the proposals from different partners including GF
- Upgrading courses
- Transfer Policy and work out ways of promoting people

Training

- Introduce appropriate training programmes in appropriate institutions
- Train microscopist as a stop-gap but ensure that entry requirements for a higher upgrade course are met
- Experts to assist on establishing training institutions
- On job training of identified workers
- Structured refresher training, once or twice a year and ensure availability of equipment and supplies
- Follow-up supervision after training
- Advocate for creation of the posts of entomologists and related cadre

Supervision

- Integration with other programmes eg. TB, HIV etc
- Zanzibar- having both technical, centrally managed supervision, in which there are skilled supervisors to provide quality supervision
- Training on supervision skills
- More appreciation of staff by their superiors to ensure
- Accountability (e.g. faith-based institutions)
- To come up with Standard Operating Procedures

Health information/M&E

- Increasing involvement and understanding of need for data collection at all levels
- Improving support supervision and accountability
- Building staff skills in data collection at all levels and analysis where appropriate
- Improving availability of infrastructural resources – computers, telephones etc
- Utilising focal people to collect data at lower levels of the health system i.e. Tanzania
- Making data available for use across the health system and to partners
- One plan and budget, one M&E system (standardisation of indicators), one coordinating mechanism (i.e. Ethiopia)
- Implementing performance-based incentives (i.e. Rwanda)
- Partners to educate donors re national reporting formats used and the importance of supporting them

Quality of HMIS data – implications for action

- Training across health system in importance and procedures for HMIS
- Training in data interpretation (HF) and data analysis (district)
- Explore ways of improving support supervision with Dhows
- Explore use of performance-based incentives
- Ensure computerisation at district levels and related training
- Ensuring roles and responsibilities are clearly defined
- Aim at developing standardised indicators for NMCP
- Ensuring one database for use at the national and district levels

- Use sentinel sites to improve quality reporting

Sustainability

Possible Solutions

- Development of clear country business plans which include financial gaps and available resources
- Advocacy for the integration of tangible strategies for engaging private sector in malaria control programs including health impact assessments and CSR policy (South Africa, Zambia)
- Community participation in creative methods for cost-sharing and resource mobilization (country/context appropriate)- Ethiopia
- Continued advocacy for funds to support programs, subsidies and free services

Net Replacement

Possible Solutions

- Need to revise country net strategies so that they are evidence based and integrated into vector control/management strategies; long term solutions, integrated into all areas of health care
- Net strategies should be based on population stratification by ability to pay, equity issues, country context (free v. subsidy)
- Identify clear mechanisms for replacing old nets (trade ins)
- Increased/improved social and behaviour change communication to increase acceptance and use of nets at community level
- Support of community led initiatives for vector control
- OR to identify, document, findings about net distribution, use, etc shared widely along with best practices (Ethiopia)

IRS

- Vector control strategies should include IRS and ITNs and other vector control measures
- Strategies should indicate how countries on the 'brink of elimination' might use IRS as part of vector control
- Continued advocacy for innovative approaches to address insecticide resistance

Procurement and Supply Management

Government Rules & International Requirements

- TA to review rules and regulations with view to unblocking stalled procurements and standardization for future
 - Harmonization of donor rules at country level and universal agreement with national government
 - Sub-contracting to civil society organization for procurement (GF dual track)
- EARN to provide more information on UNITAID and Affordable Medicines for Malaria to assist countries

Over-stretched capacity

- Train focal points with expertise in major donor requirements
- Delegate and decentralize procurement function to lower levels where possible

Conflict with Local Manufacturers

- Agreeing standard technical requirements for major malaria commodities at national level (TA)

Forecasting

- Where data is not available or reliable, include research component to capture data necessary for forecasting

Donor Coordination

- Develop annual procurement plan for all sectors

In-country Logistics

Long Supply Chain

- Reduce steps in chain, e.g. sub-contracting distributors from central level to lower level
- Active distribution – bringing the drugs to the periphery

Re-distribution System between lower levels (e.g. facility level / home based management)

- Train the level assigned for the procurement
- Incentives to lower level staff
- Consider de-regulating ACTs (over-the-counter)

Storage Capacity

- Plan for increasing storage capacity and security within proposals

Establishment of a Pull System

- Assessment to identify underlying bottlenecks and solutions (TA)
- Engagement and empower non-medical personnel to manage logistics at central and peripheral levels
- Focused training for peripheral staff on logistics management (e.g. not simply as part of “case management”)
- Micro planning at district level involving peripheral level health workers
- Contract out logistics to assist with direct distribution from central stores to facilities for short-shelf life products (ACTs)

Private Sector Supply

Non-availability of affordable ACTs in private sector

- Inform countries on initiatives on the global level (EARN).

Quality of Services

Improving diagnostic quality

- Review and implement standardized curricula (attachments, collaborations)
- Use WHO/UNICEF pre-qualified tools and reagents that adhere to GMP requirements. Do routine quality reviews by NDAs. Periodical audits of tools on the open market.

- Make additional procurements based on need
- Design and disseminate adequate job aides and encourage adherence to them.
- Develop standard supervision tools and conduct regular visits to facilities.
- Strengthen maintenance units. Train lab staff on, and regularly evaluate, maintenance of tools.
- Establish and strengthen a QAS.
- Develop regulatory mechanisms and engage the private sector.
- Improve HR levels
- Explore the possibility of introducing RDTs at comm. Level. Educate the public.

Ensuring that test results are respected when diagnosis is made

- Continuous skills development programs
- Encouraging team work within the health facility (meetings, QA involvement). This increases trust and change in attitudes.
- Monitor adherence to guidelines and implement the regulatory requirements in the private sector.
- Advocate for better remuneration and identify non-monetary motivations

Including private sector in malaria control: how to address and monitor them?

- Develop standards and guidelines that cut across all the sectors in health
- Develop and implement Public-Private Partnership Policies to encourage collaboration
- Resource mobilization

Adherence to standard protocols in order to avoid medicines and insecticide resistance

- Regular adherence tracking studies
- Intensive advocacy and BCC
- Quality control of supplies entering the country
- Forecasting needs
- Build capacities to ensure quality
- Conduct targeted studies

Harmonization

Partnership and programmatic linkages

Government

Including multi-sectoral Ministries with special focus on MOH depts.

Examples: MOF and planning, Min. of women and youth, Min. of environment and protection, Min. of education, agriculture

- Government commitment to anti-corruption
- Establish IT/communication system for transparency and information sharing
- Working with Professional Assocs., Civil Society organizations, Regional Networks and Economic Blocks for Cross-border collaboration and professional updating, sensitization and advocacy
- Engagement for other key political and community leaders beyond government staff.

Donors

- A common platform recommended for all donors and partners for planning and discussion initially excluding the government presence for the sake of open discussion of issues
- Establish a joint platform including the government in the discussion

UN agencies

- UN agencies network at all levels on issues of proposal requirement and design, M&E requirements and progress reporting

NGOs, CBOs, FBOs

- NGOs at all levels work within government guidelines
- Highlight examples of NGOs-government collaboration for establishing sustainable programs within communities

Private sector

- Public-private framework addressing fair profit and compensation for public health of benefit

Private and public service media

Community

- Capacity building and transfer of responsibility to community starting at early levels of planning
- Sustained community ownership and feedback

Session 1 opening ceremony

Day One - Tuesday 20th November 2007

Opening Ceremony

The Master of Ceremonies Mr. Peter Mbabazi Kwehangana (Regional Coordinator EARN, RBM Secretariat) welcomed all participants and introduced the chairperson of the session as Dr. Azima Simba (National Malaria Control, Deputy Programme Manager, Tanzania)

Peter briefed participants on the agenda as indicated in the meeting timetable. After requesting countries to take their seats in the designated seats, he highlighted the objectives of the meeting.

He called upon the 11 EARN members National Control Programme participants, and partner organisations who briefly introduced themselves. Peter briefly reviewed logistical arrangements, followed by a briefing on the meeting agenda¹.

Meeting Objectives – Peter Mbabazi

Peter presented the meeting objectives (see Section 6 above) and emphasised that the EARN Annual Review and Planning Meeting is essentially about the partnership working to achieve tasks set by national programmes. The specific objectives to update countries on the new developments within the RBM partnership and EARN and mechanisms available to ensure country support. To receive country updates on progress made in scaling up for impact (SUFI) to meet 2010 targets and identify implementation challenges that may hinder progress. To come up with specific solutions/proposals for addressing identified challenges, and to develop joint plan for country needs for implementation support

It also provides a valuable opportunity for participants to meet with national programmes and partners from all sectors so as to obtain updates on developments in malaria prevention and control and to interpret global issues with a national and regional perspective. Other objectives include the identification of gaps preventing the realisation of objectives, and strategising on how to achieve targets set by national leaderships within the context of global targets

EARN Overview and update – Alison

After a brief introduction on the historical background, membership, purpose and functions of EARN, she highlighted on the EARN progress of the past one year.

In the presentation the priorities of EARN were described and the main priority support priorities

- Build country capacity,
- Access to additional resources,
- Maintaining high performance,
- Track country progress,
- Ensure access to affordable malaria control commodities, provide leadership and stewardship to the RBM partnership

RBM PARTNERSHIP OVERVIEW AND UPDATE –Dr.James Banda

¹ Annex 2



Dr. J. Banda presented the RBM partnership overview and update and highlighted the following

- RBM is interested in harnessing the country programs
- Strengthen capacity and enhance performance for SUFI implementation (45 business plans, 10 priority countries)
- Keep malaria high on the development agenda and access additional resources (including through GFATM, UNITAID) >60% success rate in GFR8, 45 countries mobilize adequate resources for SUFI
- Enhance performance in countries and secure continued resources (through diagnostic and corrective responses), (95% countries currently getting funding should continue to keep it, 80% countries perform at A or B1)
- Track country progress (12-20 countries to deploy MIS, publish malaria profile and update 107 country profiles)
- Strengthen access to commodities for malaria control (45 countries have access to affordable medicines for malaria through the private sector –TBC)
- Ensure proper functioning of partnership mechanisms (track progress and report to RBM Board, >80% implementation rate of HWP)

Update on Global/targets,-Universal coverage –Dr.Josephine Namboze

- Malaria status in EARN countries, some countries documenting reduction in malaria
- Strategies for universal coverage should lead to clear progress in malaria control
- 2008 – 2010 goals of the global business plan
- Intensified implementation (proposed countries)
- Resource mobilization
- Strategies for universal coverage (first line, rectal artesunate at community level, improved treatment in private sector, free malaria medicines)
- Quality assurance and control
- Link between case management logistics and health information system – need to invest in improving records and information flow,
- LLINs & IRS are core interventions (choice depends on local feasibility, however, combination of both interventions is a pragmatic option to reach and maintain high coverage rates and maximize health impact of MVC)

- The way forward (quality of CM, target vector control >80%, studies on IRS/ITNs, strengthen research)

Questions ,discussion session–Dr.Josephine Namboze & James Banda

Q1 What is the criteria of country selection

Ans: Dr. James Banda elaborated that countries are selected according to their demand. If a country indicates a technical support need in its business plan, that country will be selected by RBM for the technical assistance it requested.

Q2 Monitoring of efficacy of ACT is difficult takes long time and is costly. What is WHO's recommendation for this?

Ans: Dr. Josephine Namboze elaborated that there is a new WHO protocol that has been developed for low transmission (cases) areas. The main element of the protocol is that it allows continuing the study during transmission season over consecutive years.

