EARN

EASTERN AFRICA ROLL BACK MALARIA REGIONAL NETWORK

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

EARN Joint Partners and NMCP Managers Consultation

On

Support for Implementation of Country roadmaps; Malaria Programme reviews; Updating of Strategic Plans and Evaluation of Country Achievements on 2010 Goals and Targets

Entebbe, Uganda: 3rd -7th May 2010

FULL REPORT

Compiled by:

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Regional Coordinator EARN

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ACRONYMS

ACT	Artemisinin-based combination therapy
AFRO	WHO Regional Office for Africa
AL	Artemether-lumefantrine
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
WARN	Roll Back Malaria Western Africa Regional Network
WB	World Bank
WHO	World Health Organization

Acknowledgements

The 10th Annual Review and Planning Meeting for Roll Back Malaria in Eastern Africa was attended by more than 123 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, Uganda
- The RBM Secretariat for financial support
- WHO Uganda office
- WHO-AFRO 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 and the manufactures 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
Dr. Josephine Namboze	WHO IST Harare	Member
Dr. Tewolde Ghebremeskel	Eritrea NMCP	Member
Dr. Kesete Admasu	Ethiopia NMCP	Member
Dr. Agonafer Tekelegne	CAME	Member
Dr. James Banda	RBM Secretariat	Member
Mr. Peter Mbabazi	EARN/RBM	Member

FOREWORD

This is the full report of the 10th EARN joint partners and NMCP managers consultation meeting that was held in Entebbe Uganda on 3rd -7th May 2010. It is indeed timely that we had this meeting in May 2010 – the international milestone for providing universal access to malaria prevention, diagnosis and treatment and for reducing malaria deaths by half of the 2005 levels, we must 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.

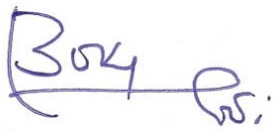
In this meeting participating countries had an opportunity to review and benchmark the progress achieved from the roadmaps set in July 2009 in Windhoek Namibia. Each country gave an update on how far they had gone in achieving the targets set, the underlying challenges as well as the targets yet to be achieved. A separate summary analysis of the country roadmaps and a summary report have been prepared.

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

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

We wish you good reading.



…….
Dr Corine Karema
EARN Co-Chair

……..
Dr Barnabas Bwambok
EARN Co-Chair

EXECUTIVE SUMMARY

The 10th EARN Annual Review and Planning Meeting was held at The Imperial Resort Hotel, Entebbe, in Uganda on 3-7 May 2010. The meeting was attended by 123 participants from the 13 countries of the EARN. The representation of the participants was diverse and included representatives from the WHO AFRO and EMRO regions, NMCP managers, Malaria NPOs plus potential national and international consultants as well as EARN partners.

This EARN meeting was a follow up of the 9th Annual Review and Planning Meeting held in Windhoek, Namibia on 6-10 July 2009. The need for the meeting came up following the launch of the Roll back Malaria Initiative in 1998, where African countries were supported by WHO and other partners to undertake a situational analysis of their malaria control activities, and develop a national malaria strategic plan. By 2006, many countries had developed their second generation national strategies to guide their malaria control programs. Majority of the strategies are five-year plans running from 2006-2010 and therefore needed to be reviewed and revised. In addition, some countries had scaled up the package of malaria control tools and were moving towards sustained control, calling for adjustments to their malaria control programs. The EARN member countries needed to assess their readiness for pre-elimination.

There are still a number of countries facing a number of challenges like the lack of comprehensive policies and strategies to scale-up malaria interventions, slow implementation of treatment with ACTs, inadequate human resource capacity and weak PSM and M&E systems. All these challenges undermine the optimal use of available resources.

The meeting in Entebbe, Uganda was a response to the support offered by the World Health Organization (WHO) together with the Roll Back Malaria Partnership (RBM), and the GFATM with the national malaria control programs in Sub-Saharan Africa to update their strategic/operational plans for the next 5-year cycle.

The meeting focused on reviewing country programme implementation progress and operational plans ("road map") set in the 9th EARN meeting in Windhoek for the achievement of the 2010 Universal Coverage Targets.

Main Objectives of meeting

The **main objectives** of the meeting were to orient and prepare programme managers and consultants on support for implementation of Country roadmaps; Malaria Programme reviews; updating of Strategic Plans and Evaluation of country achievements on the 2010 goals and targets.

Specific objectives

a) Assess progress on implementation of 2010 roadmaps
b) To Orient Participants on the process and planning for Malaria Program Reviews
c) To Orient Participants on Malaria Strategic planning
d) To update Participants on the 2010 Malaria reports
e) To operationalise the RBM board approved EARN work plan

Expected outcomes

1. Progress on implementation of 2010 roadmaps assessed
2. Participants oriented on the process and planning for MPR
3. Participants oriented on Malaria Strategic planning
4. Participants updated on the 2010 Malaria reports
5. RBM board approved EARN work plan operationalised

Method of work

The participating countries presented their country road maps and reviewed their malaria programs. The meeting was arranged in such a manner as to allow for plenary presentations that mostly covered the presentation of the guidelines and the lay out. Participants were divided into groups where they went into greater detail about the intricate MPR,& Strategic plan processes. They also updated their country road maps and oriented them on the new technical updates. Participants prepared MPR and Strategic plan updates and proposals. Session group work was done by country and thematic areas with participants selected based on areas of expertise.

Recommendations

On the whole, the meeting achieved all its intended objectives. Below are the conclusions and recommendations of the meeting.

1. The meeting was useful for sharing experiences between countries. The technical updates from the individual countries were particularly very helpful in assessing the status of implementation of the Road maps set earlier.
2. There is need for more sessions on how to strengthen in-country partnerships

Progress on implementation of 2010 roadmaps

1. Roadmaps are a good tool for reporting on progress and harmonization of support. However, there is need to speak more about the roadmaps and more details on interventions are required in future
2. There is need for more consistency on country roadmap reporting
3. In-country tracking of roadmap implementation is very important and needs to be emphasised in NCP implementations

4. Monthly teleconferences are a useful tool for tracking roadmap implementation progress and ensuring countries receive necessary support

Process and planning for Malaria Program Reviews

1. Countries need more guidance on how to improve performance of the National malaria control programs
2. Countries need support to improve performance and attract additional resources from Funding Partners
3. There is need for more participation at meetings by implementing partners and to track impact at regional **l**evel over time

Malaria Strategic planning

1. WHO tools are useful and need to be finalized and disseminated as soon as possible to all countries in the AFRO region to facilitate standardisation in Malaria Strategic Planning
2. Upcoming EARN meetings should be structured as review and planning meetings to enhance experience sharing among countries.
3. RBM in-country partners should meet regularly (and especially before EARN meetings) to update themselves of what is going on in their respective countries
4. Local HR should be developed and utilized whenever possible
5. Partnerships need to be strengthened at country level; some country partnerships are weak and are not functioning well

Updates on the 2010 Malaria reports

1. Meetings such as the EARN meeting help countries to coordinate partnership. From these partnerships, there is a lot to learn from other countries and sharing of experiences

Operationalisation of the EARN work plan

1. There is need to clarify on the types of technical support required by different countries, when it is needed, and who will deliver it to the different countries
2. There should be efforts to engage the World Bank country offices in work plan development for malaria prevention

Next EARN NMCP-Partner meeting will be held on **15th -19th November 2010 in Kigali, Rwanda**

MEETING PRESENTATIONS

DAY 1

Introduction

The 10th EARN Joint Partners and NMCP Managers consultation Meeting was held at the Imperial Resort Hotel, Entebbe, in Uganda on 3rd -7th May 2010. The Malaria review and planning meetings (ARPM) are convened each year. 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. Crucial among the current challenges is the suboptimal uptake of available malaria prevention and treatment interventions. Anecdotal evidence strongly suggests that the observed low uptake of interventions is a result of limited malaria IEC/BCC activities which have not matched the scaling up of interventions.

The meeting in Entebbe, Uganda was a response to the support offered by the World Health Organization (WHO) together with the Roll Back Malaria Partnership (RBM), the GFATM with the national malaria control programs in Sub-Saharan Africa to update their strategic/operational plans for the next 5-year cycle, with an emphasis on ensuring proper review of the previous plan and alignment with current WHO technical guidelines and the strategies of the Global Malaria Action Plan.

The **main objective** of the meeting were to orient and prepare programme managers and consultants on support for implementation of Country roadmaps; Malaria Programme reviews; updating of Strategic Plans and Evaluation of country achievements on 2010 goals and targets.

Specific objectives

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Participants

About 123 participants mainly from 11 countries in the AFRO and EMRO sub-regions attended the meeting. Each country was represented by at least 3 participants who included the Malaria Programme Managers, the GFATM country Principal Recipients and the malaria NPOs. There were also representatives of partners from both the, EARN and private manufacturers from the USA, China, RSA and France. The detailed list of participants and the meeting agenda is shown in Annex 3.

OPENING CEREMONY

The RBM Board decisions at the recent meeting held in Rio Brazil were read out to the participants by Dr. James Banda, The RBM Country Facilitation Coordinator.

He informed the meeting that Board members (composed of countries and institutions) serve as representatives of their constituencies. Members may appoint one alternate member to serve in their stead. Constituencies determine rotational or renewable status. The Board members sit on the Board for two years.

Dr. James Banda delivering his presentation at the 10th EARN Meeting in Entebbe, Uganda

He said that the RBM Board had hired an external consultant to evaluate the RBM partnership and review its achievements and organization, as it is coming to 10 years of existence. The external evaluator had made observations which included the following;

1. A strategy of global advocacy has resulted in greater attention to the problem of malaria than ever before.
2. International expenditures on malaria control have doubled. There is widespread agreement on the set of priority interventions that are required to make progress in the area of malaria control and prevention. It is possible that without RBM we would not now have a Global Fund for AIDS, Malaria and TB (Global Fund).
3. The absolute and overriding priority for RBM should be to demonstrate a significant reduction in the global burden of malaria.

To get progress quickly underway, the Evaluation Team recommended the following major reforms of the RBM global setup. It recommended:

1. The reorganization of the RBM Secretariat;
2. Creation of an independent governance board for the RBM;
3. Reconstitution of the Technical Support Network (TSN);
4. Selection of eight to twelve focus countries that show a high degree of commitment and can make rapid progress in the next three years; and
5. Appointment of Country Champions to provide dynamic leadership in these focus countries.

Dr. Banda told the meeting that the RBM Board was still reviewing the recommendations of the external Evaluation team and would soon come up with a position on the recommendations.

Opening remarks were given by Dr. Korine Karema, Program Manager – Rwanda on behalf of the WHO Representative. In her presentation, Dr. Karema emphasised the need for participants (partners and NMCP Managers to deliberate on key support elements that their countries may require. She said, with the focus on "**Counting Malaria Out**" and this year's slogan of "Communities **Engage to Conquer Malaria**", there is need to urgently review the country specific tools and ways of doing business differently if the proven malaria control interventions are to reach all the people who need them.

Official Opening of the EARN Meeting

Dr George Mukone, from the NMCP –MOH of Uganda opened the meeting on behalf of the Minister of Health. He thanked the organizers of the meeting for choosing Uganda as the venue for the 2010 EARN Meeting. He noted that well as there has been some considerable progress in controlling the malaria rates in some countries, there was need to share experience and plans so as to harmonise the proven intervention in malaria control so at to meet the MDGs and other Global targets. He emphasised that in this vein, this meeting was therefore important in that it sought to identify the bottlenecks and their solutions towards achieving the 2010 RBM targets.

After his remarks, Dr. Mukone officially opened the meeting and the participants took their group photograph outside the meeting venue.

EARN meeting group photograph

MEETING PROCEEDINGS

The meeting started with presentation of country Road maps updates. There were a total of 11 country presentations, and 2 absent. Somalia was particularly commended for their progress despite the challenging environment in their country at present. Each country presented their country summary, road map evaluation of LLIN, ACT, RDT, IRS, limiting factors, and TA needs.

Emerging Issues arising out of the Country presentations

- Each country needs to identify their funding gaps for the benefit of the funding partners
- Delays in funding disbursements, lead to delays in commodity procurements (GF)
- There is need to identify TA needs and soliciting TA to review MSPs to for 2010 targets
- There is need to update the IEC/BCC strategy (EARN); submission of GF Round 10; development of EPR strategy; or in insecticide and drug resistance monitoring
- Technical clarity with respect to universal coverage of LLINs (sleeping spaces vs people) needs to be refined in most country presentations
- Robust monitoring including in the private sector: Ensuring Partner adherence to one M&E plan
- Inadequate Human Resources affects quality of health services especially for Malaria in Pregnancy
- Prioritizing cost effective interventions for integrated vector control is required for effective interventions in malaria control. Larviciding, universal coverage for both IRS and LLINs everywhere should be evaluated for their cost effectiveness; are they speeding up insecticide resistance?
- As regards Health information systems, there is need for more training in data management for effective implementation of HIS
- In most countries, there is inadequate supply chain management
- Inadequate management and leadership at lower levels is a challenge that cuts across countries
- There is no clear strategy on Epidemic Preparedness and Response for some countries. This needs to be emphasized for effective malaria control responses
- There is need for countries to harmonize their M&E and utilization of tracking systems.
- Coordination with other ministry departments to rule out other causes of fever as incidence goes down should be emphasized in countries.

