EARN

EASTERN AFRICA ROLL BACK MALARIA REGIONAL NETWORK

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Coverage:Burundi ,Comoros, Djibouti, Ethiopia ,Eritrea ,Uganda ,Kenya, Rwanda, Somalia, Sudan North, Sudan South, Tanzania, Zanzibar

11TH EARN ANNUAL REVIEW AND PLANNING MEETING (EARPM) REPORT

ROBUST MALARIA SURVEILENCE SYSTEMS TOWARDS PRE ELIMNATION AND ASSESSING ROADMAPS ACHIEVEMNETS

Jointly organized by EARN/RBM, WHO IST/ESA & MOH Rwanda

SERENA HOTEL, KIGALI RWANDA

4th to 8th October 2010

Compiled by:
Peter Mbabazi Kwehangana
EARN Coordinator

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ACRONYMS

ACT	Artemisinin-based combination therapy
AFRO	WHO Regional Office for Africa
AL	Artemether-lumefantrine
ALMA	African Leaders Malaria Alliance
AQ	Amodiaquine
ARPM	Annual Review and Planning Meeting
BCC	Behaviour Change Communications
CHA	Community Health Agent
DDT	Dichloro-diphenyl-trichloroethane
DHS	Demographic Health Survey
EAC	East African Community
EARN	Roll Back Malaria East Africa Regional Network
EMRO	WHO Regional Office for the Eastern Mediterranean
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GMP	Global Malaria Programme
HPR	Health Promotion
IEC	Information Education Communication
IPT	Intermittent preventive treatment
IRS	Indoor Residual Spraying
IST-ESA	World Health Organization Inter-Country Support Team for East and Southern Africa
ITN	Insecticide Treated Net
JICA	Japan International Cooperation Agency
LFA	Local Funding Agent
LLIN	Long-lasting insecticidal nets
M&E	Monitoring and Evaluation
MDG	Millenium Development Goals
MIS	Malaria Indicator Survey
MMV	Medicines for Malaria Venture
MOH	Ministry of Health
MPR	Malaria Programme Review
NMCC	National Malaria Control Centre
NMCP	National Malaria Control Programme
PMI	United States of America President Malaria Initiative
QA	Quality Assurance
QC	Quality Control
RBM	Roll Back Malaria
RDT	Rapid Diagnostic Test
SADC	Southern Africa Development Community
SARN	Roll Back Malaria Southern Africa Regional Network
SPR	Slide Positivity Rate
TWG	Technical Working Group
UN	United Nations
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organization

SECTION A

ACKNOWLEDGEMENTS

The 11th Annual Review and Planning Meeting for Roll Back Malaria in Eastern Africa was attended by more than 121 participants representing 13 national malaria control programmes, as well as global, regional and national partners. EARN would like to thank the following institutions and individuals for their support, dedication and commitment without which the success this meeting would not be possible;

- National Malaria Control Programme, Ministry of Health, Rwanda
- The RBM Secretariat for financial support
- WHO /ESA –IST for the vital contribution
- WHO Rwanda office
- WHO-AFRO & GMP for key technical presentations
- The rapporteur Peter Mbabazi Kwehangana for capturing and 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 particular programe managers that personally attended this meeting; we would like to thank members of the private sector that hosted us in evenings of cocktails: Vestergaard Frandsen, Novartis, Best Net, Sanofi Aventis and exhibitors for their enthusiastic participation, exhibitions and engagement.

EARN Coordination Committee

Name	Organisation	Title
Dr. Corine Karema	Rwanda NMCP	Co-Chair
Dr. Barnabas K. Bwambok	Vestergaard Frandsen	Co-Chair
Mr. Athuman Chiguzo	KENAAM	Member
Ms. Clare Riches	Malaria Consortium	Member
Dr. Alex Mwita	Tanzania NMCP	Member
Drs. Charles Paluku/ Josephine Namboze	WHO IST Harare	Member
Dr. Tewolde Ghebremeskel	Eritrea NMCP	Member
Dr. Kesete Admasu	Ethiopia NMCP	Member
Dr. Agonafer Tekelegne	CAME ETHIOPIA	Member
Dr. Rory Nefdt	UNICEF ESARO	Member
Dr. James Banda	RBM Secretariat	Member
Mr. Peter Mbabazi Kwehangana	EARN/RBM	Secretary

FOREWORD

This is the full report of the 11th EARN Annual Review and Planning Meeting (ARPM) that was held in Kigali Rwanda from 4th to 8th October 2010. It is indeed timely that we had this meeting in October 2010 – as we approach the international milestone for providing universal access to malaria prevention, diagnosis and treatment and for reducing malaria deaths by half of the 2005 levels, it is imperative for us to show just how far we have come and how far we still have to go to make good on pledges of the African Heads of State, expressed in the Abuja Declaration of 2000 and 2005.

At this meeting participating countries had an opportunity to review and benchmark the progress achieved from the roadmaps set in July 2009 in Windhoek Namibia. Each country gave an update on how far they had gone in achieving the targets set, the underlying challenges as well as the targets yet to be achieved. A summary analysis of the country roadmaps is included. This meeting was ranked the most successful by participants from the meeting evaluation included in this report for your reference.

Participants also had exposure to the process and planning for Malaria Program Reviews, Malaria Strategic planning and surveillance. This was particularly helpful in equipping the countries in preparing their malaria control reports for 2010 and work plans for 2011.

RBM set the goals of halving the burden of malaria between 2000 and 2010, and as we work towards achieving this target the global community is also focused on the impact of reducing the malaria burden as a key component of achieving the Millennium Development Goals (MDGs). This report will be a pointer to how the EARN has performed particularly in achieving the MDG 6 (Specific disease reduction including malaria).

We say farewell to the outgoing EARN coordinator Mr. Peter Mbabazi Kwehangana for his exemplary services that has seen EARN grow from almost collapsing 3 years ago to now the most country focused and vibrant Network in Roll Back Malaria partnership, that mobilizes over 120 participants each meeting.

We are indeed honoured to be associated with the success of this invaluable meeting.

We wish you good reading.

…….
Dr Corine Karema
EARN Co-Chair

……..
Dr Barnabas Bwambok
EARN Co-Chair

SECTION B

EXECUTIVE SUMMARY

The 11th EARN Annual Review and Planning Meeting (ARPM) that was held in Kigali Rwanda from 4th to 8th October 2010. The meeting was jointly organized by EARN, WHO /ESA –IST and the Ministry of Health, Rwanda.

The purpose of the meeting was to provide a platform to review country programme achievements for the past season and since 2000. Participants are drawn from the East African Roll Back Malaria Network (EARN) country programmes (Burundi, Comoros, Djibouti, Eritrea, Ethiopia, Kenya, Rwanda, Somalia, North Sudan, South Sudan, the United Republic of Tanzania (Mainland and Zanzibar) and Uganda). The meeting was held in form of two sub meetings: the first focusing on strengthening malaria surveillance in high and low burden countries; the second meeting will focus on reviewing the progress made and planning for 2011 and 2015.The meetings were held in plenary and group discussions.

Objectives

1) To promote development of high-quality routine malaria surveillance systems in East and Southern Africa

Outcome

Routine malaria surveillance was reviewed and a plan made for the way forward for strengthening it in East and Southern Africa.

2) To provide a forum for programme review, experience sharing and joint planning for national malaria programmes.

Outcome

Progress made by NMPs were reviewed, experiences shared and a way forward outlines for each country.

2009/2010 Country Roadmap Analysis

	LLIN		IPT		ACT		RDT		IRS		M/E		BCC/ IEC		H/RCE	
	RM	UC	RM	UC	RM	UC	RM	UC	RM	UC	RM	UC	RM	UC	RM	UC
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
	31	23	23	8	62	54	38	31	46	38	38	15	31	15	38	23
	69	54	31	38	38	23	46	46	38	23	31	31	31	31	15	31
	0	15	0	0	0	0	0	0	0	8	0	8	8	8	0	0
	0	8	23	31	0	23	15	23	8	23	31	46	31	46	46	46
	0	0	23	23	0	0	0	0	8	8	0	0	0	0	0	0

CONCLUSIONS AND ACTION POINTS

Surveillance Monitoring and Evaluation

- Countries need to finalise their costed surveillance strengthening plans for resource mobilisation purposes
- Countries need to produce national monthly/quarterly malaria surveillance and logistics bulletins with data and maps by district
- Countries need to report quarterly on malaria logistics and surveillance to WHO to enable reporting to ALMA
- Countries need to produce the 2000 – 2010 malaria progress report and regular annual malaria progress reports

Programme Management

- Countries need to scale-up malaria control interventions to achieve universal coverage
- Countries need to conduct Malaria Programme Reviews and use the results to update their malaria strategic plans as appropriate.
- Countries need to develop a framework for strengthening in-country partnerships

Vector Control and Case Management

- Countries need to rapidly improve capacity for malaria parasite based diagnosis (including establishment of quality control and assurance) in order to increase the proportion of suspected malaria cases that are confirmed by microscopy/RDTs
- Countries need to establish entomological sentinel sites to monitor entomological indicators including insecticide resistance

Partners

- Partners need to support implementation of malaria control activities according to the country malaria strategic plans and needs

- Countries need to report monthly to EARN on the progress made in the implementation of road maps and participate in monthly teleconferences with EARN Secretariat

- Global fund need to ensure that there is no stock-out or disruption of treatment and prevention activities including distribution of LLINs in the event of challenges with implementation of approved grants

- WHO needs to produce quarterly sub-regional malaria surveillance and logistics bulletins

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- Countries need to finalize their road maps in the next two weeks and submit them to the EARN Secretariat for the finalization of the EARN workplan;

- Countries need to report monthly to EARN on the progress made in the implementation of road maps and participate in monthly teleconferences with EARN

- EARN Secretariat to facilitate timely brokering and provision of technical support requested by countries

Meetings

- General Assembly meeting proposed for last week of March 2011 to be held in Mombasa Kenya
- Annual Review and planning meeting proposed for September 2011. Venue to be decided during March 2011

Request to the ECC

- The participation of Yemen as an observer at the next EARN Annual Review and Planning Meeting

SECTION C

1. INTRODUCTION

The Annual Malaria Review and Planning Meetings are convened every year by national malaria programs, WHO and partners in East and Southern Africa. These meetings aim to review the malaria control program achievements of the previous year and to plan activities for the following year. They also provide an opportunity for countries to peer-review and discuss approaches and strategies in order to achieve set targets and the MDGs.

The 11th EARN Annual Review and Planning Meeting (APRM), was held at Serena Hotel, Kigali, in Rwanda on 4-8 October 2010 and was jointly organized by RBM/EARN, WHO IST/ESA and MOH Rwanda. In addition to reviewing program achievements of the previous year and planning for the next year, the meetings also provide an opportunity for countries to jointly discuss cross cutting malaria control challenges.

The 11th EARN meeting builds on the successes of the previous meetings held in: Dar-es- salaam-Tanzania in 2000, Nairobi-Kenya in 2001, Jinja-Uganda in 2003, Kigali-Rwanda in 2004, Mombasa-Kenya in 2005, Zanzibar-Tanzania 2006, Arusha-Tanzania 2007, Lusaka-Zambia in 2008, Windhoek-Namibia in 2009 and Entebbe-Uganda in May 2010.

In the same vein, the 11th EARN APRM was convened to provide a forum for countries and RBM partners to review achievements relating to malaria control over the past year as well as plan for the next year, to share experiences and best practices, and to discuss together cross cutting challenges towards improved program performance to reach RBM and MDG targets. The 11th APRM theme unfolded as follows "Robust malaria surveillance systems towards malaria pre-elimination and assessing Roadmaps achievements".

There were 2 meetings held back to back

1. Strengthening malaria disease surveillance systems
2. The annual review and planning meeting.

1.1 Objectives of the 11th APRM

The main objectives of the ARPM were:

1) To promote development of high-quality routine malaria surveillance systems in East and Southern Africa;
2) To provide a forum for program review, experience sharing and joint planning for national malaria programs;
3) To promote the development of robust routine malaria surveillance systems in the Region.

1.2 Expected outcomes of the ARPM

Key Outcomes

The key outcomes of the Meeting were as follows:

1) Routine malaria surveillance reviewed and a plan made for the way forward for strengthening it in East and Southern Africa.
2) Progress made by NMPs reviewed, experiences shared and a way forward outlines for each country.

1.3 PARTICIPANTS:

Over 120 delegates from 13 East African Country Programs (Burundi, Comoros, Djibouti, Eritrea, Ethiopia, Kenya, Rwanda, Somalia, Sudan (North and South), Tanzania (including Zanzibar), and Uganda participated. They included National Malaria Control Program Managers, NMCP Surveillance, Monitoring and Evaluation Focal Points, Global Fund Grants Principal Recipients representatives, EARN Coordinating Committee (ECC) members, WHO National Program Officers (NPOs), WHO malaria SME officers from GMP, AFRO and ISTs, Global Fund Secretariat staff, In-country or regional RBM partners, regional and global, particularly from UN agencies and multilaterals, NGOs in malaria, private sector and academic and research institutes. See list of participants in annex 3

1.4 Method of work

The meeting was conducted through plenary presentations allowed for plenary presentations followed by interactive discussions as well as group work that focused on reviewing country surveillance systems and RBM roadmaps as well as updating country roadmaps based on feedback provided in plenary. See meeting agenda in Appendix 2.

2. PROCEEDINGS

2.0 Day 1

2.1 Opening Ceremony

The welcoming remarks were given by the host Programme manager NMCP Rwanda and EARN Co-chair Dr Corine Karema

The overview and objectives of the meeting were outlined Dr Nathan Bakyaita who recalled that the meeting would give participants ample opportunity to share experience and best practices and discuss challenges faced to increase momentum toward attaining RBM and MDG targets in addition to allowing country programs and RBM partners to review performance in malaria control.