Q3: How is the people factor (behaviour change, participation, ownership) and harmonization addressed?

Ans: Many countries have indicated community involvement and this is also advocated by both WHO and RBM. The practical aspect of it however needs more effort.

Q4: There few manufactures and few ACT what are the plans?

Ans: WHO is informing companies to seek the technical assistance of WHO in getting the product certification process. However, companies are usually not ready take the extra mile required to ensure this and this has been hindering the effort of bringing more options.

Remarks by the WR Tanzania

Dr Ritha , WHO Representative, Tanzania office,

Guest of honour address and opening

Dr Azima Simba introduced the guest of honour, the Honourable Minister of Health and social Affairs, Tanzania, Prof.David Mwakyusa. The Honourable Minister was accompanied by; the Principal Secretary of the Ministry of Health, Dr M. Jiddawi; the WHO AFRO Representative, Dr. Josephine Namboze, WHO Tanzania Representative Dr. Rita Njau ; the UNICEF Representative Dr Angus Spiers,; Dr James Banda of the RBM Secretariat, Geneva;

The Honourable Minister described her pleasure in learning of the successes of EARN in establishing an effective mechanism for offering in a cost-effective manner, timely and quality malaria response services needed by countries in the Eastern Africa Sub-region. The principle of partnership on which EARN is established and the progress made in the sub-region towards genuine cohesiveness and adoption of common approaches was commended. The Honourable Minister concluded by paying tribute to all those involved in malaria control for their dedication and urged all colleagues to work diligently to save lives.



The Honourable Minister then requested all participants to spare the time to learn from the experience of Zanzibar in fighting malaria and encouraged them to enjoy the hospitality of the people of the famous historical Mt Kilimanjaro.

Vote of thanks

Dr John Bosco Rwakimari, Malaria Programme Manager, Uganda, gave a brief vote of thanks speech, in his vote of thanks he reiterated in 1950 when Governor Cowen presided over a workshop of malaria experts gathered in Kampala which hatched the idea of Malaria Eradication Campaign that began in 1955. By 1970 malaria had been eradicated in Europe and America and nearly eliminated in South East Asia and S America. He said that today the 20th of November 2007, history repeats itself as we witness the honourable minister flag off the drive to eliminate malaria and eventual eradication in Africa.

He thanked the minister for his words of wisdom and encouragement and for your pledge to support the drive to eradicate malaria including the people and the Government of the Republic of Tanzania for their hospitality. He thanked RBM Partnership for having built a strong foundation through the promotion of Public-Private Partnership now spearheading the drive towards malaria eradication. As well as the International communities for recognizing the enormous burden of malaria on the African population and committing support to our governments in form of Sector budget, projects and technical assistance.

Lastly he appreciated the significant initiatives being undertaken, these include the African Union 2006 call for the universal access coverage of all malaria key interventions; the G8 Heads of Government call to reduce the burden of Malaria; WHO re-emphasis on Indoor Residual Spraying including use of DDT; The GFATM and PMI. All these initiatives provide opportunities for maximizing the returns on the investment.

Group photo

Peter organised the group photo with the guest of honour, in the gardens by the swimming pool at Impala Hotel, this was followed by a tea break graced by the Guest of honour².



Session 2 country presentations

This session was chaired by Dr James Banda the RBM Country support coordinator, before start of the session Dr. James Banda introduced the RBM Secretariat team who are involved in the coordination of this meeting. As follows:

1. Mr. Peter Mbabazi Kwehangana- Ag.Regional Coordinator-EARN
2. Ms. Nadia Lary- Data manager RBM Geneva
3. Ms. Sophie Schmitt –Secretary for country support RBM Geneva

² Cover Photo 2

Group 1 Countries: Eritrea, Ethiopia and Kenya

No	Country	Achievements	Challenges	Support Needs
1	Eritrea	<ul style="list-style-type: none"> • New treatment policy (ACT). • high coverage of ITNs, • declining number of malaria cases and deaths 	<ul style="list-style-type: none"> • The significant reduction of malaria morbidity creates other challenging issues/factors: • low immunity of population, tendency to develop severe malaria & prone to malaria epidemics • Challenge of sustaining the achievements and successes obtained. • Creates complacency/relaxation among population, MOH, Partners among others • Generally limited infrastructure (transport, laboratory, communications); • Generally limited trained human resources in the General Health Delivery System; • Generally limited data base for linking epidemiological, entomological, ecological, and climate-related data to predict epidemics; • General concern of sustaining community based interventions (bed net issues, source reduction, case management) ownership and support for CHAs- incentives • Cross-border malaria concern 	<ul style="list-style-type: none"> • Updating of AMDs Policy, dissemination and training of HWs and CHAs; • Procurement of adequate AMDs (ACTs); • Procurement of adequate RDTs; • Procurement of LLINs, insecticides etc. • Improve the early treatment seeking behavior and use of ITNs of the population and particularly of the vulnerable groups (<5, pregnant women, the military & other non immune population) by conducting aggressive HP/BCC activities. • Goluj Project and Construction of ware house in Gash Barka (which has already eaten too much time)

No	Country	Achievements	Challenges	Support Needs
2	Ethiopia	<ul style="list-style-type: none"> • Rapid scale up in coverage of LLINs • Increased coverage in IRS • Improved access to ACT (coartem through HEW) 	<ul style="list-style-type: none"> • Mobilizing adequate resource to keep high coverage of interventions - e.g. 50 million LLINs to MDG to maintain 80%) • Ensure dependable Drugs and commodity supply system, • QA and QC of malaria diagnosis (RDTs + Microscopy) • Targeting and Delineating the role of IRS and LLINs • Improving community awareness and utilization of interventions (ITNs Utilization, ACT Compliance) • Malaria surveillance and Program monitoring and evaluation • Shortage of human power and High staff turn over 	<ul style="list-style-type: none"> • Resource mobilization, • Functional Drug and logistic supply management system • QA & QC for malaria microscopy & RDT, • Database system for routine program monitoring, • Refine malaria risk stratification, • Operationalizing Communication strategy, • Establish sentinel surveillance system & strengthen malaria epidemics preparedness and response capacity • Strengthen sentinel site study on efficacy of anti-malarial drugs and Insecticides • Strengthen technical support to FMOH and other partners working in malaria control

No	Country	Achievements	Challenges	Support Needs
3	Kenya	<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> • Poor Documentation (M&E) at all levels; process, outcome and impact • Poor Reporting and accounting of funds particularly at the periphery • Can we sustain our achievements? Dependency on donor funding is a big challenge • Timely implementation of planned activities 	<ul style="list-style-type: none"> • Documentation (M&E) at all levels; process, outcome and impact-support needed • Support in resolving Global fund round 2 • Support in round 8 proposal • Support in community based fever management • Improvement of diagnostics • To fill gap left for failure of round 7

Question and Discussion Session

Q1: to Ethiopia: How can you ensure financial sustainability if drugs and other services are provided free of charge?

A:

Q2: to Kenya: What are your plans for the expansion of ACTs to the general population given the current treatment guidelines?

A: The program is currently conducting pilot studies to establish whether AL can be deployed at community level. Then AL will be re-classified to allow roll out to the community level.

Q3 to Eritrea: What is the drug that is used at community level?

A: Chloroquine and SP are the drugs currently used in addition to an anti-pyretic.

Q4 to Ethiopia: What form of access is reflected at the level of 93%?

A: Physical access to health facilities. That is population within a 5km radius of a health facility.

Q5 to Kenya: The M&E has been over assessed and several recommendations still need to be implemented. Why the request for additional technical assistance from WHO this time round?

A: The requested TA is guide the establishment of a Malaria Information Acquisition System in order to guide decision making by the program.

General comment during the discussion: There is need to strengthen community involvement at implementation level. The involvement of CSOs is critical for the success of program activities.

Group 2 countries: Rwanda, Burundi, Somalia, Sudan south

No	Country	Achievements	Challenges	Support Needs
1	Rwanda	<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> • Coordination of partners in line with Rwanda RBM strategic plan • Antimalarial drug and insecticide Resistance • Change in Malaria epidemiology due to large scale intervention • Some funding not in accordance with Country priorities and needs. 	<ul style="list-style-type: none"> • Need assessment of Malaria Control (WHO) • Next steps of Malaria control plan
2	Burundi	<ul style="list-style-type: none"> • Improving coverage of interventions (ITNs, IRS, Case management) 	<ul style="list-style-type: none"> • Lack of formal National Malaria Program • Sustainability on ACT provision • Implementation of treatment policy in private sector • Lack of paediatric form of AQ-AS and FDC • IPT implementation in the context of high Resistance to SP • Rational ACT management in remote health facilities with shortage of skilled health workers for laboratory diagnosis • Stock outs of antimalarial drugs due to inaccurate quantification and effective logistics • Because of weaknesses, the HIS does not capture accurate data for impact measurement 	<ul style="list-style-type: none"> • Support for development of M & E plan • Support for LLIN mass distribution campaign • Develop guidelines for IRS strategies • Support for development of PSM

No	Country	Achievements	Challenges	Support Needs
3	Somalia		<ul style="list-style-type: none"> • Skilled human resource and technical capacities at all levels • Distribution of supplies to health centres • Surveillance : Proper surveillance system non existent which makes efficient planning and prioritization of areas for interventions very difficult • Private Sector development • Entomological surveillance and IVM 	<ul style="list-style-type: none"> • Scaling up LLINs distribution • Expansion of diagnosis and case management to health post levels • Piloting Surveillance • Operational research • Establishment of quality assurance systems and malaria referral labs • Increased EPR capacities • IEC • Strengthening field based coordination and technical support mechanisms
4	Sudan (South)		<ul style="list-style-type: none"> • Weak health system • Limited trained human resource within the programme • No clear budget outline for the programme • Weak coordination of partners at different levels • Country wide shortage of commodities- ACT, ITN & RDTs • Inadequate M&E and staff at various levels • M&E and documentation of impact • Weak laboratory network system lack of QC&QA and inadequate blood transfusion services 	<ul style="list-style-type: none"> • Capacity on M&E • Access to additional resources for LLITN • Resource for training, operational research • Monitoring of anti-malarial drugs and insecticides • Expansion of health services, program management ▪ Coordination and integration of malaria control with other programs

Discussion on Second Round of Country Presentation

Questions in the discussion for group 2 country presentations:

Q1 to Rwanda: What are the mechanisms for replacement of nets under the keep up phase?

A: Several mechanisms are in place and these include:

- ANC clinics
- Immunisation campaigns
- Private sector supplies
- Regular keep up campaigns every 3 years

Q2 to Burundi: In the absence of a National Malaria Control Program, does a strategic plan specific for malaria? Does a monitoring and evaluation system exist?

A: Yes there is a Strategic plan and malaria specific M&E system exists.

Q3 to Somalia: How are the IDPs being handled?

A: they are covered by the two major interventions of case management and vector control since they are in relatively more secure settings.