DAY 2

The day's presentations began with a paper by Dr. Stanley Sonoiya, a Principal Health Officer, East African Community , Arusha, Tanzania titled **Proposed "East African Community Regional Malaria Control Programme: 2012 – 2016".**

He told the meeting that Article 118 (Chapter 21) of EAC Treaty emphasizes that EAC Partner States undertake to take joint action towards the prevention and control of communicable and non-communicable diseases and to control pandemics and epidemics of communicable and vector-borne diseases such as Malaria, among others; that might endanger the overall health and welfare of the residents of the Partner States.

The EAC Treaty is strong on regional cooperation on Health issues. Chapter 21 (Article 118) of the EAC treaty concerning health issues in the Partner States covers nine (9) priority health activities including the harmonization of drug policies, registration and regulation, harmonization of drug registration procedures and standards and harmonization of national health policies and regulations and promote the exchange of information on health issues.

As a result, the EAC has come up with disease prevention and control initiatives which include establishment of the "East African Integrated Disease Surveillance and Response Network (EAIDSNet)" since 2003 which targets eighteen (18) priority diseases including, Malaria, among others; established the "EAC Regional Plan of Action for the Prevention and Control of Human and Animal Transboundary Diseases in East Africa: 2007 - 2012 since March 2007.

He singled out the EAC Epidemic Prone Diseases (8) as;

- Cholera
- Cerebro-spinal meningitis
- Rabies
- Bacillary dysentery
- Measles
- Plague
- Yellow fever
- Viral Haemorrhagic Fevers (VHFs)

A meeting of the EAC Technical Working Group on prevention and control of communicable and non-communicable human and animal diseases in East Africa was held at EAC headquarters in Arusha, Tanzania from 6th to 7th October 2008 and recommended the following steps;

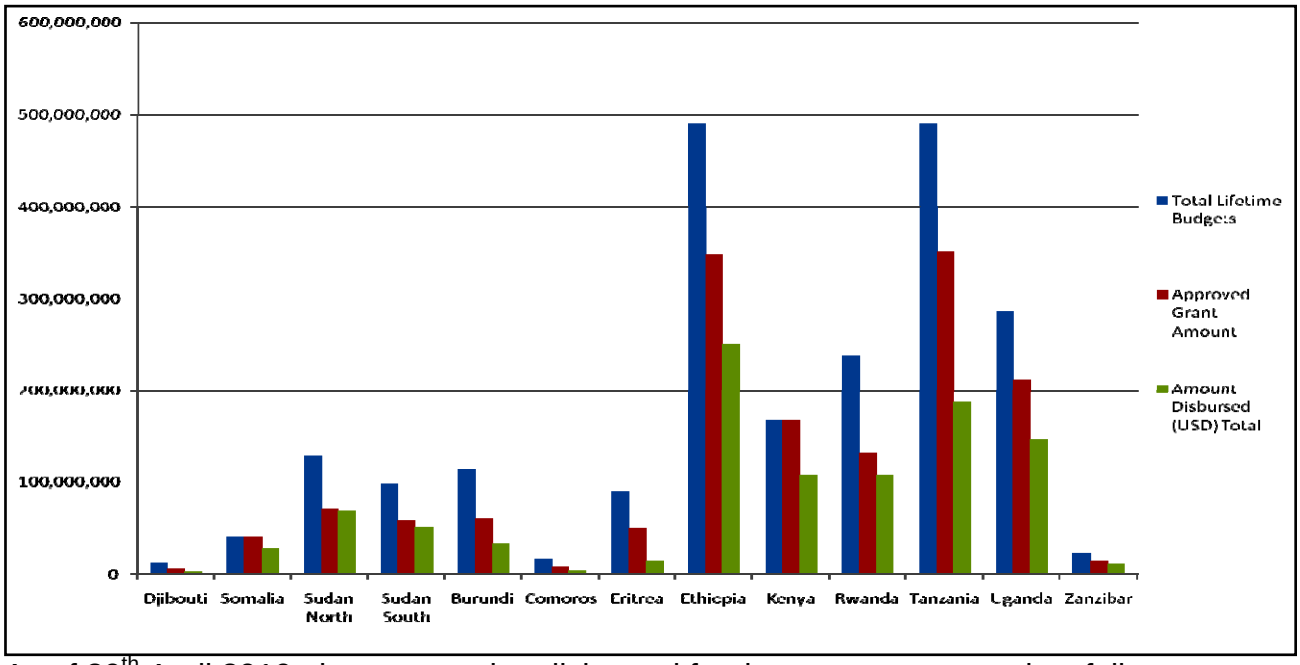
- Revitalising Malaria in EAC at regional level
- Integration of EARN/RBM into the EAC by hosting the EARN secretariat
- Development of the EAC Malaria Strategic plan in line with RBM GMAP
- Prioritizing malaria in the country budgets
- Operationalising the GMAP & Regional Malaria proposals
- EAC countries harmonizing policies, interventions including timing
- Malaria control for the Long distance (Northern Corridor) truck drivers: Mombasa-Bujumbura

- Hosting EARN in the EAC secretariat (EARN/Malaria Unit in EA Health Dept)
- Putting Malaria high in the EAC agenda (report malaria achievements in all EA meetings)
- Concept paper of EARN for hosting arrangements need to be developed and send to countries for review and adoption before submitting to the EAC secretariat before Feb 2009 for the Minister's endorsement in March 2009

He told the meeting that the EAC Technical Working Group on prevention and control of communicable and non-communicable human and animal diseases in East Africa recommended the following;

- Sustaining effort to elimination by aligning GMAP to EAC
- EAMAP developed and approved by EAC Council of Ministers by 31st March 2011
- EAC to request technical support from RBM/WHO for development of EAC MAP
- EAC and IGAD to jointly develop and sign a Memorandum of Understanding (MoU) on regional disease control initiatives to include hosting and integration of EARN coordination and operations by March 2011
- EAC/IGAD Minister's endorsement in 2011
- Harmonise all EAC Partner States' National Malaria Action Plans and Activities
- Strengthening National Disease Surveillance Systems and Networks through involvement of all multisectoral stakeholders at all levels, including the research community, disease control groups from the Ministries of Health, non governmental organizations and professional health associations as well as local communities, etc;
- Utilization of epidemiological information and preventive methods as recommended;
- Strengthening cross-border district capacities for data management and use to recognize impending epidemics and setting the support systems early enough,
- Enhancing synergistic actions and the development of functional alarm systems,
- Promoting use of Geographical Information Systems for malaria control and response
- Regional Integrated Pooled Bulk Procurement of Malaria Control and Treatment Products and Supplies

The **EARN Global Fund Grants Performance** was presented by Mr. Peter Mbabazi Kwehangana, Regional Coordinator, EARN - RBM. In his presentation, he noted that many countries in the EARN had not had all their approved grant amounts disbursed to them yet. As shown in the table below, only a fraction of the total country budgets have been disbursed.



As of 30th April 2010, the approved undisbursed funds per country stood as follows;

Country	Undisbursed (USD) Phase 1	Undisbursed (USD) Phase 2	Undisbursed (USD) RCC 1	Total
Djibouti	-	-	-	-
Somalia	169,955	-	-	169,955
Sudan North	2,953,704	162,411	-	3,116,115
Sudan South	7,397,501	405,342	-	7,802,843
Burundi	-	-	5,485,059	5,485,059
Comoros	3,863,736	63,407	-	3,927,143
Eritrea	-	3,199,601	-	3,199,601
Ethiopia	60,910,911	36,650,832	-	97,561,743
Kenya	-	59,637,928	-	59,637,928
Rwanda	16,849,924	499,860	6,182,908	23,532,692
Tanzania	79,497,199	1,000,000	7,857,823	88,355,022
Uganda	12,593,241	53,614,699	-	66,207,940
Zanzibar	3,442,623	-	-	3,442,623
REGION TOTALS:	**184,236,170**	**155,234,080**	**19,525,790**	**358,996,041**

Mr. Peter Mbabazi Kwehangana, also presented the **EARN Road Map Teleconference schedule & Meetings**. He took the participants through the planned quarterly in country RBM partnership meetings, quarterly EARN ECC Meetings and the EARN calendar.

The objective of the EARN Teleconferences & review meetings was to review country road maps so that EARN can periodically report to the RBM Board on the progress towards the 31st Dec 2010 targets.

He emphasized that the monthly teleconferences are to be attended by the RBM Secretariat, EARN Coordination Office , RBM harmonization working groups and NMCP

Day 2 also saw the presentation of the **MPR review tools**. Participants were introduced to the MPR thematic reviews by Dr. Nathan Bakyaita, SME/MAL/AFRO. These are reviews of a program or a project using available reports, data and anecdotes.

Dr. Bakyaita also presented the MPR planning process, data collection tools, proposal development , report writing and field reviews. The WHO MPR proposal formats were also discussed during the presentations.

Emerging issues

- All counties are urged to establish and functionalize RBM Partnerships that should meet quarterly at prescribed regular intervals.
- The membership of those partnerships should be all partners at country level involved in either supporting or implementing malaria related preventive/control activities. This arrangement will ensure the implementation and observation of the "3 ones" & jointly monitor/report progress
- Countries may consult Uganda (if necessary) where this RBM partnership Forum is already functional with prescribed dates of meetings.

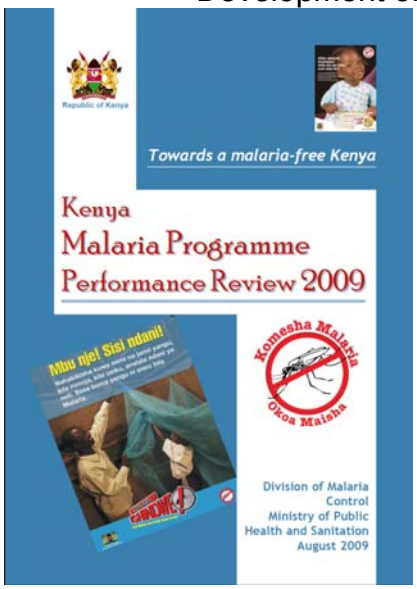
DAY 3

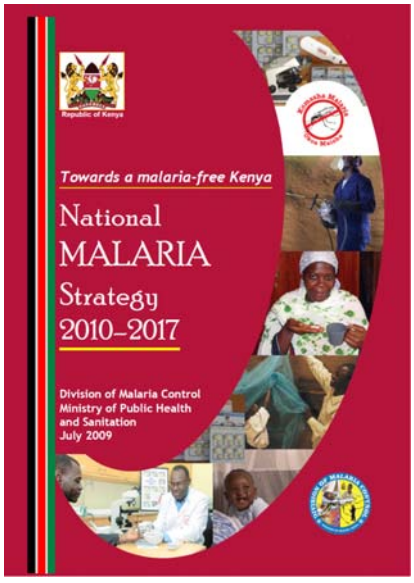
The day's presentation began with the **country experience of conducting a MPR, a case study of Kenya** presented by Dr. Elizabeth Juma, Program Manager of the NMCP, Kenya.

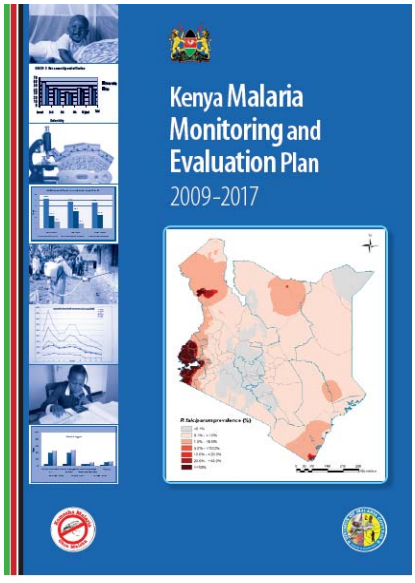
Conducted from January to June 2009, the MPR review was prompted by the need to develop a new National Malaria Strategy in line with new global targets and interventions, and also by the need to do a SWOT analysis of malaria control in Kenya especially after the 2006 mid-term review of NMS 2001-2010 elaborated only achievements

The MPR was undertaken in 3 phases;

- Phase I &II involved
  - Preparation, planning, organization and management
  - Protocol prep and Resource Mobilization
  - Desk Reviews and surveys
- Phase III involved
  - Conducting the review
  - Validation of desk reviews
  - Final thematic review reports
  - MPR Report and Aide Memoire
- Phase IV involved
  - Follow up of the review
  - Development of a new NMS 2009-2017
  - Development of the AOP 2009-2010







Some of the outputs of the Kenyan MPR.