Mr. Khoti Gausi. Provided an overview of malaria surveillance in East and Southern Africa. He presented the status of the malaria surveillance system in ESA. He maintained that reports in some countries are adequate and complete and timely delivered but that strides still needed in ensuring completeness of reports. Briefing participants on malaria statistics and trends, he noted that statistics reported are based on the malaria surveillance and information systems of countries. He stressed the need to interpret statistics with caution as the level of reporting completeness and timeliness can vary from time to time.

Dr James Banda introduced the 2011 Road Map and RBM Partnership Work Plan. He recalled that the Roadmap was initially developed for each country to achieve 2010 universal coverage targets and that some countries will have achieved 2011 universal coverage and others not for lack of sufficient resources. He mentioned that even countries with resources are facing challenges. He recalled that the RBM Board expects countries to brief the Executive committee on expected achievements every month. With respect to resources, he noted that problems arising from late disbursements of funds cause delays in implementation and lack of specification of technical assistance needs causes delayed execution. He announced that there is a 2 year user-friendly work plan serving as a guide and detailing what has been agreed upon with countries in terms of assistance and areas in which countries need assistance.

During the opening ceremony, of the RBM Executive Director, launched in 1998 with a view to efforts to control malaria. He people in African countries have an additional 3 million lives are underlined the importance of funds, especially in the current global financial crisis.

Dr James Banda made remarks on behalf in which he recalled that the RBM was intensifying and coordinating international revealed that the lives of a number of been saved in the past ten years and that expected to be saved by 2015. He also efficient and effective utilization of donor

Dr. Lamine-Cissé Sarr, WHO country Representative in Rwanda, maintained that the annual Malaria Review and Planning Meetings (ARPM) are convened each year to allow NMCPs and RBM partners to review program achievements of the previous year and planning for the next year in addition to giving participants ample opportunity to share experience and best practices.

The official opening speech by Dr. Richard SEZIBERA, Minister for Health of Rwanda in his capacity as the Guest of Honour was in consonance with the theme of the meeting where he urged delegates to come up with roadmaps towards eliminating malaria in their respective countries. He emphasized low-cost, high-impact interventions and increased access to anti-malaria commodities, namely ACTs, RTDs and LLINs can lead to impact. He recalled that the distribution of mosquito nets is not an end in itself but a means to an end entailing the need to ensure that people use them. He noted that Rwanda is on the right track to achieve malaria- related MDGs and that since 2008 malaria control interventions have been scaled up. He noted that tremendous progress has been made in the battle against malaria, but strategic challenges still abound. These include the higher costs of ACTs when compared to monotherapies. He mentioned that the most effective means of addressing this issue would be to ensure access to highly subsidized Artemisinin-based combination therapies (ACTs). He also touched upon the importance of robustness of healthcare systems and the need to develop and reinforce cross-sector and cross-border partnerships on which the prospects for the success of malaria control depend. He concluded his remarks by sharing his hope that delegates would be up to the task of demonstrating their dedication and

devotion which would greatly contribute to the overall success of the meeting. After his remarks, he officially opened the meeting, with thunderous clap and standing ovation from the EARN members present.

The EARN Co-chair, Dr. Barnabas in step with Hon. Minister leading to the photo grounds where several snaps were taken as part of history in the making.

The Hon.Minister with Peter & Corine /EARN Co-chairs with James and Peter

The EARN Programme managers and ECC members pose with the Guest of honour

The General Group photo for EARN members at the Kigali meeting taken from the left

2.2 Surveillance Proceedings

2.2.1 Science, evidence and epidemiology behind routine systems.

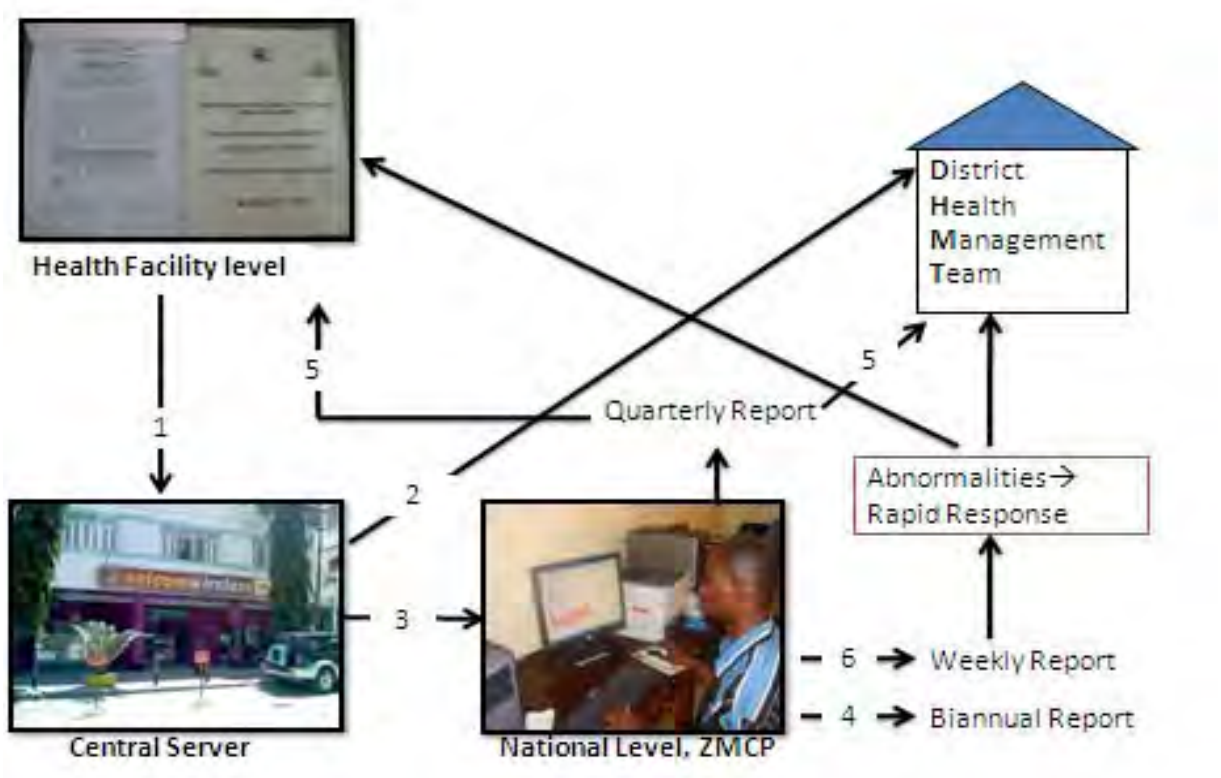
Dr. Mac W. Otten, Jr made a presentation on the Science, evidence and epidemiology behind routine systems. His presentation gave practical examples from both low and high burden situations. It also helped to identify strengths and weaknesses of surveillance routine systems. He highlighted the core malaria surveillance indicators and their limitations. He mentioned that research studies and some national data show declines in inpatient and outpatient malaria cases after scale-up of malaria as well as evidence that disease surveillance trends mirror population-level disease burden trends.

Zanzibar, Tanzania, Kenya and Uganda made presentations on" key innovations for malaria surveillance: data transmission using new technologies",

In Zanzibar, a system of transmitting malaria surveillance data using mobile phones called Malaria Early Epidemic Detection System (MEEDs) has improved weekly collection of surveillance and logistics data from peripheral health facilities. Challenges when using the new system include occasional network instability.

Figure xx

MEEDs



In Tanzania Mainland, SMS technology was introduced to track movement of drugs and stock levels in health facilities and ensure prompt distribution or redistribution of malaria medicines as appropriate.

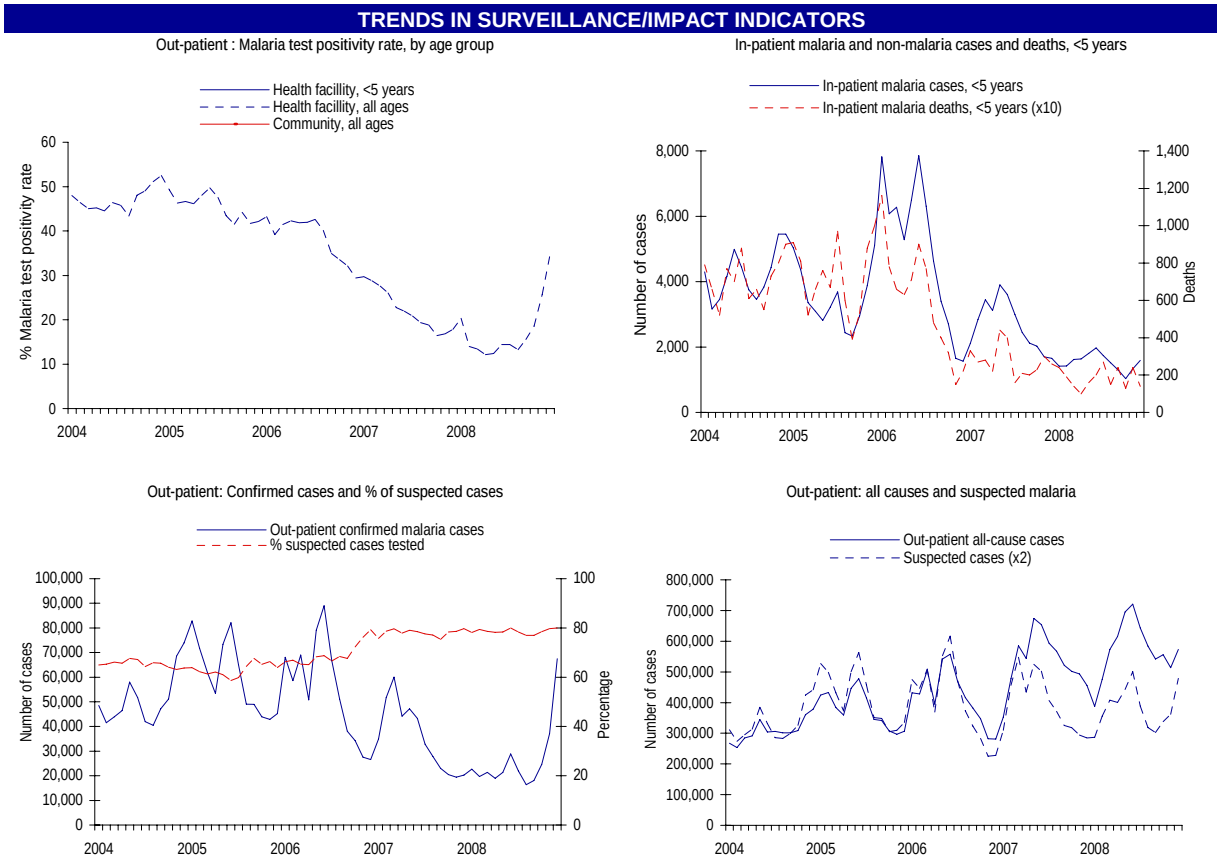
In Uganda, a rapid SMS surveillance reporting system was introduced .Using this technology, Village Health Teams (VHTs) sends text messages to report cases of malaria, which messages are received in centralized database, disaggregated and analyzed automatically. Such messages serve as the basis for adequate response to malaria threats.

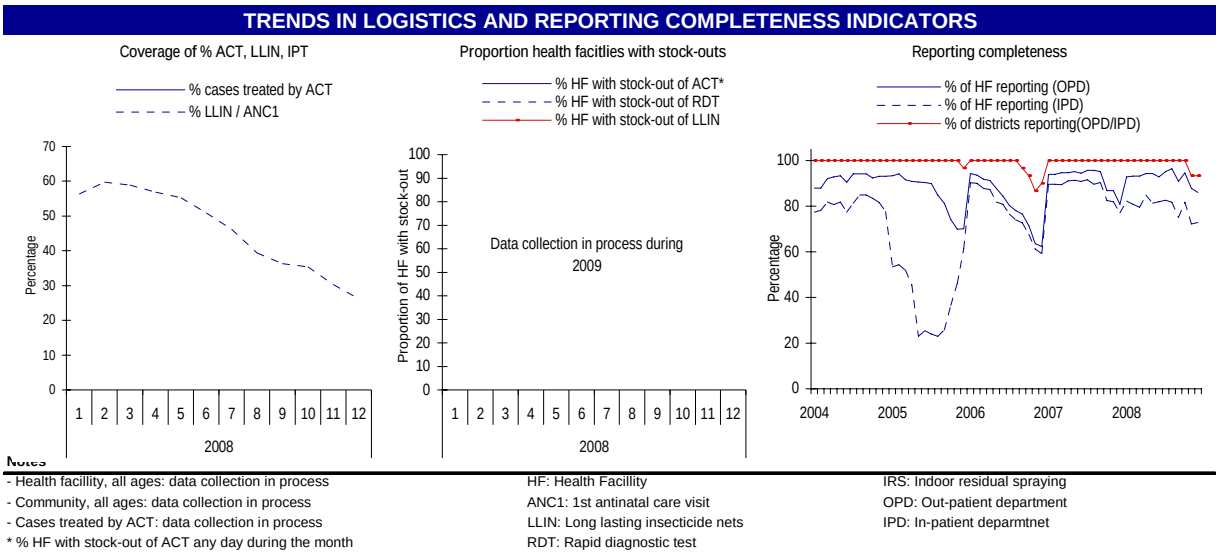
In Kenya, an M-Health system was introduced and helps to provide alerts for events detected in health facilities weekly. The system auto- generates reports and is used to give feedback. It presents advantages such as speedy response, timeliness, completeness, and accuracy of data.