General comments during the discussion:

- Taking opportunity of the GF to pay allowances and salary top-up for key program staff
- Need to explore avenues for harmonization of partners

Need to have in place key guiding documents such as Procurement and M&E plans

Group 3 Countries: Uganda, Zanzibar, Sudan (North)

No	Country	Achievements	Challenges	Support Needs
1	Uganda	<ul style="list-style-type: none"> Coverage indicators - progress over time 	<ul style="list-style-type: none"> Inadequate Resources: Human resources at all levels; Inadequate Financial resources Delayed commodity procurements. Weak health systems / HMIS difficult to measure impact (M&E) Weak diagnostic services' 	<ul style="list-style-type: none"> Support for development of PSM plan Support for development of M&E plan Support for development of Global Fund round 8 proposal Support for development of management system/structures Support for training laboratory technicians
2	Zanzibar	<ul style="list-style-type: none"> 100% of the population - via Public HFs 21% of malaria cases treated within 24hrs with ACT – far from the national target! High coverage of interventions, Declining number of malaria cases and deaths 	<ul style="list-style-type: none"> Financial gap 2009, 2010 on wards M & E and Surveillance in low endemicity Human resources 	<ul style="list-style-type: none"> Study tour for Zanzibar and Eritrea to EMRO (Muscat Oman) to exchange ideas and learn about malaria "elimination techniques". PSM BCC M&E HMIS
3	Sudan (North)	<ul style="list-style-type: none"> Case management scaled-up, Integrated vector management Epidemic detection & containment Capacity Building and Partnership 	<ul style="list-style-type: none"> Availability of Artesunate suppositories for pre-referral HF with lab diagnosis is <35% False positivist is still high RDT use is limited ACTs use advocacy is limited Resistance to DDT and Malathion, & Pyrethroids tolerance ITNs coverage & culture is still weak ITNs re-treatment rate is very low IRS ... Weak analysis of epidemic risk data at state or peripheral level M&E system needs strengthening Public private sector to avoid the potential for conflicts of interest 	<ul style="list-style-type: none">

Questions in the discussion for group 3 country presentations

Questions directed to Zanzibar:

Q1: Why give IPT_p when the endemicity of malaria is currently very low? What is the WHO guidance on this?

A: The low endemicity is due to the unexpectedly high impact of the scale up of key interventions. The situation is still very fragile to withdraw IPT_p. WHO will make a clear statement on this issue in the course of next year.

Q2: How does the country prevent or control cross-border infections?

A: This calls for joint effort between the mainland and Zanzibar. There is need to develop a comprehensive package of intervention at key points on the mainland.

Q3: With already 3 rounds of IRS, how long shall IRS continue and what is the exit strategy? Is there government commitment?

A: IRS will continue for the next 3 to 5 years. The exit strategy is use of LLINs. The commitment of government will be ascertained after presenting and discussing the current malaria figures with the key authorities in government.

Q4: Regarding ACT use, how has it progressed over the years?

A: Not yet captured

Questions to Uganda: What is meant by support for management structures? Are there plans to do a Malaria Indicator Survey?

A: The support is in terms of developing a Procurement, Supplies and Logistics Management comprehensive plan. Yes, the country intends to conduct a MIS in 2008 alongside an HIV Sero-Behavioural survey.

Cross-cutting questions:

Q1: What are the vector resistance strategies used by countries that use IRS?

A: These include:

1. Mosaic strategy
2. Insecticide efficacy monitoring every after 2 years
3. Adherence to vector control guidelines that are country specific

Q2: In Uganda and Tanzania, how has integration of HIV and Malaria programs been done in terms of management and coordination at the National level?

A1: In Tanzania, this is still difficult.

A2: In Uganda, program designs are beginning to be integrated. For example, the PEPFAR package involves distribution of nets to HIV clients. Also, the MIS is going to be integrated into the HIV Sero-Behavioural Survey in 2008.

General comment:

- There is need to pay close attention in the process of accessing ACTs for the private sector through the Global ACT subsidy and tease out how it impacts on the general health system.

9.2.1 Other key issues:

1. Ensuring community participation and involvement
2. Prioritising MIP
3. Ensuring Inter-sectoral collaboration
4. Resistance management for insecticides and ACTs
5. ACT use at the community level
6. Integration of programs
7. Durability of nets
8. Harmonization of partners and plans
9. Institutional strengthening
10. Engaging the Private sector
11. External Quality Assurance
12. Involving the social sector

13. Fore-casting of needs (Quantification)
14. Safe disposal of IRS residues, packaging materials etc
15. Integration with on-going development projects

Day Two - Wednesday 21st November 2007

A to Z Special Session

Participants visiting A to Z factory

Day Three – Thursday 22nd November 2007

EARN Annual Review and Planning Meeting – Ricky Orford

Ricky orford convened a plenary discussion appropriateness, suitability, and format of the EARN meeting in light of WHO's decision to hold a joint annual planning meeting for both the Eastern and Southern Africa regions of WHO-AFRO. Participants were reminded that a questionnaire evaluation of EARN, including the annual meeting, had been carried out in 2005, and this supported the continuation of the EARN annual meeting, however, this evaluation was conducted prior to the decision by WHO to hold the combined ESAMC meeting.

Some of the responses received from the floor are summarised below:

The annual EARN meeting was still considered to be a useful meeting, as it is different from WHO-led meetings, principally through the encouragement of a broader participation of partners, many of which are not represented at the ESAMC and other similar meetings. Eritrea was a vocal supporter of the EARN meeting, as it is unable to attend many international meetings, but always attends EARN, as it is considered to be one of the most important meetings in the malaria calendar.

There was a call for an even greater emphasis and focus on helping countries to solve some of the technical and operational challenges faced in implementing their programmes. While the broad range of subjects presented was generally welcomed, it was felt that this left too little time to discuss some of the implications, especially in key areas such as ways to manage the flow of fake antimalarial medicines onto the market in Africa, before the situation becomes as serious as that seen in Asia.

Several participants proposed that the meeting may no longer be required to be held over a full five days, with some of the technical updates being left to the joint ESAMC meeting instead. It was suggested that as many of the issues raised by countries had also been raised at the ESAMC meeting, then the agenda of future EARN meetings could at least partially be driven by the recommendations and action points of the ESAMC meeting, as well as inputs from country programmes, in order to minimise overlap. A useful suggestion was made in relation to the timing of the next meeting, which it was proposed could be scheduled to facilitate participating countries to undertake a peer review of GF proposals prior to the submission deadline.

Conclusions, Recommendations and Action Points – Josephine Namboze

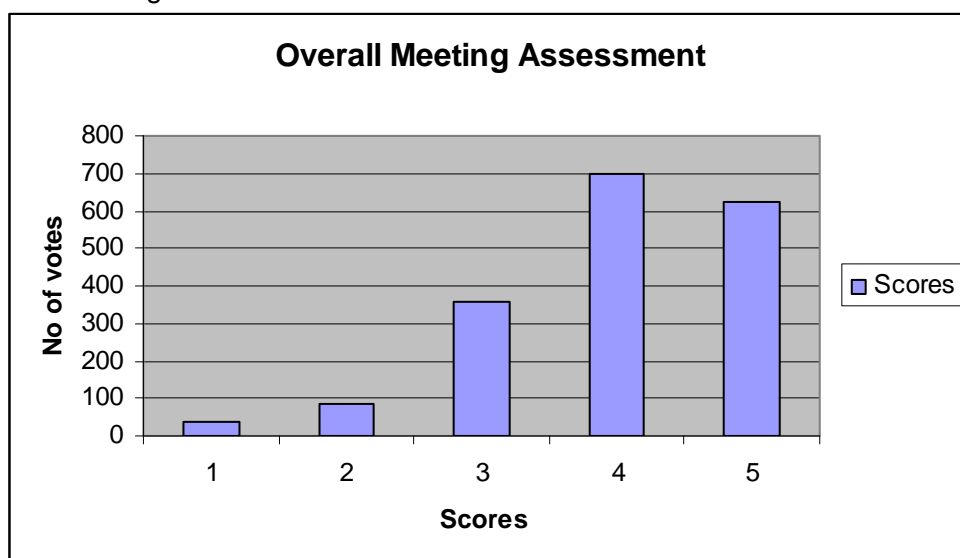
Issues and recommendations arising during the meeting were presented and discussed and final consensus on wording was reached. See Section 7 above.

Meeting Evaluation

Participants were requested to provide comments on the organisational and logistical aspects of the meeting, including the venue, agenda, etc. Participants were also asked to grade the sessions on a scale of 1,2,3,4,5 scoring from 1 for poor to 5 for excellent.

Results of meeting evaluation

The meeting was evaluated and the overall assessment was as follows in the chart below



It can be seen from the chart that 2.0% voted 1, 4.8% voted 2, 19.9% voted 3, 38.7% voted 4 and 34.7% voted 5. This showed that overall the participants were satisfied with the way the meeting was conducted and that facilitators were generally good.(see annex..)

Closing Ceremony

Guests of honour at the closing ceremony included the

Photo of the closing ceremony

ANNEX 1: Meeting programme

Time	Session Topic	Presenter	Chairperson
Sunday 18 November			
3:00- 4:00	Arrival of secretariat staff	Secretariat	EARN FP
5:00- 6:00	Meeting NMCP Tz, and Hotel officials	EARN Focal Point	EARN FP
Monday 19 November			
9:00-12:00	Photocopying, and parking files,	Secretariat	EARN FP
12:00- 6:00	Arrival of participants,		EARN FP
12:00-18:00	Registration and administrative support,	Secretariat	EARN FP
19:00-20:00	EARN coordination meeting	Cord Team	EARN FP
Tuesday 20 November			
8:00- 9:00	Late Registration and administrative issues	Secretariat	EARN FP
Session 1	Opening ceremony		
9:00 – 9:15	Administrative announcements	EARN Focal Point	Cord Team Member
9:15 – 10:00	Review of meeting objectives, expected outputs, programme, self introductions, expectations from participants	EARN Focal Point	Cord Team Member
10:00–10:15	RBM partnership, over view and Update	Dr. James Banda	Cord Team Member
10:15-10:30	EARN Overview and Update	Dr. Harima	PM NMCP Tz
10:30-11:00	Guest of Honour address and Opening	Hon. Minister of Health Tz	Dr. James Banda
11:00-11:10	Group Photo	Photographer	EARN Focal Point
11:10-11:30	Coffee/Tea,		
Session 2	Country presentations		
11:30-13:00	Overcoming Challenges to Achieve SUFI (Each country presentation for 15 minutes, 15 minutes for discussion)	Djibouti Eritrea Ethiopia Kenya	Dr James Banda
13:00-14:00	Lunch Break		
14:00-15:30	Overcoming Challenges to Achieve SUFI (Each country presentation for 15 minutes, 15 minutes for discussion)	Rwanda Burundi Somalia Sudan (North)	Dr James Banda
15:30-16:00	Coffee/Tea Break		
16:00-17:00	Overcoming Challenges to Achieve SUFI (Each country presentation for 15 minutes, 15 minutes for discussion)	Sudan (South) Tanzania Uganda Zanzibar	Dr James Banda
19:00-	EARN coordination meeting	Cord Team	EARN FP

Time	Session Topic	Presenter	Chairperson
Sunday 18 November			
3:00- 4:00	Arrival of secretariat staff	Secretariat	EARN FP
5:00- 6:00	Meeting NMCP Tz, and Hotel officials	EARN Focal Point	EARN FP
Monday 19 November			
9:00-12:00	Photocopying, and parking files,	Secretariat	EARN FP
12:00- 6:00	Arrival of participants,		EARN FP
12:00-18:00	Registration and administrative support,	Secretariat	EARN FP
19:00-20:00	EARN coordination meeting	Cord Team	EARN FP
20:00			