Group work

Participants were later divided into groups by country and were to come up with country plans on malaria control. This presentation was chaired by Khoti Gausi.

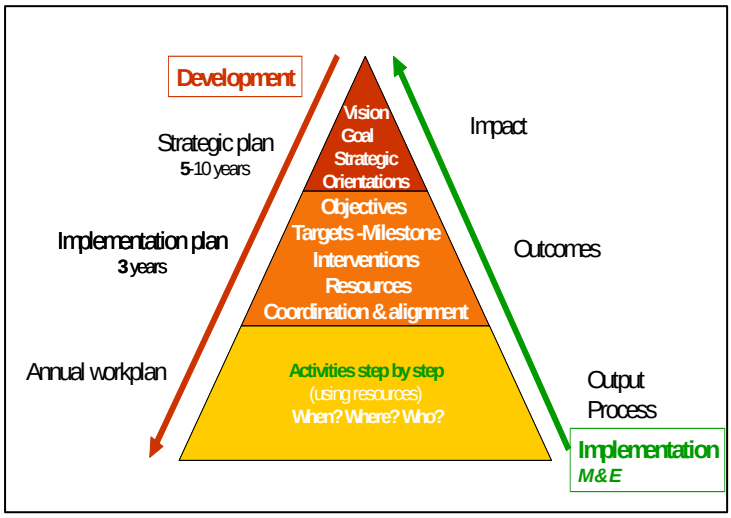
The countries were grouped thus;

1. Rwanda, Uganda, Zanzibar
2. Ethiopia, Somalia, NSD
3. SSD, Kenya, Tanzania
4. Burundi, Comoros

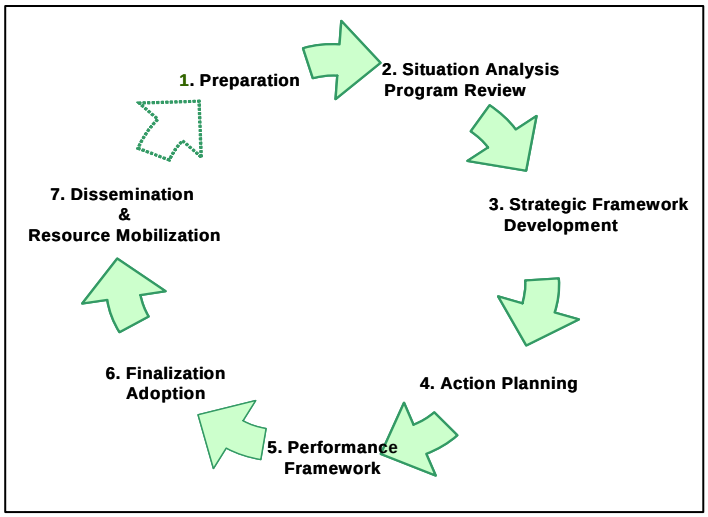
Specifically, the groups came up with updates on the following aspects of malaria control;

- Where are you in terms of MPR and SP
- Phases 1, 2, 3, 4.
- What needs to be done?
- Timelines and TA needed
- Attempt to work on a proposal

After the various groups made their presentation, the day's last session was on development of plans (NSP). A presentation was given which highlighted the different types of country plans, logical hierarchy and link between the different types of plans, National MSP development process and the various phases for malaria strategic planning.



Logical hierarchy and link between the different types of plans



National MSP development process

A set of questions were given to the participants as a case study to help them appreciate the overall National Malaria Strategic planning process.

Emerging Issues

- Countries resolved to conduct MPR in 2007 during the Malaria Annual Review & planning meeting
- 3 countries so far done MPR (Kenya, Botswana & RSA)
- MPR necessary to asses current strategies/activities with a view of re-strategizing and or strengthening the programme or systems
- MPR is an extended SWOT analysis of the programme (is not a survey but can feed into the surveys)
- MPR is country led and therefore a primary responsibility of NMCP (PM) as a coordinator
- MPR not a fault finding process but a way of providing evidence for advocacy and more support from partners
- NMCP Focal point officers to lead their respective thematic reviews
- Possibility of soliciting local TAs to support the process (WHO to provide international TAs if requested)
- The products of MPR will depend on the objectives of the review
- The following are the generic basic products/outcomes of MPR
  - Aide memoire
  - MPR Report
  - Thematic Review reports
  - Updated Malaria Strategic Plan
  - (Updated Malaria Policy)
- All countries should have a malaria strategic plan (MSP), operational/implementation/business plan and Annual work plan. Having MSP without the other plans is poor planning
- M&E plan and PSM plans after the development of MSP
- Process for development of MSP is very crucial/important for all partners to buy-in and respect the plan
- The process of developing the MSP should be highly consultative, all inclusive by involving all relevant malaria partners
- MSP development should be a country led process and use of consultants should be avoided as much as possible
- MSP development should always be preceded by reviewing the previous MSP or MPR

DAY 4

M & E Plan Development was presented by a representative from WHO. He pointed out that it is important to have a strategic plan against which an M and E plan can be developed. He advised that it is important to have one agreed action framework that forms the basis for coordinating the partners. The various components of an M and E plan were presented and the presenter summariesd the steps to be followed in developing an M and E plan. The importance of having a log frame in any M and E plan was emphasized and if not available, it should be derived from the strategic plan document.

He advised that M and E budgets be well-done as one of the necessary conditions for its efficient operationalisation and eventual purpose.

Dr. Ebony Quinto, M&E Specialist, NMCP – Uganda gave a presentation on **the M&E strategic plan 2008-2010: Uganda NMCP Implementation Experience**. In his presentation Dr. Quinto highlighted the steps taken in M&E plan development, implementation, challenges and next steps. He underscored that the M&E Plan is part of the "3 ones" that countries should have, and this should include

1. One Strategic plan (including operational plans)
2. One Coordination mechanism
3. One M&E plan

Dr. Betty A.T. Mpeka, Regional Coordinator- CLOVER HSS programme, Malaria Consortium shared their practical experience in **Health Systems Strengthening for Equitable Access to Malaria and Communicable Disease Control**. She said CLOVER is an Irish Aid funded health systems strengthening programme implemented in four countries of Ethiopia, Mozambique, Uganda and Zambia and it is running in 3 Phases over 7 years.

Dr. Mpeka gave the participants the WHO definition of a health system as…the sum of all organizations, institutions and resources whose primary purpose is to improve health. She also gave the meeting the WHO - Health Systems Building Blocks as;

- **Service Delivery:** Health services must be efficient, effective, and accessible.
- **Health work force:** A number of well-trained staff should be available.
- **Information:** Health information systems should generate useful data on health determinants and health system performance.
- **Medical products, vaccines & Technologies:** Access to medicines, vaccines, and medical technologies must be equitable.
- **Financing:** Health financing systems must raise adequate funds for health, ensuring that people can access affordable services.
- **Leadership:** Leadership must guarantee effective oversight, regulation, and accountability.

An overview of the Global Fund PSM Policies and the Pharmaceutical & Health Product Management Country Profile was given by Mr. Joseph SERUTOKE, Pharmaceutical Management Advisory Services at the Global Fund in Geneva. In his presentation, he gave the Global Fund's approach to PSM and underscored the importance of procurement and supply chain management

Dr. Karema Corine from Rwanda and Murakoze Kanze from Burundi shared their **countries' experience with using the PAM in malaria prevention**. Afterwards, the different country group work reports on MPRs that had been assigned on Day 3, were presented to the participants.

Emerging Issues

M&E Plans

- M&E plans must be prepared against a Malaria Strategic plan (MPR-----MSP-----M&E Plan)
- There is need to involve all partners in the development process of the plan to capture all relevant indicators from partners
- NMCP should ensure that malaria data bases are functional to provide a one point repository of data for all partners
- The plan should include all the components; including wider dissemination, roles/responsibilities of each stakeholder (Template available in the RB tool kit at RBM web site)

PSM Plans & GF orientation

- GF policy on PSM
  - Should be country owned
  - Build on existing system
  - Buy Quality assured products
  - Lowest price
  - Compliant to national & international laws
  - Transparent process and competitiveness
- New approaches (regarding country profile, revised PSM plans and standard PSM plans)
- Currently GF requires PSM Plan, performance frame work, wkplan & budget for reach GF proposal,

- But now: moving towards use of country profile & Revised PSM plan to simplify work and avoid duplication.

- If a country submitted a PSM in the existing GF grant, only a revised PSM plan & country profile shall be required in subsequent proposals

- A revised PSM plan is simplified and excludes the narrative part.

- Revised PSM only includes
  - List of health products to be procured with grant resources (quantities & unit costs)
  - Procurement schedule
  - Forecasting methodology

- A revised PSM plan must be submitted with a country profile

- Country profiles must include all the 3 diseases (ATM)

- All countries not submitting the two docs above will continue to submit the standard PSM plans

- Inclusion of 10% of LLINs as losses in the PSM plan is not allowable unless a justifiable explanation is included (like population increase)

HSS country experiences

- It was observed that there is great opportunity with GF grants to strengthen systems (citing a good example presented by Rwanda), hence countries should endeavor to write convincing HSS components
- Considering the importance of HSS, the consultants used to write HSS section should be HSS experts but not necessarily the disease specific officers who sometimes fail to write a well linked HSS components.

Country MPR, MSP preparations

- Timings/schedules should be done
- Needs for TAs noted
- There is need to
  - Inform country partners (RBM partnership/stakeholders) and bring them on board
  - Inform TWGs and Top Mgt of MOH
  - Develop costed MPR workplan
  - Mobilize resources from national partnership and external partners as required

DAY 5

The participants were guided to come up with the EARN Work plan update (May – December 2010) by Mr. Peter Mbabazi Kwehangana, Regional Coordinator, EARN RBM.

Participants were also given forms to evaluate the whole organisation of the meeting. Different aspects of the meeting that included the conference logistics - travel arrangements from the airport to hotel, organisation of the meeting, accommodation, composition of participants, and the meeting sessions. A complete analysis of the participants' responses is hereby attached ín Annex 4.

CONCLUSIONS AND RECOMMENDATIONS

The following were the conclusions by the participants of the EARN meeting;

1. The meeting was useful for sharing experiences between countries. The technical updates from the individual countries were particularly very helpful in assessing the status of implementation of the Road maps set earlier.
2. There is need for more sessions on how to strengthen in-country partnerships

Recommendations

Progress on implementation of 2010 roadmaps

1. Roadmaps are a good tool for reporting on progress and harmonization of support. However, there is need to speak more about the roadmaps and more details on interventions are required in future
2. There is need for more consistency on country roadmap reporting
3. In-country tracking of roadmap implementation is very important and needs to be emphasised in NCP implementations
4. Monthly teleconferences are a useful tool for tracking roadmap implementation progress and ensuring countries receive necessary support

Process and planning for Malaria Program Reviews

1. Countries need more guidance on how to improve performance of the National malaria control programs
2. Countries need support to improve performance and attract additional resources from Funding Partners
3. There is need for more participation at meetings by implementing partners and to track impact at regional **l**evel over time

Malaria Strategic planning

1. WHO tools are useful and need to be finalized and disseminated as soon as possible to all countries in the AFRO region to facilitate standardisation in Malaria Strategic Planning
2. Upcoming EARN meetings should be structured as review and planning meetings to enhance experience sharing among countries.
3. RBM in-country partners should meet regularly (and especially before EARN meetings) to update themselves of what is going on in their respective countries
4. Local HR should be developed and utilized whenever possible
5. Partnerships need to be strengthened at country level; some country partnerships are weak and are not functioning well

Updates on the 2010 Malaria reports

1. Meetings such as the EARN meeting help countries to coordinate partnership. From these partnerships, there is a lot to learn from other countries and sharing of experiences

Operationalisation of the EARN work plan

1. There is need to clarify on the types of technical support required by different countries, when it is needed, and who will deliver it to the different countries
2. There should be efforts to engage the World Bank country offices in work plan development for malaria prevention

APPENDIX 1: COUNTRY ROAD MAP UPDATES

BURUNDI

It was presented in French.

