EARN
EASTERN AFRICA ROLL BACK MALARIA REGIONAL NETWORK
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Covering: Burundi ,Comoros, Djibouti, Ethiopia ,Eritrea , Kenya,
Rwanda, Somalia, Sudan North, Sudan South, Tanzania and Uganda

12th Eastern Africa Sub-Regional Network (EARN) Annual Meeting
General Assembly meeting, Mombasa, Kenya, 4-8 April 2011
Traveller's Beach Hotel

Compiled by Joaquim Da Silva
EARN Coordinator

TABLE OF CONTENTS

ACRONYMS

ACT	Artemisinin-based combination therapy
ALMA	African Leaders Malaria Alliance
AMFm	Affordable Medicines Facility – malaria
ARI	Acute respiratory infection
BCC	Behavior change communication
CCM	Community case management
CHMIS	Community Health Management Information System
CHW	Community Health Worker
CQ	Chloroquine
DDT	Dichlorodiphenyltrichloroethane
EANMAT	East Africa Network for Monitoring Antimalarial Treatment
EARN	Eastern Africa Roll Back Malaria Regional Network
ECC	EARN Coordination Committee
ESA	Eastern Africa
GCC	Gulf Cooperation Council
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GMAP	Global Malaria Action Plan
GMP	Global Malaria Programme
GPARC	Global plan for artemisinin resistance containment
HEW	Health extension workers
HMIS	Health Management Information System
HSS	Health Systems Strengthening
HWG	RBM Harmonization Working Group
iCCM	Integrated community case management
IDA	International Development Association
IEC	Information, education and communication
IPTp	Intermittent preventive treatment for pregnant women
IRS	Indoor residual spraying
IST	Inter-country support team
ITN	Insecticide-treated net
LLIN	Long-lasting insecticide-treated net
M & E	Monitoring and Evaluation
MACEPA	Malaria Control and Evaluation Partnership in Africa
MARP	Most At Risk Population
MDGs	Millennium Development Goals
MIS	Malaria Indicator Survey
MOH	Ministry of Health

MOP	Malaria operational plan
MPR	Malaria Program Performance Review
NGO	Non-governmental organization
NMCP	National Malaria Control Program
NMSP	National malaria strategic plan
NSP	National strategic plan
ORS	Oral Rehydration Salts
PMI	President's Malaria Initiative
RBM	Roll Back Malaria
RDT	Rapid diagnostic test
RUTF	Ready to Use Therapeutic Food
SAM	Severe acute malnutrition
SARN	Southern Africa Roll Back Malaria Network
SME	Surveillance and monitoring and evaluation
SP	Sulfadoxine-pyrimethamine
SWOT	Strengths / Weaknesses / Opportunities / Threats
TET	Therapeutic Efficacy Testing
TRP	Task Review Panel
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WHO-AFRO	World Health Organization Regional Office for Africa
WMR	World Malaria Report
WWARN	WorldWide Antimalarial Resistance Network

ACKNOWLEDGEMENTS

The 12th Eastern Africa Sub-Regional Network (EARN) Annual Meeting was attended by over 100 participants representing 12 national malaria control programs, 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 of this meeting would not be possible.

- National Malaria Control Program, Ministry of Health, Kenya
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We would like to thank the Ministry of Health of Kenya, along with private companies that hosted us in evenings of cocktails and provide items such bags, caps and T-shits to participants: the DFI / BASF, Vestergaard Frandsen, Novartis, Best Net, Sanofi-Aventis and exhibitors for their enthusiastic participation, exhibitions and engagement.

EARN Coordination Committee

Name	Organization	Title
Dr. Corine Karema	Rwanda NMCP	Co-Chair
Dr. Barnabas K. Bwambok	Vestergaard Frandsen	Co-Chair
Mr. Athuman Chiguzo	KENAAM	Member
Ms. Clare Riches / Grace Nakanwagi	Malaria Consortium	Member
Dr. Mohamed Ali / Renata Mandike	Tanzania NMCP	Member
Drs. Charles Paluku / Josephine Namboze	WHO IST Harare	Member
Dr. Tewolde Ghebremeskel	Eritrea NMCP	Member
Dr. Kesete Admasu	Ethiopia NMCP	Member
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Dr. Rory Nefdt	UNICEF ESARO	Member
Dr. James Banda	RBM Secretariat	Member
Dr. Joaquim Da Silva	EARN / RBM	Secretary

FOREWORD

Comment [LB1]: Joaquim: I will leave this to you to complete

Six month after the Kigali meeting, EARN held its 12th General Assembly meeting in Mombasa, Kenya, from 4th to 8th April 2011, under the theme of "*Achieving Progress and Impact in Malaria control in East Africa*", to review progress of implementation of its 2011 workplan and address various issues pertaining countries roadmaps towards full implementation of the Global Malaria Action Plan (GMAP) in East Africa. Participants to the meeting and the RBM Secretariat discussed strategic issues regarding the implementation of countries roadmaps, activities and practices, and decided on the operational direction to follow in the near future. The main issues addresses were related to country malaria control roadmaps updates, management of Artemisinin resistance containment, and management of vector resistance to insecticides used for malaria vector control. The meeting also reviewed the status community management of malaria and surveillance M&E systems, cross boarder issues and their important role in achieving progress and reporting impact in the sub-region.

Countries reported on the implementation of ban of monotherapies as well as on the status on taxes and tariffs for anti-malaria commodities. The Meeting also addressed the need to strengthen in-country malaria partnerships as a way to improve the use of available resource, create synergies and avoid wastage. Countries used the roadmaps to assess their achievements with regard 2010 GMAP targets and establish new targets and miles stones towards the 2015 goals. The 12th General Assembly Meeting also provided a forum for different NMCPs and partners to share information and best practices as well as factors that could influence or limit the implementation of country roadmaps. From the outset, the meeting acknowledged the need to focus on major bottlenecks hindering implementation of national malaria control workplans and provide solution to overcome them.

This meeting was particularly helpful in equipping the countries to update their malaria control reports for 2011 and work plans and identify the technical assistance needs that could be solved with support from EARN partners. A summary analysis of the country roadmaps is included. This meeting was ranked the most successful and useful by participants from the meeting evaluation included in this report for your reference. The evaluation also indicated to the need of improving on airport transfer arrangements, opening ceremony, the organization of the market place as well as time keeping. There are suggestions to shorten the next similar meeting to three days.

As many parts of East Africa have recently experienced significant reduction of malaria morbidity and mortality, EARN is looking ahead to continue to work with countries and support them to tackle their ambitious and realist plans of reducing the socio-economic burden of malaria, promote development and reaching near zero deaths by 2015. We are indeed honored to be associated with the success of this invaluable meeting. We wish you good reading.


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Dr Corine Karema
EARN Co-Chair

Dr Barnabas Bwambok
EARN Co-Chair

1 INTRODUCTION

The 12th East Africa Sub-Regional Network (EARN) meeting was held in Mombasa, Kenya from April 4-8. The purpose of the meeting was to review the progress of implementation of East Africa countries roadmaps towards the achievement of the RBM Global Malaria Action Plan (GMAP) and coordinate actions to support countries to address major bottlenecks through provision of quality technical support.

The Annual Malaria Review and Planning Meetings are convened by national malaria programs, WHO and partners in East 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 Millennium Development Goals (MDGs).

This meeting brought together national malaria control program representatives and WHO national program officers of 11 countries (Burundi, Comoros, Djibouti, Ethiopia, Kenya, Rwanda, Somalia, Sudan North, Sudan South, Tanzania, and Uganda, as well as representatives from the RBM partners, WHO, UNICEF, the private sector, non-governmental organizations (NGOs) and academic and research institutes. Yemen participate for the first time as observer member of EARN.

The general objective of the meeting was to provide a forum for the partners to coordinate their efforts to control and eliminate malaria in order to ensure the resources deployed are used optimally and to minimize waste.

1.1 Objectives of the 12th EARN Annual Meeting

The main objectives were the following:

- Midterm review of the RBM Harmonized Work plan
- Review country needs
- Countries and partners share information on how to overcome specific challenges
- Countries and partners to develop joint 2011 plan to address the needs and achieve goals / targets
- Elect new constituency representatives of the EARN-EARN Coordination Committee (ECC)

1.2 Expected outputs of the EARN Annual Meeting

The key outputs of the meeting were to:

- Share country needs
- Develop a joint 2011 implementation work plan to meet country needs
- Obtain a list of new constituency representatives

1.3 Participants

The meeting brought together participants from national malaria control programs and WHO national program offices of 12 countries (Burundi, Comoros, Djibouti, Ethiopia, Kenya, Rwanda, Somalia, Sudan North, Sudan South, Tanzania, Uganda and Yemen). Of note, Zanzibar has decided to participate in the Southern Africa Roll Back Malaria Network (SARN) meeting going forward while Tanzania mainland will remain a member of the EARN. Eritrea representatives were not able to attend the meeting. Also, as was decided at the 11th EARN Annual Review and Planning Meeting organized in Kigali, Rwanda in October 2010, Yemen participated in this meeting as an observer.

In addition to delegates from the countries mentioned above, the meeting gathered representatives from the EARN Coordinating Committee (ECC), WHO malaria SME officers from GMP, AFRO and Intercountry Support Teams (ISTs), in-country or regional RBM partners, the private sector, academic and research institutes, NGOs, and UN agencies. For a comprehensive list of participants, refer to Appendix 5.

1.4 Method of work

The meeting was articulated around plenary presentations, followed by interactive discussions or group work. It was conducted in English with simultaneous interpretation in French. For more details, see meeting agenda in Appendix 1.

2 PROCEEDINGS

2.1 Day 1

2.1.1 Opening Ceremony

The first day of the meeting was chaired by Dr Corine Karema; EARN Co-Chair and Rwanda NMCP Director.