Issues raised included the cost of establishing and running these systems, the hosting of databases abroad instead which would compromise national sovereignty and data ownership.

Mac W. Otten presented on Surveillance phases: From High to Low Transmission to Elimination. There are four phases on the continuum from control to malaria elimination and include: malaria control, pre-elimination, elimination, and prevention of reintroduction. Countries move from control to pre-elimination when diagnostic test-positivity is less than 5% the presentation outlined three malaria surveillance phases, namely High transmission, Low transmission and Elimination.

The following seven core graphs showing trends in surveillance/impact indicators were highlighted in the presentation:





Nathan Bakyaita presented on WHO malaria SME Guidelines by, briefing participants on the guidelines contents and their importance so that they could easily refer to them during group work.

3.0 DAY 2

3.1 Use of GIS in malaria control

The day's presentation began with presentation on the use of GIS in malaria control by Mr. Samson Katikiti. He said that GIS plays a vital role in strengthening malaria surveillance information management and analysis. GIS provides excellent means for tracking disease outbreaks, transmission foci and identifying populations at risk. The use of GIS assists with investigation of various spatial aspects of malaria. In Zambia, Swaziland and Malawi, GIS played a role in tracking disease burden and implementation of ITN and IRS programmes.

3.1.1 Emerging issues on GIS

Etienne Minkoulou, presented the National Malaria Program Database (NMPD). He highlighted the rationale for the NMPD. The NMPD can store data coming from various sources and requires different partners to work together. The database includes such sections as malaria morbidity data from HFs and communities, monitoring of drug resistance, planned activities, funds and training of health personnel, integrated vector management, and malaria control indicators. The NMPD has been rolled out and is working effectively in several countries especially in Madagascar where all partners agreed to work together an UNICEF paid for a fulltime data manager.

3.2 Country Quarterly Reporting

Nathan Bakyaita presented on Quarterly reporting to WHO. He described the organizations and alliances that have agreed to work with WHO and countries to provide monthly and quarterly data on malaria surveillance and logistics. ALMA (African Leaders Malaria Alliance) as well as the Alliance for Malaria

prevention (AMP) have requested WHO and the countries to provide the data to enable production of quarterly reports and planning for mass ITN campaigns respectively. He shared the templates that have been developed for collection and submission of the data.

3.2.1 Issues arising on quarterly reporting

It was noted that some of the forms are not practical and lead to duplication. Moreover countries are often pressurized to produce too many disjointed reports calling for a need to integrate all the forms and reports (ALMA, AMP, GF) so that each partner can later extract the data they need.

3.3 Role of Partners in malaria surveillance

Gladys Tetteh presented on the Role of Partners in malaria surveillance on behalf of the President's Malaria Initiative (PMI). She recalled that PMI works as part of a larger global effort to support country malaria control strategies. PMI is engaged in scaling up proven prevention and treatment interventions. Its targets and objectives are aimed at providing universal coverage of all malaria control interventions. PMI is already engaged in funding surveillance activities in Ethiopia, Uganda, Tanzania (Mainland and Zanzibar), Madagascar, Kenya and Rwanda.
Nathan Bakyaita presented on Developing a Costed Routine Surveillance Plan, He outlined the key items that should be costed once a clear assessment of the surveillance system has been done. He also introduced the participants to the WHO checklist for developing SME plans.

4.0 DAY 3

4.1 2009 ARPM Recommendations

Dr. Charles Paluku presented the 2009 ARPM recommendations. He recalled that the Conference theme was "BCC for improved community uptake of malaria interventions" with the slogan –"Promote community malaria control awareness and acceptance" and recommendations thereof as countries were expected to report about the achievements vis-à-vis these recommendations. The 2009 ARPM recommendations were by thematic areas including program management, vector control, case management and included, inter alia, the development of an evidence based malaria BCC strategy, the conduct of annual vector surveillance including vector resistance monitoring and rapid improvement of capacity for malaria case management in order to increase the proportion of suspected malaria cases that are confirmed by microscopy/RDTs.

4.2 2009/2010 country roadmap presentations

Mr. Peter Mbabazi Kwehangana introduced country presentations 2009 -2010 achievements and roadmap review. Countries were expected to present country surveillance workplans, the 2009-2010 progress report, progress towards achieving Windhoek recommendations, and funding status. Also, he called upon groups to state problems faced and how they were solved and lessons to be learnt for improved performance in future and which will inform the

EARN work plan.

A total of 13 countries made presentations on roadmaps and received feedback in plenary. Country presentations were focused on the review of surveillance indicators, data collection and transmission issues, feedback mechanisms, supervision of surveillance activities, Performance Assessment, gap identification, way forward, 2009-2010 progress Report, Achievements – progress 2009-2010 in terms of coverage, Key facilitating factors for these achievements, Key challenges and solutions, 2010 Roadmap Report, Funding Status, Summary of rate-limiting factors over the next 17 months and Roadmap October 2010 Evaluation-TA needs.

4.2.1 Analysis of Country Road Maps

ANALYSIS OF SUMMARY OF ROADMAPS BY COUNTRY

	COUNTRY	LLIN		IPT		ACT		RDT		IRS		M/E		BCC/ IEC		H/RCE	
		RM	UC	RM	UC	RM	UC	RM	UC	RM	UC	RM	UC	RM	UC	RM	UC
1	COMOROS																
2	BURUNDI																
3	DJIBOUTI																
4	ERITREA																
5	ETHIOPIA																
6	KENYA																
7	RWANDA																
8	SOMALIA																
9	SUDAN NORTH																
10	SUDAN SOUTH																
11	TANZANIA																
12	UGANDA																
13	ZANZIBAR																

SHADING KEY

	COUNTRIES THAT HAVE REACHED THEIR SET TARGETS/OBJECTIVES
	COUNTRIES THAT HAVE NOT REACHED THEIR SET TARGETS
	COUNTRIES THAT HAVE COVERED THEIR NEEDS AS IDENTIFIED EARLIER
	NO DATA AVAILABLE
	NOT YET UNDERTAKEN

RM	Roadmap	**ACT**	Artemisinin-based Combination Therapy
UC	Universal Coverage by the end of	**IPT**	Intermittent Preventive Treatment

	2010		
NA	Not Applicable	**RDT**	Rapid Diagnostic Test
LLIN	Long-lasting Insecticide-treated Nets	**IRS**	Indoor Residual Spray
BCC/ IEC	Behaviour Change /Information Education Communication	**H/RCE**	Human Resources (incl Capacity Bldg as training)

Note that Road Maps are developed based on secured funding, that means that you can achieve the RM target but not necessarily Universal coverage, this is an attempt to make a distinction.

For example Red for RM means you have not achieved the ITN coverage set in Road map, at the same time Yellow for UC means you have secured funds for Universal Coverage, but they are yet to be procured/ distributed to cover the beds.

ROADMAP PERFORMANCE ANALYSIS BY PERCENTANGE

	LLIN		**IPT**		**ACT**		**RDT**		**IRS**		**M/E**		**BCC/ IEC**		**H/RCE**	
	RM	UC	RM	UC	RM	UC	RM	UC	RM	UC	RM	UC	RM	UC	RM	UC
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
	31	23	23	8	62	54	38	31	46	38	38	15	31	15	38	23
	69	54	31	38	38	23	46	46	38	23	31	31	31	31	15	31
	0	15	0	0	0	0	0	0	0	8	0	8	8	8	0	0
	0	8	23	31	0	23	15	23	8	23	31	46	31	46	46	46
	0	0	23	23	0	0	0	0	8	8	0	0	0	0	0	0

A summary of country presentations are given in Appendix 3.

4.2.2 Emerging Issues from Country presentations

- Countries need to increase their technical capacity for analysis and interpretation of data;
- Late transmission of data at peripheral level and non- availability of data from private HFs negatively affects timeliness and completeness of reports;
- Countries are urged to produce a periodical epidemiological bulletin that provides a snapshot of malaria trends;
- There is need to strengthen GIS and Epidemic forecasting and early warning system especially in countries which are moving toward malaria pre- elimination phase;
- There is unavailability of more regular feedback bulletin with analysis of all core malaria indicators;
- Development of an aggressive plan of action for malaria surveillance is required in area targeted for malaria pre- elimination;
- The strengthening of the reporting system through mobile phones must feature high on the agenda of malaria control programs;

- The reduction of malaria morbidity in some countries creates other challenging issues such as low immunity of population, tendency to develop severe malaria and prone to malaria, sustainability of community based interventions and the sustainability of achievements and successes;
- Efforts should be made to move towards the application of advanced Malaria Early Warning System;
- There is a number of opportunities in data collection and transmission which include existing systems of data collection such as HMIS, IDSR, LMIS;
- Data collection entails such challenges as Transcription errors, Human resource capacity and capability constraints, Lack of tools, infrastructure, complex and numerous forms, lack of valuing data amongst health personnel, poor quality of data;
- Need to increase direct funding to district hospitals and health centres to conduct monthly review meetings, supervision of reporting;
- Need for countries to investigate approaches to establish line listing reporting of malaria inpatients and deaths;

Programme Management

- Delays in funding disbursements, lead to delays in commodity procurements (GF);
- A major challenge facing all countries is the general inadequacy of human resources;
- Some countries are yet to submit financial requests for technical assistance needs to end 2010;
- Cross border initiatives to be intensified in order to tackle malaria and sustain achievements and successes;
- More focus needs to be placed on supporting study tours to countries practicing malaria elimination and experience sharing;
- Need to ensuring procurement of quality products like insecticides, ITNs/LLINs
- More focus needed on building strong partnership with key partners: WHO, GFATM, IBD, UNICEF, NGOs, private sector, etc.
- There is limited information sharing between stake holders;
- NMCPs are faced with high staff turnover, which requires motivation;
- In some countries, there is lack of focal points at the district and regional level who should supervise the district and health facilities on the trends of the disease surveillance indicators;
- Poor flow of reports from NMCP Officers and Partners;

BCC /IEC

- Complacence/relaxation among population, MOH, Partners among others remains a concern and Intensive IEC & BCC need to be conducted;
- Adequate awareness among the community as well as the health workforce need to be created on malaria control and prevention activities through BCC/IEC in all gender, vulnerable and age groups;
- Need for strengthen linkage between NMCPs and existing systems to collect and report data for M&E, updating and standardizing guidelines and policies for data entry and processing;

Case Management

- Eventual emergence of vector and parasite resistance which requires research for new products;
- Necessity to expand reach of ACTs in the Private Sector;
- Need to integrate and strengthen community and private sector reporting through workshops and meetings;

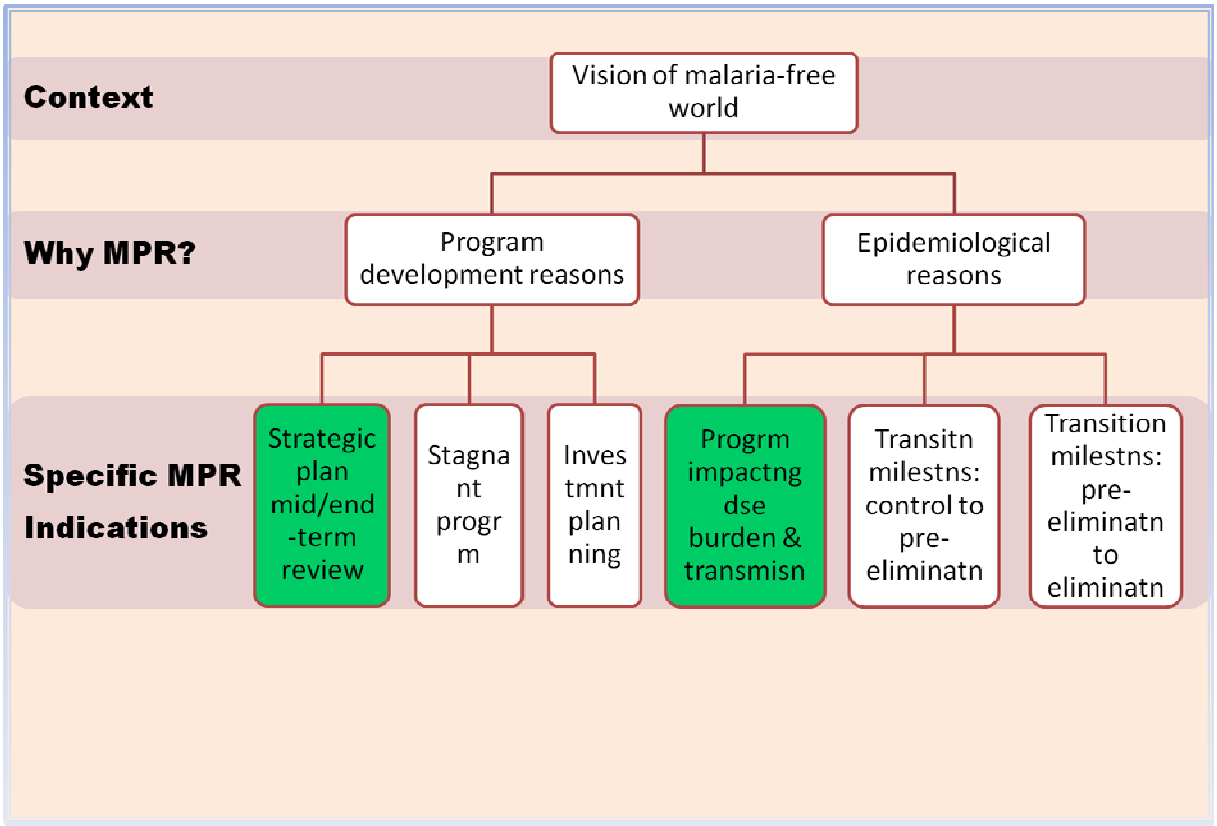
- Need to improve integration of RDT into surveillance system;

Details on country presentations on review of surveillance indicators are attached in Appendix 4

4.3 Country Malaria Reports and MPRs

Nathan Bakyaita presented on Global, Africa and Country Malaria Reports. Data is collected through a questionnaire that is sent to the countries every year. , These reports enable assessment of progress by region, and sub region. He highlighted that despite more than a decade of existence of RBM, there are still some countries which have difficulties producing country annual malaria reports. He mentioned that annual malaria reporting should be institutionalized the near future.