Wednesday 21 November			
Time	Session Topic	Presenter	
9:00-9:15	Wrap up and review of day 1, and review of day 2 agenda	Rapporteur	EARN FP
Session 3	Identification of implementation challenges		
9:15 – 10:30	Addressing Implementation challenges (Group discussions)	Facilitator	Coordination Team Member
10:30-11:00	Coffee/Tea Break		
11:00-12:00	Addressing Implementation challenges (Group discussions)	Facilitator	Coordination Team Member
12:00-13:00	Addressing Implementation challenges (Group discussions)	Facilitator	Coordination Team Member
13:00-14:00	Lunch Break		
14:00-15:30	Addressing implementation challenges – best practices (Plenary discussions)	Facilitator	Coordination Team Member
15:30-16:00	Coffee/Tea Break		
16:00-17:00	Addressing implementation challenges – best practices (Plenary discussions)	Facilitator	Coordination Team Member
17:00-18:00	Manufactures presentation (15 min each)	Manufacturers Rep	EARN FP
19:00-20:00	EARN coordination meeting	Cord Team	EARN FP
20:00-23:00	Reception	Participants	EARN FP
Thursday 22 November			
9:00 - 9:15	Opening, review of day 2, and review of day 3 agenda	Rapporteur	Coordination Team Member
Session 4	Addressing implementation challenges		
9:15-10:30	Presentation of country needs matrix	EARN FP	Coordination Team Member
10:30-11:00	Country teams identifying support needs, planning with partners to address challenges	Facilitator	Coordination Team Member
11:00-11:30	Coffee/Tea Break		
11:30-13:00	Group work by countries – identifying support needs, planning with partners to address challenges	Facilitator	Coordination Team Member
13:00-14:00	Lunch Break		
Session 5	Feed back from group discussions and way forward		
14:00-14:15	Country needs and support matching and timeline	EARN FP	Coordination Team Member
14:15-14:30	Next Steps and Wrap Up	Rapporteur	Coordination Team Member
14:30-15:00	Meeting Evaluation	Participants	EARN FP
15:00-16:00	Guest of Honour address and Closure	WHO WR Tz	James Banda
16:00-17:00	Coffee/Tea Break		
19:00-20:00	EARN coordination meeting	Cord Team	EARN FP
Friday 23 November			
8:00–10:00	Departure of participants	Participants	

ANNEX 2: Participants List

EARN Annual coordination for implementation support meeting 2007 participants

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ANNEX 3: Speech by the WR Tanzania



STATEMENT BY THE WORLD HEALTH ORGANIZATION REPRESENTATIVE TO TANZANIA, DR. MOHAMMED BELHOCINE AT THE EAST AFRICAN ROLL BACK MALARIA NETWORK ANNUAL MEETING

Impala Hotel, Arusha
20th – 22nd November 2007

The Honourable Minister for Health and Social Welfare –
Prof. David Homeli Mwakyusa
Representatives from the municipality in Arusha – Representative of the Regional Administrative Secretary – Dr O Chande
Representative from the RBM Partnership – Dr James Banda
Representatives from the WHO/AFRO – Dr Josephine Namboze
Representative of the Regional Director UNICEF – Dr Angus Spiers
Programme Managers from the 11 EARN countries represented at this meeting
Ladies and Gentlemen

Malaria remains one of the major tropical challenges in the world today. The number of malaria deaths globally is estimated at 1.3 million and incidence rates are up to half a billion per annum. The disease is endemic in 107 countries with half of the world population at risk of transmission.

In the past three decades, malaria has, however, encroached upon areas where it had formerly been eradicated or had been successfully been controlled, offsetting the gains attained in the latter half of the past century.

Honourable Guest of Honour

We all understand that Sub-Saharan Africa bears the brunt of the disease with 60% of the cases of malaria worldwide, 75% of global falciparum cases and more than 80% of malaria deaths.

Plasmodium falciparum causes the vast majority of infections in this region and at least 18% of deaths in children under five years of age.

Malaria is also a major threat to pregnant women and adversely affects foetal growth and newborn survival through low birth weight.

The socio-economic impact of malaria is extremely high in endemic countries. It has been observed that over the past 25 years the economic growth in malarial countries has been hampered. From 1965 – 1990, growth of income per capita for countries with severe malaria has been 0.4% per year, while the average growth rate for other countries has been 2.3%, which is five times higher. Hence the disease is recognised as a development issue with a key influence on poverty reduction. It incapacitates the workforce, leading to decreased economic productivity and output in various sectors of the economy. I believe all the countries in the sub-region present here are a testimony to these statements.

Honourable Guest of Honour

Controlling the enormous health impact associated with malaria has become a global priority as evidenced through the commitment by African Heads of States on the 'Declaration of Roll Back Malaria' in April 2000. Similarly through the Millennium Development Goals (MDG's) member states of the United Nations pledged to achieve by 2015 targets which relate directly or indirectly to malaria.

Honourable Guest of Honour,

Most recently there has been a paradigm shift in the fight against this disease with the goal of 'massively scaling up for impact and an emphasis towards elimination where feasible.'

The malaria control package has now been outlined as follows by the Global Malaria Programme:

Diagnosis of malaria cases and treatment with effective medicines

Long – Lasting Insecticidal Nets (LLINs) for community prevention, with 80% coverage of total population at risk (2 or 3 LLINs/household)

Indoor Residual Spraying (IRS) to reduce and eliminate malaria transmission - 80% coverage

Monitoring and Evaluation through the 'Three Ones'

Honourable Guest of Honour,

What does this mean for the malaria endemic countries represented here? It means intensified implementation using the evidence based tools available to us while consolidating the partnership in this endeavour and resource mobilization. In other words we have to do business unusual.

Honourable Guest of Honour,

In closing, I have been informed the countries represented here will be taking stock of their achievements in malaria control in the past year. However as they plan for the future they need to take-up the challenge of 'front-loading' the disease for massive impact and elimination where it is feasible. The task seems insurmountable; but already there is evidence of our partners offering their support such as; the Bill and Melinda Gates, the GFATM, the PMI just to mention a few. Without such partnership it will not be possible to achieve the new milestones set ahead of us.

I wish you fruitful deliberations.

Thank you.

ANNEX 4: Opening Speech by the Minister for Health Tanzania

SPEECH BY THE MINISTER FOR HEALTH AND SOCIAL WELFARE, PROF. DAVID MWAKYUSA AT THE OPENING CEREMONY OF THE ROLL BACK MALARIA NETWORK MEETING FOR EASTERN AFRICA COUNTRIES; IMPALA HOTEL, ARUSHA, 20TH NOVEMBER 2007

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Dear Participants

On behalf of my country, my ministry and on my own behalf, I would like to extend to all of you a warm and heartfelt greeting. Welcome to Arusha, the headquarters of East African Community.

I am aware that participants from the East African Community, Ethiopia, Eritrea, and Somalia, Sudan are all here. I have reliably been told that in the next three days, under the able leadership of the Roll Malaria Partnership you are going to deliberate and come up with country business plans on how our countries are going to scale up implementation towards the elimination of malaria in our sub region.

Elimination of malaria?-it sounds like grand impossible task- undoable. If one considers the levels infection and the burden of disease in countries like mine (mainland Tanzania) or Southern Sudan for that matter, it is as if we are aiming to reach the moon while we don't have the rockets to propel us there.

Dear Participants

Recent experiences from Eritrea, Zanzibar and Southern Mozambique all indicate that with the low tech tools available today like nets, insecticides and antimalarial drugs when used in combination and to scale it is quite possible to make significant reductions in malaria transmission, cases and deaths.

There is no doubt that we face a lot of challenges for reaching high coverage in implementing the combination of interventions needed to have an impact on malaria. Let me highlight some of the main obstacles we face:

The high costs of ACTs

Most if not all our countries in the sub region have adopted ACTs. ACTs are known for their superior cure rates, they save lives and their gametocidal activity has been associated with a reduction in malaria transmission. However, unsubsidized, they are too expensive for both our governments and patients to afford.

Access to LLINs

Research indicates that nets reduce all cause childhood deaths by 25%, and maternal anemia by 50%. If every household in the sub region was to have a net per sleeping space, malaria cases will be reduced by 50%. Yet coverage of nets is still very low in most of our countries

Weak Health Systems

Human conflict is not the only reason for weak health systems; there are several reasons. My country for example, has enjoyed years of harmony and tranquility among our people, yet our health system leaves a lot to be desired. The main reason for us is a weak economy which cannot meet all our aspirations.

Dear participants

It would appear from the description above that everything is doom and gloom. No, not at all; our friends in rich countries have shown great compassion to assist us in our plight. They are contributing funds to our development efforts either through bilateral assistance or through multilateral organizations like WHO, UNICEF, Global Fund etc. We need to take this window of opportunity to act. Last month The Ministers for health from Ethiopia, Mozambique, Zambia

and Tanzania were privileged to attend a meeting in Seattle in the United States which was organized by Bill and Melinda Gates Foundation. Bill and Melinda Gates gave shared us their vision of world free of malaria. They inspired the delegates, most of whom were top leaders from international organizations and the scientific community that effective deployment of the existing tools to fight malaria can indeed eliminate malaria in the world today.

Dear participants

The Roll Back Malaria Partnership has arranged this meeting so that you can come up with ambitious business plans for the elimination of malaria. I would just ask you to do exactly that. Without ambitious plans, we cannot come to grips with a ruthless enemy like malaria. Let's do it and I have no doubt that with a combination our efforts and those of our friends malaria elimination should be around the corner.

I would like to thank Roll Back Malaria Partnership for taking the leadership in facilitating this important meeting and I wish all of you success in your planning.

It is my honor and pleasure to declare that this business planning meeting for East Africa RBM Network officially opened.

THANK YOU FOR YOUR ATTENTION AND GOD BLESS YOU

ANNEX 5: Vote of thanks

Vote of thanks

Hon Minister
Executive Director RBMP
WHO Representative
UNICEF Representative
All Distinguished Guests
Ladies and Gentlemen

It is my honour and great pleasure to move a vote of thanks on behalf of the participants.

In 1950 Governor Cowen presided over a workshop of malaria experts gathered in Kampala which hatched the idea of Malaria Eradication Campaign that began in 1955. By 1970 malaria had been eradicated in Europe and America and nearly eliminated in South East Asia and S America.

Today the 20th of November 2007, history repeats itself as we witness the honourable minister flag off the drive to eliminate malaria and eventual eradication in Africa.

Mr Minister sir, we thank you whole heartedly for the words of wisdom and encouragement and for your pledge to support the drive to eradicate malaria.
We thank the people and the Government of the Republic of Tanzania for their hospitality.

We thank RBM Partnership for having built a strong foundation through the promotion of Public-Private Partnership now spearheading the drive towards malaria eradication.

We thank the International communities for recognizing the enormous burden of malaria on the African population and committing support to our governments in form of Sector budget , projects and technical assistance.

We appreciate the significant initiatives being undertaken, these include the African Union 2006 call for the universal access coverage of all malaria key interventions; the G8 Heads of Government call to reduce the burden of Malaria; WHO re-emphasis on Indoor Residual Spraying including use of DDT; The GFATM and PMI. All these initiatives provide opportunities for maximizing the returns on the investment.

Once again thank you .