Ressources disponibles pour réaliser les cibles 2010 pour les MIILDA

FONDS DISPONIBLES ($ US)	SOURCE	COMMENTAIRE
16 036 814	Fonds Mondial	RCC & proposition R9
1 000 000	UNICEF	UNICEF a planifié ce montant pour la campagne 2010
2 700 000	USAID	USAID a planifié d'acheter 545000 MIILDAs
600 000 MII	Croix rouge Burundi	100 000 étaient prévues pour la campagne de 2009 mais seront distribuées au cours de la campagne 2010.
150 000	RSS-GAVI	25000 MIILDAs

Road map May 2010 Evaluation-LLIN

INTERVENTION: LLINS	Activity implemented (Yes/No)	Is the activity achievable by Dec 2010? (Yes/No)	Can Universal coverage be achieved by Dec 2010? (Yes/No)	Comments
Quantities	Oui	Oui	Oui	Dépends de la rapidité de décaissement et livraison des MII/VPP du R9 en cours de négociation
Dates d'achat	Non	Oui	Oui	Novembre 2010
Date de livraison prévue	Non	Oui	Oui	
Date Campagne	Non	Oui	Oui	4ème trimestre 2010
BCC/Community mobilization	Oui	Oui	Oui	
Distribution	Non	Oui	Oui	

Monitoring and evaluation	Non	Oui	Oui	

Road map May 2010 Evaluation-IRS

INTERVENTION: IRS	Activity implemented (Yes/No)	Is the activity achievable by Dec 2010? (Yes/No)	Can Universal coverage be achieved by Dec 2010? (Yes/No)	Comments
Besoins en Pyrethrinoïdes	Non	Non	Non	Fonds disponible insuffisants
Planning des achats	Non	Non	Non	
Formation	Non	Non	Non	
CCC/IEC	Non	Non	Non	
Pulvérisation	Non	Non	Non	
Suivi et évaluation	Non	Non	Non	

Résumé des facteurs limitant l'accélération au cours des 16 prochains mois

Problèmes	Solutions
Insuffisance de ressources financière (gap est de 28 160 984 USD)	Plaidoyer et mobilisation des ressources, maintien de la bonne performance du projet du FM
Faible Capacité technique du personnel du PNILP	Renforcement des capacités techniques et managériales des cadres du PNILP
Temps limité par rapport à l'échéance de fin 2010	
Hypothèse d'acceptation de la proposition R9	
Instabilité du personnel	Politique de stabilisation du personnel en cours d'exécution.

ETHIOPIA

Country Summary: Population at risk: (68% of 79,835,354 = 54,288,040)

Intervention	Need to 2010	Already covered	Funded and expected to be distributed before end 2010	Gap
LLINs (Universal Access)	23,101,294	7,213,975	13,870,000	2,017,319
ACTs	12,000,000		12,000,000	0

IRS (using Deltamethrin 2.5% in Kg)	1,250,000		920,000	330,000
RDTs	16,000,000		14,500,000	1,500,000
IPTp	(women to be treated)		NA	NA
M&E*	24,027,347		4,800,665	19,226,682
BCC/IEC*	30,218,318		22,619,147	7,599,171
Human Resources (Capacity Bldg)			3,392,180	
Other				

ACT resources available to achieve the 2010 targets

FUNDS AVAILABLE (US $)	SOURCE	COMMENT
6,000,000	GFATM R5	6 million ACT CE forwarded, waiting for release of fund by GFATM to UNICEF-SD
2,100,000	PMI	Fund received in last week of April 2010, on procurement process by UNICEF
4,000,000	UNITAD	CE approved by FMOH, on procurement process by UNICEF
12,100,000	Total	No gap for 2010.

IRS resources available to achieve the 2010 targets

FUNDS AVAILABLE (US $)	SOURCE	COMMENT
5,610,000	PMI	PMI allocated resources
6,663,516	GFATM R8	For 2010

Summary of rate-limiting factors over the next 8 months

- Delay in disbursement of GFATM funds
- Still have financial gap to reach universal coverage
- Resistance of vectors to IRS chemicals
- Logistic and supply management
- Utilization of interventions

KENYA

Country Summary

Intervention	Need to 2010	Already covered	Funded exp to be distributed b4 end 2010	GAP
LLIN	11 million LLIN	Nil	1 million	10 million*
ACT	12 million	12 million	-	Nil
IRS	21,000 kg	10,500kg	10,000	Nil (epidemic prevention)
RDT	12 million	2,128,000	2.1 million	10 million
IPTp	400,000	400,000	-	-
S,M&E	US $ 7.8mill	US $ 2.6 mill	-	US $ 5.2 mil
Human Resource	US $240,000	-	-	US $240,000

Road map May 2010 Evaluation-LLIN

INTERVENTION: LLINS	Activity implemented (Yes/No)	Is the activity achievable by Dec 2010? (Yes/No)	Can Universal coverage be reached by Dec 2010? (Yes/No)	Comments
Quantities	3,100,000	Yes	No	No funds for LLINs for mass campaign
Procurement dates	Jul 09 Mar 10	Yes		
Expected delivery	Jan – Jul 2010	Yes		
Campaign Date	On going			
BCC	On going			
Community mobilization	N/A			
Distribution	On going			
Mechanisms of distribution.	Routine clinic			
Monitoring and evaluation	Continuous			

Road Map May 2010 Evaluation-ACT

INTERVENTION:	Activity implemented	Activity not implemented	Is the activity achievable by Dec 2010? (Yes/No)	Can Univesal coveage be eached by Dec 2010? (Yes/No)	Comments

ACTs required	Yes 12 million doses	-	Yes	Yes	ACT free in all gov't and FB health facilities since 2006
Procurement schedules	Jun – Nov 09 May 2010 (HMM)	-	Yes	-	HMM in malaria endemic districts through AMFm
BCC	On going	-	Yes	-	-
Mechanisms of distribution	Health facilities	-		-	-
Drug Efficacy Monitoring	On-going	-	Yes	-	-
Monitoring and evaluation	On-going	-	Yes	-	-

Road Map May 2010 Evaluation-RDT

INTERVENTION:	**Activity implemented**	**Activity not implemented**	**Is the activity achievable by Dec 2010? (Yes/No)**	**Can Univesal coveage be eached by Dec 2010? (Yes/No)**	**Comments**
RDTs required	Yes, DFID/GF		Yes	No	Mobilizing resources to implement diagnosis based testing
Procurement schedules	May 2010				
BCC	Yes				
Mechanisms of distribution	Yes				
Drug Efficacy Monitoring	Yes				
Monitoring and evaluation	Yes				

Road map May 2010 Evaluation-IRS

INTERVENTION: IRS	**Activity implemented**	**Is the activity achievable by Dec 2010? (Yes/No)**	**Can Universal coverage be archived by Dec 2010? (Yes/No)**	**Comments**
Pyrethroids required	Yes	Yes	N/A	IRS for epidemic prevention, IRS in 10 districts for disease burden reduction
Procurement schedules	Jun – Sep 09			
Training	March 2010			
BCC	March 2010			
Spraying	April – May 2010			

Monitoring and evaluation (*bioassays, insecticide resistance etc*)	Aug/ Oct 2010			

Road map May 2010 Evaluation-Other Core interventions

INTERVENTION: LLINS	**Activity implemented (Yes/No)**	**Is the activity achievable by Dec 2010? (Yes/No)**	**Can Univesal coveage be eached by Dec 2010? (Yes/No)**	**Comments**
IPTp Implementation Evaluation WHO Sept 2009	Yes	Yes	N/A	Recommendations incorporated in NMS
IEC campaigns Net hanging and use Aug – Nov 2009	Yes	Yes		
"Haraka Upesi" – call to prompt treatment seeking behaviour Aug – Nov 2009	Yes	Yes		
M&E 2010 MIS Jul – Aug 2010	On-track	Yes		

Road map May 2010 Evaluation- Limiting Factors (Mitigation)

Limiting factor	**What are mitigation measures taken?**	**Still a limiting factor**	**Is the activity achievable by Dec 2010? (Yes/No)**	**Can Universal coverage be archived by Dec 2010? (Yes/No)**	**Comments**
Funding gap for commodities	-	-	-	-	-
LLINs (US$ 140 million 2010)	Resource mobilisation from other partners	Yes	No	No	-
IRS (US$ 9.5 million 2010)	Funding from PMI GF R4	No	Yes	N/A	-
RDTs (Nil)	-	-	-	-	-
IEC/BCC M&E	-	-	-	-	-
Procurement bottlenecks • Long processes	-	-	-	-	-
• Delayed disbursements from Global Funds	Negotiations	No	Yes	N/A	Universal coverage not part of Round 4
Human resource needs • M&E	2 new staff	-	-	-	-
• Logistics	Partners to support	Yes	Yes	-	-
• Planning and coordination	-do-	Yes	Yes	-	-

Road Map May 2010 Evaluation- TA needs

INTERVENTION:	Did you receive planned TA (Yes/No)	If not, did you make a formal request either to WHO or to EARN (Yes/No)	If yes , was TA on time? (Yes /No)	If Yes,Level of satisfaction 1-Non Satisfied 2-Average 3-Very satisfied	Comments
Planning for mass net distribution to meet universal coverage in 2010 (if nets become available	Yes, UNICEF, WHO	N/A	Yes	3	Plan of action in place including development of LLIN tracking tool

RWANDA

Country Summary

Intervention	Units used	Need to 2010	Already covered	Funded and expected to be distributed before end 2010	Gap
LLINs (Universal Access – avg 1 net for 2 pp)	Nets	11,946,968	7,318,225	4,628,743	2010 targets will be achieved
ACTs	Treatments	6,596,775		6,596,775	2010 targets will be achieved
RDTs	Number of tests	1,147,625		1,147,625	2010 targets will be achieved
IPTp	Women to be treated	Revision of the policy		NA	NA
IRS	Financial / USD	5,157,147		2,525,000	2,632,143
M&E	Financial / USD	15,253 ,628		7, 626,814	7,626,814
BCC/IEC	Financial / USD	8,808,048		8,808,048	2010 targets will be achieved
Human Resources (incl Capacity Bldg as training)	Financial / USD			1 ,588, 562	

Road map May 2010 Evaluation-LLIN

INTERVENTION: LLINS	Activity implemented (Yes/No)	Is the activity achievable by Dec 2010? (Yes/No)	Can Universal coverage be achieved by Dec 2010? (Yes/No)	Comments
Quantities	Yes	Yes	Yes	580000 HH Jan 10 1,8 Millions in U5 April10 campaign 374000 for ANC in may

				1.7 Millions Sept-Dec 10
Procurement dates	The contract of 2.5 Millions is already signed	Yes	Yes	
Expected delivery	Yes	Yes	Yes	
Campaign Date	Yes	Yes	Yes	Campaign in April and Quarter 4 2010
BCC	Yes	Yes	Yes	
Community mobilization	Yes	Yes	Yes	
Mechanisms of distribution	Yes	Yes	Yes	Household distribution,integrated mass campaign
Monitoring and evaluation	Yes	Yes	Yes	DHS, monitoring of the efficacy of insecticide, HH visits

Road Map May 2010 Evaluation-ACT RDT

INTERVENTION:	**Activity implemented (Yes/No)**	**Is the activity achievable by Dec 2010? (Yes/No)**	**Can Universal coverage be achieved by Dec 2010? (Yes/No)**	**Comments**
ACTs required	Yes	Yes	Yes	The private sector is not covered for adult group
RDTs required	Yes	Yes	Yes	The private sector is not covered and some districts not supported by the GF
Procurement schedules	Yes	Yes	Yes	The delay in the procurement process due to WHO (change of RDTs)◊ Direct to supplier
BCC	Yes	Yes	Yes	Health providers and CHWs are trained and sensitized on the new malaria case management
Mechanisms of distribution	Yes	Yes	Yes	Health facilities and community
Drug Efficacy Monitoring	Yes	Yes	Yes	Protocol in devpt
Monitoring and evaluation	Yes	Yes	Yes	DHS, Pharmacovigilance system

Road map May 2010 Evaluation-IRS

INTERVENTION: IRS	**Activity implemented (Yes/No)**	**Is the activity achievable by Dec 2010? (Yes/No)**	**Can Universal coverage be achieved by Dec 2010? (Yes/No)**	**Comments Discussion on insecticide longevity 6-9 Months**
Total Households targeted	No			Negotiation with PMI on insecticide longevity
DDT required (quantities)	N/A	N/A	N/A	

Pyrethroids required (quantities)	Under procurement 15000 sachets for Round 1			Negotiation with PMI on insecticide longevity
Distribution (Locations)	2 Districts for round 1/2 districts for round 2	?	?	Negotiation with PMI on insecticide longevity
Training (dates)	yes	yes	yes	
BCC / IEC (dates, types)	yes	yes	yes	
Spraying (dates, locations)	Only 1 full round Negotiation for round 2			Negotiation with PMI on insecticide longevity
Monitoring and evaluation (*bioassays, insecticide resistance etc*)	YES	yes	yes	

Road map May 2010 Evaluation-Other Core interventions

INTERVENTION: LLINS	Activity implemented (Yes/No)	Is the activity achievable by Dec 2010? (Yes/No)	Can Univesal coveage be eached by Dec 2010? (Yes/No)	Comments
IRS: cross border interventions				
Community based management (RDT extension in 18 district)	Yes	Yes	Yes	7 districts
Review of malaria strategic plan	Yes	Yes	Yes	May-June 2010
Development of malaria strategic plan 2011-2015	Yes	Yes	Yes	May-June 2010
BCC campaign	Yes	Yes	Yes	Finalization of the strategy,training of health workers