Dr Paluku presented recent experiences with conducting the Malaria Program Reviews (MPR) as basis for program re-orientation. In his presentation, he noted that the MPR serves as a tool for timely identification of what is working why. The MPR is important for sustaining efforts aimed at scaling up it is a country-led process for evidence-based programming. The chart below, shows situations that justify conducting a MPR including the shift from one malaria control phase to another.



Countries like Kenya, Zambia, Botswana, and South Africa had conducted the MPR that helped guide programme re-orientations. For example, in Zambia, the strategic plan was due to expire and so the country commissioned an MPR to help guide the development of the new strategic plan. WHO and partners have developed guidelines for the MPR and the RBM harmonization Working Group has provided seed-money to countries to implement the MPR.

5.0 DAY 4

5.1 Technical Updates

5.1.1Malaria Indicator Survey Experiences in ESA

Mr.Khoti Gausi presented on Malaria Indicator Survey Experiences in ESA, the purpose of the MIS is to collect nationally representative data on coverage of malaria interventions, measuring impact through collection of biomarkers such as anaemia and parasite prevalence during the peak transmission season. Most countries in ESA have conducted at least one MIS and some are planned in 2011-2012.

5.1.2 Malaria Case Management

Dr. Peter OLUMESE presented updates on Malaria Case Management. He noted that early diagnosis and prompt treatment with effective medicines is important for effective malaria case management. The components of Malaria Case Management include malaria diagnosis (clinical and parasitological confirmation), prompt and effective treatment within 24 hours of the onset of symptoms. He stressed that prompt parasitological confirmation by microscopy or alternatively by RDTs is recommended in all patients suspected of malaria before treatment is started. As far as malaria diagnosis is concerned he recalled that treatment solely on the basis of clinical suspicion should only be considered when a parasitological diagnosis is not accessible. For treatment of uncomplicated Falciparum Malaria, he noted that Artemisinin-based combination therapies (ACTs) are the recommended treatments for uncomplicated falciparum malaria. Recommended ACTs include Artemether + lumefantrine; artesunate + amodiaquine; artesunate + mefloquine; artesunate + sulfadoxine-pyrimethamine; and dihydroartemisinin + piperaquine.

Concerning the treatment of severe malaria, he noted that for adults, artesunate i.v. or i.m or quinine remains an acceptable alternative. He stressed the need to scale up parasitological confirmation of cases and training of health workers on malaria diagnosis.

5.1.3 Malaria Vector control updates

John Govere presented on Malaria vector Control updates. The main vector control interventions include LLINs, IRS and Larviciding. The RBM vector control target is to achieve universal coverage of targeted populations with the two interventions by 2010. He maintained that success in IRS delivery must be evidence-based with baseline information malaria vector bionomics, detailed maps of the target areas obtained through geographical reconnaissance as well as adequate and sustained human, financial and logistical resources. Success in LLINs delivery builds, among other things, on routine distribution as free mass distribution campaigns to achieve rapid universal coverage. LLINs and IRS could be combined in low transmission areas where elimination is within reach. He noted that specific objectives of vector surveillance include determining changes in distribution and density of vector population by time and place as well as and interventions and enabling early recognition/detection/investigation of malaria outbreaks. He noted that malaria entomological profile helps to identify vector species, distribution, entomological inoculation rate, sporozoite rate and human blood index. It also allows unveiling the relationships between the vector, its ecology and behaviour, the parasite and the host in order to develop and implement effective vector control strategies.

6.0 DAY 5

6.1 Global Fund updates

Mr Linden Morison the head of East African cluster at GF secretariat presented Global Fund Updates. The presentation focused on Global Fund Key Corporate Priorities including 2010 Universal bed nets coverage, Rollout of key initiatives including AMFm, implementation of new grant architecture, single stream funding (SSF) and strengthening of partnerships to support scale up of interventions.

It was noted that priorities of the GF/RBM Partnership include keeping malaria high on the development and public agenda & mobilizing financial resources to reach MDGs and GMAP targets; ensuring future financial resources for countries and ensuring proper functioning of RBM mechanisms. The presentation proposed the following:

- Sustain achievements and focus on countries that account for most malaria cases and deaths
- Development of routine information systems for malaria program management disease surveillance as well as systems for surveillance of resistance to antimalarial medicines and insecticides
- Support periodic malaria program reviews that contribute to strategic planning and program refocusing/reorientation.
- Strengthening health and community systems capable of efficiently procuring and delivering vector control interventions, diagnostics for the parasitological confirmation of malaria and treatment with ACTs
- Strategies to delay Artemisinin resistance and insecticide resistance
- Further strengthening of partnerships including GF, RBM etc.

6.2 Presenting Country Road maps

Participating countries had an opportunity to present roadmap updates by focusing on country summary with respect to interventions and services, assumptions for calculating the commodity as well as financial resources needed to achieve 2011 Targets, a summary of technical assistance needs to end 2011, summary of rate-limiting factors and solutions over the next 12 months.

6.2.1 Emerging issues

- The rate- limiting factors include inadequate financial and human resources;
- Insufficient fund for IRS chemical procurement;
- Logistic supply management- procurement, storage, distribution;
- Technical assistance needs to end 2011 in countries includes such areas as IRS, ACTs, RTDs/Microscopy, GF grants implementation, Surveillance, MPR, MIS,
- There is relaxation of efforts due to reduced level of malaria transmission;

6.2.2 EARN 2011 workplan

Mr. Peter Mbabazi Kwehangana presented on the EARN work plan 2011 focusing on 2011 targets. He recalled hat EARN articulated the following 7 core targets:

1. 100% of all country roadmaps are maintained and implemented to the end of 2011;
2. 80% of country assistance requests via SRNs receive a response outlining a plan to meet the request and satisfactory to the country concerned within two weeks of the initial request;
3. RBM Community and Heads of State informed on the achievements of 2010 universal coverage and preparation for 2015 targets;
4. Mobilize resources and political support to achieve the $6B annual target to fund the GMAP through 2011 – 2015
5. 45 countries/territories to align their strategic/operational plans with best practices to achieve the GMAP by the end of 2011;
6. Global and regional strategies for drug and insecticide supply and resistance management to be developed by relevant RBM WGs and WHO-GMP, rolled out, and fully implemented by end 2011;
7. RBM Mechanisms receive management support from the Secretariat consistent with Board decisions throughout 2011.

7.0 MAIN CONCLUSIONS AND ACTION POINTS

7.1 Surveillance Monitoring and Evaluation

- Countries need to finalise their costed surveillance strengthening plans for resource mobilisation purposes
- Countries need to produce national monthly/quarterly malaria surveillance and logistics bulletins with data and maps by district
- Countries need to report quarterly on malaria logistics and surveillance to WHO to enable reporting to ALMA and AMP
- Countries need to produce the 2000 – 2010 malaria progress report and regular annual malaria progress reports

7.2 Programme Management

- Countries need to scale-up malaria control interventions to achieve universal coverage
- Countries need to conduct Malaria Programme Reviews and use the results to update their malaria strategic plans as appropriate.
- Countries need to develop a framework for strengthening in-country partnerships

7.3 Vector Control and Case Management

- Countries need to rapidly improve capacity for malaria parasite based diagnosis (including establishment of quality control and assurance) in order to increase the proportion of suspected malaria cases that are confirmed by microscopy/RDTs

- Countries need to establish entomological sentinel sites to monitor entomological indicators including insecticide resistance

7.4 Partners

- Partners need to support implementation of malaria control activities according to the country malaria strategic plans and needs
- Countries need to report monthly to EARN on the progress made in the implementation of road maps and participate in monthly teleconferences with EARN Secretariat
- Global fund need to ensure that there is no stock-out or disruption of treatment and prevention activities including distribution of LLINs in the event of challenges with implementation of approved grants
- WHO needs to produce quarterly sub-regional malaria surveillance and logistics bulletins

7.5 EARN

- Countries need to finalize their road maps in the next two weeks and submit them to the EARN Secretariat for the finalization of the EARN workplan;
- Countries need to report monthly to EARN on the progress made in the implementation of road maps and participate in monthly teleconferences with EARN
- EARN Secretariat to facilitate timely brokering and provision of technical support requested by countries

7.6 Meetings

- General Assembly meeting proposed for last week of March 2011 to be held in Mombasa Kenya
- Annual Review and planning meeting proposed for September 2011. Venue to be decided during March 2011

7.7 Requests to the ECC

- The participation of Yemen as an observer at the next EARN Annual Review and Planning Meeting

8.0 Closing ceremony

8.1 Fare well Speech by EARN Coordinator

Mr. Peter Kwehangana MBABAZI, the outgoing EARN Coordinator, in his farewell speech, expressed appreciation for the expertise of participants regarding malaria control issues and extended gratitude to them for the achievements registered during his 3-year assignment with EARN. He also expressed his happiness about the participation of Somalia as a full member although it is currently in crisis. He noted that EARN has grown stronger supported by numerous partners. He wished the best of luck to the incoming coordinator.

As a token of appreciation for his exemplary service to EARN, Dr James Banda on behalf of the EARN Coordination Committee, presented a Certificate of Merit to Mr. Peter Mbabazi Kwehangana accompanied by his wife Mrs Sarah Mbabazi.

The National Malaria Control Programme managers of Eritrea and Djibouti, Dr Tewolde Ghebremeskei and Mme. Hawa Hassan Gueso respectively, on behalf of all 13 EARN Programme Managers, presented a flamed picture of a child under a net to the outgoing EARN Coordinator for his dedicated services to EARN.

8.2 Speech by EARN Co-Chair

The closing remarks were given by Dr. Corine KAREMA, Program Manager – Rwanda on behalf of the Minister of Health of Rwanda. In her remarks, she thanked participants for having spared time for the 11th ARPM and having chosen Rwanda as the host. She called upon NMCP Managers to continue to display their commitment in the fight against malaria. She recalled that EARN has grown stronger through participants' efforts. She introduced the new incoming EARN Coordinator, Dr Joachim Da SILVA, to whom she pledged support on behalf of EARN members.

9.0 Meeting evaluation

9.0.0 Evaluation of the whole meeting

Travel, Accommodation & Logistics	Poor & fair	Good	Above good
	%	%	%
Communication prior to the workshop	27	34	39
Registration procedure	19	43	38
Transport pick-up	19	33	48
Suitability of location	15	18	67
Accommodation	32	11	57
Space/facilities	10	26	64

9.1.0 Malaria Surveillance Meeting

Workshop Content	Poor & fair	Good	Above good
Clarity of content	9	49	42
Order and organization of content	9	44	47
Usefulness of materials/information resources	9	35	56
Length of workshop	26	47	28
Workshop Presentation			
Style and appropriateness of presentations	12	49	40
Time allotted for discussion	18	55	27
General Rating of Surveillance Meeting			
General rating	11	53	36

	Yes	No or not sure
Did this surveillance meeting meet your expectations?	81	19
Was the surveillance meeting useful?	86	14

9.2.0 Annual Review and Planning Meeting

Workshop Content	Poor & fair	Good	Above good
Clarity of content	8	55	38
Order and organization of content	13	43	45
Usefulness of materials/information resources	12	36	52
Length of workshop	13	46	41
Workshop Presentation			
Style and appropriateness of presentations	12	51	37
Time allotted for discussion	23	44	33
General Rating of Surveillance Meeting			
General rating	13	34	53

	Yes	No or not sure
Did this surveillance meeting meet your expectations?	89	11
Was the ARPM meeting useful?	95	5

For details refer to Appendix 5

APPENDIX 1: AGENDA OF THE MEETING

Malaria Review and Planning Meeting for East and Southern Africa 2010

4-8 October 2010, Serena Hotel, Kigali,

Introduction

This is 2010, 10 years after the 2000 Abuja Declaration, 5 years after the Abuja Call and the target year for the achievement of Universal Coverage. This meeting will thus focus on reviewing country programme achievements for the past season and since 2000. Participants are drawn from the East African Roll Back Malaria Network (EARN) country programmes (Burundi, Comoros, Djibouti, Eritrea, Ethiopia, Kenya, Rwanda, Somalia, North Sudan, South Sudan, the United Republic of Tanzania (Mainland and Zanzibar) and Uganda). The meeting will be held in form of two meetings: the first focusing on strengthening malaria surveillance in high and low burden countries; the second meeting will focus on reviewing the progress made and planning for 2011 and 2015.

Objectives

3) To promote development of high-quality routine malaria surveillance systems in East and Southern Africa
4) To provide a forum for programme review, experience sharing and joint planning for national malaria programmes

Outcomes

1) Routine malaria surveillance reviewed and a plan made for the way forward for strengthening it in East and Southern Africa.
2) Progress made by NMPs reviewed, experiences shared and a way forward outlines for each country.