ANNEX 6: Bottle necks Group discussions

Group I: Human Resources

Overall group	Identified challenge/bottleneck	Underlying causes of the bottleneck	Possible solutions for overcoming bottleneck	Has solution been tried before-where and what was the outcome
Human resources	Management structures	<p>Burundi-Civil servants recruited in the capital (recruitment is centralized).</p> <p>Centrally, the ministry can only recruit a limited number of personnel, due to budget ceiling</p> <p>Allied health personnel do not have a definite hierarchy in the system eg. Burundi-very low status of nurses.</p> <p>Staffing Norms are determined centrally without necessarily addressing specific needs of the districts</p>	<p>Burundi-decentralization will help in decision affecting HR, such that district will identify their needs.</p> <p>Advocate for more donor funding to increase the ceiling of staff costs</p> <p>Advocacy for establishment of advancement of all health personnel</p> <p>Advocacy for staffing norms to address both physical structure and workload</p>	<p>Establish departments to oversee all professionals (Kenya, Tanzania, Uganda)</p> <p>Eritrea-districts identify gaps and inform the MOH and they are recruited accordingly</p>
	Management capacity	There is lack of established structure/skills for administrative/supportive cadres in health (logistics, secretaries, administrators, accountants, data managers, etc.)	<p>Advocate for creation of additional posts to cater the administrative functions</p> <p>Develop skills of available staff to bridge the gap</p>	
	Decision making	<p>Lack of regulatory mechanisms of available health workers</p> <p>Misinterpretation of decentralization: Ministry of Health is not mandated on the disciplinary matters of the personnel and often HW have dual allegiance in decentralized systems</p>	<p>Set up a regulatory council for the nurses and allied health personnel</p> <p>Clarify roles of different centres of influence</p>	
	Retention strategies	Burundi- Health Professionals refuse postings especially to the rural areas because of lack of housing, poor working environment etc.	Uganda, ZNZ- those deployed in rural areas stand better chances of recommendation for	Kenya Police Staff are deployed to specific areas to work. people

		<p>Low salary is a common problem which causes qualified personnel to look for greener pastures elsewhere (in and out of the country)</p> <p>Lack of sufficient HW at low levels</p> <p>Lack of career structures, no advancement in terms of responsibility</p>	<p>further training and set a bonding agreement</p> <p>Pay top up-eg. The case of Tanzania (BM Foundation)</p> <p>Performance –based incentives</p> <p>To work it in the proposals from different partners including GF</p> <p>Upgrading courses</p> <p>Transfer Policy and work out ways of promoting people</p>	<p>adhere to policy- they are obliged to go where they are posted</p> <p>Kenya: UNO GFATM personnel can be recruited and paid better</p> <p>Introduction of upgrading courses as is done in Sudan</p>
	Training	<p>Inadequate training of allied health professionals eg. Burundi-No pharmacists in the system. Only auxiliary nurses to manage the workload</p> <p>Uganda- Training institutions provide training of technologists, which requires recruitment, while the system needs more microscopists for diagnosis of malaria</p> <p>South Sudan- Lack of training institutions, lack of basic qualifications to be enrolled into the institutions</p> <p>Quality of training including facilitation of those who are trained</p> <p>Lack of personnel with knowledge on mosquitoes at National as well as peripheral level</p>	<p>Introduce appropriate training programmes in appropriate institutions</p> <p>Train microscopist as a stop-gap but ensure that entry requirements for a higher upgrade course are met</p> <p>Experts to assist on establishing training institutions</p> <p>On job training of identified workers</p> <p>Structured refresher training, once or twice a year and ensure availability of equipment and supplies</p> <p>Follow-up supervision after training</p> <p>Advocate for creation of the posts of entomologists and related cadre</p>	<p>Eritrea- Institute of Public Health Technicians</p> <p>Provide RDTs a stop-gap for which can provide microscopy</p>

- Making data available for use across the health system and to partners
- One plan and budget, one M&E system (standardisation of indicators), one coordinating mechanism (i.e. Ethiopia)
- Implementing performance-based incentives (i.e. Rwanda)
- Partners to educate donors re national reporting formats used and the importance of supporting them

1. Quality of HMIS data – implications for action (1)

- Training across health system in importance and procedures for HMIS
- Training in data interpretation (HF) and data analysis (district)
- Explore ways of improving support supervision with DHOs
- Explore use of performance-based incentives
- Ensure computerisation at district levels and related training
- Ensuring roles and responsibilities are clearly defined
- Aim at developing standardised indicators for NMCP
- Ensuring one database for use at the national and district levels
- Use sentinel sites to improve quality reporting

2. Evaluation of malaria programme – challenges

- Insufficient funds available for evaluation
- Lack of commitment to evaluation
- Lack of M&E workplan and framework
- Research may not reflect programmatic information needs and priorities
- Evaluation results not distributed or used by implementers or policymakers

3. Evaluation of malaria programme – solutions

- Develop and implement periodic surveys
- Combine common themes (HIV, malaria, TB...) in surveys to reduce costs
- Utilise data from sentinel sites
- Develop M&E plans and frameworks where not available
- Develop mechanisms for communicating research needs and priorities, incl. coordination with NMCP and researchers
- Allocate/identify funds for short-term operational research to solve programmatic problems
- Training/ building capacity in operational research

4. Information based decision-making – challenges

- Decisions often based on availability of funds
- Donations may not be accepted based on local need or priorities
- Information systems and committees to detect epidemics may not be established, used or effective

3. Information based decision-making – solutions

- Ensure sufficient consultation to identify needs
- Communicate needs effectively to donors
- Establish cross-cutting committees to review data and consider appropriate action (i.e. HMIS committees in Ethiopia)
- Establish or improve epidemic detection systems (to report against a locally agreed threshold) and committees to inform district decision making (i.e. Tanzania and Ethiopia)

Group III: Sustainability

Key Issues

- Keep up strategies
- Net replacement/IRS implementation
- Moving from control to elimination
- Keeping donors and stakeholders interested

Identified Challenge/bottleneck

- Lack of clear country business plans with clear and realistic funding gaps

Possible Solutions

- Development of clear country business plans which include financial gaps and available resources
- Advocacy for the integration of tangible strategies for engaging private sector in malaria control programs including health impact assessments and CSR policy (South Africa, Zambia)
- Community participation in creative methods for cost-sharing and resource mobilization (country/context appropriate)- Ethiopia
- Continued advocacy for funds to support programs, subsidies and free services

Net Replacement

- Need to move from strategies emphasizing 'scale up' to those focusing on maintaining net coverage for the long term
- Campaign based net strategies not long term oriented
- Lack of acceptance of need for nets (free or not)
- Not widely integrated in general health services

Possible Solutions

- Need to revise country net strategies so that they are evidence based and integrated into vector control/management strategies; long term solutions, integrated into all areas of health care
- Net strategies should be based on population stratification by ability to pay, equity issues, country context (free v. subsidy)
- Identify clear mechanisms for replacing old nets (trade ins)
- Increased/improved social and behaviour change communication to increase acceptance and use of nets at community level
- Support of community led initiatives for vector control
- OR to identify, document, findings about net distribution, use, etc shared widely along with best practices (Ethiopia)

IRS

- Vector control strategies should include IRS and ITNs and other vector control measures
- Strategies should indicate how countries on the 'brink of elimination' might use IRS as part of vector control
- Continued advocacy for innovative approaches to address insecticide resistance

Group IV: PSM

Challenge / Bottleneck	Underlying Causes	Possible Solutions	
		Immediate Action	Longer Term Advocacy / Action
Topic 1: Procurement			
Government Rules & International Requirements	<ul style="list-style-type: none"> • Different and complex procedures and requirements (intl. vs. national) • Donors have different requirements (technical specifications, procedures, procurement source requirements, etc.) 	<ul style="list-style-type: none"> • TA to review rules and regulations with view to unblocking stalled procurements and standardization for future • Harmonization of donor rules at country level and universal agreement with national government • Sub-contracting to civil society organization for procurement (GF dual track) • EARN to provide more information on UNITAID and Affordable Medicines for Malaria to assist countries 	<ul style="list-style-type: none"> • Harmonization of donor rules at international level for major funding mechanisms
Over-stretched capacity	<ul style="list-style-type: none"> • Not enough people in procurement department • Untrained personnel 	<ul style="list-style-type: none"> • Train focal points with expertise in major donor requirements • Delegate and decentralize procurement function to lower levels where possible 	
Conflict with Local Manufacturers	<ul style="list-style-type: none"> • Lack of clarity on technical specifications • Conflict between international specifications and national qualification • Local manufacturers are more accessible to national government 	<ul style="list-style-type: none"> • Agreeing standard technical requirements for major malaria commodities at national level (TA) 	<ul style="list-style-type: none"> • Support local manufacturers to meet international standards / requirements
Forecasting	<ul style="list-style-type: none"> • Lack of information at country level and guidance on variables 	<ul style="list-style-type: none"> • Where data is not available or reliable, include research component to capture data necessary for forecasting 	<ul style="list-style-type: none"> • Universal tool for modeling needs which takes into consideration key variables
Donor Coordination	<ul style="list-style-type: none"> • Disjointed planning 	<ul style="list-style-type: none"> • Develop annual procurement plan for all sectors 	
Topic 2: In-country Logistics			
Long Supply Chain	<ul style="list-style-type: none"> • System has been in place for a long time and doesn't accommodate short shelf life drugs 	<ul style="list-style-type: none"> • Reduce steps in chain, e.g. sub-contracting distributors from central level to 	

		<ul style="list-style-type: none"> lower level • Active distribution – bringing the drugs to the periphery 	
Re-distribution System between lower levels (e.g. facility level / home based management)	<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> • Train the level assigned for the procurement • Incentives to lower level staff • Consider de-regulating ACTs (over-the-counter) 	
Storage Capacity	<ul style="list-style-type: none"> • Existing infrastructure suited for drugs not bulky items (nets) 	<ul style="list-style-type: none"> • Plan for increasing storage capacity and security within proposals 	
Establishment of a Pull System	<ul style="list-style-type: none"> • Lack of adequate personnel at the peripheral facility level • Lack of motivation for existing already over-stretched peripheral staff • Lack of understanding benefits of pull system 	<ul style="list-style-type: none"> • Assessment to identify underlying bottlenecks and solutions (TA) • Engagement and empower non-medical personnel to manage logistics at central and peripheral levels • Focused training for peripheral staff on logistics management (e.g. not simply as part of “case management”) • Microplanning at district level involving peripheral level health workers • Contract out logistics to assist with direct distribution from central stores to facilities for short-shelf life products (ACTs) 	
Topic 3 : Private Sector Supply			
	Unclear policies		
Non-availability of affordable ACTs in private sector		Inform countries on initiatives on the global level (EARN).	
Non-availability of correct formulation in private sector			
Countries have adopted a policy of ensuring supply of affordable drugs through private sector - bottleneck is there is no plan in place			

Group V: Quality of services

Overall group	Identified Challenge/ Bottleneck	Underlying of the causes bottleneck	Possible solutions for overcoming bottleneck	Has solution been tried before-where what was and the outcome	Implications for action
Quality of services	Improving diagnostic quality	<ul style="list-style-type: none"> Poor implementation of curriculum for lab personnel Lack of quality diagnostic tools (Equipments, test kits & reagents) Low coverage of diagnostic tools Lack of SOPs and lack of adherence to SOPs Poor supervision of lab staff Lack of regular maintenance of laboratory tools Absence of a Quality Assurance system Supplier induced demand for services especially among the private sector Lack of basic laboratory staff (S/Sudan) The HBMF strategy which is largely presumptive 	<ul style="list-style-type: none"> Review and implement standardized curricula (attachments, collaborations) Use WHO/UNICEF pre-qualified tools and reagents that adhere to GMP requirements. Do routine quality reviews by NDAs. Periodical audits of tools on the open market. Make additional procurements based on need Design and disseminate adequate job aides and encourage adherence to them. Develop standard supervision tools and conduct regular visits to facilities. Strengthen maintenance units. Train lab staff on, and regularly evaluate, maintenance of tools. 	<ul style="list-style-type: none"> Eritrea & N.Sudan Eritrea Most countries in the group 	<ul style="list-style-type: none">

Ensuring that test results are respected when diagnosis is made

- Incompetent lab staff
- Lack of trust among prescribers for lab results
- Job security & need for income generation in the private sector
- Lack of communication between staff of different departments
- Lack of motivation to follow guidelines

- Establish and strengthen a QAS.
- Develop regulatory mechanisms and engage the private sector.
- Improve HR levels
- Explore the possibility of introducing RDTs at comm. Level. Educate the public.