Dr. Barnabas Bwambok (EARN co-chair) welcomed all the participants on behalf of the ECC, acknowledged the Kenyan government support to host this EARN meeting as well as the EARN secretariat for their support. He presented the sessions of the day as per the agenda made available to all, then invited all participants to introduce themselves. Dr Joaquim Da Silva, the new EARN coordinator, after informing of administrative arrangements, turned it over to Dr Corine Karema (Co-chair EARN) who presented the general meeting objective and 5 specific objectives along with the expected outputs and methodology.

Dr James Banda, Head of the RBM coordination and country support team, gave opening remarks by stating the following expectations: i) now that we are in 2011, can we analyze whether we achieved universal coverage by the close of 2010?, b) what do we expect to produce by the end of 2011?, iii) have we kicked off our work in 2011?, and iv) in terms of planning for the 2011-2015, what are the targets, what do we need to do immediately to define our operations on the road to 2015?

Dr Karema highlighted participants were from 11 countries in Eastern Africa plus Yemen and the host Dr Elizabeth Juma, guest of honor representing the Ministry of Health and Public sanitation, welcomed all participants on behalf of the Kenyan Ministry of Public Health and Sanitation. She opened the meeting, inviting countries to share experiences with each other and emphasized the need to share the experiences of the countries that achieved the RBM 2010 targets with countries that have not yet, so that they know what it takes to meet the targets.

2.1.2 EARN 2010-2011 work plan and targets

Dr Joaquim Da Silva introduced the EARN 2010-2011 work plan and the six following targets as they were laid out (for more information about the activities under each target, refer to Appendix 2).

- ✓ Target A: 100% of all country roadmaps are maintained and implemented through to the end of 2011
- ✓ Target B: 80% of country assistance requests via Sub-Regional Networks receive a response outlining a plan to meet the request and satisfactory to the country
- ✓ Target C: RBM Community and Heads of State informed on the achievements of 2010 universal coverage and preparation for 2015 targets
- ✓ Target D: Mobilize resources and political support to achieve the US$6B annual target to fund the GMAP through 2011 – 2015
- ✓ Target E: Countries / territories to align their strategic / operational plans with best practices to achieve the GMAP by the end of 2011
- ✓ Target F: RBM Mechanisms receive management support from the Secretariat consistent with Board decisions throughout 2011

To meet these targets, Dr Joaquim Da Silva underlined some challenges and next steps:

- Need to improve on consistency of monthly teleconference with countries to track roadmap progress
- Decide on two countries for in-country partnership evaluation and document lessons learned, and deploy consultants
- Finalize the malaria program performance reviews (MPRs), strategic plans and publish on the RBM Website
- Get feedback from countries in order to respond to technical assistance needs
- Need to agree with countries on the dates for ECC mission to countries to support in-country partnership strengthening
- Difficulty to operate in an environment with limited support from WHO-IST team

2.1.3 Overview and update of the GPARC

Peter Olumese explained that antimalarial drug resistance was the ability of a parasite strain to survive and / or multiply despite the administration and absorption of a drug given in doses equal to or higher than those usually recommended but within tolerance of the subject. The concept of an artemisinin-based combination therapy (ACT) relies on the artemisinin component to reduce parasite bio-mass (and not to achieve full clearance) and the partner drug to clear residual parasites. The term "artemisinin resistance" should not be based on treatment failure with an ACT, but on the presence of parasites at Day 3 following treatment, in other words, a day-3 positivity rate > 3%.

Peter Olumese introduced the Global plan for artemisinin resistance containment (GPARC) to the audience. The aim of the GPARC is two-fold: given that no other antimalarial medicines available offer the same level of efficacy and tolerability as ACTs, there is a need to protect ACTs as an effective treatment for *Plasmodium falciparum* malaria; key to this was regular therapeutic efficacy testing (TET) and enforcing ban on artemisinin monotherapies. Furthermore the plan is intended to mobilize global and local stakeholders for

the containment and ultimate elimination of artemisinin resistance where it has emerged and for the prevention of its emergence in or its spread to new locations (beyond the Thai-Cambodia border).

The objectives of the GPARC are to:

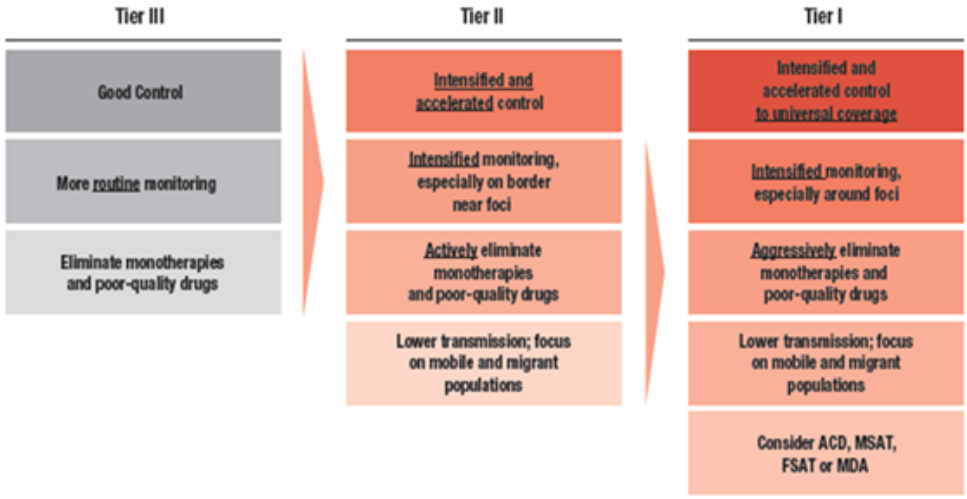
- Define priorities for the containment and prevention of artemisinin resistance
- Motivate action and describe responsibilities by constituency
- Mobilize resources to fund the containment and prevention of artemisinin resistance
- Increase collaboration and coordination for artemisinin resistance containment and prevention among relevant stakeholders
- Define governance mechanisms and indicators for continual assessment of progress made in implementing the GPARC

There is a need to include issue of counterfeit / falsified drugs on the market in all countries. So i) data must be available about the quality of the drugs and ii) a mechanism is needed to enforce / strengthen national drug regulations. In practical terms, WHO recommends each endemic country evaluate its level of risk and then apply the GPARC recommendations accordingly in designing a containment or prevention program. To do so, three levels or tiers are defined:

- Tier 1: areas for which there is credible evidence of artemisinin resistance
- Tier II: areas with significant inflows of mobile and migrant populations from tier I areas or shared borders with tier I areas.
- Tier III: *P. falciparum* areas which have no evidence of artemisinin resistance and limited contact with tier I areas

Then, depending on where they stand, countries are expected to take the following actions:

FIGURE 5. Recommendations by tier



As a conclusion, parasite resistance to artemisinin could reverse the malaria control achievements of the past decade. Still, it is evitable if the correct course of action is taken. This is why regional and sub-regional networks on monitoring drug efficacy are so critical, hence the need to evaluate reasons for the demise of the East Africa Network for Monitoring Antimalarial Treatment (EANMAT) and find ways to revitalize it.

2.1.4 WorldWide Antimalarial Resistance Network (WWARN)

Ambrose Talisuna introduced the WWARN (www.wwwarn.org), a global initiative working on clinical drug efficacy, and tracking antimalarial resistance. This initiative can take over the advocacy role that EANMAT used to have. After presenting information regarding the resistance of different antimalarials over the centuries and past decades, he spelled out the overall goal of the WWARN project: support the collection of antimalarial resistance data that are high quality, up to date, comprehensive, and comparable between countries, regions and studies. This project (tool) has five linked modules: clinical efficacy, pharmacology, *in vitro* susceptibility of isolates, molecular markers, and drug quality.

The WWARN explorer enables to see studies of clinical data (resistance) that have been conducted across the globe. The tool gathers information about antimalarial quality to its data repository, this is why countries are expected to share their data or get resistance studies conducted, all the more as funding for resistance monitoring can be part of the Global Fund proposals. He highlighted that poor quality antimalarials, either counterfeit or falsified, may lead to the emergence of artemisinin resistance.

KEMRI (Nairobi, Kenya) and University Cheick Anta Diop (Dakar, Senegal) are the regional centers for Africa. During discussions, the question was raised on the reason(s) for initiating WWARN without evaluating reasons for demise of EANMAT.

2.1.5 Management of Severe Malaria: The AQUAMAT Contribution of IV Artesunate in Reducing Mortality

Dr. Sama Cage, Researcher in KEMRI, on behalf of MMV, presented the AQUAMAT project which is an open randomized comparison of artesunate vs. quinine in the treatment of severe *falciparum* malaria in 5,425 African children. This study led to the following conclusions:

- Parental artesunate should replace quinine everywhere in the world as the first line treatment of severe *falciparum* malaria. The severe malaria policy should indeed be updated accordingly.
- There are approximately 8,000,000 severe malaria cases / year (resulting in 800,000 deaths). If half of these patients received artesunate then 100,000 lives would be saved each year.

Following the AQUAMAT study, WHO has taken into consideration the outcomes and will update the recommendation for the treatment of severe disease. Therefore, artesunate will momentarily be said to be the preferred treatment of severe malaria.

Peter Olumese concluded that the objective of the treatment of severe disease is to prevent deaths, which is different from treating uncomplicated malaria. Monotherapy (artesunate injection) is the recommendation for the treatment of severe malaria as an urgent step, and then full treatment course should be given.

2.1.6 Overview of insecticide resistance management framework

Dr. Birkinesh Ameneshewa (WHO-IST-Eastern Africa [ESA]) explained that vector resistance is the implementation of vector control strategies based on evidence on the status of susceptibility of the vector(s) in order to delay the loss of insecticide efficacy and prolong the effective life of available interventions. The resistance management framework has two components: the monitoring of susceptibility status and of the trend, and the management of the resistance.

Regarding management of resistance, two components were presented: i) delaying the appearance of resistance within countries and -if detected- b) the need to limit and control the impact of resistance. These include such interventions as rotation, mosaic, mixture and combination.