Agenda Summary

Date	Morning	Afternoon
4/10/2010	▪ Overview of malaria surveillance in ESA ▪ Elements of Surveillance in Control and Low Burden Countries	▪ Elements of Surveillance in Control and Low Burden Countries ▪ WHO Guidelines for Routine Surveillance
5/10/2010	▪ The role of partners in Malaria Surveillance	▪ Group Work – Way Forward
6/10/2010	▪ Summary of experiences on MIS, MPRs and MSP ▪ Key Technical Updates	▪ Progress Review

7/10/2010	▪ Progress Review ▪ Reporting for Abuja Targets and MDGs	▪ Partner Forum ▪ Planning and Technical Assistance
8/10/2010	▪ Progress Review ▪ Closing	

Detailed Programme

4-5 October 2010: Strengthening Malaria Surveillance in ESA

The main objective of **Meeting Two** is to promote development of strong routine malaria surveillance systems in East and Southern Africa	1) Review the science and evidence behind the use of routine data for surveillance and logistics monitoring 2) Review existing country level systems for surveillance and logistics monitoring 3) Discuss draft WHO guidelines on surveillance and logistics monitoring 4) Develop country work plans for improving routine malaria surveillance.
Specific Objectives	

Day One: Monday, 4 October 2010

	Chair:	Paluku/Bakyaita	
	Rapporteurs:	XXXXXX	
0800	Registration		
	Session 1: Opening Ceremony		
0830	Opening Ceremony by Hon Minister of Health of Rwanda (detailed agenda available in conference room)		
1000	**TEA BREAK**		
	Session 2: Overview of Malaria Surveillance in ESA		
1030	Overview and objectives of the workshop		Bakyaita
1040	Overview of malaria surveillance in East and Southern Africa		Gausi
1100	Science, evidence, and epidemiology behind routine systems ▪ Practical examples from low and high burden countries ▪ Strengths and weaknesses of routine systems		Otten
1140	Discussion, Q&A		Chair
1150	Key innovations for malaria surveillance: data transmission using new technologies		Kenya, Zanzibar, Tanzania, Uganda
1220	Discussion, Q&A		Chair
Session 3: Elements of Surveillance in High and Low Burden Countries			
1230	▪ Objectives and elements of surveillance in high burden countries ▪ Discussion, Q&A		Otten
1300	**LUNCH BREAK**		

1400	▪ Core indicators, data elements, core graphs and interpretation of data ▪ Discussion, Q&A	Otten
1430	Rapid Impact Assessment	Bakyaita
1445	▪ Objectives and elements of surveillance in low burden countries ▪ Discussion, Q&A	Otten
1515	**AFTERNOON BREAK**	
1540	NMP Database	Katikiti
1600	▪ Mapping and Surveillance ▪ Discussion, Q&A	Katikiti
Session 4: WHO Guidelines for Routine Surveillance		
1625	Overview of WHO Routine Surveillance Guidelines	Bakyaita
1640	Discussion, Q&A	Chair
1650	Introduction to Group Work (Planning for improving surveillance)	Gausi
1700	**END OF DAY**	

Day Two: Tuesday, 5th October, 2010

	Chair:	Bakyaita	
	Rapporteurs:		
0830	**Feedback** ▪ Surveillance Feedback (from district and provincial levels) (Katikiti) ▪ National malaria feedback bulletin (Minkoulou) ▪ Examples of Bulletins: Rwanda and Zambia (Katikiti) ▪ Quarterly reporting to WHO and production of quarterly bulletin by IST (Bakyaita/Katikiti)		Katikiti
0930	Discussion, Q&A		Chair
0945	**MORNING BREAK**		
Session 5: The Role of Partners in Malaria Surveillance			
1015	Presentation by PMI/CDC		PMI Rep.
1035	Use of Global Funds for strengthening SME		GF Rep.
1055	Discussion		Chair
Session 6: Group Work – Way Forward			
1110	Developing a costed routine surveillance plan		Bakyaita
1125	Introduction to group work		Gausi
1130	Group Work		Chair
1300	**LUNCH BREAK**		

1400	Group Work continues	Chair
1500	**TEA BREAK**	
1530	Group Work continues	Rapporteurs
1630	Conclusions and Way Forward	Gausi
1700	**END OF SURVEILLANCE MEETING**	

6-8 October 2010: Annual Review and Planning Meeting

The main objective of **Meeting Three** is to provide a forum for programme review, experience sharing and joint planning for national malaria programmes in ESA.

Specific objectives

1) To share experiences on MIS, MPR and MSP in East and Southern Africa.
2) To review country road maps and progress towards targets and country programme reporting.
3) To provide a forum for partners to share experiences in supporting NMCPs.
4) To finalize plans and technical support needs for 2011.

Day Three: Wednesday, 6 October 2010

	Chair:	Uganda	
	Rapporteurs:	PMI	
Time	**Activity**		**Facilitator / Presenter**
0830	Registration and Administrative Issues		Secretariat
0840	Recap of the Surveillance Meeting		Gausi
Session 1: Country Progress Updates (To review country road maps and progress towards achieving impact targets)			
0900	Presentation and Discussion of 2009 ARPM Recommendations and Progress made		Paluku
0920	Introduction to Country Presentations (2000-2010 achievements and Roadmap review)		EARN Coordinator
0930	Burundi Country Progress Presentation		Dr Kamyo Julien
1015	**TEA BREAK**		
1045	Comoros Country Progress Presentation		Dr Affane Bacar
1130	Djibouti Country Progress Presentation		Mme. Hawa Hassan Guessod
1215	Eritrea Country Progress Presentation		Dr Tewolde Ghebremeskel

1300	**LUNCH BREAK**	
1400	Ethiopia Country Progress Presentation	Dr. Kesetebirhhan Admasu
1445	Kenya Country Progress Presentation	Dr Elizabeth Juma
1530	**TEA BREAK**	
1600	North Sudan Country Progress Presentation	Dr Khalid
1645	Annual and 2000-2010 reporting	Gausi
1700	World Malaria Report and Africa Malaria Report	Bakyaita
1715	**END OF MEETING**	

Day Four: Thursday, 7 October 2010

	Chair:	**MACEPA**	
	Rapporteurs:	**Ethiopia**	
Time	**Activity**		**Facilitator / Presenter**
0830	Administrative Announcements		Secretariat
0840	Recap of Day Three		Rapporteur
0900	Somalia Country Progress Presentation		▪ Dr Abdiqani ▪ Dr Abdi Abillahi ▪ Dr Hussein Elmi ▪ Mr Abdullahi
0945	Tanzania Zanzibar Progress Presentation		Dr. Abdullah Ali
1025	Djibouti Country Progress Presentation		Mme. Hawa Hassan Guessod
1105	**TEA BREAK**		
1130	Uganda Country Progress Presentation		Dr Seraphine Adibaku
1210	Rwanda Country Progress Presentation		Dr Corine Karema
1300	**LUNCH**		
Technical Updates			
1400	Parasite control, infection and disease diagnosis, radical treatment		Olumese
1420	Targeted and combined vector control interventions		Govere
1440	Experiences from MIS conducted in the sub-region		Gausi
Session 4: Planning and Way Forward (To finalize Roadmaps for 2011 and TA plans)			
1455	Introduction to Group Work on Roadmap		
1500	**TEA BREAK**		

1600	Group Work	
1700	**End of Meeting**	

Day Five: Friday, 8 October 2010

	Chair:	**Network Co-chair**	
	Rapporteurs:	**Malaria Consortium**	
Time	**Activity**		**Facilitator / Presenter**
0800	Administrative Announcements		AO Zanzibar
0830	Recap of Day Three		Rapporteur
0850	GFATM Updates		
0920	Country Presentations (15 minutes each)		Chair
1000	**TEA BREAK**		
1020	Country Presentations (15 minutes each)		Chair
1230	EARN Work Plan 2011		Peter Mbabazi
1330	Conclusions and Recommendations		Katikiti
1345	Closing Ceremony		
1415	**LUNCH**		

APPENDIX 2: MEETING PARTICIPANTS

Detailed list of participants for 11th EARN Annual Review and planning Meeting

	NAMES	TITLE	ORGANISATION	COUNTRY	TELEPHONE	E-MAIL
1	DR VALENCE NIMBONA	TECHNICAL COORDINATOR MALARIA PROJECT	CED-CARITTAS BURUNDI	BURUNDI	25779590494	
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APPENDIX 3: COUNTRY ROADMAPS

ROAD MAP SUMMARY FOR THE 2009/2010

Country	Population at risk	Intervention	Units used	What was Target for 2010	No. Achieved by end 2010	No. secured but not delivered by end 2010	Gap (=B-(C+D))	Time of achievement of Universal Coverage	Funding Sources	Challenges	Solutions	Update
Burundi		**LLINs (Universal Access – avg 1 net for 2 pp)**	Nets	4 626 059	2 424 955	2 214 273	-	Février 2011	GF (Round 4 - 39'089'883)	Insuffisance de resources pour certaines composantes (IRS)	Mobilisation de ressources supplémentaires	
		ACTs	Treatments	3 736 274	3 323 454				GF (RCC - 19,694,151)	Gaps programmatiques (TPI, PECADO)	Orientation techniques de l'OMS	
		RDTs	Number of tests	375 720					GF (Round 9 - 21'578'809)			
		IPTp	Women to be treated	408 558								
		IRS	Financial / USD	2 250 000	185 434		2 064 565					
		M&E	Financial / USD	4 806 428								
		BCC/IEC	Financial / USD	5 998 383								
		Human Resources (incl Capacity Bldg as training)	Financial / USD	5 129 820								

Country	Population at risk	Intervention	Units used	What was Target for 2010	No. Achieved by end 2010	No. secured but not delivered by end 2010	Gap (=B-(C+D))	Time of achievement of Universal Coverage	Funding Sources	Challenges	Solutions	Update
Comoros	666,986	**LLINs (Universal Access – avg 1 net for 2 pp)**	Nets	337 900	75 000	262,900	-	2,010	GF (Round 2 - 2 422 471)	Elaboration du plan de communication	Non	
		ACTs	Treatments	225 600	93 360	132 240	-	2,010	GF (Round 8 - 5'755'825)	Formation sur la Gestion de données	Non	requête non soumise
		RDTs	Number of tests	25 000	-	25,000	-	2,010	Gouvernement - 52 600	Enquête MIS	En cours	
		IPTp	Women to be treated	27 000	1,500	25,500	-	2,014		Elaboration du plan de lutte contre les épidémie	Non	
		IRS	Financial / USD	131 363	91 629	39,734	-	2,014		Etablissement de la reconnaissance géographique	Non	Requête soumise
		M&E	Financial / USD	167 944	167 944		-	2,014		Formation des agents sur le PID	Non	Activités de 2011
		BCC/IEC	Financial / USD	193 495	193 495		-	2,014				
		Human Resources (incl Capacity Bldg as training)	Financial / USD	655 800	327 900		-	2,012				

Country	Population at risk	Intervention	Units used	What was Target for 2010	No. Achieved by end 2010	No. secured but not delivered by end 2010	Gap (=B-(C+D))	Time of achievement of Universal Coverage	Funding Sources	Challenges	Solutions	Update
Djibouti	833,315	**LLINs (Universal Access – avg 1 net for 2 pp)**	Nets	416,658	174,000	48,500	194		GF (Round 6 - 3900000 ($))	Insuffisance des ressources financières	Accentuer le plaidoyer aupres des partenaires nationaux et internationaux	
		ACTs	Treatments	5,491		5,491	-		GF (Round 9 - 6591356(Euro))	Ressources Financières disponibles	1)Signature du R9	
		RDTs	Number of tests	238,200		238,200	-		GEF (26000($))	SNIS Performant et Operationnel à tous les niveaux	1)Renforcement du SNIS	
		IPTp	Women to be treated	11,453		11,453	-		WB (39000($))	Pérénnisation des interventions	Plaidoyer pour la mobilisation des fond interne et implication de la population	
		IRS	Financial / USD									
		M&E	Financial / USD	279,995		31,370	248,625					
		BCC/IEC	Financial / USD	456,830		58,368	398,461					
		Human Resources (incl Capacity Bldg as training)	Financial / USD	363,630		181,500	182,130					

Country	Population at risk	Intervention	Units used	What was Target for 2010	No. Achieved by end 2010	No. secured but not delivered by end 2010	Gap (=B-(C+D))	Time of achievement of Universal Coverage	Funding Sources	Challenges	Solutions	Update
Eritrea	2.2 m	**LLINs (Universal Access – avg 1 net for 2 pp)**	Nets	1,280,902	345,000	935,902	-	Q1 of 2011	GF (Round 6 - 12'301'265)	Delay of LLINs	Urgent Procurement of 30,000 LLINs	
		ACTs	Treatments	171,667 doses	52, 395	118,872	-	Achieved	GF (Round 9 - 29'815'990)	Quality control issues regarding LLINs /Insecticides/RDTs	Provision of TA	TA form WHO/partners requested
		RDTs	Number of tests	191,825 tests			-	Achieved		Delay of TA for GIS, Epidemiology and entomology	Provision of TA from WHO	TA Already requested
		IPTp	Women to be treated	NA			-	Achieved		Concern of cross border issues	Provision of study tours and experience sharing	None
		IRS	Financial / USD	1,798,132 USD			-	Achieved		Concern of complacence/relaxation among population, MOH, Partners among others;	Strengthen IEC/BCC activities	Intensive IEC & BCC to be conducted
		M&E	Financial / USD	475,531 USD			-	Achieved				
		BCC/IEC	Financial / USD	2,673,020 USD			-	Achieved				
		Human Resources (incl Capacity Bldg as training)	Financial / USD	142,657 USD			-	Achieved				