Road map May 2010 Evaluation- Limiting Factors (Mitigation)

Limiting factor	**What are mitigation measures taken?**	**Still a limiting factor**	**Is the activity achievable by Dec 2010? (Yes/No)**	**Can Universal coverage be archived by Dec 2010? (Yes/No)**	**Comments**
Delays in disbursements of funds	Yes	Yes	Yes	Yes	
Procurement delays	Yes	Depending on channel used	Yes	Yes	

Availability of commodities on the market	LLIN production	Yes depending on LLINs manufacturer	Yes	Yes	

Road Map May 2010 Evaluation- TA needs

INTERVENTION:	Did you receive planned TA (Yes/No)	If not, did you make a formal request either to WHO or to EARN (Yes/No)	If yes , was TA on time? (Yes /No)	If Yes,Level of satisfaction 1-Non Satisfied 2-Average 3-Very satisfied	Comments
End –use verification of antimalarial drugs	Yes	Yes	Yes	2	
BCC strategy	Yes	yes	Yes	3	
Need assessment/Programme review	Not yet	yes	Yes	-	
Support of drug quality assurance	Yes	yes	Yes	3	
Assessment of RDT on the community level	Not yet	WHO assessment for CCM	Yes	3	
Environmental Compliance	Yes	yes	Yes	3	
PCR/Elisa Technical Lab	yes	yes	Yes	2	
HFS	Yes				
DHS	YES	yes	Yes	Yes	

SOMALIA

General Context

3 distinct areas:	1. Somaliland, 2. Puntland, 3. Central/South Somalia
Health indicators:	UMR: 225 (per 1,000) - MMR: 1100 (per 100,000) - Malaria prevalence 5 – 10%
Political / Social	Population – approx 8 million
Insecurity	Population displacement Few health workers Health system is fragmented & under financed
	• Currently funded under the GF Rd 6 from Nov 2007 to Oct 2012. – Phase 1: Sept 2007 to Oct 2009 - 13million – Phase 2: Nov 2009 to Oct 2010 - 14million
	• Implementation of activities guided by the National Malaria Strategy 2005 to 2010

	• Just revised the NMS / M&E Plan (2010 to 2015) – Courtesy of the EARN/RBM support to finalize and endorse (March 31, 2010)
• *Case Management*	• Introduction of ACT/RDT started in 2006, covering all Hospital & MCH • Guidelines in place BUT need revision • Just introduced ACT/RDT at the lower Health post levels (2009) • No funding Gap
• *Malaria prevention*	• 1.2 Million LLINs planned for distribution under Rd 6 ending Nov 2012 • 715,000 distributed: 50,000 procured and planned for distribution • 76,800 ordered & expected in September 2010 • Balance to be procured – 358,200: Gap of 1.1 million • So far coverage is estimated at 40 to 45 %
• *IEC*	• Implementation guided by Malaria communication strategy (2006/2010) • Malaria Communication strategy needs to be updated • Activities – Trained 30% of HWs on communication techniques: Community dialogue: Conducting malaria field days and annual World Malaria Day
• *Malaria in pregnancy*	– Implemented only in the CSZ of Somalia – SP is procured by UNICEF: No funding gap – LLINs distributed as part of mass coverage (No ANC distribution)
• *Health system strengthening*	– 60% of labs undergoing QC – 30% of laboratory technicians trained – 8 senior lab tech to be trained in lab QC
• *Epidemic Preparedness and response*	– 7% of health staff trained on epidemic preparedness & response – No clear EP&R strategy (mapping not done, estimate not done) – TA required
• *HMIS*	– On-going under Rd 6: All districts covered in Somaliland & Puntland is on-going – Data has started flowing
• *Strengthening of Malaria Control Program*	– Established in Somaliland and Puntland – NMCP Manager trained and supported

Road map May 2010 Evaluation - LLIN

INTERVENTION: LLINS	**Activity implemented (Yes/No)**	**Is the activity achievable by Dec 2010? (Yes/No)**	**Can Univesal coveage be eached by Dec 2010? (Yes/No)**	**Comments**
Situation analysis	YES	NO	NO	Analysis indicates LLINs need (1.1 million)
Procurement	YES	YES	NO	
Training	YES	YES	YES	

Distribution	YES	YES	YES	Take over of warehouse and looting of LLINs by A.G.E

Road Map May 2010 Evaluation-ACT RDT

INTERVENTION:	Activity implémented (Yes/No)	Is the activity achievable by Dec 2010? (Yes/No)	Can Universal coverage be reached by Dec 2010? (Yes/No)	Comments
Procurement & Logistic	YES	YES	NO	ACT/RDT has been introduced up to MCH level : Lower level HP not covered
Training	Partially	YES	YES	Roll out to HPs level is on-going
Distribution	Partially	YES	NO	Need to map out the HPs, affected by insecurity (take over of warehouse by A.G.E

Road Map May 2010 ESupervision & Capacity building valuation

INTERVENTION:	Activity implemented (Yes/No)	Is the activity achievable by Dec 2010? (Yes/No)	Can Univesal coveage be eached by Dec 2010? (Yes/No)	Comments
60% of labs undergoing QC	Yes	Yes	Yes	HF Not supported by GF need to be considered
80 MMRT	Yes	Yes	Yes	Maintenance & Supervision
167 HWs trained in malaria communication	Partially	YES	Yes	Roll out is on-going
326 health staff trained on EPR	YES	Yes	Yes	7% covered new SR (Mentors) on board to cascade trainings
4 to be trained in VC	YES	YES	YES	

Road map May 2010 Evaluation- Limiting Factors (Mitigation)

Limiting factor:	What are mitigation measures taken?	Still a limiting factor	Is the activity achievable by Dec 2010? (Yes/No)	Can Universal coverage be archived by Dec 2010? (Yes/No)	Comments
Lack of strong central government	Problem solving & Under standing	Yes in NEZ& NWZ zones	Yes in NEZ & NWZ	Yes in Zones	SCZ in ?
Poor capacity of SR	Improve coordinatio	SCZ	Yes in NEZ&NWZ	Yes in NEZ & NWZ	Strengthening

					Problem solving
Weak HMIS/MIS	Training data mangement	Yes	Yes	Yes	Improve & update data mangement system
Trained staffs turn over.	Improve staff motivation				
Sustainability of the ACT& RDTs supply for Somalia (After GF support?)	Préparation of Future plan Support	N0	Yes	Yes	
Inadequate human capacity in malaria microscopy and Entomology & VC	Training	No	Yes	Yes	
Lack of central reference laboratory for malaria QC	Established NE&NW zone	YEs	yes	Yes	

Road Map May 2010 Evaluation- TA needs

INTERVENTION:	**Did you receive planned TA (Yes/No)**	**If not, did you make a formal request either to WHO or to EARN (Yes/No)**	**If yes , was TA on time? (Yes /No)**	**If Yes,Level of satisfaction 1-Non Satisfied 2-Average 3-Very satisfied**	**Comments**
National Malaria Strategy & M/E update (2011-2015)	DONE	YES	YES	3	
Updating communication strategy for malaria	NO	NO	Not done		
Develop Rd 10 proposal	no	Yes	Yes	Awaiting	
Develop EP&R strategy	no	Not submitted			
Operational research (AMDR-Study) and insecticide resistance monitoring	Yes	Yes	Yes		
Establishment of insectory	no	no	Not done		
Health Facility mapping	no	Not done			

SOUTH SUDAN

Country Summary

Intervention	Need to 2010	Already covered	Funded and expected to be distributed before end 2010	Gap
LLINs (Universal Access)	5.2 million (total in circulation)	4.5 M	1.5 M	None
ACTs	4.9 million doses		3.6 million doses	1.3 million
IRS	(financial need)		Not applicable	Not applicable
RDTs	1.98 million tests		0.88 million tests	1.1 million
IPTp	195,816 women		391,632 (doses)	0
M&E	US $ 1,820,00		I million (MIS)	820 K
BCC/IEC	US $ 782,364		US $ 782,364	0
Human Resources (Capacity Bldg)	US $ 1.3 million		US$ 707,379	US$ 529,621

Road map May 2010 Evaluation-LLIN

INTERVENTION: LLINS	Activity implemented (Yes/No)	Is the activity achievable by Dec 2010? (Yes/No)	Can Universal coverage be achieved by Dec 2010? (Yes/No)	Comments
Quantification	Yes	Yes	Yes	
Procurement dates	Already done	Yes	Yes	LLINs already procured
Expected delivery	In-country	Yes	Yes	2,161,899 LLINs distributed as of March 2010
Campaign Date	ongoing	Yes	Yes	ongoing
BCC	ongoing	Yes	Yes	ongoing
Community mobilization	ongoing	Yes	Yes	ongoing
Distribution	ongoing	Yes	Yes	ongoing
Mechanisms of distribution	ongoing	Yes	Yes	ongoing
Monitoring and evaluation	ongoing	Yes	Yes	ongoing

Road Map May 2010 Evaluation-ACT RDT

INTERVENTION:	Activity implemented (Yes/No)	Is the activity achievable by Dec 2010? (Yes/No)	Can Universal coverage be achieved by Dec 2010? (Yes/No)	Comments
ACTs required	Yes	Yes	No	Limited coverage of health facilities; HMM just introduced
RDTs required	Yes	Yes	No	Weak health system
Procurement schedules	completed	Yes	NA	
BCC	Yes	Yes	No	Need for more community level
Mechanisms of distribution	Yes	Yes		
Drug Efficacy Monitoring	No	No	NA	
Monitoring and evaluation	Partial	No	No	No consumption data

Road map May 2010 Evaluation- Limiting Factors (Mitigation)

Limiting factor	**What are mitigation measures taken?**	**Still a limiting factor**	**Is the activity achievable by Dec 2010? (Yes/No)**	**Can Universal coverage be archived by Dec 2010? (Yes/No)**	**Comments**
Funding gaps: UNITAID LLIN operational costs (US$ 2.5 M)	Resource mobilization from other partners	Yes	Yes	Yes	If funds for distribution are available in time
ACT delivery through HMM	Recriutment of more CBOs	Yes	Yes	No	If further recruitment of SRs is approved
MIS support (US$ 150K)	Resource mobilization from other partners	Yes	Yes	NA	Lack of funds delaying completion of MIS

Road Map May 2010 Evaluation- TA needs

INTERVENTION:	**Did you receive planned TA (Yes/No)**	**If not, did you make a formal request either to WHO or to EARN (Yes/No)**	**If yes , was TA on time? (Yes /No)**	**If Yes,Level of satisfaction 1-Non Satisfied 2-Average 3-Very satisfied**	**Comments**
Drug efficacy – planning and executing studies at sites	No	No	NA	NA	Planned for Q3 and Q4 of 2010

Vector control: susceptibility and entomological parameters (determination)	No	Yes	No	NA	Waiting for TA
RDTS quality assurance	No	Yes	NA	NA	Waiting for TA from WHO and EARN
BCC training	No	No	NA	NA	TA required from WHO and EARN

ZANZIBAR

Country Summary

Intervention	Need to 2010	Already covered	Funded and expected to be distributed before end 2010	Gap
LLINs (Universal Access)	(nets)	6/10 districts	1,653,000 USD	None
ACTs	(drug needs)	140/140 HFs	324, 000 USD	None
IRS	(financial need)	2009	1 Round 2010	1.4m USD
RDTs	(number of tests)	114/114 HFs	300,000 USD	None
IPTp	(women to be treated)	114/114 HFs	294,500 USD	None
M&E	(financial need)	MEEDS, Surveillance	ACT Efficacy trial, Insecticide and vector susceptibility test	None
BCC/IEC	(Financial need & IEC Material)	Communication strategy, Tv, School prog., Billboards etc	809,888 USD	None
Human Resources (Capacity Bldg)	(financial need)	2-MSc Ento. 1-MSc, Paras. 1- MSc Epid. 2- BSc & BCC	-	430,000 USD

Road map May 2010 Evaluation-LLIN

INTERVENTION: LLINS	Activity implemented	Activity not implemented	Is the activity achievable by Dec 2010? (Yes/No)	Can Universal coverage be eachied by Dec 2010? (Yes/No)	Comments
Quantity	325,000	Not yet implimented	Yes	Yes	
Procurement dates	June - 2010		Yes	Yes	
Expected delivery	9/10 districts delivered; August - Sept. 2010		Yes	Yes	

Community mobilization and BCC/Campaign	Sept – October 2010		Yes	Yes	
Distribution	Within two weeks of its arrival		Yes	Yes	
Mechanisms of distribution	Through Districts and community leaders				
Monitoring and evaluation	Through MIS, ITNs durability study and cross-sectional surveys and IRS campaign		Yes	Yes	