He finally made the following conclusions:

- Resistance monitoring is absolutely critical for effective VC (scaling up for universal coverage)
- Resistance monitoring is not research but integrated component of vector control programs
- Resistance management helps to preserve insecticide efficacy, slow down evolution of resistance & prolong effectiveness of vector control interventions
- Where there is a very high level of long-lasting insecticide-treated net (LLIN) coverage in an area, WHO does not recommend not to spray, but to use a different insecticide as the one that is used for LLINs (pyrethroid)

2.1.7 Malaria Surveillance Regional Trends and Priorities

Khoti Gausi (WHO-IST-ESA) defined malaria surveillance as the ongoing systematic collection, analysis and interpretation of outcome-specific data, closely integrated with the timely dissemination of these data to those responsible for taking action to prevent and control disease. In this context, he prompted countries to count cases of malaria now, and disseminate this information to WHO through bulletins.

On surveillance and its priorities morbidity and mortality data was presented showing divergence of progress over the years. The need to focus preferably on integrated systems (including community health management information systems [CHMIS], e.g. example of Rwanda) with clear core indicators (pg. 7 & 8 of World Malaria Report [WMR] 2010) was highlighted. He showed the example of Rwanda that has an excellent surveillance system, if not the best in ESA. The country has indeed been bold in doing the following:

- Going for an aggressive integrated approach (based on the district and not on the central level, the district is responsible for what happens therein)
- Putting a system for accountability (zero tolerance on corruption), and a performance-based system (as a worker in the system, you get 30% of your system and the remaining 70% is based upon performance)
- Empowering the managers at all levels (the national malaria control program [NMCP] manager has the lead role and is responsible for the program performance)

He stressed the point to go with integrated surveillance as opposed to vertical surveillance (by district). He put up five priorities:

- Before going parallel the integrated approach is the first call
- Surveillance and M & E (SME) plans need to be finalized and let WHO get the bulletins out
- Use page 7 and 8 of the WMR 2010 to choose the key indicators you need to be collecting. Use them to put pressure on health management information systems (HMIS) if need be.
- Move step by step to build the information culture in your health system and capacitate it if possible.

- Learn from Rwanda – great challenge to conquer (all malaria SME officers to a field visit to Rwanda and see for themselves).

2.1.8 Integrated Community Case Management (iCCM): Regional experience

Dr. R. Nefdt (UNICEF ESARO) defined iCCM as a strategy enabling assessment, classification, treatment and referral of pneumonia, malaria, diarrhea and severe acute malnutrition (SAM) at community level. It aims at diagnosing and treating sick children (2 months to 5 years) in the community for the main causes of Under 5 mortality. He underlined that iCCM can be better done at community level (through community health workers [CHWs] in Ethiopia for example) supported by a functional health system and the tools for implementing iCCM are rapid diagnostic tests (RDTs) for fever diagnosis, ACT malaria drug, antibiotics and timer for pneumonia, Ready to Use Therapeutic Food (RUTF) for SAM, Oral Rehydration Salts (ORS) and zinc for diarrhea.

2.1.9 Malaria program review: progress in East Africa Update

Dr Charles Paluku (WHO IST ESA) indicated that an MPR was a periodic, collaborative evaluation of national malaria control programs and aimed at improving program performance in the delivery of anti-malaria interventions, in order to reduce morbidity and mortality. It is a tool for stakeholder to dialogue on malaria control policies, strategies and service delivery and is a country-led process for evidence-based programming. He then prompted countries that have not filled in the EARN country timetable for MPRs to do so promptly, the most important ones being Phase I and Phase II activities. Once country plans are finalized, they will be shared with all countries for appropriate technical assistance and participation.

2.1.10 Rwanda Malaria Program Review

Dr Corine Karema indicated that the national strategic plan covering the 2008-2012 period, the MPR accounted for a mid-term review. The process followed the recommended phases: phase 1 (planning, defining need for the MPR), phase 2 (thematic desk review), phase 3 (validation of the thematic reports). The findings presented were that the country had an excellent routine information system. She also highlighted the ongoing development of a harmonized logistics management information system and that there had been extraordinary progress in the fight against malaria with provincial and district variations in the gains in malaria control. Still, Rwanda's gains in malaria control are fragile and will be sustainable if available data is used to monitor malaria burden, and if transmission foci are identified and help guide local action.

She made the following conclusions:

- Future funding for malaria control in Rwanda needs urgent attention. Undertake resource mobilization
  - Increase domestic funding
  - Undertake advocacy for public-private partnership for malaria control
  - Mobilize more funds from GFATM and other multi-lateral and bilateral organizations
- Regular performance review meetings should take place between the program and partners to address the need for increased information on financial expenditures from all partners

2.1.11 MPR processes in Zambia and Rwanda – lessons learned and challenges

Based on an analysis of the MPR processes carried out in Rwanda and Zambia, Dr A. Kalu brought the following points to the attention of the assembly:

- The current definition of the MPR is not policy-maker friendly, not useful for advocacy purposes, and not good for successful MPR marketing. There is a need for a sharp and policy-oriented definition, including the following aspects:
    - It is a periodic, country-led collaborative review of national malaria control programs
    - It is a tool for stakeholder dialogue on malaria control policies, strategies and service delivery
    - It aims to improve program performance in the delivery of anti-malaria interventions, in order to reduce morbidity and mortality

- The MPR process is still heavy and needs further streamlining to make it more user-friendly:
    - Review the goal, purpose and objectives of the MPR to align with the actual aim of in-country process (capacity building)
    - Review final report framework in order to
        - Align the thematic reports frameworks with the final MPR report framework
        - Remove repetition in the various sections of the final report
        - Align the performance standards with the thematic reports
    - The checklists for sub-national consultations are too heavy, questionnaire-like and misaligned with the aim of the consultations
    - No checklist for interaction with CHWs
    - The information collected from consultations at sub-national levels is not fully integrated into final MPR report
    - Need to standardize the process of facilitating MPR, by developing a standardized facilitators' guide for phases 2, 3 and 4 in order to ensure uniformity

In conclusion, there is a need for a meeting of all partners to revise and update MPR guidelines and tools. In addition, country capacities for MPR should be strengthened over time so that it becomes an in-country activity, by ensuring continued participation of program staff in other countries' MPRs, and by involving countries in the review and updating of the guidelines.

2.1.12 Yemen: Intercountry Collaboration: GCC Experience on Elimination

Dr A. Nasser Al-Jasari, Yemen NMCP Director, shared his country's experience in malaria cross border collaboration and regional malaria elimination initiative. He presented the experience shared by the Gulf Cooperation Council (GCC), the origin, the process of the inter-country cross border collaboration for malaria elimination in the Gulf States. In the Gulf, 4 GCC countries are malaria free since some time - Qatar (1970), Bahrain (1979), Kuwait (1980) United Arab Emirates (certified in 2007)- and the collaboration of high malaria burdened Yemen with Saudi Arabia started in 2001 with a view to eliminate malaria.

Through the Joint Supervision committee, both countries carry out cross-border malaria activities, namely indoor residual spraying (IRS) campaign, periodic larviciding, and entomological surveillance.

The lesson learned from this collaboration, in addition to the challenge of political instability in the north of Yemen recently, is that cross-border malaria collaboration is a long-term investment that requires strong political commitment and allocation of adequate financial and other resources.

2.1.13 Updated GMAP objectives, targets and priorities beyond 2011

Dr Peter Olumese (co-chair of the Harmonization Working Group [HWG]) indicated that, overall, GMAP goals, targets and objectives remain unchanged. However, to ensure that the 2015 objectives are achieved, mid-term targets and milestones are being set for clarity and focus, for resource mobilization, and for monitoring and tracking progress. For the 3rd generation of strategy plans it means that:

- They should be aligned to GMAP targets, in other words, countries need to ensure their annual operational plans are built around meeting them
- Implementation / business plans derived from the strategy plans should be "front loaded" to ensure that the timing reflects these updated milestones
- Programmatic / funding gap analysis should reflect these target and milestones

For detailed information about the GMAP targets, the targets across objectives beyond 2011, and the GMAP priorities, refer to Appendix 3. Of note, these are draft targets that may be adjusted and will be finalized at the May RBM Board meeting.

2.1.14 National Malaria Strategic Planning (tips for development for the 3rd generation)

Dr Charles Paluku (WHO-IST-ESA) introduced this session by presenting the lessons learned of the strategic planning: a high level political commitment is required and partner involvement facilitates consensus and resource mobilization. The strategic planning process is broken down into the following activities and steps:

- Organization of the national malaria strategic planning process: define expectations and stakeholders, interact with WHO for technical assistance, and define work plan
- Desk review and analysis, then a Strengths / Weaknesses / Opportunities / Threats (SWOT) analysis. These activities can be replaced with the MPR if the latter was conducted
- Visioning: agree on the span of the strategic plan, develop or review the mission statement of the program, review the principles and values of the NMCP, and develop a program vision
- Definition of goals and objectives
- Gap analysis and change management
- Action planning, which includes the strategy definition for each objective as well as the plan development and costing
- Performance measurement: develop performance framework, identify key indicators, define collection methods of the key indicators, and define data sources and responsibilities
- Review and finalization of the national malaria strategic plan (NMSP): share the document for review, hold technical stakeholders' meeting to review it, then finalize
- Dissemination and resource mobilization

Dr Paluku detailed out the outline of a 5-year malaria strategic plan which then includes the vision / goals / strategy of the national malaria control program (with an MPR at the end), the 3–year country business plan (with actions to achieve strategy / roles and milestones / budget, along with an MPR at the end), and the annual work plan including detailed activities and timelines / responsibilities / measures of achievements.

2.2 Country roadmaps

In the morning of Day 2, six countries presented their achievements against their roadmaps, but also their needs (both quantitative and financial) by intervention / service through the end of 2011. Burundi, Comoros, Djibouti, Ethiopia, Kenya and Rwanda also shared their assumptions for this needs calculation to achieve the 2011 targets, their implementation plans, as well as a summary of rate-limiting factors / solutions over the next 12 months. The country roadmaps for Somalia, Sudan North, Sudan South, Djibouti (part II), Tanzania and Uganda were presented in the morning of Day 3.