Country	Population at risk	Intervention	Units used	What was Target for 2010	No. Achieved by end 2010	No. secured but not delivered by end 2010	Gap (=B-(C+D))	Time of achievement of Universal Coverage	Funding Sources	Challenges	Solutions	Update
Kenya	38.6 m	**LLINs (Universal Access – avg 1 net for 2 pp)**	Nets	11 milllion	-	9 million	2 million	40,878	GF (Round 4 - 162,173,085)	Health System Strengthening	Recruitment of Health workers	
		ACTs	Treatments	21,932,875	21,932,875	Nil	Nil	2,010	PMI (MOP 2010 - 40,000,000)		Community System strenghtening	
		RDTs	Number of tests	4,487,220	-	128,000	#######	41,974	DFID (2010/2011 - 6,150,000)		PMCC/DMCC	
		IPTp	Women to be treated	515,843	4139443 Doses of SP	Nil	Nil	2,010	WB (TOWA - 23,000,000)		Epidemiologist	
		IRS	Financial / USD	16,389,008	14,989,008	Nil	N/A	2,010			Partnership coordinator	
		M&E	Financial / USD	7,577,360	2,744,500	Nil	#######	2,014				
		BCC/IEC	Financial / USD	8,210,432	7,688,612	Nil	521,820	2,010				
		Human Resources (incl Capacity Bldg as training)	Financial / USD	1,848,754 (capacity building)	1,848,754	Nil	Nil	2,010				

Country	Population at risk	Intervention	Units used	What was Target for 2010	No. Achieved by end 2010	No. secured but not delivered by end 2010	Gap (=B-(C+D))	Time of achievement of Universal Coverage	Funding Sources	Challenges	Solutions	Update
Sudan - North	30 million	**LLINs (Universal Access – avg 1 net for 2 pp)**	Nets	1,081,000	650,000	[redacted]	431,000	2,011.00	GF (Round 7 - 38'296'873)	•Turnover of staff	National capacity building, Incentives and motivation including fellowships, systematic training and rewards; at national, state and locality levels	
		ACTs	Treatments	5,903,856	4,807,712		#######			•Non-availability of key commodities: ACTs , RDTs, microscopes, LLINs, IRS insecticides, etc..	Strengthening of Health Systems (HSS including strengthening of PSM system)	
		RDTs	Number of tests	4,132,699	4,132,699		-			•Un timely availability of funds and commodities	GF procurement guidelines	
		IPTp	Women to be treated	192,800 According to the results of the lates MIS 2009, IPTp is no more a strategy in Sudan						•Un timely roll-out of implementation activities	Development of robust QA and QC systems	
		IRS	Financial / USD	1,541,736	[redacted]					•High need to improve the quality of malaria case management	Advocacy for LLIN, ACT and RDT usage	
		M&E	Financial / USD	840,000						• Non-utilization and coverage of key interventions – LLINs, IRS, ACTs	Malaria Surveillance and M&E properly implemented	
		BCC/IEC	Financial / USD	350,000						•Vector resistance to insecticides;	Insecticide resistance management through rotation -> higher costs	
		Human Resources (incl Capacity Bldg as training)	Financial / USD	1,723,000						•Security issues which hinder the implementation or monitoring and evaluating the implementation of key interventions		

Country	Population at risk	Intervention	Units used	What was Target for 2010	No. Achieved by end 2010	No. secured but not delivered by end 2010	Gap (=B-(C+D))	Time of achievement of Universal Coverage	Funding Sources	Challenges	Solutions	Update
Rwanda		**LLINs (Universal Access – avg 1 net for 2 pp)**	Nets	11,946,968				2,010	GF (Round 3 - 38'597'403)	RDT change as WHO report	RDT Change	CHW and health providers trained, tools developped and tender ongoing , 343770 already distributed and used
		ACTs	Treatments	6,596,775				2,010	GF (Round 5 - 39'649'362)	IRS-Partner discussion on insecticide lasting	2 rounds to be conducted but partner informed reduction to 180000 Structures ; Not yet solutions	
		RDTs	Number of tests	1,147,625			500,000	2,010	GF (Round 8 - 52'835'617)			
		IPTp	Women to be treated	Revision of the policy				N/A	PMI (MoP09 - 16,300,000)			
		IRS	Financial / USD	5,157,147		2nd round of IRS not done		2,010	WHO (Technical Assistance)			
		M&E	Financial / USD	15,253 ,628				2,010				
		BCC/IEC	Financial / USD	8,808,048				2,010				
		Human Resources (incl Capacity Bldg as training)	Financial / USD									

Country	Population at risk	Intervention	Units used	What was Target for 2010	No. Achieved by end 2010	No. secured but not delivered by end 2010	Gap (=B-(C+D))	Time of achievement of Universal Coverage	Funding Sources	Challenges	Solutions	Update
Sudan - South		**LLINs (Universal Access – avg 1 net for 2 pp)**	Nets	5,842,000	4,139,000	1,703,000	0		GF (Round 7 - 72,762,615)	•Limited coverage of health services; 25% of population has ready access to formal health services, Private sector still limited especially in rural areas		
		ACTs	Treatments	7,500,000	1,881,537	5,618,463	0		USAID (3,000,000)	•Inadequate Human resources at all levels; NMCP has only 6 national technical staff , 3 states don't have full time malaria coordinators , Almost 50% of health workforce at peripheral level are CHW, High Attrition of staff		
		RDTs	Number of tests	1.9 8 million test	880,000	880,000	1,1 million tests		DFID (1,300,000)	•Weak support systems – Drug Supply Management, HMIS, Referral, Laboratory, Blood transfusion etc		
		IPTp	Women to be treated	195,816 women	391,63 women	0	0		Sanofi Aventis (Training - 30,000)	•Infrastructural constraints – communication, road networks, insecurity etc		
		IRS	Financial / USD	N/A	N/A	N/A	N/A	N/A		•Inadequate financing – lack of essential malaria commodities		
		M&E	Financial / USD	$1,820,000	N/A	##########	$ 300,000 (MPR)	2011				
		BCC/IEC	Financial / USD	$580,000	N/A		$ 1,000,000 (MIS)					
		Human Resources (incl Capacity Bldg as training)	Financial / USD	150 students recruited into health training institutions	On target for 150 students trainned by end of Nov 2010	N/A						

Country	Population at risk	Intervention	Units used	What was Target for 2010	No. Achieved by end 2010	No. secured but not delivered by end 2010	Gap (=B-(C+D))	Time of achievement of Universal Coverage	Funding Sources	Challenges	Solutions	Update
Tanzania	40 million	**LLINs (Universal Access – avg 1 net for 2 pp)**	Nets	22 million	10.8	11,2	NO NE	40695	GF(Round 1)	Timely flow of Funds		
		ACTs	Treatments	15. 8million	12 million	3.8 million	NONE	40603	GF (Round 4)	Procurement Delays		
		RDTs	Number of tests						GF(Round 7)			
		IPTp	Women to be treated	1.7 million	640000		NONE	41244	GF(Round 8)			
		IRS	Financial / USD	13920000	13920000		NONE	SELECTIVE	GF (Round 9)			
		M&E	Financial / USD	4191431	2500000		1.7E+07					
		BCC/IEC	Financial / USD	3362942	3205500		157442					
		Human Resources (incl Capacity Bldg as training)	Financial / USD	[redacted]				HSS PLAN for MOH				

Country	Population at risk	Intervention	Units used	What was Target for 2010	No. Achieved by end 2010	No. secured but not delivered by end 2010	Gap (=B-(C+D))	Time of achievement of Universal Coverage	Funding Sources	Challenges	Solutions	Update
Uganda	32 m	**LLINs (Universal Access – avg 1 net for 2 pp)**	Nets	(in nets) 20607510	2,695,711 ; 17,666,984 (GF) 1,600,000 (PMI)	10.6 M LLINs awaited. 5.3 M distributed by Dec	6.9 Million nets	Ideally December 2010 but may extend to March 2011	GF (Round 4 - 137'467'137)	Internal/External Procurement management bottlenecks (VPP Vs. TPPA; PPDA)	Advocacy, Diplomacy, International guidance and presence; Dialogue	Slowly overcoming constraints
		ACTs	Treatments	22,397,900 (public sector only); 6,000,000 doses for the next 3 months	9,457,062 M first release, a futher 6M for Nov and Dec 2010	3M Doses to be delivered after Dec 2010	None	By December 2010	GF (Round 7 - 51'422'198)	Delayed processing of funds requisitioned	Advocacy; regular meetings with all stakeholders chaired by DG	Internal systems slowly adapting
		RDTs	Number of tests	8,393,627 for 21 districts	1,438,365; $450,000 from PMI for training for RDTs and microscopy	1438500	6,955,462 Tests	Most of the activities to be pushed to AMFm implementation period starting 1st March 2011	GF (Round 10 - Submited targeting ACTs, RDTs, LLINs)	Uncertainty of funding commitments from partners	One annual comprehensive plan; RBM partnership meetings	Yet to complete first annual Comprehensive plan
		IPTp	Women to be treated	80% of 1,569,000 PW will need 2,511,400 doese of IPT (IPT 1&2)	960,000 Doses for distribution . Completion of whole training cascasde	Doses covered by GOU (DOTS materials and training by other partners) $625,000 from PMI	1,551,400 Doses	40603		Delayed consensus on implementation modalities (ICCM Vs. HBMF)	Policy guidance; Dialogue.	HBMF to proceed as planned until next funding
		IRS	Financial / USD	16 Districts to be sprayed	9 Districts 3 of which are GoU	All 9 Districts to be sprayed	No gap due to Policy change	2010 and for only the targeted Districts		Weak health systems: HMIS, Supply chain, weak management and leadership	Review of HMIS, plan for appropriate training & Supervision, Engage NMS; WB UHSSS Project in MoH	Completed review of HMIS; Completed Malaria M&E training module; Project on
		M&E	Financial / USD	USD 13,059,820	USD 3,030,553	USD 528,153	USD 9,501,112	Dec-10				
		BCC/IEC	Financial / USD	USD 11,951,826	USD 4,705,000	USD 1,188,706	USD 5,435,119	Dec-10				
		Human Resources (incl Capacity Bldg as training)	Financial / USD	$245,000 (PMI); Programme Administrator and M&E Specialist funded by Global Fund	USD 245,000 PMI Programme Assistant and M&E Specialist in place	0	0	N/A				

Country	Population at risk	Intervention	Units used	What was Target for 2010	No. Achieved by end 2010	No. secured but not delivered by end 2010	Gap (=B-(C+D))	Time of achievement of Universal Coverage	Funding Sources	Challenges	Solutions	Update
Zanzibar	1.2 m	**LLINs (Universal Access – avg 1 net for 2 pp)**	Nets	254,000	34,000	210000	0	? Dec 2010	GF (3,622,261)	Lack of consensus among the Clinicians and Lab technicians on malaria diagnosis	Dialogue on malaria case management; On job/site re-orientation; Training of lab tech on parasite detection in low mal endemicity	STG revised incooperating low malaria endemicity - Situation is changing though in a slow pace
		ACTs	Treatments	131,097 for 09/10	131,097	-	-	Achieved	PMI (836,000)	In adequate capacity (tech know – how) on malaria rapid response at district level	Training to DHMTs on malaria rapid response conducted	User friendly laminated guidelines prepared and disseminated - TA assistance from National level still needed
		RDTs	Number of tests	601,267	200,000	501,260	100,000	40,513				
		IPTp	Women to be treated									
		IRS	Financial / USD	1.4 m	1.4m	0	0	Achieved				
		M&E	Financial / USD									
		BCC/IEC	Financial / USD									
		Human Resources (incl Capacity Bldg as training)	Financial / USD									

Country	Population at risk	Intervention	Units used	What was Target for 2010	No. Achieved by end 2010	No. secured but not delivered by end 2010	Gap (=B-(C+D))	Time of achievement of Universal Coverage	Funding Sources	Challenges	Solutions	Update
Ethiopia	54.3 m	**LLINs (Universal Access – avg 1 net for 2 pp)**	Nets	23,101,294	19.7Million	3.4 Million	-	Early 2011	GF (Round 5 - 140'687'413)	Financial gap	Moblizing additional resources	GFATM R10 applied
		ACTs	Treatments	12,000,000	12,000,000		-	Achieved in 2010	GF (Round 8 - 133'089'526)	Insecticide resistance IRS	Interm solution Deltametrine used , for coming years study is being conducted to determine the alternate IRS chemical	
		RDTs	Number of tests	19,890,000	10,800,494	5,000,000		Early 2011	PMI (US$20million/year)	Logistic and supply mx	PFSA being strenghened,	
		IPTp	Women to be treated				########			Utilization of intervention	Community based IEC/BCC	
		IRS	Financial / USD	Not app								
		M&E	Financial / USD	25,168,291	6,518,454		########	??				
		BCC/IEC	Financial / USD	7,843,200	4,667,945		########					
		Human Resources (incl Capacity Bldg as training)	Financial / USD	10,521,229	8,069,800		1.830,000					

Country	Population at risk	Intervention	Units used	What was Target for 2010	No. Achieved by end 2010	No. secured but not delivered by end 2010	Gap (=B-(C+D))	Time of achievement of Universal Coverage	Funding Sources	Challenges	Solutions	Update
Somalia		**LLINs (Universal Access – avg 1 net for 2 pp)**	Nets						GF (Round 5 - 24'996'033)	1. Security concerns/CS Zone		
		ACTs	Treatments							2. High staff turn over (Brain Drain)	• Motivation	
		RDTs	Number of tests							3. Inadequate of skilled staff	•Capacity building in different fields	
		IPTp	Women to be treated							4. Sustainability of malaria activities	•Mobilize resources and community involvement.	
		IRS	Financial / USD	6551 HH	3823 HH (750/NEZ, 1247/NWZ & 1826/CSZ)				GF Rd 6 ($17,636.25)	5. Malaria data collection	• Recruitment of malaria data manager per zone; •Introduce of SMS system.	
		M&E	Financial / USD	3 studies	one				GF Rd 6 ($311)	6. Lack of private sector involvement of malaria control activities.	•Rd 10 might take care	
		BCC/IEC	Financial / USD									
		Human Resources (incl Capacity Bldg as training)	Financial / USD									