- Continuous skills development programs
- Encouraging team work within the health facility (meetings, QA involvement). This increases trust and change in attitudes.
- Monitor adherence to guidelines and implement the regulatory requirements in the private sector.
- Advocate for better remuneration and identify non-monetary motivations.

Including private sector in malaria control: how to address and monitor them?

- Perception that private is very different from the public sector
- Competition between private and public sectors
- Lack of national capacity to implement

- Develop standards and guidelines that cut across all the sectors in health
- Develop and implement Public-Private Partnership Policies to encourage

• Uganda

•

regulatory mechanisms in the private sector.

- collaboration
- Resource mobilization

Adherence to standard protocols in order to avoid medicines and insecticide resistance

- Differing consumer preferences (Compliance issues)
- Lack of adequate stocks of drugs
- Lack of awareness of the treatment policy changes
- Incompetent IRS staff
- Failure to comply to GMP requirements

- Regular adherence tracking studies
- Intensive advocacy and BCC
- Quality control of supplies entering the country
- Forecasting needs
- Build capacities to ensure quality
- Conduct targeted studies

Group VI: Harmonization

Overall categories	Group	Identified Bottleneck	Challenge/	Underlying causes of the bottleneck?	Possible solutions for overcoming bottleneck?	Has solution been tried before - where and what was the outcome?	Implications for Action
1. Government	multi-sectoral	Lack of collaboration among Ministries and Departments within MOH (examples, EPI, HIV/AIDS)	Challenge/	➤ Lack of collaboration mechanisms to strengthen linkages (eg. MOUs)	➤ Government commitment to anti-corruption		

<p>with special focus on MOH depts. Examples: MOF and planning, Min. of women and youth, Min. of environment and protection, Min. of education, agriculture</p>	<p>MCH,M&E,EPI, Vector Borne diseases, etc.</p>	<ul style="list-style-type: none"> ➤ Absence of ad-hoc advisory committees consisting of critical partners ➤ Absence of information sharing systems developed for purpose of information updates ➤ Competing priorities and conflict of interest ➤ Human resources constraints ➤ Lack of good management and administrative skills committed to results and a shared vision ➤ Need for result-based contract system ➤ Focus on improvement on governance issues and anti-corruption within government 	<ul style="list-style-type: none"> ➤ Establish IT/communication system for transparency and information sharing ➤ Working with Professional Assocs., Civil Society organizations, Regional Networks and Economic Blocks for Cross-border collaboration and professional updating, sensitization and advocacy ➤ Engagement for other key political and community leaders beyond government staff. 		
<p>2. Donors</p>	<p>Power plays between donor governments and competition</p>	<ul style="list-style-type: none"> ➤ Competing for recognition ➤ Lack of a shared ownership of national programming objectives ➤ Ideological conflicts ➤ Weakness in management coordination ➤ Lack of continuity of staffing personnel 	<ul style="list-style-type: none"> ➤ A common platform recommended for all donors and partners for planning and discussion initially excluding the government presence for the sake of open discussion of issues ➤ Establish a joint platform including the government in the discussion 	<p>Example: Ethiopia</p>	

3. UN agencies	Bureaucracy across organizations	<ul style="list-style-type: none"> ➤ In addition to the above, issue of individual organizational mandates ➤ Agencies specific bureaucracies as an obstacle 	UN agencies network at all levels on issues of proposal requirement and design, M&E requirements and progress reporting	Encouraging movement toward collaboration across Malaria, TB and HIV/AIDS for resources Business plans from national authorities for presentation to donors for their consideration	
4. NGOs, CBOs, FBOs	Rapid program implementation pace limits sub-contracting with CBOs for direct implementation responsibilities; need time for necessary capacity-building experience in order to meet donor requirements	<ul style="list-style-type: none"> ➤ Shifting human resource, staff turn over ➤ Historical burden: have image of NGOs as bodies planted to challenge governments ➤ International NGOs failing to recognise CBOs and FBOs ➤ NGOs acting independently of government priorities and initiatives 	<ul style="list-style-type: none"> ➤ NGOs at all levels work within government guidelines ➤ Highlight examples of NGOs-government collaboration for establishing sustainable programs within communities 	Malaria programs across countries with subcontracting with CBOs Example: Zanzibar and Kenya	
5. Private sector	Lack of working Public – Private partnerships	<ul style="list-style-type: none"> ➤ Corporate responsible issue is emerging requires a long-term perspective vs. short term profit ➤ Overcome the perception and suspicion that private sector are profit oriented only 	<ul style="list-style-type: none"> ➤ Public-private framework addressing fair profit and compensation for public health of benefit 	<ul style="list-style-type: none"> ➤ Gates Foundation's and others subsidizing ACTs, LLINs RDTs and future vaccine development ➤ Private sector pharmaceutical companies and LLIN producers investing in R&D for new improve products ➤ MMV acting as support to private 	

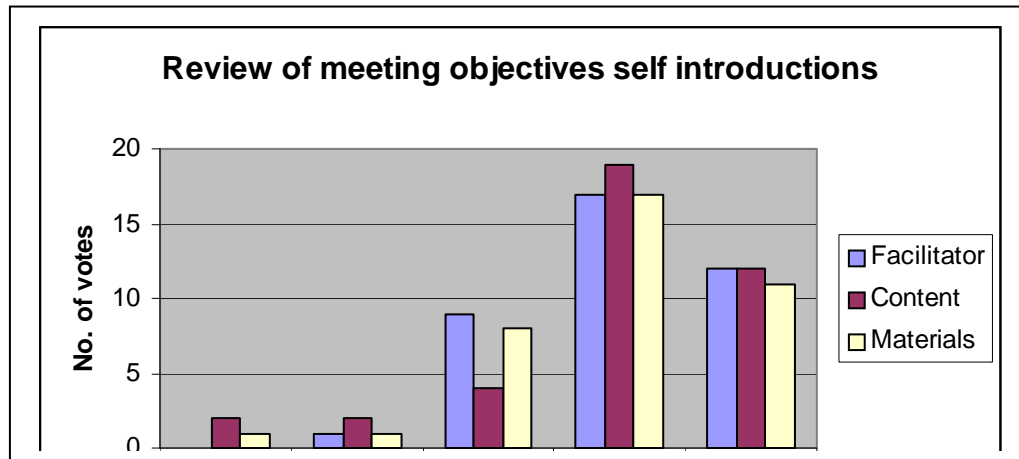
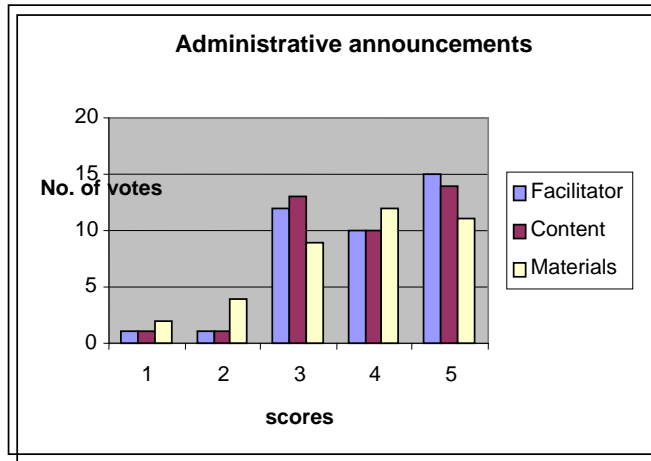
				<p>sector and malaria programs for new improve products</p> <ul style="list-style-type: none"> ➤ Private sector aware of need for pricing limitations for their products ➤ Possibility of developing generics. Example: Clinton Foundation 	
6. Private and public service media	<p>Inexperienced in health issues : profit-driven media reporting from private side</p> <p>Poorly informed on critical issues of health education for consumer</p> <p>Unregulated advertising for drug claims</p>	<ul style="list-style-type: none"> ➤ Media are perceived as being anti-government ➤ Media are profit-oriented ➤ Specialisation for accurate reporting ➤ Association of media to promote health and establish reliable best practices for reporting (need for incentive for empowering media) 		<ul style="list-style-type: none"> ➤ MAWG has helped to identify and educate private sector and media regarding the situation and the progress possible through RBM interventions at national level <p>Example: Coverage of Africa Malaria Day by national and international media</p>	
Community	<p>Communities have been perceived as passive recipient only.</p> <p>Lack of appreciation of their central contribution and capacity to partner</p>	<ul style="list-style-type: none"> ➤ Communities not engaged at critical planning stages ➤ Their understanding of local situation and adaptability never tapped into implementation options ➤ Lack of appreciation for their abilities to understand technical requirements and need for documentation ➤ Lack community ownership and critical 	<ul style="list-style-type: none"> ➤ Capacity building and transfer of responsibility to community starting at early levels of planning ➤ Sustained community ownership and feedback 	<ul style="list-style-type: none"> ➤ Example: CARE International: local NGOs to come from community and subcontracting them. ➤ Example of Rwanda ➤ Health service extension workers in Ethiopia ➤ Home based management of fever 	