Road Map May 2010 Evaluation-ACT RDT

INTERVENTION:	**Activity implemented**	**Activity not implemented**	**Is the activity achievable by Dec 2010? (Yes/No)**	**Can Universal coverage be archied by Dec 2010? (Yes/No)**	**Comments**
ACTs required	60,000 doses	Not yet implemented	Yes	Yes	
RDTs required	500,000 kits		Yes	Yes	
Procurement schedules	ACT: June 2010 RDT: Mid May and August 2010		Yes	Yes	
BCC	It is on going		Yes	Yes	
Mechanisms of distribution	Through Central and Zonal medical Stores		Yes	Yes	
Drug Efficacy Monitoring	2010, May		Yes	Yes	
Monitoring and evaluation	Regular district supervisions, MIS		Yes	Yes	

Road map May 2010 Evaluation-IRS

INTERVENTION: IRS	Activity implemented (Yes/No)	Is the activity achievable by Dec 2010? (Yes/No)	Can Universal coverage be archived by Dec 2010? (Yes/No)	Comments
Pyrethroids required	Yes	Yes	Yes	
Procurement schedules	December 2009	Yes	Yes	
Training	Yes	Yes	Yes	
BCC	Yes	Yes	Yes	
Spraying	8/10 Districts sprayed 2 districts no sprayed	Yes	Yes	
Monitoring and evaluation *-bioassays,* *-insecticide resistance*	May 2010 June- July 2010	Yes	Yes	

Road map May 2010 Evaluation- Limiting Factors (Mitigation)

Limiting factor	What are mitigation measures taken?	Still a limiting factor	Is the activity achievable by Dec 2010? (Yes/No)	Can Universal coverage be archived by Dec 2010? (Yes/No)	Comments
Inconsistence in prescription of antimalaria	-Re-fresher Training to all priscribers - distribution of reviewed treatment guidelines to all HFs - Increase awareness to the public	No assessement done however there are some changes/improvements	Yes/No, this is about change of professional behaviour/attitude.		More efforts will be directed to the clinicians during follow up visits
Mono-therapy is still being used for confirmed and suspected malaria cases mainly at private health facilities	Introduction of AMFm Legal procedures to ban mono-therapy	So far Yes	Yes	Yes	Legal procedures are part of AMFm activities
Shortage of Laboratory Technicians in some of the public health facilities	- Provision of RDT to the HFs with no lab staff	Minimized	Yes	Yes	
No funds committed for IRS after November 2009 to 2010	- Funds made available and 8 districts sprayed - 2 Districts will be sprayed in June 2010	No gap	Yes	Yes	No comments

Road Map May 2010 Evaluation- TA needs

INTERVENTION:	Did you receive planned TA (Yes/No)	If not, did you make a formal request either to WHO or to EARN (Yes/No)	If yes , was TA on time? (Yes /No)	If Yes,Level of satisfaction 1-Non Satisfied 2-Average 3-Very satisfied	Comments
Establishment of ITNs distribution data base	No	Yes (WHO)	No TA provided. Lack of effective communication	N/A	Improve communication between NMCPs and ICST WHO

Establishment and strengthening of QA/QC system/guidelines for microscopy and RDT	Yes	N/A	N/A	N/A	PIM provided –TA still on going
Development of guidelines on efficacy trials	Yes	N/A	N/A	N/A	WHO provided the guidelines for implementation
Monitoring of efficacy and durability of LLINs	No	Funds not available	N/A	N/A	TA was not requested as there were no funds to carry out the study
IPT implementation in low malaria ndemicity					No TA requested

TANZANIA

Case management

Planned activities	By When	Gap	Status
ACTs in public and Faith-based health facilities. (R 7, R9)	On-going	No Gap	complete
ACTs in private health facilities and drug outlets (AMFm)	September, 2010	No gap	Waiting for implementation letter to be signed

Diagnosis

Planned activities	By When	Gap	Status
Roll out of RDT use 4 regions	2009	No gap	complete
Roll out of RDT use in whole country	2010	No Gap	8 regions will be covered this year. (whole country has 21 regions)
Quality control of the RDT system	2010	No Gap	The protocol is in its final stages, not yet approved

LLINs

Planned activities	By When	Gap	Status
Completion of the under-five catch-up campaign (>7 million LLINs)	May 2010	No Gap	Only one region, Dar es Salaam, has left. LLINs will be distributed by May, 2010.
Distribution of free LLINs for universal coverage. (R8) (14.6 million LLINs)	June 2011	Not known by now	Waiting for completion of contracting out procurement process

Upgrading PW voucher to a fixed rate, Tsh 500/=	Nov 2009	No gap	completed
TA to redefine LLINs keep up strategy	2010	TA	For the time being, voucher scheme is being used as keep-up strategy for vulnerable groups- infants and pregnant women. The fund ends by March, 2011. There is still need to redefine the keep-up strategy for the whole population

IRS

Planned activities	By When	Gap	Status
IRS in whole Kagera region (PMI)	2009	No Gap	completed
IRS in lake zone (Kagera, Mwanza and Mara) (PMI)	2010	No gap	Logistics phase in two new regions
IRS in coastal zone (27 districts)	2011	USD 18,500,000	Seeking funds

Larviciding

Planned activities	By When	Gap	Status
sustain larviciding in 15 wards in Dar es Salaam	2010	No gap	On going
Expansion of larviciding to cover whole Dar es Salaam region	2010	USD 3,950,000	Seeking funds
Expansion of larviciding to cover 12 urban districts in the country	2011	USD 16,786,000	Seeking funds
Establishment of a biolarvicides plant	2012	USD 22,307,688.	Seeking funds

Entomological monitoring

Planned activities	By When	Gap	Status
Susceptibility test to insecticides in 13 selected sentinel sites	2009	No gap	11 sites completed
Monitoring of insecticides resistance in 13 selected sentinel sites	2010	No gap	Logistic arrangements are underway

IEC/BCC

Planned activities	By When	Gap	Status
Complete the communication strategy	2009	No gap	completed
Continuous TV and Radio spots	2010	No gap	On going
Establishment of CCAs in villages –help to emphasize malaria control interventions	2010	No gap	3 regions are covered.

M &E

Planned activities	By When	Gap	Status
consolidate M & E plans	2010	No gap	Completed
DHS	2010	No gap	Compiling reports
MPR	2010/2011	Not yet known	Proposal is being prepared
MIS	2011	Not yet known	

UGANDA

Country Summary

Intervention	Need to 2010	Already covered	Funded and expected to be distributed before end of 2010	Gap
LLINs (Universal Access)	20,607,510 (3 nets per household of 6 people plus 10% buffer)	2,695,711 (LLINs still viable by end 2010) 125 m by GF 6.5m by PMI 300,000 by Unicef	17,666,984 (GF) 1,600,000 (PMI)	None
ACTs	34,096,900 (public sector only); 5,400,007 for Private sector		7,810,255 (GF Rd 4 for public sector nationwide	31,686,655 Doses
IRS	16 districts expected to be sprayed with funds from PMI	6 Districts were sprayed, Use of DDT suspended	Spraying of the very high risk Districts is ongoing by Uganda IRS Project	10 Districts
RDTs	8,393,627 for 21 districts	800,000 tests $450,000 from PMI for training for RDTs and microscopy;	1,438,165from GF Rd 4 p2 1,923,923 RDT(Amfm) expected Sept.2010 rejected	6,955,462 Tests
IPTp	(women to be treated) 2,418,000 pregnant women (3,385,200 doses of IPTp needed for 2 doses/woman)	All doses covered by GOU DOTS materials and training covered by other partners $625,000 from PMI .	Government funding not fully utilised due to policy related issues	Need to provide free drugs for distribution
M&E		PMI=$1,475,000 Rd 4=$ 4,050,560 Rd 7=$ 7,534,260	602,782 released by GF for the six months "	Nil
BCC/IEC	(Should be 10% of the budget of any program)	This is an intermix of different interventions	526,169 Released by GF for six months	Nil

Human Resources (Capacity Bldg)	1 programme assistant 1 M & E specialist	1 Programme Administrator and 1 M&E Specialist funded by Global Fund up to end of FY	Renewal of contracts for another FY	Funding for the next FY

Case management

ACTs required	34,096,900 (public sector only); 5,400,007 for Private sector USD 9,423,131 from Global Fund drugs ordered USD 15,000,000 Govt, drugs being suplies
RDTs required	8,393,627 for 21 districts
Procurement schedules	ACTs and RDTs procured and delivered quarterly.
BCC	Continuous
Mechanisms of distribution	Through NMS (20% to JMS)
Drug Efficacy Monitoring	Studies ongoing 2009 (UMSP, Epicentre)
Monitoring and evaluation	Support supervision, MIS in 2009 and 2011, QA for RDTs (FIND)

IRS resources available to achieve the 2010 targets

FUNDS AVAILABLE (US $)	SOURCE	COMMENT
8,760,000	PMI	For 6 districts (Kitgum, Pader, Apac, Oyam, Gulu, Amuru)
1,200,000	Pilgrim	Katakwi
1,800,000	GOU	Kumi

Indoor Residual Spraying

DDT required	1329 barrels (PMI) for 2 districts (Apac/Oyam)
Pyrethroids required	For 4 districts (Kitgum/Pader/Gulu/Amuru) (PMI); 1 district (Katakwi) (Pilgrim); 1 district (Kumi) (GOU)
Procurement schedules	DDT is in country; Pyrethroids likely September/October 2009 (PMI)
Training	Prior to spraying
BCC	Prior to spraying
Spraying	Oct/Nov 2009 (2 districts); Jan/Feb 2010 (2-4 districts); July/Aug 2010 (6 districts) – PMI preliminary schedule; August 2009 (Pilgrim)
Monitoring and evaluation (*bioassays, insecticide resistance etc*)	Nationwide insecticide resistance surveillance Aug-Oct 2009 (PMI); Insectory Oct-Dec 2009 (PMI); entomological surveillance sites (PMI); epidemiological studies (pre- and post-)

Other core interventions to be delivered over the next 8 months

- NMCP Evaluation - Apr 2010
- Development of New NMCP Strategic Plan – Apr 2010
- Approval of revised National Malaria Control and Prevention Policy – May 2010
- MIS – Nov 2009
- Field operational studies (Drug efficacy studies, Pharmacovigillance, etc)
- Update M & E Plan – Jun 2010
- Training on and operationalization of the Malaria Database
- EPR Guidelines finalization and Training – Sep 2010
- Establishment of an insectary and field entomological insecticide susceptibility monitoring sentinel sites –Sep 2009

Summary of rate-limiting factors over the next 8 months

- Time-consuming stringent conditionalities by GF leading to funds disbursement delays

- Delayed disbursement of funds from all sources

- Weak health systems
  - Weak HMIS
  - Inadequate supply chain mgt
  - Inadequate management and leadership at lower levels

Summary of technical assistance needs to end 2010

Need	**From whom**
Evaluation of the Current NMCP Strategic Plan and Programme Review (MPR)	WHO
Update the malaria Strategic Plan	WHO
Updating the Malaria Communication Strategy	SMP
LLINs Distribution Plan	GF
Update the M & E plan and operationalize the Malaria Database	WHO/PMI
Establish an insectary and field entomological insecticide susceptibility monitoring sentinel sites	WHO/PMI

COMORES

Population couverte

Ile	Population	MILD	ACT	PID
Mohéli	45012	40000 *(89%)*	Disponible, distribution gratuite	0%
Anjouan	291043	54720 *(19%)*		0%
Gde Comore	350998	66092 *(19%)*		0%
Total	687053	160812 *(23,4%)*	100%	0%

Feuille de route

Activités	Mai	Juin	Juil	Aoû	Sep	Oct	Nov	Déc
1. Distribution MILD								
1.1 Micro planification	x	x						
1.2 Recensement lits		x	x					
1.3 Distribution							x	
1.4 Distribution CPN					x	x	x	x
2. Pulvérisation Intra Domiciliaire								
2.1 Cartographie			x	x				
3. Prévention du paludisme pendant la grossesse								
Traitement Préventif Intermittent (TPI)	x	x	x	x	x	x	x	X
Toutes les activités de distribution de masse des MILD, prise en charge, PID… seront soutenues par les Formations, IEC et supervision								

Tableau recapitulatif des interventions

Interventions	**Besoins estimés**	**Besoins couverts**	**Gap**
LLINs (Universal Access)	286 700	286 700	0
ACTs	209 138	209 138	0
IRS	8056566 $	337 240 $	7 721 326 $
RDTs	677 688	161 000	516 688
TPI	41 082	41 082	0
M&E	1 508 781 $	1 300 536 $	208 245,00$
BCC/IEC	470500 $	330 342 $	140 158 $
Human Resources (Capacity Bldg)	1 138 819 $	1 138 819 $	0