As we did during the meeting, we are not capturing achievements made by countries in this report (you can access the full country roadmaps on the RBM website by clicking this link). Instead, you will find below a summary -per country- of the gaps and bottlenecks identified, as well as a list of the issues raised. As for the technical assistance required, a specific session addressed was held for this purpose, and a summary is provided under section 2.5.4.

2.2.1 Burundi

- Many areas have no gaps except the following:
  - IRS: strategic plan was developed and there is a gap for 45,000 households (=US$250,000)
  - Intermittent preventive treatment for pregnant women (IPTp): the policy has to be developed and the corresponding needs budgeted
  - Surveillance is weak and the systems (sentinel and HMIS) need to be strengthened
  - MPR is scheduled over the May-July period.
- Implementation bottlenecks
  - Need to strengthen quality assurance for microscopy and RDTs and to train lab staff
  - Limited funding to sustain technical assistance from IST from the country office

2.2.2 Comoros

- There is a gap in LLINs of 134,000 (=US$1.1m). Distribution of LLINs in ANC was hampered by delayed deliveries in insufficient numbers. Funding sources are being explored
- A study on insecticide resistance is underway but the sampling is insufficient
- Malaria Indicator Survey (MIS) is in progress. RBM is to help with data entry and analysis, tabulation and report writing
- The Monitoring and Evaluation (M & E) system needs strengthening (=US$220k in total incl. contract extension of international M & E expert)

2.2.3 Djibouti

- There is a gap of 80,000 LLINs due to limited funding
- Need to strengthen the HMIS
- Develop a new strategic plan for 2011-2015 with a focus on elimination if relevant
- Establish community case management
- Reactivate entomological surveillance system

- Needs:
  - Support establishment of database
  - National malaria survey every 2 years
  - Consultant for IRS campaigns
  - A growing number of fever cases in Djibouti – support to identify and address the cause for them
- Bottlenecks
  - GFATM to inform about way forward for Round 9
  - Urgent need for an MPR so that it informs the national strategic plan (NSP) development

2.2.4 Ethiopia

- Lack of resources for LLIN distribution, IRS activities, M & E including operational research, and information, education and communication (IEC) / behavior change communication (BCC)
- Funding of US$6.5m available for capacity building activities (these have not yet been identified and budgeted)
- There is a need for a strong surveillance system
- May need to either scale IRS activities down or select the use of insecticide from evidence generated from the field (given insecticide resistance)

2.2.5 Kenya

- There is a gap of US$754,000 for RDT procurement
- There is a funding gap is of US$3m for routine surveillance and M & E activities.
- Poor access to diagnostics given funding gap for a long time

2.2.6 Rwanda

- Arrival of half a million LLINs delayed for mass distribution campaign. Also gap in Under 5 routine distribution
- ACTs are expiring in Rwanda while Uganda needs them
- ACTs are destroyed and cannot be given to another country due to GFATM procedures and insurance policies. The HWG will address this issue
- RBM to support the selection of reliable ACT / LLIN suppliers to avoid non-compliance with contractual turnaround times (6-month delays in deliveries).
- Cross border initiatives are possible (Tanzania, Rwanda, Uganda and some more / others) and steps may need to be taken. But higher level commitment as well as a strategic framework across borders is required to facilitate it
- There is a need to explore use of other disease cross-border protocols (and plans) and use them for malaria. WHO can inform on this specific topic
- Rwanda needs EARN guidance on selection criteria for LLIN procurement besides lead-time and cost
- The idea emerged about a task force to look into creating some cross border initiatives in East Africa and report back in the next EARN meeting

2.2.7 Somalia

- Gap

- There is a LLIN gap of 800,000, worth US$5.6m: might be covered under round 10 beginning in Oct 2011.
- Microscopy gap: 50 microscopes might be covered under Round 6
- BCC gap worth US$45,000 for development of new strategy

- Implementation bottlenecks
  - Insecurity
  - Coordination of meetings given existence of 3 administrative zones, ministers
  - Lack of motivation of health workers leading to a high turnover
  - Shortage of human resources (HR)

2.2.8 Sudan North

- Gap
  - LLINs gap of 386,418 nets worth US$2.5m: might be covered under round 10
  - IRS gap of 770,047 structures worth US$5.4m
  - ACTs gap worth US$101,880
  - RDTs gap of 143,079 worth US$200,300
  - M & E gap worth US$201,500
  - BCC gap worth US$747,000
- Implementation bottlenecks
  - Disbursement delays from GFATM and complicated procedures & delay of commodity procurements
  - Political commitments at state and locality level to ensure smooth implementation of activities
  - Pyrethroid resistance reported recently in some parts of the country

2.2.9 Sudan South

- Gap
  - ACT gap worth US$838,391
  - RDTs worth US$673,425
  - M & E worth US$2.2m
  - LLIN gap of 115,194 worth US$426,140

- Implementation bottlenecks
  - The general health systems strengthening (HSS) is weak, e.g. both the M & E system and the supply chain are weak
  - Inadequate capacity of state malaria control units to coordinate and supervise malaria activities
  - Delayed startup of GFATM round 7 case management activities due to prolonged contractual mechanisms
  - Poor infrastructure limiting access to some areas,
  - Inadequate BCC approaches,
  - Weak coordination and linkage with state, country and lower levels

2.2.10 Djibouti

- Gap

- LLINs gap worth US$3.3m for both mass distribution (285,600 nets) and routine (93,900 nets)
- IRS gap of 14,700houses worth US$212,500
- RDTs gap of 10417 worth US$16,000
- M & E gap worth US$60,000
- BCC gap worth US$200,000
- HR (capacity building) worth US$85,000
- HSS / service delivery worth US$26,850

• Implementation bottlenecks
  - Epidemiological surveillance and inactive sentinel sites
  - Absence of database
  - Insufficient HR and financial resources

2.2.11 Tanzania

• Gap
  - IRS gap of US$18.5m for coastal zone
  - Larviciding gap worth US$2.65m
  - MPR funding gap of US$256,000
• Implementation bottlenecks
  - Delay in disbursements of funds from donors and procurement processes
  - Inadequate HR to manage program implementation
  - HMIS system, quality of data and delayed reporting
  - Not certain about the continuation of UCC
  - Funding for the Tanzania National Voucher Scheme
  - Major threat to sustainability of donor based achievements

2.2.12 Uganda

• Gap
  - LLIN gap of 885,000nets worth US$4.425m for routine distribution
  - IRS gap for 6 districts worth US$5.9m
  - MPR gap worth US$84,041
  - HR capacity building worth US$168,000
  - HMIS (US$524,210), Supervision (US$562,532), drug quality assurance (US$90,000)
• Implementation bottlenecks
  - Stringent funding conditionalities
  - Undue political interference in technical decisions making processes
  - Lack of shared vision, internal cohesion, staffing, team work and program functionality
  - Inadequate staffing
  - Quality of service delivery and HMIS, availability of diagnostics, medicines
  - Poorly coordinated RBM Partnership

2.3 Malaria Market Place

In the afternoon of Day 2, a Mombasa malaria market place was organized. This was an avenue for all stakeholders in malaria control to engage with each other and share knowledge on the status of malaria control as well as on recent developments and advances in tools and technologies for malaria control. The

market place provided opportunity for practitioners to showcase their products (hardware, software, medicines, diagnostics and other intellectual products) and learn about emerging global trends. The event provided a convenient opportunity for NMCPs, academia and private sector supplying malaria control commodities (LLINs, IRS commodities and equipment, malaria drugs and diagnostics), to interact with each other and network. It represented a unique opportunity for users of malaria control technologies and providers as well as NGOs, academic institutions to discuss ways of innovating and improve organizational functions that can bring about efficiencies to malaria control interventions and programming.

The participants were from ministries of health and / or public / private partners that collect, analyze and disseminate information and technologies about malaria control in East Africa and beyond.

Comment [LB2]: Do we have a list of all exhibitors? Do we want to list them?

With the Malaria Market Place being expected to become common place within the EARN network, participants and visitors highlighted the following improvements that would be appreciated:

- Encourage national malaria control programs to set up stalls at subsequent market places
- Exhibitors to provide information on cost analysis of their interventions
- Advance planning (time and effort) required to prepare for future market places
- Larger room to be arranged to allow for better movement and interaction

Thus, this event will foster innovation and generation of affordable solutions that will enable to advance malaria control and elimination in East Africa and help to build bridges between malaria control practice, malaria commodities industry, research community and academia. This practice will hopefully and ultimately enhance the goal of evidence-based malaria programming and strong case for best practices, sound and affordable technologies, and networking opportunities among malaria control practitioners with positive impact on the landscape of malaria control in East Africa.

2.4 Day 3 afternoon

2.4.1 ALMA scorecard

Melanie Renshaw presented the ALMA scorecard that tracks progress in sustaining coverage and key tracer indicators for MNCH. It includes data from RBM roadmaps on LLIN coverage and use, IRS coverage, parasitological diagnosis, financing information and grant performance as well as on the impact of interventions. Simple and easy to understand, this scorecard is a powerful tool to hold countries and partners accountable for their commitments. This is shared with heads of state on a monthly basis to see if they are on track and the tool proves to be a comprehensive repository for country data.
Progress is color-coded (red for 'not on track', yellow for 'some progress', green for 'target achieved / on track') and the information gives accountability and transparency for leadership and call to action for countries and the international community.

With this powerful tool in place, the next steps are the following:

- Improve reliability and regularly update the roadmap data – remember this will be shared with heads of state (so they see the data presented in the country roadmaps) and global, regional and country level partners
- Develop longer term programmatic gap analyses -3.5 years- allows adequate time for advocacy and fundraising and forecasting for commodities
- Incorporate global milestones and targets and ensure definitions of universal coverage are clear

2.4.2 Panel discussion on community case management (CCM)

Rory Nefdt, UNICEF-ESAR0 facilitated the session based on the CCM experiences in Ethiopia, Rwanda, Iran and Myanmar, prompting countries to discuss how much integration had been possible and what the state of their system was.