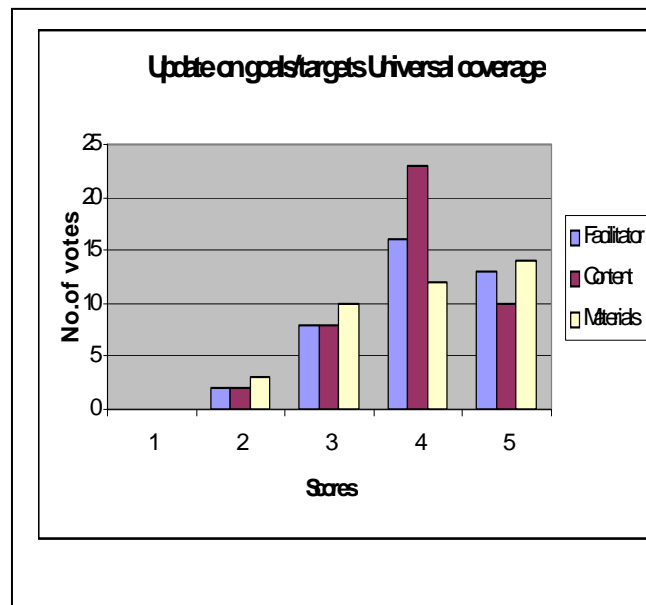
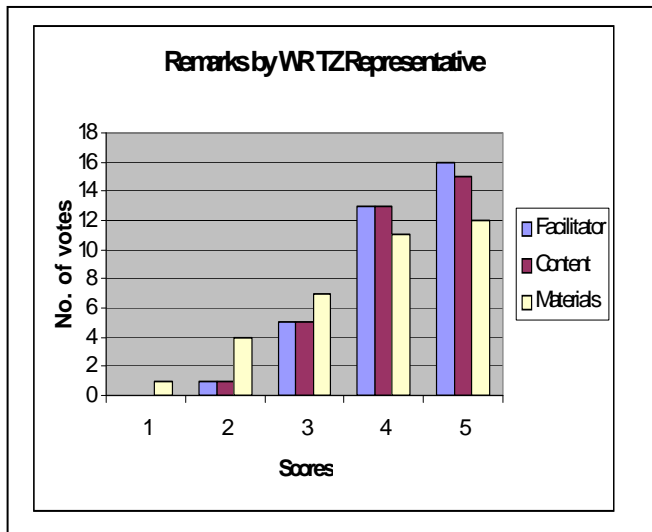
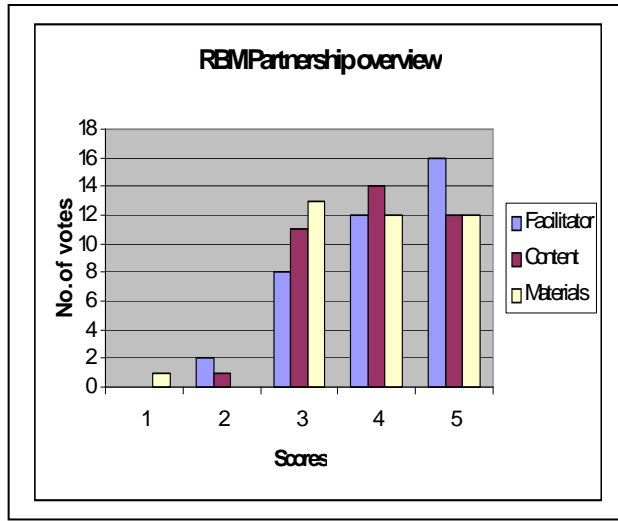
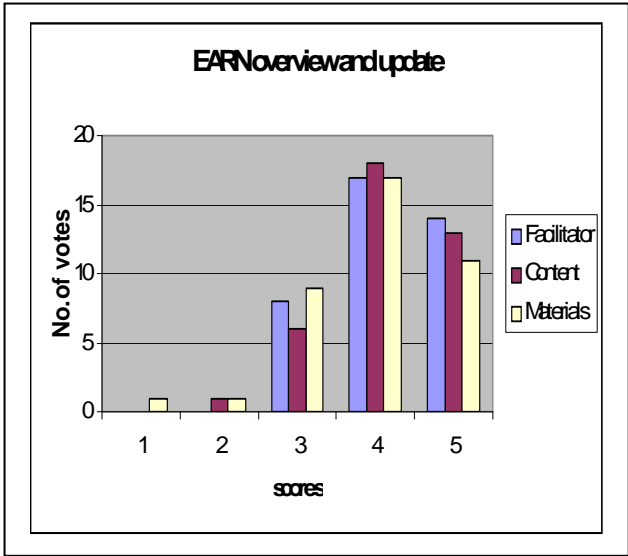
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Annex 7: Meeting Evaluation

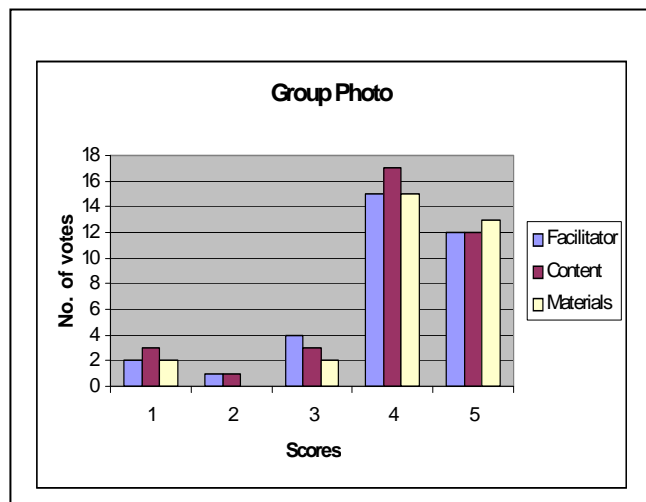
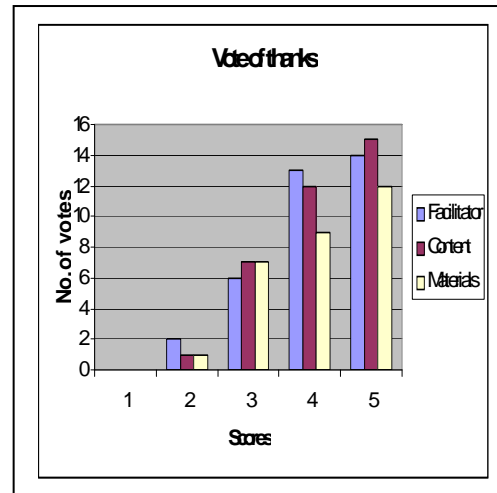
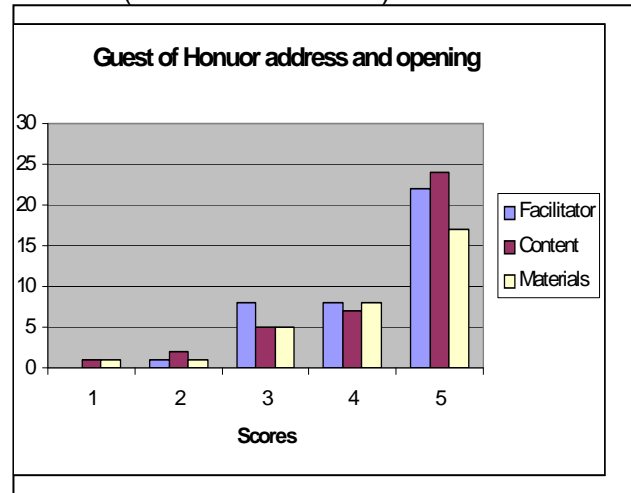
Day 1 (20 November 2007)

Session 1: Opening Ceremony.





Day 1 Cont'd (20 November 2007)



Session 2-Country Presentations

Did you find the presentations useful?

- Greater numbers found it useful

What suggestions do you have for improving this session?

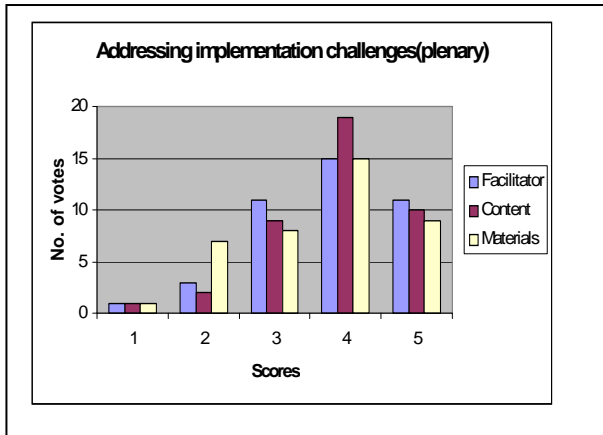
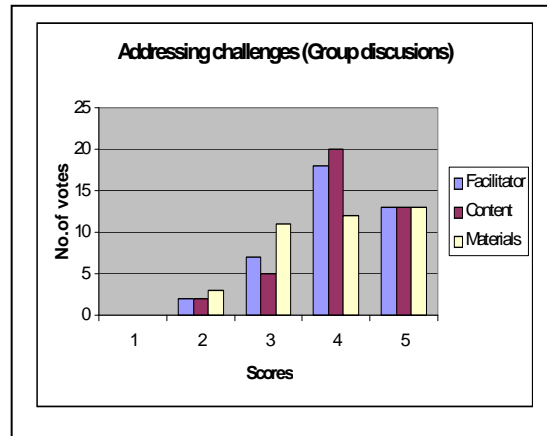
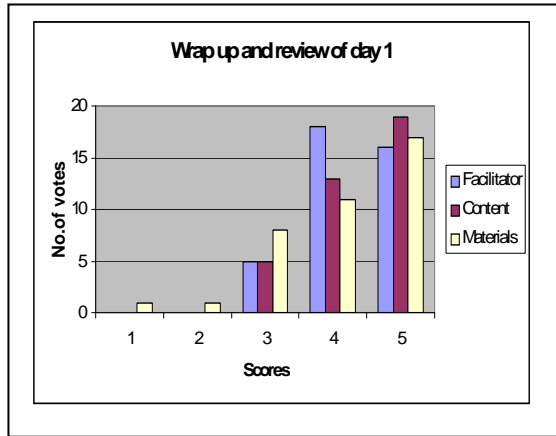
- All countries should comply with the presentations template for easy experience
- countries should strict to the assigned program
- we need a part of this session to discuss cross border collaboration as well
- It should be inline with instructions provided
- survey/research component
- L could wish there should be a common format of information required from countries
- it is acceptable
- Include past planned activities
- make presentations more usually interesting
- Since there are so many countries this session should be brief so that participants do not get tired.
- not to be in defined forms, to let countries to present freely all their achievements and works done in RBM
- more interactive discussion
- information to be summarized on a poster
- to adhere to the agreed template and time format
- Time factor 20 minutes
- fulfillment of the counties needs
- more time is needed
- Every country should follow the agenda
- Adhere to the format
- indicators vs performance ,standardize presentation style,i.e powerpoint
- we need to see testimony from the attached community
- Presenters have to be more focus to the points rather than moving around,showing photos.
- I was expecting presentations from high profile experts on new thermology_malaria prevention and control such as the new malaria vaccines.
- limited time
- There is need for uniformity and presentations
- countries with success story should be used to show case the process to the attainment of the success
- To be short and to the point
- 20 minutes handouts less data more practical/implementation.
- More time for details
- Be more organized especially administrative issues
- To remind the countries what we want to see in their presentation

What other comments do you have?

- countries should be equally represented
- participation of research
- Technical support needs country specific problems in relation to supporting each country.
- some best practices should be presented separately, so that we can learn
- Presentation from local research organisations for up dates
- some presentations were too long
- presentations need to be made shorter
- Format provided to be followed by all countries
- The technical and financial support needed by countries should be looked at
- To practice what we present
- provide guidelines for country presentations
- have better conference room arrangement avoid classroom type
- participation need to be improved, country coordinating mechanism member could be invited too
- LCD have to be well organised to be viewed better to all the viewers and the
- EARN should be continued on yearly basis but needs to be done a better way
- Encourage to use template outline
- No BCC session(Big session)

Day 2 (21 November 2007)

Session 3 - Identification of implementation challenges



Did you find the presentations useful?

- Yes

What suggestions do you have for improving this session?