Feuille de route

Activités	Juin	Juil	Aoû	Sep	Oct	Nov	Déc	Jan
Besoins en assistance technique								
IRS/PID: Cartographie (Formation et production des cartes		x	x					
Communication: Elaboration du plan de communication	x							
S&E/MIS: Echantillonnage		x						
S&E/MIS: Formation et mise en œuvre							x	
S&E/MIS: Traitement et analyse des données								x

Activités	Mai	Juin	Juil	Aoû	Sep	Oct	Nov	Déc
Besoins en assistance technique (suite)								
Formation sur gestion des programmes				x				
Formation sur la gestion de base des données							x	
S&E/MIS: Pharmaco-résistance								Déc – Jan
Elaboration Plan de lutte contre les épidémies				x				
S&E/MIS: Evaluation du PNLP								x

SUDAN NORTH

Resources

- GFR7: ACTs, LLINs, RDTs
- UNICEF: ACTs, LLINs, RDTs
- WHO: TA, SME
- UNITAID: ACTs? (received in 2008)
- GEF and Bill &Melinda Gates Foundation: IVM
- GOS : HR, HSS, capacity building
- Others including IDB and NGOs

LLINs

No. of LLINs required to reach universal coverage: 14,567,209
No of LLINs distributed in 2008: 1,756,540
No of LLINs distributed in 2009: 3,470,931
No of LLINs distributed in 2010: 663,380
No. of LLINs expected in 2010 : 2,761,601
Total : 8,652,452
Gap for universal coverage : 7, 359,757

ACTs

- No. of ACTs needed 2010 : 3,800,000
- No of ACTs available 2010 : 450,000
- No. of ACTs expected 2010 : 925,856
  Gap : 2,424,144

Achievements

- Wide coverage of ACTs (4,326 HF)
- Expansion in implementation of HMM
- High coverage of LLINs
- Involvement of more partners
- Strong political commitment

Key Challenges Sudan

- Timely availability of funds and commodities
- Timely roll-out of implementation activities
- Pending RCC approval
- IRS
- Advocacy for LLIN, ACT and RDT usage
- Security issues
- Human resources (locality level)
- Staff turn over

Way forward

- Strengthening of malaria unit at locality level
- Expansion in malaria free zone initiative
- ACTs free of charge provided only to confirm malaria cases.
- Implementation of IRS in target areas.
- Sustainability of partnership

APPENDIX 2: AGENDA OF THE MEETING

EARN MEETING AGENDA

Entebbe 3rd to 7th May 2010

Time	Session Topic	Presenter	Chairperson
DAY 1	**MONDAY 3RD MAY 2010**		
SESSION 1	**INTRODUCTION**		
8:00 - 8:30	Registration	EARN Secretariat	EC
8:30 - 8:50	Introductions, workshop goals and objectives, administrative notice.	EARN Coordinator	ECC Co-Chair
8:50 - 9:10	RBM Board decisions	Dr Banda James	ECC Co-chair
9:10 - 9:30	Welcome remarks from ECC co chair	ECC Co-Chair	MOH/ECC
9:30 - 9:40	Opening Remarks	WHO Representative	MOH/ECC
9:40 - 9:50	Official Opening	Minister of health	MOH/ECC
9:50 - 10:00	Group Photo	EARN Coordinator	ECC
10:00 - 10:30	**TEA & COFFEE BREAK**		
SESSION 2	**COUNTRY ROAD UPDATES**		
10:30-11:00	Presentation of Burundi 2010 Road Map update	Dr KAMYO Julien	Comoros
11:00-11:30	Presentation of Comoros 2010 Road map update	Dr Affane Bacar	Burundi
11:30-12:00	Presentation of Djibouti 2010 Roadmap update	Mme. Hawa Hassan Guessod	Somalia
12:00-12:30	Presentation of Ethiopia 2010 Road map update	Dr. Kesetebirhhan Admasu	Kenya
12:30-13:00	Presentation of Eritrea 2010 Road map update	Dr Tewolde Ghebremeskel	Zanzibar
13:00-14:00	**LUNCH BREAK**		

Time	Session Topic	Presenter	Chairperson
14:00-14:30	Presentation of Kenya 2010 Road map update	Dr Elizabeth Juma	Rwanda
14:30-15:00	Presentation of Uganda 2010 Road map update	Dr George Mukone	Tanzania
15:00-15:30	Presentation of Rwanda 2010 Road map update	Dr Corine Karema	Sudan North
15:30-16:00	Presentation of Somalia 2010 Road map update	1. Dr Abdilsalam Mohamed Hersi 2. Dr Abdi Abillahi Ali 3. Dr Hussein Elmi 4. Mr Abdullahi Hassan	Sudan South
16:00-16:30	**TEA & COFFEE BREAK**		
16:30-17:00	Presentation of Sudan North 2010 Road map update	Dr Salah Mubarak	Djibouti
17:00-17:30	Presentation of Sudan South 2010 Road map update	Dr. Edward Lado Bepo	Eritrea
17:30:18:00	Presentation of Tanzania 2010 Road map update	Dr Alex Mwita	Uganda
DAY 2	**TUESDAY 4TH MAY 2010**		
8:00-8:30	Recap of Day 1	Rapporteur	ECC Co-chair
SESSION 2	**COUNTRY ROAD MAPS CONT'D**		
8:30-9:00	Presentation of Zanzibar 2010 Road map update	Dr. Abdullah Ali	Ethiopia
9:00 – 9:10	EAC Regional Malaria control Programme	Dr Stanley Sonoiya	WHO
9:10 – 9:20	IGAD Regional Malaria control Programme	Mme Fathia Alwan	WHO
9:20 - 9:50	Global Fund EARN grant performance updates	Mr. Linden Morison	World Bank
9:50-10:05	Management tools for tracking of roadmaps	EARN coordinator	ECC Co-chair
10:05-10:15	Country Monthly teleconference calendar	EARN coordinator	ECC Co-chair
10:15 -10:30	Response plan	EARN coordinator	ECC Co-chair
10:30-11:00	**TEA & COFFEE BREAK**		
SESSION 3	**TECHNICAL UPDATES**		
11:00-12:00	2nd edition of the Malaria Treatment Guidelines & and other technical updates from WHO	WHO	MMV
12:00 -12:30	RBM Tool box	MACEPA	WHO

Time	Session Topic	Presenter	Chairperson
SESSION 4	**MALARIA PROGRAMME REVIEW**		
12:30 – 13:00	Introduction to the MPR	WHO	Global Fund
13:00-14:00	**LUNCH BREAK**		
14:00 – 14:30	Introduction to the MPR cont'd	WHO	Global Fund
14:30 – 15:30	Thematic reviews	WHO	PMI
15:30 –16:30	MPR Tools	WHO	PMI
16:30-17:00	**TEA & COFFEE BREAK**		
17:00 –18:00	Introduction of the proposal	WHO	Sudan South
DAY 3	**WEDNESDAY 5TH MAY 2010**		
8:00-8:30	Recap of Day 2	Rapporteur	ECC Co-chair
SESSION 5	**MALARIA PROGRAMME REVIEW CONT'D**		
8:30-9:30	Country experience of conducting MPR: Kenya	KENYA	WHO
9:30-10:00	Preparation and conducting field work	WHO	Tanzania
10:00 - 10:30	**TEA & COFFEE BREAK**		
10:30-11:00	Report Writing	WHO	Zanzibar
11:30-13:00	Country plans (group work)	WHO	Kenya
13:00-14:00	**LUNCH BREAK**		
SESSION 6	**DEVELOPMENT OF PLANS**		
14:00-15:00	Strategic plan development process and content	WHO	EAC
15:00-16:00	Implementation plan	WHO	ECC Co-chair
16:00-16:30	**TEA & COFFEE BREAK**		
16:30-17:30	Petauke case study	MACEPA	World Bank
DAY 4	**THURSDAY 6TH MAY 2010**		
8:00-8:30	Recap of Day 3	Rapporteur	ECC Co-chair
8:30 - 9:30	M & E Plan development	WHO/Global Fund	UNICEF
9:30-10:30	PSM Planning & implementation	MSH/Global Fund(PSM)	PSI/PACE
10:30-11:00	**TEA & COFFEE BREAK**		

Time	Session Topic	Presenter	Chairperson
11:00-11:30	Experience sharing in HSS	Malaria Consortium	MACEPA
11:30-13:00	Group work for Country preparation	WHO	Malaria Consortium
13:00-14:00	**LUNCH BREAK**		
14:00-16:00	Country presentation for MPR and NSP preparation	WHO	MACEPA
16:00-16:30	**TEA & COFFEE BREAK**		
16:30-17:30	Plenary Discussion	WHO	EAC
17:30-18:00	Response plan	EARN coordinator	ECC Co-chair
DAY 5	**FRIDAY 7TH MAY 2010**		
8:00-8:30	Recap of Day 4	Rapporteur	ECC Co-chair
SESSION 7	**REPORTING FOR 2010-2011**		
8:30-9:30	2010-2011 Reporting	WHO/MERG/Global Fund	World Bank
9:30-10:30	Group work for 2010-2011 country plans preparation	EARN Coordinator	ECC Co-chair
10:30-11:00	**TEA & COFFEE BREAK**		
11:00-12:00	2010-2011 Country plans reporting	Programme managers	ECC Co-chair
12:00-12:30	Response plan	EARN Coordinator	ECC Co-chair
12:30-13:00	Conclusions, next meeting, way forward & Meeting Evaluation	Rapporteur	ECC Co-chair
13:00-13:10	Closing remarks	MOH Official	ECC Co-chair
13:10-14:00	**LUNCH BREAK**		
END OF WORKSHOP			

APPENDIX 3: EARN MEETING PARTICIPANTS

EASTERN AFRICA ROLL BACK MALARIA REGIONAL NETWORK (EARN)						
	NAME	**TITLE**	**ORGANIZATION**	**COUNTRY**	**ADDRESS TELEPHONE**	**EMAIL**
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APPENDIX 4: EARN MEETING PARTICIPANTS' EVALUATION

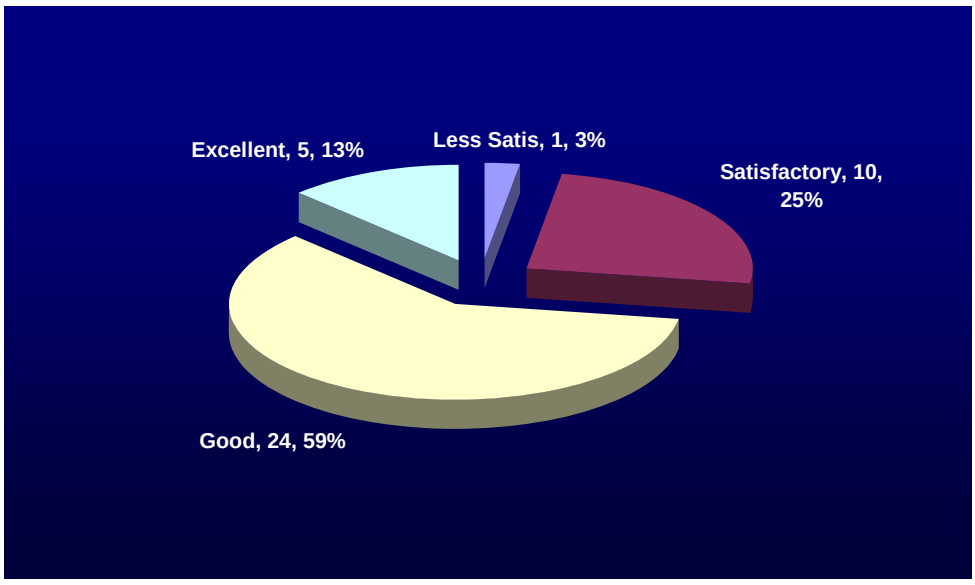
Below is a summary of the evaluation of the EARN meeting by the participants based on the issues identified. They were ranked on a scale of 1-5, with 1 being poor, 2 – less satisfactory, 3 - Satisfactory, 4 - good and 5 - Excellent

1. **Travel arrangements**

Majority of the participants (45.45%) mentioned that they had good travel arrangements from the airport. Only 4 participants had had some difficulty in accessing the transport to the hotel.

2. **Organization of the meeting**

The meeting was well organized as noted from the participants' evaluation. The overall ranking of the meeting organization by the participants ranged from good to excellent. Majority of the participants ranked the overall organization of the meeting as good (24 of the 40 who responded to the question, amounting to 59%).