For Ethiopia, Dr Dereje Olana presented the Health Extension Program launched in 2004 which aimed to provide preventive, promotive and minimal curative services focusing on Maternal Newborn and Child Health. Today the program comprises over 32,000 female community health workers (2 per health post / village) who completed high school and were trained for a year. Under the malaria management, CHWs can diagnose (using multi-species RDT), deliver ACT and chloroquine (CQ), do the referral of severe cases, distribute LLIN, and play a role in IRS, IEC / BCC and reporting. The integrated community case management (malaria, pneumonia, diarrhea and severe acute malnutrition) is taking place in four regions, where health extension workers (HEW) assess, classify and treat / do referrals.

In Rwanda, Corine Karema underlined iCCM was established in 2008 with CHWs involved in the management of malaria, diarrhea, acute respiratory infections (ARI) / pneumonia and malnutrition. Rwanda numbered over 60,000 CHWs in 2010 with each village having 4 CHWs: a binome of 1 male and 1 female, 1 female in charge of maternal health and 1 person in charge of social affairs, and CHWs perform a broad range of activities including preventive, curative and promotive services (in 2009, RDTs were introduced at community level).

CHWs need to have followed at least three years of primary education, to be able to read and write, and have access to distance learning (audio-video modules developed by partners). They are equipped with mobile phones, organized in cooperatives to ensure income generation and accountability, and a community-based health insurance covers 85% of the population.

Approximately 4,500 malaria cases are reported in Iran annually (primarily *vivax* infections). In each village, the community selected one man and one woman -paid by the Ministry of Health (MoH)- to deliver health services: vaccination, family planning, support to IRS activities and to the distribution of LLINs. The minimum level of education is primary school except for some areas. Of note, the treatment of malaria is only provided by the public sector.

In Myanmar, there are 2 CHWs per village (1 man and 1 woman) who deliver a full package of health services. Their activities are supervised by staff from the health facility, or staff from NGOs. It is an NGO-based CHW program as the NGO staff takes care of the delivery of supplies for example.

These experiences highlighted that iCCM was a prerequisite to achieve universal coverage and the participants stressed that we need to make sure CHW programs are extended to all age groups and not to U5 as is the case most often to date (Ethiopia and Rwanda). The major issues raised during the discussions were the following:

- Need to interact with communities on package of interventions to implement
- Motivation of community workers is still a challenge
    - Paid government HW vs. volunteer
    - Selection criteria

- Supervision of community health workers linked to the existing health system
- Replenishment of supplies
- Government commitment is critical

2.4.3 Overview of the RBM operating framework and taskforce #2

Dr James Banda gave an overview of RBM operating framework and taskforce #2. He encouraged all participants to read up briefing materials on roles and responsibilities of EARN, constituency membership, by-laws, the terms of reference of the sub-regional networks, then to raise questions as needed the following day so that everyone is informed prior to the EARN elections.

2.5 Day 4

2.5.1 GFATM updates: Round 10 support and Round 11 applications

Melanie Renshaw indicated that RBM's HWG supported 15 country proposals to the GFATM Round 10 series (6 from EARN) and only 2 did not go get through. HWG support in Round 10 represented a success rate of 89%, a higher mark than what was experienced in previous rounds. Out of 79, 16 proposals have completed Task Review Panel (TRP) clarifications and the first signatures are expected in June 2011. She added that the average estimated time for grant negotiation was over 9 months, and that at least 39% of the Round 10 grants will be consolidated (SSFs). In Africa, Guinea, Liberia, Mali, Senegal, Sierra Leone, Zimbabwe and Kenya already confirmed they will do so.

She then presented the timeline for Round 11 confirming that new guidelines were being tested up to mid-May, leading to new versions being edited, and approved at the end of June. The proposal development process will be launched on August 15, 2011 and application will be due by December 15 with a Board decision in April / May 2012.

Among the new policies in Round 11 she pointed out that consolidation was mandatory for all applicants with existing same disease grants, the possibility of expanding Most At Risk Populations (MARPs) to include tuberculosis and malaria and to submit stand-alone HSS funding requests. Of note, a joint GFATM / GAVI proposal form will be used for all HSS requests and greater focus and scrutiny will be given to counterpart financing requirements. In the proposal form, the questions will be streamlined, there will be an increased emphasis on evaluation of current and future programming, and budget details will be required for the first three years of implementation. She added that new tools will help applicants with consolidated disease proposals, and that new measures will help smooth the transition to grant signing.

More importantly, the TRP panel has a new and very important review criterion: value for money. It will indeed now be critical to justify the value of using more than one intervention and to show how the intervention chosen in your specific intervention is cost-effective. Eventually, she laid out essential steps that could be taken in advance of the Round 11 launch:

- Consolidation of existing grants

    - Planned (or actual) merging of existing grant activities, budgets and performance frameworks will allow for focus on strategic issues at the time of proposal writing
- Evaluation of successes (and failures) of current programming
    - Applicants are encouraged to use new proposals as an opportunity to reprogram to address existing weaknesses
- Strategic planning for future years
    - Identification of future needs and gaps should inform proposal strategy
    - Consider Value for Money

In the discussions, it was repeated that the Global Fund strongly recommends consolidating (unless a grant is about to expire in which case it is not worthwhile). During the consolidation process, the grant is still implemented as it is, although consolidation is envisaged (in case your application fails). To conclude, Peter Olumese made 3 important remarks:

- The concept of MARPs was used for the Round 10 because there was a possibility of funding shortage, so a prioritization was asked, although in the end there were enough funds. This concept will be extended to tuberculosis and malaria. Consequently, there will be 2 categories: i) a normal pool and ii) a targeted pool with a limited amount of money, e.g. low burden population with high incidence, and countries will not be allowed to apply for both.
- Value for money: given that larviciding is not a global recommendation, it is up to countries to provide evidence of cost-efficiency in this context. So countries envisaging to roll out this intervention are recommended to turn it into an operational research context (and do pilot studies).
- External consultants: in most countries, local consultants have supported Global Fund applications in previous years and can now serve as consultants to other countries. So countries are encouraged to get these consultants to apply for the pool.

2.5.2 World Bank Booster Program for malaria control in Africa

Dr N. Chisaka reiterated the World Bank's commitment to malaria control through a two-pronged approach: supporting rapid scale-up of proven interventions and strengthening health systems. He highlighted that the Booster Program, consisting of projects adapted to country contexts and lending instruments, was country-led, regional (in that it addresses multi-country and cross border issues), results-focused, and emphasized partnership.

He described the Booster Program as a ten-year effort broken down into 3 phases: US$500 million to support the scaling-up of interventions from July 2005 to June 2008, US$1 billion to contribute to eliminate malaria in Africa from June 2008-2011, and some more funding to sustain the gains made over the previous phase from July 2011-June 2015. The World Bank works across sectors (health, nutrition, agriculture, social protection for example) because malaria is not only a health problem but also a broader development problem. Dr Chisaka mentioned that the current International Development Association (IDA) funding totaled US$762 million (active and pipeline) and that the World Bank had multiple active projects in different African countries, with a strong focus on DR Congo and Nigeria. Additional funds of US$200 million were announced in April 2010 to support the procurement of LLIN in DRC (100k), Ethiopia (12k), Kenya (20k), Mozambique (15k), Nigeria (16k), etc.

During open discussions, Dr Chisaka indicated that ministries of health of countries needed to make a request to the World Bank in order to be on the list of countries supported, which is a prerequisite for any assistance project. He also stressed that the World Bank supported countries as opposed to interventions (hence the World Bank cannot solve the issue of diagnostics availability overall for example) and was fully committed to cross border malaria control. He then concluded on the key lessons learned:

- Partnership work is imperative to success but requires a commitment of significant time and resources
- Sprinkling effect – IDA envelope constraints have led to some programs being substantially limited in size and scope
- Monitoring & Evaluation – Donors and technical agencies need to better harmonize reporting demands placed on country systems. In-country M & E capacity will need to be further strengthened for well-performing systems to provide quality information needed for programmatic decision-making
- The World Bank needs to communicate more effectively the Bank's contribution to malaria control

2.5.3 Scaling-up malaria biological diagnosis-based case management

Dr Peter Olumese explained that diagnosis is recommended in all patients before treatment and that treatment without confirmation should only be given when diagnosis is not available. This will lead to improved case management, prevention of unnecessary use of antimalarials, and improved malaria case detection and reporting. He underlined that diagnosis was still very low in the AFRO region, compared with other regions.

He stated that microscopy was the gold standard, although it requires well-trained microscopists, and regular maintenance, so RDTs should be used in places without microscopy. WHO has published guidelines on malaria microscopy including a clear implementation plan, structured quality assurance support, as well as a competency-based training and accreditation. A wide range of RDTs being available on the market, WHO and FIND have conducted a product testing, which led to the production of an interactive guide accessible online at http://www.finddiagnostics.org/programs/malaria/find_activities/product_testing/malaria-rdt-product-testing. Currently, WHO and FIND are conducting a lot-testing program and requests can be sent to either of these organizations.

He then addressed the quantification of RDTs and explained that when determining the quantities of RDTs needed, one should take into account all suspected cases, the use of microscopy, the effect of universal coverage of intervention, and the scope and rate of malaria diagnosis scale-up. As for the community case management, he emphasized that trained community health providers should have ACTs, rectal artemisinin, RDTs, IEC materials, patient registers and reporting forms. After addressing the quantification issue he mentioned some challenges with RDTs in the field, that is, the sensitivity, the stability and the user safety. For transport and storage, he recommended to use cold chain as much as possible and suggested to consider in-ground storage.