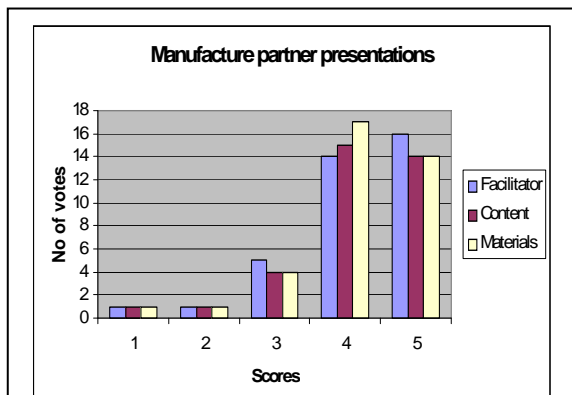
- To give more time to plenary discussions
- Discussions after group presentation during the plenary session giving a chance to contribution of earlier parts from other groups.

- On outlining the bottleneck, each countries should present separately
- composition of groups was not equally good
- Implementation challenges should be indicated by countries
- we need to present soluble challenges because some challenges presented need political decisions and are beyond our limits
- group presentations should be short
- more time for discussions of individual presentation
- Always provide clarifications
- This should have been done by country because it then more useful in creating the country work plan
- focus on few groups
- No need for making presentations after the group work
- There was opportunity to share which was nice
- present country strategic operational plans
- more time
- clear from work for presentation
- Again more standardized presentation format
- presenter have to be confident and trust in then selves of what they are presenting
- focus only on what EARN can help rather than discussing the whole challenges
- Need to have very clear template for discussions
- provide participants with our main issues agreed upon

What other comments do you have?

- At least one technical specialist should be present
- Evaluate % of technical support provided to assess the usefulness of the meeting even EARN it self
- some manufacturers want to have only their ideas(dominance)
- was a bit confusing at start
- have more time for discussion
- presentation style, some are not experienced on the way to face and present the audience
- country presentation include incidence of malaria case and deaths and the role of community in ROLL BACK
- Improve the materials(flipchart,

Session 4 - Manufactures and partners presentations



Did you find the presentations useful?

- meeting partners
- very useful
- yes, but difficult

What suggestions do you have for improving this session?

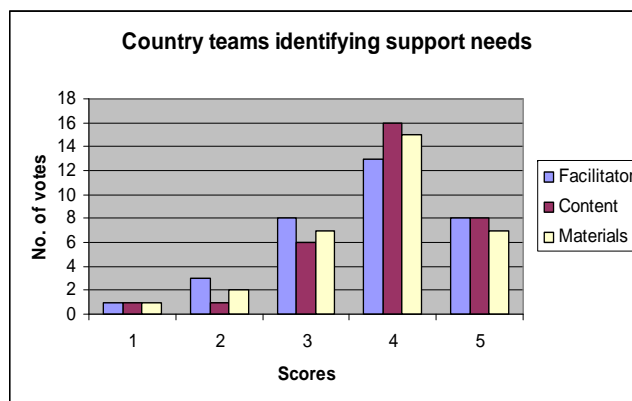
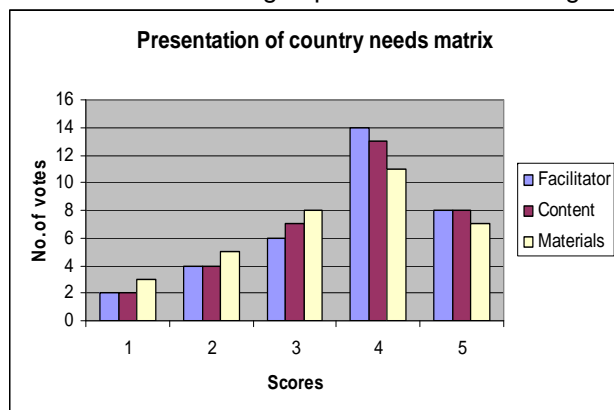
- more manufactures should be invited for better competition
- More manufactures to participate
- more manufacturers need to be invited
- include more manufacturers/partners
- more time is needed
- They should display outside the meeting
- There are business people
- integration of partners
- To give more time for discussions
- They could sell the products to participants as well
- more experienced on the commodities
- manufacturers need to give right information using their chemical experts not avoid confusion and misunderstanding
- we want verification from WHO
- Need to give much time to each presentation
- Better overview of objectives of the exercise
- A format for expected information to be given to the presenter

What other comments do you have?

- Allocate more time to plenary/experience exchange in addressing challenges between countries
- too many pages for evaluation forms, should be specific
- ensure updates always available
- perhaps they should present earlier in the program
- very important document/significant input(too few participants at the meeting)
- some people were eager to learn from others
- The time for prevention was very short, some questions was not asked
- let them present in the outside breakout sessions or reception

Day 3 (22 November 2007)

Session 5 - Addressing Implementation Challenges



Did you find the presentations useful?

- Yes
- It was because the mandate was unclear
- it was loose
- It was loose and not fully clarified

What suggestions do you have for improving this session?

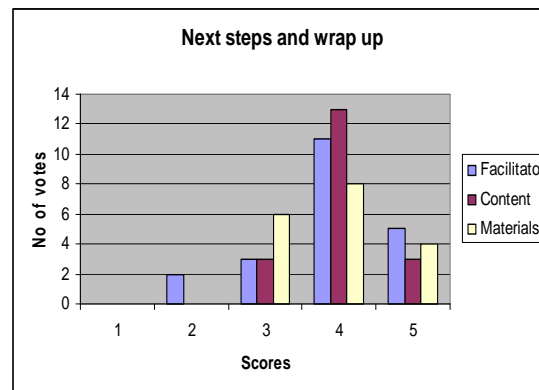
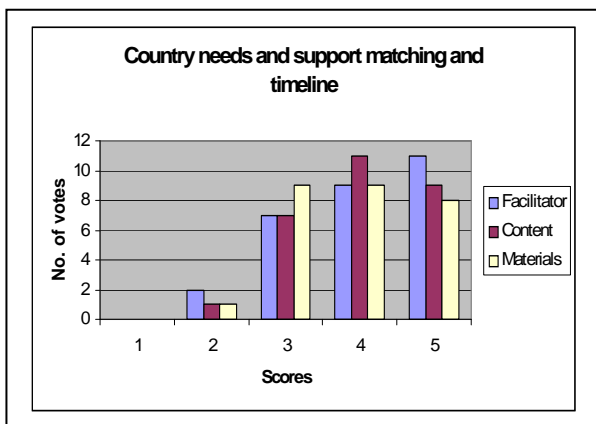
- The facilitator to give more clarifications to participants.
- any country should be allowed to underline needs without abiding itself to template provided

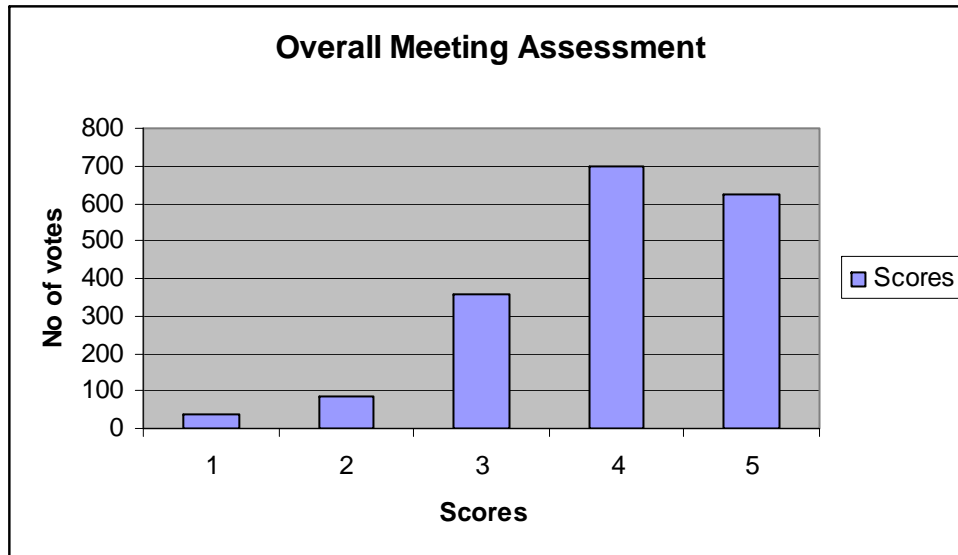
- An EARN staff should be present at groups to guide process
- The format was very limiting and didn't address country needs
- Discussions need to be focused and specific to questions need to be formulated and discussed
- country need to discuss their plans on a daily basis
- more country partners round the table
- It should not be the last thing on the agenda. most participants had left already
- I suggest invitations for all RBM partners to attend and present their effort to the meeting in RBM
- continue in the next meeting
- have time to discuss more on this
- To agree on the what to use
- more time for elaboration
- make process more simpler
- keep it up
- we want verification from WHO
- again provide participants with clear issue agreed upon
- Inviting many partners from different country members
- To precise exercise because it was not clear

What other comments do you have?

- Give targets, benchmark and other countries

Session 6 - Feedback from discussions and way forward





Did you find the presentations useful?

- Yes

What suggestions do you have for improving this session?

- it need to be country focused and analyse country presentations(EARN coordinators)
- session ok
- presentations should be on PowerPoint and not valid word

What other comments do you have?

- Research result funding
- To give more time to synthesis the country need discuss the way forward
- more best practice updates

- Time management was poor and needs to be improved for subsequent meetings
- meeting should be organised once a year, whatever name is given
- Development updates given by WHO and manufacturers

What were the most valuable concepts you learned in this meeting?

- Exchange of experience
- sharing experience between countries
- it was quite frank and gives insight to country experience
- Value in sitting in country teams with partners to review growth, updates and needs
- Challenges/bottleneck/solutions
- SUFI
- Different views from different countries

What suggestions do you have for improving this meeting?

- I would like the meeting to ask countries clearly what they want and partners what they can offer and RBM as well
- Development of a more comprehensive regional plan for direct implementation that helps national Governments to be guided in their country plans
- Less frequent and support EARN members to attend other forums like GF meetings, WHO/RBM meetings
- Invite more from civil society
- Too many pages of evaluation
- The number and carder of personnel need to be encouraged to attend major NGOs need support and get their presentations
- keep it short- 2.5 days
- let us have clear outputs for the meeting can pass from this meeting be implemented
- the meeting needs to be short and precise so that participants can go back to their work
- need private sector
- have common work plans
- Too many meetings, need to harmonize the technical meetings with the bottlenecks meetings, the single annual meeting could be four or five days with the first two days tackling technical issues and the last two or three days we can talk about partner best practices bottlenecks and solutions
- Harmonize these planning meetings. Indicate how they complement the outcomes of earlier meetings
- Harmonisation of the suggested two meetings onto one
- one meeting per year, give it any name
- organise meetings in these countries you have not met in for long, like Eritrea
- I would like to improve the moral of health workers so that they can practice well what we plan and help the community to practice positive behaviours towards health
- field visits best practices, different interventions
- To have representatives from donor agencies attending this meeting

- Focus on building capacity and challenges
- countries to be more elaborative of their interventions and reality of achieving Abuja targets-be honest
- invite country out of Africa to share their experience on how they managed to control
- more preparations, more participation from all sides
- More involvement of programme managers, donors, partners
- EARN has been a good partnership forum for all of us.
- More technical issues need to be included
- Strong organisation support organisation committee should be strong,
- Introduce performance based contracts see which countries are implementing recommendations and tie funding to performance
- Build capacity and enhance participation
- Invite NGO'S that they can give their experience in the project
- very good meeting but we need to have BCC session