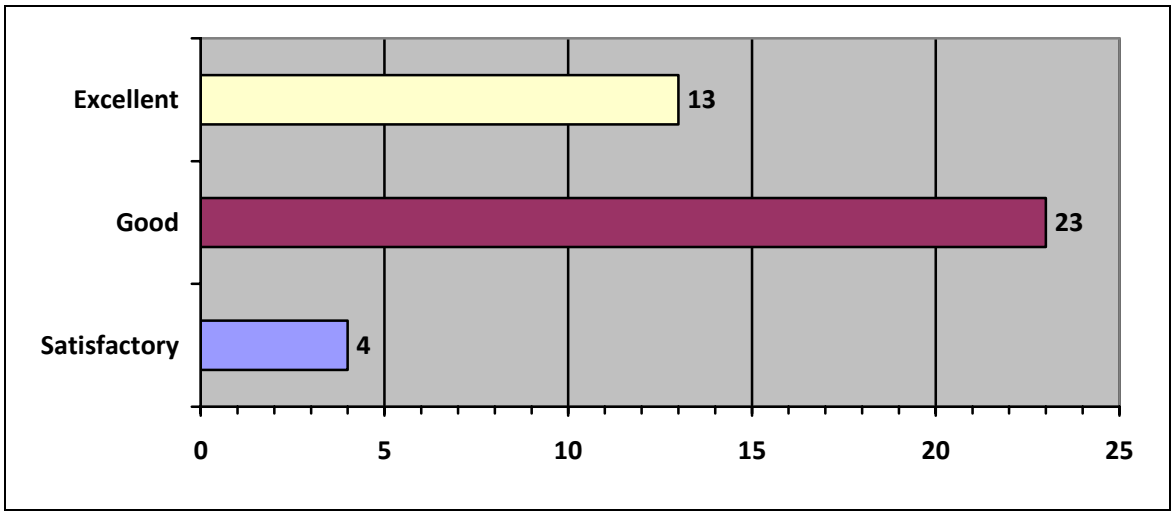


3. **Accommodation**

The accommodation was highly commended with majority (55.26%) ranking it satisfactory as opposed to 5.26% that said it was less satisfactory.

4. **Composition of the participants**

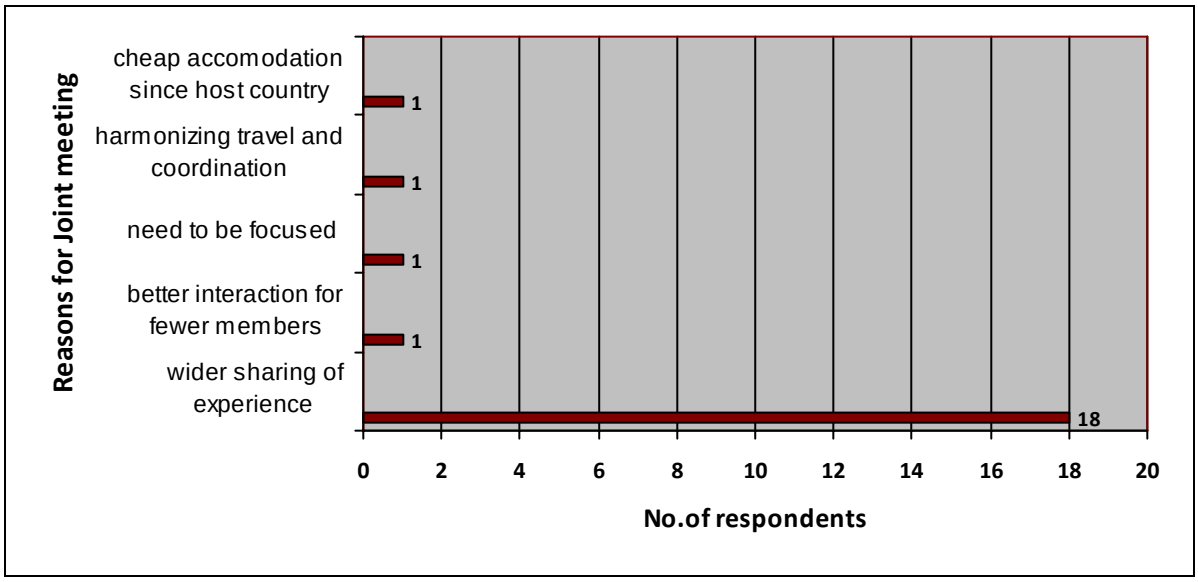
The composition of the participants to the meeting was good,as ranked by the participants. 23 (accounting for 57.5%) ranked the composition as good, while 13 (31.5%) said it was excellent.

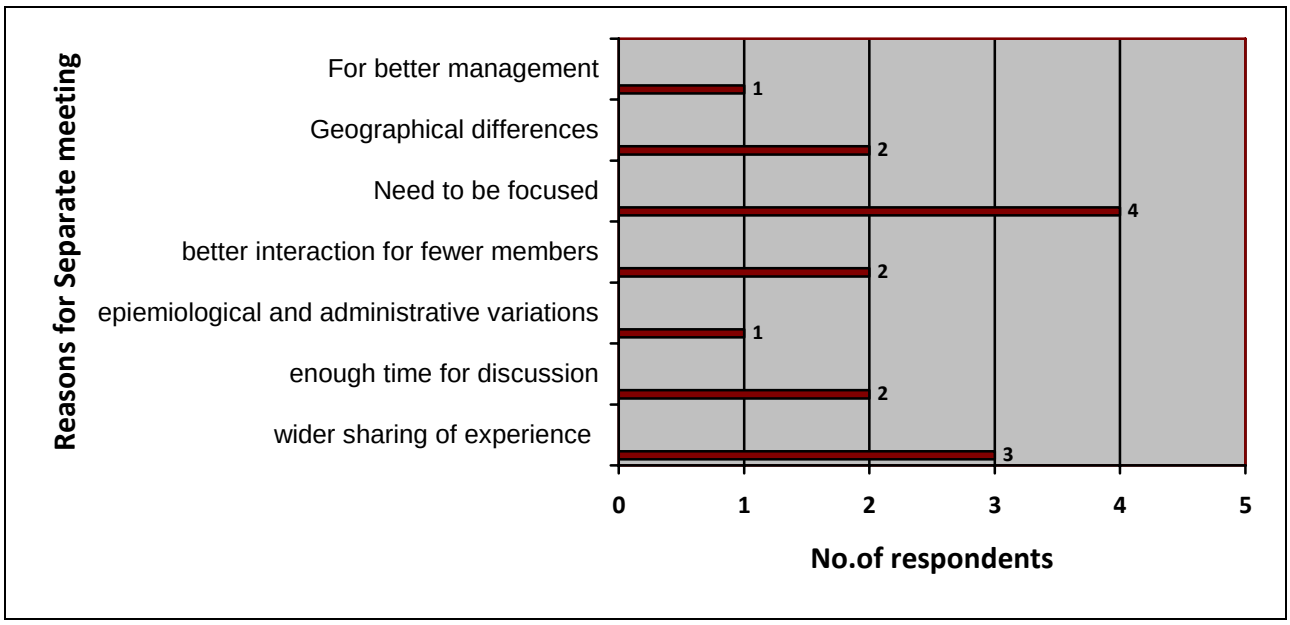


5. Preference for type of meeting

Participants were asked to choose whether they preferred a joint meeting or a separate meeting in future. 24 of the 41 respondents (58.54%) preferred a joint meeting as opposed to 17 (41.46%) that preferred a separate meeting.

5.1 Reasons for their choices of category differed but the majority felt that the joint meetings provide a fora for wider sharing of experiences that the individual countries require as evidenced in the graph below;



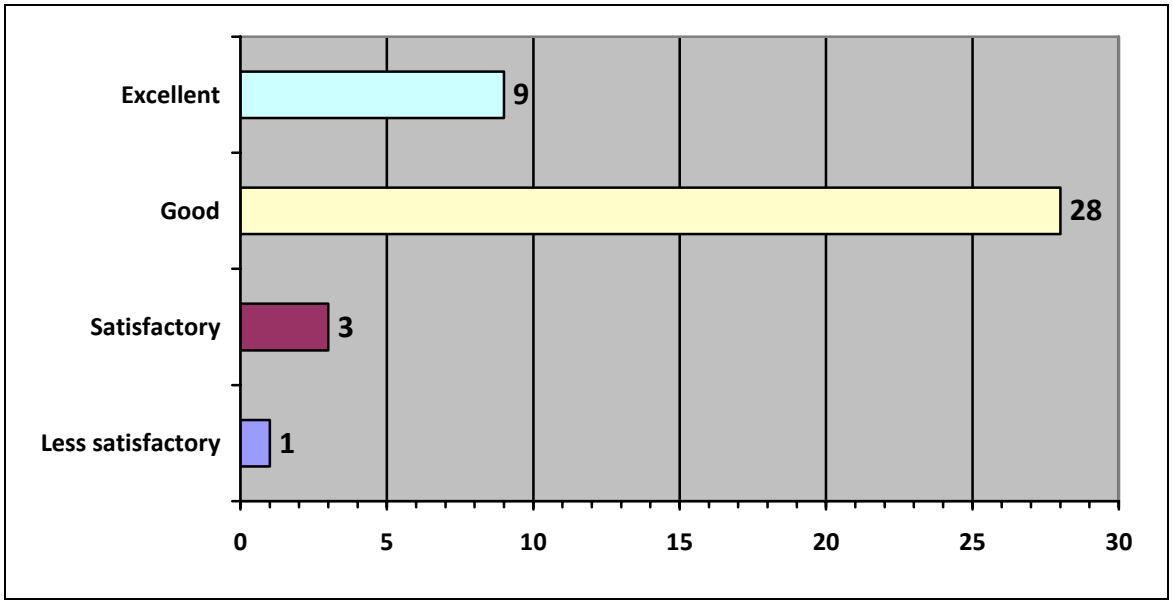


6. Evaluation of sessions

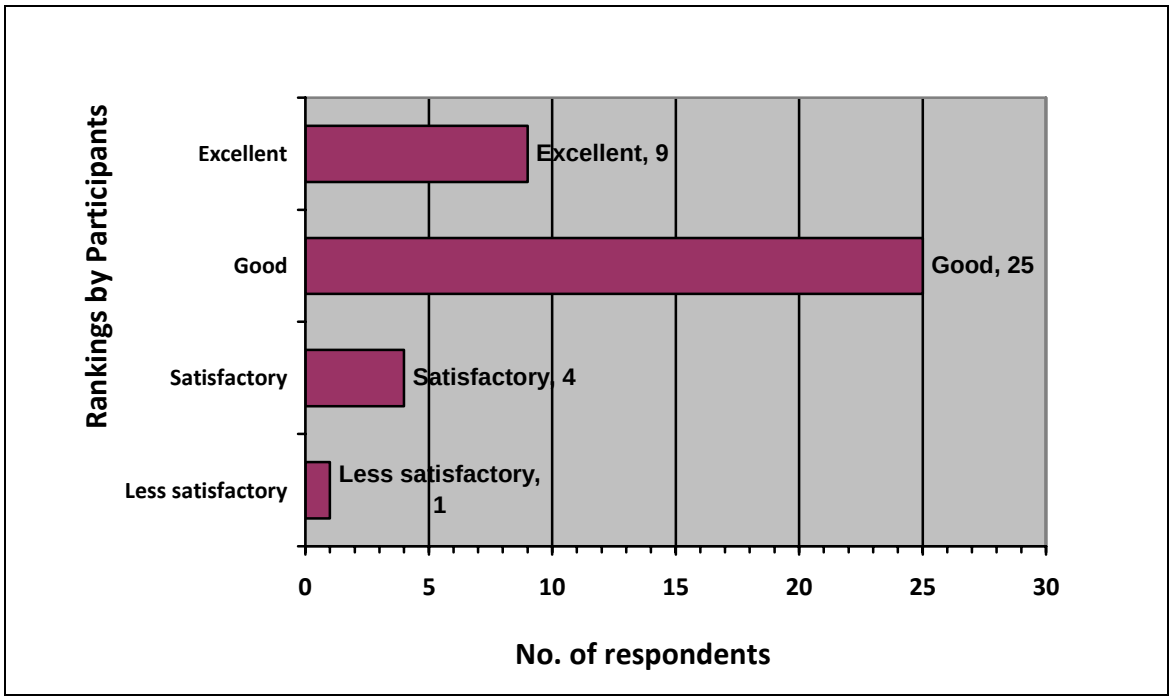
The sessions were evaluated as being good as evidenced by the responses thus;

Session	*1 (Poor)*	*2 (Less Satisfactory*	*3 (Satisfactory)*	*4 (Good)*	*5 (Excellent)*
Road Maps updates	0	2 (4.76%)	10 (23.81%)	23(54.76%)	7 (16.67%)
Technical updates	0	0	4 (10.26%)	24(61.54%)	11 (28.21%)
Malaria Program review	0	0	3 (7.14%)	25(59.52%)	14 (33.33%)
Malaria Strategic Planning	0	1 (2.44%)	4 (9.76%)	24(58.54%)	12 (29.27%)
Development of plans	0	2 (5.00%)	6 (15.00%)	25(62.50%)	7 (17.50%)
Reporting for 2010-2011	0	1 (2.94%)	14 (41.18%)	17 (50%)	2 (5.88%)

7. General Rating of the meeting



8. Were your expectations met?



9. Why do you think that this meeting was useful?