In the context of Affordable Medicines Facility – malaria (AMFm) he explained that advocacy for the introduction of an AMFm-like subsidy for RDTs should be pursued. In the meantime, AMFm makes more resources available (savings from procurement of ACTs) that can be channeled towards diagnosis. It also

provides an opportunity for learning how best to introduce malaria diagnostics in the private sector through operational research, supply chain system, quality Assurance systems, etc.

He concluded that as countries move to pre-elimination, microscopy becomes more important than RDTs (e.g. Djibouti) and this is something to consider/include in the NMSPs.

2.5.4 Technical assistance planning with countries

As an introductory note, Dr James Banda highlighted the types of country plans that are needed by countries (for submission to EARN too) to achieve the GMAP:

- By June 2011 – Submission to EARN of three-year country business plans (which is a resource mobilization plan over 2011-2012-2013) with an MPR at the end of the three-year period. The business plan lays out actions to achieve strategy / roles and milestones / budget. The template included in the country roadmap will continue to be used.

- By December 2011 - all EARN countries should have an updated NSP based on an MPR for the 2011-2015 period. The NSP describes the vision, goal and strategy, and the tool to use for it is the MPR on the last year of the NSP in order to inform the subsequent one.

- As for annual work plans, they need to include detailed activities and timelines / responsibilities / measures of achievements.

He pointed out that now that the EARN has collected all country roadmaps, technical assistance needed to be probed so that the RBM Partnership was informed ahead of time of the help / consultancy required, along with the anticipated timeframe for this assistance. Countries were divided into 4 groups (with three facilitators for each group) in order to probe these technical assistance requirements, excluding what relates to GFATM grant consolidation and signing processes, because the HWG has specific funds for this purpose. The second objective was to make sure existing funds were not already available to cover the need. The assistance required, along with the envisaged timeframe, is shown in Appendix 4 for the 12 countries.

2.5.5 Constituency meetings, reporting back and briefs in plenary

There are seven constituencies represented on the ECC: endemic countries, multilateral organizations (UNICEF, WHO, World Bank), NGOs (incl. Northern & Southern NGOs), the Private Sector, Academia and Research, Donor Countries, and Foundations. Each constituency gathered their members and discussed how / to what extent they will contribute to the EARN in 2011. Then elections were organized to determine who will represent each constituency on the ECC. Below is a short summary of the main decision points:

Report back from the endemic countries

Constituency members will need to communicate further with each other (teleconferences). There was an agreement that institutional memory and continuity were critical, so Rwanda will remain on the ECC and

Kenya, Comoros and North Sudan are the new elected representatives to sit on the ECC. As for the membership of Yemen, it was agreed that it was important that they are part of the EEC but that all terms of reference be considered for the NMCPs to approve / reject.

Report back from the private sector constituency

The private sector feels that they contribute much and in many ways by providing materials and it looks forward to participating more by putting pooled funds for the payment of activities (as opposed to each private sector funding X or Y activity). Representatives greatly appreciated the market place and it was decided that a rotational representation will be adopted in the future. Elected are Sanofi Pasteur and Verstergaard Frandsen.

Academia and research

ECC representative: Dr Ambrose Talisuna (WWARN). The alternate representative is Stephen Munga, KEMRI.

NGOs

It was decided that human resources and funds could be transferred to support country MPRs, and that tools development and their application can be shared among NGOs. Malaria Consortium was elected and MACEPA is the alternate. For Southern NGOs, Kenaam was elected (with CAME as the alternate).

Multilateral representatives

The constituency gathered 18 participants from WHO, UNICEF, and the World Bank. Only WHO and UNICEF were eligible because they have regional offices so their terms were renewed. Of note, the World Bank is about to decentralize their structure in the future, so will then become eligible too.

2.6 Main recommendations and way forward

Below are the action points resulting from the 12th EARN annual meeting:

1) Use GPARC to do regular therapeutic efficacy testing and strengthen market surveillance of counterfeit drugs as well as strengthen drug regulatory authorities.

2) ECC to advocate for implementation and put in place mechanisms to reinforce the banning of monotherapy for treatment of uncomplicated malaria.

3) ECC to evaluate reasons for the demise of EANMAT and find ways to revitalize it.

4) Strategize on how to limit and control the effects of insecticide resistance by developing insecticide resistance plans and using available tools such as rotation, mosaic, mixture and combination.

5) ECC to ensure that NMCPs work with Ministries of Health in order to strengthen malaria surveillance using the malaria surveillance plans made in October 2010 as a starting point.

6) ECC to ensure that all countries have updated their NMSPs by Dec 2011 using MPRs and new GMAP targets among others.

7) ECC to ensure that all countries which are conducting MPRs should finalize their plans to facilitate planning for technical support before and during Phase 3.

8) The RBM Partnership / EARN to make a decision on the suggestion of convening an MPR guideline review meeting by the end of April.

9) ECC should put in place a task force to look into creating some cross border initiatives in East Africa and report back in the next EARN meeting.

10) ECC should ensure that country roadmaps are updated so that they are shared with the heads of states and government through the ALMA scorecard.

11) ECC to ensure countries scale up iCCM in order to expand access to malaria control interventions at community level and hard to reach communities.

12) RBM to support dialogue with GFATM and partners in order to make sure that those that tender should deliver on time and have a system of blacklisting those that are unable to deliver on time to avoid loss of life.

13) HWG Chairs / WHO to discuss with the GFATM on how ACTs (and other drugs) expiring in one country could be used in another country by easing the GFATM procedures.

14) Based on the fact that countries are getting substantial resources to scale up anti-malarial interventions towards malaria consolidation and malaria pre-elimination in endemic countries and that this requires strong technical skills the ECC should call upon the RBM and relevant stakeholders to advocate for urgent support to WHO AFRO to enable the organization to carry out its normative mandate and support the countries to sustain the gains made.

2.7 Key issues raised during the meeting

The following is a summary of the issues brought up during the 12th EARN annual meeting:

1) The meeting highlighted the need to contain resistance to artemisinin-based combination drugs and insecticide resistance and insecticide resistance plans.

2) GPARC was presented as a plan to protect ACTs as effective treatment for *plasmodium falciparum* and to avoid resistance to Artemisinin. Key to this was regular therapeutic efficacy testing and enforcing ban on artemisinin monotherapies.

3) WWARN (and other networks) has been created as a platform for sharing info on therapeutic efficacy testing (TET).

4) While malaria surveillance is improving in some EARN countries it is still very weak in other countries and sometimes its performance is incommensurate with the investment efforts made in malaria control over the past few years.

5) GMAP objectives and targets were shared and these are set to be finalized at the upcoming RBM Board meeting.

6) Recommendations on improving the process and tools of MPR were proposed.

7) Impact of malaria burden in neighboring countries at the borders and experiences in cross border collaboration show that high level commitment, participation, lengthy discussions and sustained efforts are required to see the cross border initiatives built.

8) With the creation of the ALMA scorecard country roadmaps can be linked to the scorecard and country progress for wide sharing

9) The meeting underscored the importance of iCCM (integrated community case management of malaria (including use of RDTs), pneumonia, diarrhea and SAM) as a way of achieving universal coverage of malaria control interventions and that this should be built on a robust health system and its specific package designed to country context.

10) Concerns were raised regarding the supplier's delays in delivery of life saving commodities at country level.

11) Countries were reminded to consolidate their existing GFATM grants (unless they are about to expire) and prepare for GFATM round 11 applications.

12) Countries were reminded to use their road maps for PMI MOP planning.

13) Rwanda reported on the potential coming expiring ACTs due to malaria decline and hence low consumption, similar to the 2008 experience of expired drugs which were destroyed due to lack of mechanism in partners' policy and requirements of GFATM.

2.8 Closing ceremony

The closing remarks were given by Dr Karema who thanked Kenya for hosting this EARN meeting, all the participants, including the RBM Secretariat for all their support, the rapporteurs, and the private sector.

Dr James Banda congratulated the EARN working group for a successful meeting that exceeded his expectations and reiterated that, with the country roadmaps and the partnership work plan, we now have the tools needed to fight malaria. The roadmaps can indeed be used to help resource mobilization and serve as a management tool, while the partnership work plan will include recommendations directed to the ECC.

Dr Juma expressed gratitude to the RBM Secretariat led by James Banda and Richard Carr, to WHO HQ and WHO-AFRO-IST, UNICEF, the NGOs, the private sector, program officers and managers for organizing and / or attending this fruitful meeting. She expressed gratitude and warm welcome to the Yemen team and EMRO WHO. She thanked all malaria endemic countries, stressing that tackling malaria was not only about each of us, but was also about partnerships. She finally asked everyone to make sure the coordination of the partnerships is done well in-country and she called to not forget the private sector, he NGOs, the CBOs, and all the strengths they all bring together.