Key

NO AVAILABLE DATA

Appendix 4: Country presentations on review of surveillance indicators

Country	Indicators	Feedback	Supervision	Performance assessment	Gap identification
Burundi 	Tous sont récoltés à tous les niveaux sauf ceux en rapport avec la couverture en MII (9) et les rupture de stock (10) ; seules les ruptures en CTA sont rapportées Les graphiques peuvent aussi être tracé pour ces indicateurs Données sur la morbidité transmises chaque semaine par téléphone: CDS-District-Province-Niveau central Les autres données transmises mensuellement sur version papier aux districts puis version électronique aux autres niveau	Pas de bulletin de rétro information, Personnel non sensibilisé (formé) en analyse et interprétation des données à tous les niveaux, d'où nécessité de : Formation sur le rapportage et utilisation des outils de collecte, Sensibilisation à la culture de rétro information et d'utilisation de l'information à tous les niveaux ;	Lutte contre le paludisme intégré au niveau district et périphérique (pas de point focal spécifique malaria), Supervision mensuelle des CDS intégré incluant les indicateur en rapport avec le paludisme, Supervision trimestrielle par le niveau central	Réunion trimestrielle de suivi évaluation au niveau périphérique ; Réunions semestrielles de suivi évaluation au niveau national	Insuffisance de capacité technique pour l'analyse et l'interprétation des données à tous les niveaux, Insuffisante des équipements informatiques et logiciels appropriés; Transmission tardive des données au niveau périphérique Pas de compréhension harmonisée de la

Country	Indicators	Feedback	Supervision	Performance assessment	Gap identification
					définition des cas de paludisme rapportés, Non disponibilité des données des hôpitaux particulièrement dans les hôpitaux privés
Comoros 	Cas de paludisme confirmés chez les malades ambulatoires Taux de positivité des tests de paludisme, malade ambulatoires Cas de paludisme hospitalisés Décès par paludisme de malades hospitalisés Diagnostics –pourcentage de cas ambulatoires suspectés de paludisme et soumis au diagnostic de laboratoire Traitement (ACT)– pourcentage de malades Ambulatoires ayant le paludisme et recevant un traitement antipaludique approprié	Bulletin spécifique palu trimestriel (situation épidémiologique de la période, appréciation promptitude et complétude; synthèses programmatiques des activités réalisées et planifiées) est prévu Ressources humaines et financières disponibles pour la production du bulletin	Point focaux existent au niveau des districts et des îles Contrôle de qualité des informations fournies pour renseigner les indicateurs Vérification de la disponibilité des outils de collecte pour le renseignement	Existence des évaluations trimestrielles regroupant des points focaux des niveaux national, régional et districts Les cibles des indicateurs à atteindre sont revus	Collecte : insuffisance du système d'information sanitaire: collecte parallèle Analyse: Pas de logiciel fiable pour l'analyse des données, insuffisance de ressources humaines disponibles pour le suivi et

Country	Indicators	Feedback	Supervision	Performance assessment	Gap identification
	conforme aux orientations politiques nationales MII – distribution en routine de MII aux populations à risque TPI – TPI chez les femmes enceintes Exhaustivité des rapports mensuels des établissements de santé pour la surveillance MILD – couverture en MILD PID – pourcentage d'habitations ciblées pour être protégées par PID		des ces indicateurs		évaluation, Dissémination de l'information: manque de bulletin d'information
Eritrea 	Eritrea has data for all the below listed indicators by facility, sub-zone, zone and national levels: • Outpatients – Confirmed cases – Test positivity rate – % tested • Inpatients – Malaria cases and deaths • Logistics	Feedback is given to zones/sub zones/HFs by telephone and sometimes in writing, non-regularly; Sometimes some of the feedback is given during supportive supervision to the health facilities by the national, zonal and sub-zonal teams;	Currently the NMCP produces a bi-annual malaria update newsletter which contains some malaria surveillance data (clinical and confirmed malaria case and malaria	There are quarterly zonal malaria coordinators and NMCP staff coordination meetings Malaria surveillance and logistics data	Current data is managed in excel and not in an access database or other data bases; Unavailability of GIS based mapping in malaria control despite the fact

Country	Indicators	Feedback	Supervision	Performance assessment	Gap identification
	– Stock levels of ITNs – Stock levels of RDTs – Stock levels of ACTs Stock levels of insecticides for IRS and larvicing		deaths by zones disaggregated by age) Currently mapping of malaria data is not being done but it is planned to be done very soon What needs to be improved is the frequency of reporting and analysis of more indicators for the data that is available by sub-zone. In addition information on logistics will be added to the feedback bulletin	discussed during these meetings Bi-annual meeting of senior staff of MOH HQ and Zonal staff is conducted by the department of health services Bi-annual meetings are also conducted at the zonal level with health facilities to discuss all health issues including malaria – surveillance data Annual review and planning meeting of Senior MOH HQ, Zonal staff,	that the country is moving towards malaria Pre-Elimination phase; Unavailability of more regular feedback bulletin with analysis of all core malaria indicators (Bi-annual Malaria updates newsletter available

Country	Indicators	Feedback	Supervision	Performance assessment	Gap identification
			including mapping of indicators.	Referral Hospital staffs and implementing Partners	
Ethiopia 	Outpatient confirmed malaria cases Outpatient malaria TPR Inpatient malaria cases Inpatient malaria deaths Outpatient suspected malaria cases Outpatient suspected malaria cases tested Outpatient confirmed malaria cases Outpatient all cases Stock out Completeness reporting- number HFs reported Completeness reporting- number HFs expected Completeness reporting- number districts reported Completeness reporting- number districts expected	Feedback is given on quarterly basis pertaining to completeness, timeliness & accuracy at d/t level It is integrated with other diseases Feedback is by phone & email usually (for Urgent Issues)	Bi -annually(RHBs, Federal Hospitals) at national level Quarterly(ZHDs, regional Hop.s and Districts and district Hop.) in form of regional & Zonal supportive supervision Every 2 Months and with HP monthly at District level to Health center & District Hospital	Community with health facility on quarterly basis HF with district team on quarterly basis District team with provincial supervisors or other provincial on quarterly basis Staff – quarterly (for performance review) on quarterly basis Provincial supervisors or	Collection : Data aggregated at each level Missing variables Flow: Frequecy is on quarterly basis Analysis: Incomplete (e.g. lack of quality monitoring chart) Information dissemination: frequency is on quarterly basis Action: Lack of contingency resource

Country	Indicators	Feedback	Supervision	Performance assessment	Gap identification
				other provincial staff with national staff on semi-annual basis	
Kenya 	• Indicators measured monthly – OP confirmed malaria cases – OP malaria TPR – IP malaria cases – IP malaria deaths – Diagnostics: %OP suspected tested – ITN routine distribution – IPTp – Stockouts – Completeness of reports • Indicators measured annually – ITN coverage – IRS coverage (population) – IRS coverage (households)	HMIS: No feedback IDSR: Provides feedback Mainly electronic (weekly EPI bulletins): limited LMIS: Provides feedback; District level analysis of data for decision making: *All systems leave raw data at facility-level*	District level: DHMT (DMCC, DHRIO, DDSC, DPHO, DPHN,DPF) Frequency of supervision: Monthly/every facility once a quarter/depending on need All facilities Provincial level: PHMT (PMCC, PHRIO, PDSC, PPHO, PPHN,PPF) Frequency of supervision: Quarterly	Surveillance activities will be monitored as per M&E plan Will include: National semi annual meetings involving province; Provincial quarterly meetings involving district teams DHMT meetings to examine surveillance trends	Gaps in collection: Clinicians not keen to record in registers; Personnel collecting data usually casuals & not always trained so make transcription errors Gaps in analysis: Analysis is not consistently done at health facility, district level; Lack of capacity at lower levels to do data analysis Gaps in

Country	Indicators	Feedback	Supervision	Performance assessment	Gap identification
			Targeted facilities (high performing/non-performing) National: DOMC, HMIS, DDSR Frequency of supervision: twice a year Visit all 8 provinces		information: Existent tools do not collect all information needed to calculate our selected indicators Gaps in dissemination: Delayed dissemination (e.g. HMIS reports), Limited circulation as it is transmitted electronically (e.g. Weekly EPI bulletin) Gaps in action: Bureaucratic structures cause delays in action; Fund limitations

Country	Indicators	Feedback	Supervision	Performance assessment	Gap identification
					(availability/access)
North Sudan 	All surveillance indicators, core data elements and core graphs are available at national and state levels Outpatient confirmed malaria cases Outpatient malaria Test Positive Rates (TPRs) Inpatient malaria cases Inpatient malaria deaths % of outpatient suspected malaria cases that undergo laboratory diagnosis % of outpatient malaria cases that received appropriate anti-malarial treatment according to national policy LLINs – routine LLIN distribution ; Sudan is going for universal coverage in the targeted states IPT – NOT AN INDICATOR IN SUDAN ANYMORE % of health facilities without stock-outs of first line	Information sharing occurs through: Regular feedback to states, reports to concerned bodies, telephone conversation, review meetings. Regular feedback to states on weekly and monthly basis Quarterly meetings with state coordinators.	There is a plan for supervision: From national to state level. From state to locality level. From locality to district level/ There are focal person(s) at each level.	To examine surveillance trends :Monthly meetings of health facility staff at the locality level; Quarterly meetings of locality staff at the state level; Quarterly meetings of state coordinators at the national level.	

Country	Indicators	Feedback	Supervision	Performance assessment	Gap identification
	Completeness of monthly health facility reports on surveillance and logistics % of population at risk that was targeted for IRS % of targeted structures protected by IRS				
South Sudan 	Disease surveillance: Outpatient: tested, confirmed Inpatient: malaria cases and malaria deaths Logistics: Number of LLIN, ACT, IPT2, ANC1 Stock-outs: LLIN, ACT, RDT Completeness of reporting by health facility and community level (HMM) Number reported / expected to report % of HH with at least 1 LLIN % of HH with at least 2 LLINs % of HH with more than 2 LLINs (Universal Coverage) % OF CU5 who slept under an LLIN last	CHD review and discussion of monthly reports received : Alert State Malaria Program and NMCP on irregular trends: Malaria specific bulletins published on monthly basis: Ensure wide dissemination Aggregated by state, county, sex, facility and age	NMCP will conduct regular Quarterly supervision visits to all 10 states to monitor: Completeness of reporting – all data requirements are fulfilled, Quality of data submitted in reporting – accuracy of reporting	Hold quarterly national coordination meetings (MTWG on monthly basis) Hold Quarterly regional coordination meetings (state level MTWG to be formed and meet on monthly basis) Hold monthly county coordination	Delayed report submission at all levels Poor communication & transportation infrastructure (difficult to logistics i.e.: transportation, fuel, computers etc.) High staff turnover

Country	Indicators	Feedback	Supervision	Performance assessment	Gap identification
	night % of PW who slept under an LLIN last night % of HFs without stock outs of LLINs % of outpatient confirmed malaria cases by microscopy or RDT % of HFs without stock outs of diagnostics % of malaria cases receiving appropriate antimalarial treatment at health facility % of HFs without stockouts of first-line antimalarial medicines % of malaria cases treated with ACTs at community level Completeness of reporting by communities and health workers/volunteers expected to report % of CBDs without stockouts of first-line antimalarial medicines % of malaria cases referred to HFs from community level % of PW who have received IPT1 % of PW who have received IPT2		NMCP to prepare to transfer submitted data into Graphs (requires system set-up & training of NMCP focal point) Review of graphs, Data analysis & discussion at National level Hold regular meetings: HF with county health departments = Monthly; County health departments = Quarterly; State Health Ministries with national level = Quarterly	meetings (with HF staff and review surveillance trends)	No M&E focal point at national level (NMCP, State and County level) No NMP and State Databases:
Tanzania	Reported at Health Facility:	Kind of feedback: Data flows from HF to	Malaria focal	Surveys: RBM	Data collection:

Country	Indicators	Feedback	Supervision	Performance assessment	Gap identification
	Outpatient: confirmed malaria cases, malaria positivity rate (RDT regions) Inpatient: malaria cases, deaths Diagnostics – percentage of outpatient suspected malaria cases that undergo laboratory diagnosis (sentinel site) Stock-outs percentage of the HF without stock – outs of first line anti-malarial and diagnostic (SMS for Life) IPT – IPT in pregnant women Other indicators reported at the HF: Total number of pregnant women attending ANC; Number of children <5 receiving a blood transfusion; Total number of pregnant women who attended first ANC visit; Number of total outpatients <5, 5+; Number of clinical outpatient cases of malaria <5, 5+; Total number of anemia cases <5, 5+; Number of total inpatients <5, 5+; Total number of PW voucher provided at ANC; Total number of infant voucher provided at ANC; Total number of PW tested for	district level, then from district to the region level on quarterly basis. From region level to national level annually; The system is not responsive to the immediate need of the HF because there is no feed back from the hierarchal levels; Sentinel site feedback: SSO collects information (agreed indicators) from the HF and send them to the program on monthly basis. NMCP shares this information with the HMT on quarterly basis at the respective facility Mode of dissemination: Meetings e.g. annual malaria and IMCI conference, RMO's conference, partners meeting and supervision report dissemination meeting: Frequency, Annually	persons: Are present at the regional and district levels Roles of malaria focal points: Implements and supervises malaria control in the their respective areas; Twice a year NMCP and Partners undertake supervisory district to the districts	Assessment Tool	Data extraction from HMIS Complex and numerous forms (vertical programs) Inadequate human resource Lack of valuing data amongst health personnel Poor quality of data Data Analysis: Inadequate human resource Retentions of qualified staff Lack of effective reporting system