APPENDIX 1: MEETING AGENDA

Day 1: Monday, 4 April

	Chair: ECC- Co Chair Dr Karema	
	Rapporteurs: Mr. Athuman Chinguzo and Dr. Ritha Njau	
Time	Activity	Facilitator / Presenter
SESSION 1: OPENING OF THE WORKSHOP		
08:00	Registration and Administrative Issues	Dr. J Da Silva
08:30	Welcome remarks and introductions	ECC Co-Chair
08:40	Administrative Announcements	Dr. J Da Silva
08:45	Objectives and Expected Results	ECC Co-Chair
09:00	Overview of Conference Methodology	ECC Co-Chair
09:20	RBM Partnership overview and update	Dr. J. Banda
09:20	Official Opening Ceremony	MoH / DOMC Kenya
09:50	Group Photo	Dr. J Da Silva
10:00	Morning Tea Break & Group Photo	
10:30	EARN 2010-2011 work plan and targets	Dr. J. Da Silva
SESSION 2: MALARIA CONTROL TECHNICAL UPDATES AND GUIDELINES		
10:40	Overview and update of the GPARC	Dr. Peter Olumese
11:15	Worldwide antimalarial resistance network (WWARN)	Ambrose Talisuna
11:30	Management of severe malaria – the AQUAMAT contribution of IV artesunate in reducing mortality	Sama Cage on behalf of MMV
12:00	Discussion, Q&A	
12:25	Overview of Insecticide Resistance management framework	WHO-IST-ESA
13:00	Malaria Surveillance Regional Trends and Priorities	WHO-IST-ESA
13:30	Discussion, Q&A	
14:00	Lunch Break	
15:15	Integrated Community Case Management (iCCM): Regional experience	Dr R. Nefdt
SESSION 3: MALARIA PROGRAM REVIEWS AND MALARIA STRATEGIC PLANS DEVELOPMENT UPDATES		
15:45	Malaria Program Reviews: Progress in East Africa Update	Dr. Paluku
15:50	Malaria Program Review: Country experience	Rwanda
16:10	MPR Processes in Zambia and Rwanda: Lessons learnt & challenges	Dr. A. Kalu
16:20	Coffee Break	
16:35	Yemen: InterCountry Collaboration: GCC Experience on Elimination	Dr. A. Nasser Al-Jasari
17:45	Updated GMAP objectives, targets and priorities beyond 2011	Dr. Peter Olumese
18:00	National Malaria Strategic Planning (tips for the development of the 1st generation)	Dr. Charles Paluku
18:15	Facilitators meeting	Dr. C. Karema
18:30	End of the Day	

Day 2: Tuesday, 5 April

	Chair: Dr. Charles Paluku	

	Rapporteurs: Mr. Gausi and Dr. Worku	
SESSION 4: GMAP COUNTRY ROADMAP TRACKING, TECHNICAL NEEDS UPDATES-I		
Time	Activity	Facilitator / Presenter
08:30	Feedback from day #01 deliberations	Mr Athuman Chinguzo
09:00	Burundi Roadmap review and update	NMCP Burundi
09:45	Comoros Roadmap review and update	NMCP Comoros
10:20	Djibouti Roadmap review and update – part I	NMCP Djibouti
11:00	Coffee Break	
11:20	Ethiopia Roadmap review and update	NMCP Ethiopia
12:05	Kenya Roadmap review and update	DOMC Kenya
12:30	Rwanda Roadmap review and update	NMCP Rwanda
13:00	Lunch Break	
SESSION 5: MARKET PLACE AND CONSTITUENCIES MEETINGS		
14:00	Malaria Market Place & Constituencies Meetings	Dr. B. Bwambok
15:00	Malaria Market Place & Constituencies Meetings	Dr. B. Bwambok
16:00	Malaria Market Place & Constituencies Meetings	Dr. B. Bwambok
17:00	Facilitators meeting	Dr. Paluku
17.30	End of the Day	Dr. Paluku

Day 3: Wednesday, 6 April

	Chair: Dr. Elizabeth Juma	
	Rapporteurs: Dr. Jeylani A. Mohamoud and Grace Nakanwagi	
SESSION 5: GMAP COUNTRY ROADMAP TRACKING, TECHNICAL NEEDS UPDATES-II		
Time	Activity	Facilitator / Presenter
08:30	Feedback from day #02 deliberations	Mr Laurent Bergeron
09:00	Somalia Roadmap review and update	NMCP Somalia
09:30	Sudan North Roadmap review and update	NMCP Sudan-North
10:00	Sudan South Roadmap review and update	NMCP Sudan-South
10:30	Discussion, Q&A	
10:45	Coffee Break	
11:00	Djibouti Roadmap review and update – part II	NMCP Djibouti
11:30	Tanzania Roadmap review and update	NMCP-Tanzania
12:30	Uganda Roadmap review and update	NMCP Uganda
13.00	Lunch Break	
SESSION 6: ALMA SCORECARD, CCM, RBM OPERATING FRAMEWORK AND TASKFORCE		
	Chair: Dr. B. Bwambok	
14:00	ALMA scorecard	Melanie Renshaw
15:00	Panel discussion on community management of malaria	Ethiopia / Rwanda / WHO-EMRO / UNICEF
16:00	Tea Break	
16:30	Overview of RBM operating framework and taskforce	Dr. James Banda
17:00	Facilitators meeting	
17:30	End of the day	

Day 4: Thursday, 7 April

	Chair: Dr. Chisaka	
	Rapporteurs: Dr. Bekele Worku	
SESSION 7: GFATM & WB UPDATES, TA PLANNING, CONSTITUENCY MEETINGS		
Time	Activity	Facilitator / Presenter
09:00	Feedback from day #03 deliberations	Grace Nakanwagi
09:10	GFATM updates: Round 10 support and Round 11 applications	Dr M. Renshaw
09:40	World Bank Booster Program for malaria control in Africa	Dr N. Chisaka
10:00	Scaling-up malaria biological diagnosis-based case management	Dr P. Olumese
10:30	Tea Break	
11:00	Technical assistance planning with countries Burundi / Comoros / Djibouti Ethiopia / Kenya / Rwanda Somalia / Sudan-North / Sudan-South Tanzania / Uganda / Yemen	 Gausi / Bergeron / Hoda Paluku / Barnabas / Nakanwagi Jamal / Olumese / Zamani Banda / Tekalegne / Nfedt
12:30	Lunch Break	
13:30	Constituency meetings, reporting back and briefs in plenary	Dr Banda and Bwambock
15:45	Tea Break	
16:00	Main recommendations and way forward	Mr. Gausi / L. Bergeron
16:30	Closing Ceremony	Dr. Karema / Dr. Juma
17:00	Facilitators Meeting	Dr. Karema

Day 5: Friday, 8 April

	Chair: Dr. Corine Karema	
	Rapporteurs: Mr. Athuman Chinguzo	
SESSION 8: EARN ECC MEETING		
Time	Activity	Facilitator / Presenter
09:00	Opening remark and welcome of the new ECC Members	Dr. Barnabas Bwambok
09;30	Overview of 2010-11 EARN Work plan & Report to the board	
10:00	Briefing on SRN Mechanisms to the new ECC members	
10:30	Tea Break	
12:00	Briefing from Constituencies	constituencies
13:00	Lunch Break	constituencies
14:00	Report to the RBM Board	Dr. James Banda
15:00	AOB	Dr Corine Karema
16:00	Closing remarks	Dr. Corine Karema
17:00	End of the Day	

APPENDIX 2: EARN 2011 WORK PLAN AND TARGETS

Target A: 100% of all country roadmaps are maintained and implemented through to the end of 2011

- Status review of in-country partnerships to review how EARN can best support
- Select two countries to document how functional partnerships are through deployment of a consultant
- Monthly Teleconference with countries
- Two 5-days visits per country by ECC members to engage with partnership through CCM
- Provide technical support to overcome bottlenecks

Target B: 80% of country assistance requests via Sub-Regional Networks receive a response outlining a plan to meet the request and satisfactory to the country

- Monthly roadmap monitoring scheme in place and functioning - bottlenecks threatening milestone achievement are detected and anticipated
- Timely and appropriate response to long- and short-term assistance requests

Target C: RBM Community and Heads of State informed on the achievements of 2010 universal coverage and preparation for 2015 targets

- Planned reports generated in line with 2010 reporting framework
- In Collaboration with ALMA with prepare for the stock taking meeting with AU head of states highlighting successes and challenges
- Meeting in ESA targeting ministers of finance and health
- Workshop on taxes and tariffs in Nairobi

Target D: Mobilize resources and political support to achieve the $6B annual target to fund the GMAP through 2011 – 2015

- Ad hoc requests mainly for GFATM support implementation support
- We responded to Burundi, Comoros, Djibouti, Eritrea, Ethiopia, Rwanda, Uganda, Somalia, Tanzania
- EARN provides secretarial support to the Minister of Health Kenya, Member of RBM Board and her alternate the Minister of health Sudan
- Collaboration with AU, IGAD and EAC

Target E: Countries / territories to align their strategic / operational plans with best practices to achieve the GMAP by the end of 2011

- Malaria Program Reviews are ongoing in 5 out of 9 target countries
- Third generation strategic plans to be developed in these countries
- Workshop in collaboration with EMRO for MPRs benefiting our EMRO countries and MENA countries
- Support a collaborative process between EGAD and EAC for the development and management of a regional resistance (drug & Insecticides)

Target G: RBM Mechanisms receive management support from the Secretariat consistent with Board decisions throughout 2011

- We have adequate support from the secretariat
- Participate in weekly / monthly teleconferences with other working groups
- Increased collaboration with other WG to support countries to solve bottlenecks
- We report monthly to Executive Director after endorsement by ECC

APPENDIX 3: UPDATED GMAP OBJECTIVES, TARGETS AND PRIORITIES BEYOND 2011

GMAP Targets

By 2010, through targeting universal coverage:

- 80% of people at risk from malaria are using locally appropriate vector control methods
- 80% of malaria patients are diagnosed and treated with effective anti-malarial treatments;
- in areas of high transmission, 100% of pregnant women receive intermittent preventive treatment (IPT);
- the global malaria burden is reduced by 50% of the 2000 levels

By 2015:

- universal coverage continues with effective interventions;
- global and national mortality is near zero for all preventable deaths;
- global incidence is reduced by 75% from 2000 levels;
- the malaria-related MDG is achieved: halting and beginning to reverse the incidence of malaria by 2015
- at least 8-10 countries currently in the elimination stage will have achieved 0 incidence of locally transmitted infection

Updated GMAP Targets – Beyond 2011 (Draft)

Objective 1 - Reduce global malaria deaths to near zero by 2015

Target 1.1 Achieve universal access to case management in the public sector

- By 2012, 100% of suspected cases receive a malaria diagnostic test and 100% of confirmed cases receive treatment with appropriate and effective antimalarial drugs.
    - Milestone: none, as the target is set for 2012.

Target 1.2 Achieve universal access to case management, or appropriate referral, in the private sector.