Country	Indicators	Feedback	Supervision	Performance assessment	Gap identification
	malaria during their first ANC; Total number of PW tested for hemoglobin during their first ANC				
Somalia 	Outpatient confirmed malaria cases Outpatient malaria TPR Inpatient malaria cases Malaria deaths Stock-outs – percentage of health facilities without stock-outs of first-line antimalarial medicines, mosquito nets and diagnostics, by month Completeness of monthly health-facility reports on surveillance and logistics2	In Somaliland and Puntland feedback is carried quarterly at the zonal level. In CSZ partners are given feedback on a semiannually basis (6 Months). Monthly malaria working group meeting is conducted in a zonal basis. Feedback sessions include overall reporting of statistics as well as reporting and data quality issues. HMIS data is currently available only through UNICEF and is shared with partners through feedback forums.	CSR officer at regional level through health staff in district report malaria cases in integrated with other six diseases The CSR staff report malaria cases on weekly basis but not all the malaria indicators they do supervision when any districts report on increased Malaria cases.	There is quarterly national malaria control staff meeting for Malaria performance assessment involving regional staff. Monthly Malaria working group hold on the Zonal level but not in the district level. There are annually malaria review meeting on national level. National health and nutritional	Data Collection: Lack of standardized data collection forms were; Lack of staff motivation; High staff turn over. Analysis: Technical assistant is lacking on data analysis at zonal level; Three data managers is needed (one per zone); Need of three trained epidemiologist in zonal level (NMCP)

Country	Indicators	Feedback	Supervision	Performance assessment	Gap identification
			NMCP quarterly supervision Regional PHC coordinators monthly supervision	quarterly meeting. Regional health and nutrition meeting.	Information: Limited information sharing between stake holders Dissemination: Limited feedback to the health facility levels. Lack of stander database for surveillance. Bottlenecks in strengthening malaria surveillance system: Low motivation of the staff; No Support transportation and DSA; Limited communication between all level; No capacity

Country	Indicators	Feedback	Supervision	Performance assessment	Gap identification
					building of Surveillance Staff; inadequate equipment for the Center; Lack of funds for Emergency response
Zanzibar 	Surveillance indicators and the core data elements that can be collected are as follows: At Peripheral, District and Hospital level • Outpatient – Confirmed cases (Micro/RDT) – IPT in pregnant women • Inpatients – Confirmed Malaria cases – No. of deaths • Core data elements – Outpatients:	By phone: when necessary Quarterly reports submitted to District level not at peripheral facilities Supervisory visits Annual refresher training/meeting Bi annual surveillance reports Bi annual Partners meeting One to one approach No focal points at the district and regional level, however District Surveillance officers (not for malaria specific) are responsible for supporting health facilities This is done jointly with ZMCP	No regional/district focal points however, In house quarterly review meetings involving focal persons within the Program are conducted *No quarterly regional performance assessment involving district malaria focal*		

Country	Indicators	Feedback	Supervision	Performance assessment	Gap identification
	suspected and confirmed – Inpatient: malaria cases and malaria deaths *Logistics – LLIN distribution – at ZMCP level; Stock levels of ACT, RDTs – done at CMS*		*points* Quarterly meetings organised for health facility In charge's are used to discuss surveillance and other malaria issues		
Djibouti 	Nombre de tous les cas recevant un traitement antipaludique conformément aux directives nationales Nombre de cas de paludisme peu compliques traités conformément aux directives nationales. Nombre et pourcentage des cas confirmés de paludisme (utilisation de la microscopie et/ou RDT du nombre total des cas de fièvre Nombre et proportion des laboratoires existants, équipés, réhabilités et fonctionnels Nombre de personnel de santé formé et	Existence d'un bulletin trimestriel de retro information au SNIS pour toutes les structures sanitaires	Supervision trimestriel au niveau du programme Supervision semestriel intégrée avec tous les programmes prioritaires du MS Supervision conjointe avec les partenaires	Revue des performances du programme au niveau du CCMI. Revue trimestriel des performance par le FM et BM Rapport annuel des performances du programme.	Problème de définition des cas au niveau des prestataires Difficultés remplissage des outils de collecte Absence des points focaux au niveau des régions sanitaires Retard dans la transmission des

Country	Indicators	Feedback	Supervision	Performance assessment	Gap identification
	recyclé (, protocole de traitement, contrôle vectoriel, suivi évaluation et surveillance sentinelle) Nombre et proportion de foyers pulvérisés dans les zones à risque de transmission du paludisme dans les 12 derniers mois. Nombre de gites larvaires détruits. Nombre de moustiquaire imprégnés d'insecticide distribués Proportion des foyers touchés par les activités de CCC communautaire dans les zones de haut risque Proportion des femmes enceintes qui ont dormi sous une moustiquaire imprégnée d'insecticide la nuit dernière dans les zones de haut risque Proportion d'enfants de moins de 5 ans qui ont dormi sous une moustiquaire imprégnée d'insecticide la nuit dernière dans les zones à haut risque Proportion des foyers situés dans les zones à risque possédant au moins une imprégnée d'insecticide		technique et financiers.		données surtout aux niveaux des régions

Country	Indicators	Feedback	Supervision	Performance assessment	Gap identification
	Nombre de personnel de santé formé dans la surveillance sentinelle et le suivi Nombre de centre de santés soumettant le rapport dans le temps conformément aux directives nationales Incidence des cas de paludisme clinique Taux de mortalité du paludisme parmi la population générale Les informations concernant la surveillance sont récoltés à tous les niveaux de la pyramide sanitaire sauf le 3ème (Structures Hospitalières) Les données de routine sont récoltées mensuellement et disponibiliser trimestriellement pour le programme				
Uganda 	• OPD No uncomplicated malaria cases Rx within Public and NGO HF Proportion cases confirmed by Microscopy or RDT Proportion of cases confirmed by RDT Rx malaria cases with a +ve. parasitological diagnosis No Malaria cases treated who have a	Overall there are weaknesses in feedback including: Lack of targeted feedback (detail per level) Lack of commitment by national and district levels (Planning, prioritization, interest in CQI, incentives & deterrents) Lack of morale affecting all aspects of implementation	Central Support Supervision (NMCP/Zonal Coordinator to Districts and Hospital levels) Extended DHT supervision of Health Facilities	Monthly Health facility meeting Weekly Referral Hospital meetings Quarterly (MoH) Progress Review meetings Quarterly RBM partnership forum	Lack of analysis and use at point of collection; Reliance on paper based reporting Lack of infrastructure and reliable IT

Country	Indicators	Feedback	Supervision	Performance assessment	Gap identification
	positive result No Malaria cases treated who have a negative result No ACTs distributed to HF/National and Peripheral No RDTs distributed to HF/National and Peripheral % HF with no stock out of 1st line ACTs in last 1/12 % HF with no stock out for IPT drug in last 1/12 % Children U5 treated within 24 hours of symptoms by VHT No of adverse drug reactions reported (National/Peripheral) • In patient % HF with no stock out of 2nd line Antimalarials No malaria cases admitted Total all cause cases admitted % severe malaria cases treated according to national policy in HF (Sentinel sites) Total all cause Deaths from the wards	Weaknesses with Accuracy, timeliness, completeness, validity Capacity: Human resource, work overload, numbers, knowledge, skills, attitude, behaviour, use of generated information for decision making, prioritization in resource allocation, lack off commitment Vertical reporting systems weakening "One National M&E approach" Poor flow of reports from NMCP Officers and Partners Dissemination problems: Inappropriate packaging, coverage, frequency Action: Lack of response, feedback, follow up, capacity, health hour (On radio… quoting papers, publications etc)	and HC IV, III. The rest supervised by lower HW District (1) Malaria Focal Person (2) HMIS Focal person and (3) Surveillance focal persons for weekly, monthly, quarterly reporting Quarterly review meetings with CMDs/VHTs In patient surveillance (UMSP Pilot in two hospitals)	meetings Area Team supervision Annual Malaria Performance Reports Sentinel site surveillance reports Joint Review Mission	Gaps in planning and prioritization; Lack of use of meteorological data – poor coordination with relevant department; Weaknesses with Accuracy, timeliness, completeness, validity Capacity: HR (staffing), work overload, numbers, knowledge, skills, attitude & behavior; use of generated information for decision making,

Country	Indicators	Feedback	Supervision	Performance assessment	Gap identification
	No of cases admitted who died of malaria Proportion of Health Facilities reporting Number of PW receiving LLINs through ANC Number of U5 receiving LLINs through EPI Number of LLINs sold through the private sector (subject to verification) No Insecticide susceptibility tests conducted Entomological surveillance studies Drug Efficacy tests conducted Proportion of targeted HF receiving an integrated support supervision visit Proportion of HW trained in SME				prioritization in resource allocation, and lack off commitment Multiple and Vertical reporting systems weakening "One National M&E approach" Poor flow of reports from NMCP Officers and Partners
Rwanda 	Outpatient confirmed malaria cases Outpatient malaria TPR Inpatient malaria cases Inpatient malaria deaths Diagnostics: % outpatient suspected malaria cases tested Treatment: % outpatient malaria cases tx with ACTs following guidelines	Recent workshop with all district M&E officers (supervisors) responsible for malaria report from HC to central level. Outcomes: agreed on use of quarterly bulletin of district level malaria indicators by the central level for peripheral for review and verification Quarterly workshop with HC officers,	Provincial supervisors from Malaria Unit District supervisors provide integrated supervision for HIV, TB,	Nationwide HMIS assessment conducted MESST conducted twice and action plan developed Routine data	15 % discrepancies found on data quality audits often due to miscalculation of registers Complex HMIS

Country	Indicators	Feedback	Supervision	Performance assessment	Gap identification
	ITN: Pregnant women, U5 routine distribution % HF without stock out of ACTs % HF without stock out ITN % HF without stock out of lab equipment:RTDs Completeness of monthly HF report on surveillance and logistics	district supervisors to review source documents, analyze and interpret data. Shortcomings: Time constraints of central and district staff finance in the pipeline but feedback just commencing	malaria,… No routine review of district specific trends	quality audits conducted by integrated team Regular meetings between district supervisors and HC staff	form: integrated with all programs: 24 pages of HCs and 31 for hospitals, Multiple categories, Community and private sector information not complete

Appendix 5: Evaluation of the EARN Annual Review and Planning Meeting 2010

The whole meeting

Travel, Accommodation and Logistics	Poor and fair	Good	Above good
	%	%	%
Communication prior to the workshop	27	34	39
Registration procedure	19	43	38
Transport pick-up	19	33	48
Suitability of location	15	18	67
Accommodation	32	11	57
Space/facilities	10	26	64

Malaria Surveillance Meeting

Workshop Content	Poor and fair	Good	Above good
Clarity of content	9	49	42
Order and organization of content	9	44	47
Usefulness of materials/information resources	9	35	56
Length of workshop	26	47	28
Workshop Presentation			
Style and appropriateness of presentations	12	49	40
Time allotted for discussion	18	55	27
General Rating of Surveillance Meeting			
General rating	11	53	36

	Yes	No or not sure
Did this surveillance meeting meet your expectations?	81	19

Was the surveillance meeting useful?	86	14

How do you advise us to follow you up on the actions suggested in your country costed malaria surveillance actions?

1) communication by emails (8)
2) monthly teleconferences (5)
3) visit some countries (2)
4) call countries in advance so that information is submitted in good time
5) quarterly reporting with formats

Please suggest any improvements for future workshops

1) Increase time for discussion and group work 5
2) Give more time to sessions to build capacity of participants 4
3) Focus next meeting on feedback from countries on malaria surveillance
4) Put the meeting into context of the surveillance system
5) Arrangement of special visas
6) Reducing number of reports

Any other comments

1) Agenda changing too often
2) Midterm review in March to check progress
3) Need one format for surveillance data needs by all partners
4) Send planning templates before the participants come to meeting to avoid ad hoc planning
5) Sponsorship to attend to conference should be availed to NGOs
6) Accommodation arrangements were not appropriate
7) Increase the number of days of the meeting to say 3 days
8) Invite some key technical guest speakers on specific topics

Annual Review and Planning Meeting

Workshop Content			
Clarity of content	8	55	38
Order and organization of content	13	43	45
Usefulness of materials/information resources	12	36	52
Length of workshop	13	46	41
Workshop Presentation			
Style and appropriateness of presentations	12	51	37

Time allotted for discussion	23	44	33
General Rating of Surveillance Meeting			
General rating	13	34	53

	Yes	No or not sure
Did this surveillance meeting meet your expectations?	89	11
Was the ARPM meeting useful?	95	5

How do you advise us to follow you up on the actions suggested in your country costed malaria surveillance actions?

1) Monthly progress reports through email (more than 50%)
2) through teleconferences
3) Follow up by email communication to all EARN

Please suggest any improvements for future workshops *(order of importance from highest to lowest)*

1) Provide clear templates a month before meeting (7)
2) Send info about meeting at least one month before (2)
3) Have a topical technical focus for the meeting with suggestions from countries (2)
4) Roadmaps should not be presented in plenary (2)
5) Shorten meeting in future
6) Separate the 2 meetings
7) Improve visa arrangements (group visas)

Any other comments

1) very very good workshop
2) keep and sustain the existing network and further strengthen the RBM network and communicate with countries continuously and know their urgent needs and constraints
3) EARN to give some countries special attention eg Somalia