- By 2015, 100% of suspected cases receive a malaria diagnostic test and 100% of confirmed cases receive treatment with appropriate and effective antimalarial drugs.
    - Milestone: By 2013, in endemic countries, 50% of persons seeking treatment for malaria-like symptoms in the private sector report having received a malaria diagnostic test and 100% of confirmed cases having received treatment with appropriate and effective antimalarial drugs.

Target 1.3 Achieve universal access to community case management (CCM) of malaria.

- By 2015, in countries where CCM of malaria is an appropriate strategy, 100% of fever (suspected) cases receive a malaria diagnostic test and 100% of confirmed uncomplicated cases receive treatment with appropriate and effective antimalarial drugs, and 100% of suspected and confirmed severe cases receive appropriate referral.
    - Milestone 1: By 2012, all countries where CCM of malaria is an appropriate strategy have adopted policies to support CCM of malaria (including use of diagnostic testing and effective treatment).
    - Milestone 2: By 2013, in all countries where CCM of malaria is an appropriate strategy, 80% of fever cases receive a malaria diagnostic test and 80% of confirmed cases receive treatment with effective anti-malarial drugs.

Objective 2 - Reduce global malaria cases by 75% by 2015 (from 2000 levels)

Target 2.1 Achieve universal coverage with and utilization of prevention measures

- By 2012, in countries where universal coverage and utilization have not yet been achieved, achieve 100% coverage and utilization for all populations at risk with locally appropriate interventions.
    - Milestone: none, as the target is set for 2012.

Target 2.2 Sustain universal coverage with and utilization of prevention measures

- By 2015 and beyond, all countries sustain universal coverage and utilization with an appropriate package of preventive interventions.
    - Milestone: In 2012, 2013 and 2014, universal coverage and utilization of appropriate preventive interventions are maintained in all countries.

Target 2.3 Accelerate development of surveillance systems

- By 2015, all districts are capable of reporting monthly numbers of suspected malaria cases, number of cases receiving a diagnostic test and number of confirmed malaria cases from all public health facilities, or a consistent sample of them.
    - Milestone: By 2013, 50% of malaria endemic countries have met the 2015 target.

Objective 3 - Eliminate malaria by 2015 in 10 new countries (since 2008) and in the WHO Europe Region

- Milestone: By 2012, eliminate malaria in 3 countries.

GMAP Priorities – Beyond 2011 (Draft)

- Priority 1: Accelerate progress and impact in countries with the highest burden of malaria-related deaths.
- Priority 2: Fully implement the Global Plan for Artemisinin Resistance Containment (GPARC).
- Priority 3: Develop and launch a Global Plan for management of insecticide resistance.
- Priority 4: Revise GMAP for the years beyond 2015.

APPENDIX 4: TABLE OF TECHNICAL ASSISTANCE REQUIRED BY COUNTRIES

Country	Area of Work	Activity	Type of support	Partner / Source of funding	Proposed Timelines (Month / week)								
					A	M	J	J	A	S	0	N	D
Burundi	Cross-cutting issue	MPR	Financial gap for experience sharing with Tanzania or Djibouti	EARN									
		MPR	International consultant for thematic review	EARN			W1-2						
		MPR	Guidance for Phase 3	EARN					W3-4				
		MIS planning for data collection in Sept-Oct	1 international consultant for protocol and questionnaire definition	EARN		W2-3							
	QC/QA	Setup of manual of procedures	Consultant (1w) for validation of documents	EARN				W2					
	DES		Financial support and consultant expertise (2w) for adaptation of protocols and orientation of surveyors	EARN					W2-3				
Comoros	MIS	Consultant needed for data and report writing	a) Technical expertise for the second half of the mission b) (all consultant fees already covered)	EARN		W2-3 & 3-4	W1						
	MPR	Action plan	Phase 2: local consultant Phase 3: Technical support	EARN							Oct 3-4	W1,2	
	Database Creation		Financial support for data management for two years (consultant)	EARN				W3-4					
	Application to Round11		1 international and 1 local consultant for the GF R11 application	HWG									
	M & E	Training for the epidemiologist	Financial gap to cover	GFATM									
		Contract extension of the technical assistant tasked with M & E	Financial costs from Oct 2011 (for 18 months)	GFATM									
Djibouti	MPR-NSP	Consultant to support development of the NSP 2011-2015	International consultant for 4 weeks	x	x	x							
	M & E	Database	International consultant to create this DB and train staff (2 weeks)										
	Case management		Consultant (2 weeks)										
	CCM strategy approval / validation		International consultant										

Ethiopia	EARN	EARN mission					W3						
	IRS	Consultant to guide VC WG on selection of insecticide for IRS and insecticide resistance management-	Ethiopia will developTORs and mobilize funds from PMI?				W1						
		MPR	Consultant	EARN		Ph3 18-30th		Ph4-3 W4					
	GF grant	Round 11 proposal writing	Consultant	HWG						W1-2			
	Cross cutting: M & E	MIS	Consultant for training and tool dev't	Govt and MACEPA					W2				
		QC/QA for malaria control interventions (microscopy, RDTs, IRS, Drug and ITNs)										W1	
Kenya	EARN	EARN mission					W5						
	Case management	QA / QC for diagnostics(both microscopy and RDTs)	Consultant identification	WHO / DFID		W1							
	GF Grant	Selection of SR for Rd 10	Funding to support process	EARN	W4								
		Grant negotiation for Rd 10	Consultant and funds for the meeting	EARN		W1							
	Other	Advocacy for introduction of RDT Subsidy alongside AMFm ACTs	Advocacy										
Rwanda	EARN	EARN mission	Need entomologist on team to guide Rwanda on IRS		W4	W1							
	Cross cutting	NSP	Consultant to conduct Gap analysis before PMI MOP	EARN		W1							
		NSP, M & E plan and corresponding business plan	Consultant to write content	EARN			W1						
		Epidemic preparedness plan	Consultant	EARN	W4								

Somalia	Round 10	Negotiation & signing process	TA support	Gap funding (EARN)		X (W4)							
	IEC/Bcc	Strategy development 2011-2015	TA/Consultant	Gap funding (EARN)						X (W2)			
	Epidemic preparedness & response	Strategy development 2011-2015	TA/Consultant	Gap funding (EARN)				X (W2)					
	Case management at Health Post	Package of Community case management tools at health post (diagnosis, treatment and reporting)	TA	Gap funding (EARN)							X (W3)		
	Human Resource	HR Need Assessment	TA	Gap funding (EARN)				X (W1)					
	ACT	Antimalarial drug efficacy study	TA	Gap (WHO and WWRN)									
	Mapping	Health facility mapping	TA	Gap funding (EARN)							X		
	Data management	Country malaria data base	TA/Consultant	Gap funding (EARN)							X		
Sudan-North	Data management	Country malaria data base	TA/Consultant	No Gap		x							
	LLIN	Tracking system	TA/Consultant	No Gap				x					
	ACT	Antimalarial drug efficacy study	TA	Gap (WHO and WWRN)						x			
	BCC	Review and update BBC strategy	TA/Consultant	No Gap					x				
	MPR	Phase 3	TA	Gap funding (EARN							x		
	ICCM	Finalization of ICCM	TA	No Gap	x								
	Round 10	Negotiation & signing process	TA support	Gap funding (EARN)			X (W4)						
Sudan-	LLIN?												

South	ACT	Antimalarial drug efficacy study	TA	Gap (WHO and WWRN)			X			X	X				
	MPR	Phase 2&3	TA	Gap funding (EARN								X	X		
	Data management	Country malaria data base (early next year)		Gap funding (EARN)											
	Round 10	Negotiation & signing process	TA support	Gap funding (EARN)			X (W4)								
	GF Grant	Round 11 proposal development		HWG						Before mock TRP?					
	Other	Find a quick fix to expiring ACTs		HWG											
Tanzania	Vector Control: LLINs	Re-define Keep Up Strategy	Procurement of consultancy ongoing	GF/SDC											
	Diagnosis: RDTs/microscopy	Training on Microscopy	Water REED malaria project	PMI											
	Program Management	Malaria Programme Review (MPR) Phase 2 to 4	Financial and technical support	WHO, PMI, and other partners											
	Resource Mobilization	Development of detailed plan for RD 8 phase two	Technical assistance	RBM											
	Resource Mobilization	GF Grant development Rd 11	Technical and Financial Assistance	None											
		MPR													
Uganda	GF Grant Implementation	Documentation of R4 P2, R7 P2 and AMFm implementation		RBM, GF											
	Malaria risk mapping	Malariogenic Stratification of the Country		RBM, PMI											

	EIC/BCC	Hire of Communication Specialist and Communications Officer 1 year Contracts		RBM, PMI									
	MIP	Studies to establish alternative for SP for MIP		RBM, PMI									

APPENDIX 5: MEETING PARTICIPANTS

Detailed list of participants for the 12th EARN Annual Meeting

	Name	Title	Organization	Country	Address	Phone number	Email
1	Dr. Lidwine Baradahana	NMCP Manager	NMCP	Burundi	Burundi, Bujumbura	257 77738590	baradahanalidwine@yahoo.fr
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12th EARN General Assembly Evaluation Score Card						
	ITEM	RATING				
		1	2	4	5	
1	Travel arrangements from airport		10	50	20	
2	Organization of the meeting		5	38	37	
3	Accommodation		10	20	50	
4	Back to back meeting arrangement		07	04	69	
5	Conference Objectives			10	70	
6	Composition of Participants invited			05	75	
7	Conference Official Opening	25	20	20	15	
8	Poster Presentations Session		15	50	15	
	Overall Rating of the Meeting			YES	NO	
9	In your view, was this meeting useful?			80	0	
10	Were your expectations met?			75	5	
11	Which 2 sessions did you not like or was boring?			None		
12	Which 2 session did you like the most			Roadmaps	Technical updates	
				57	23	
13	Why do you think that this meeting was useful/ not useful? Give one reason			Information sharing		
14	What do you think was lacking in this meeting?			GFATM Presence including PRs		
15	Please, indicate any other comments that you feel are necessary			More focus and shorter (3 days), better logistics and improve opening		