Roll Back Malaria Partnership

Forum V Report

The Yaoundé Call to Action:

"Unite Against Malaria to save lives and reduce poverty."

Yaoundé, Cameroon, 18 and 19 November 2005

Unite against Malaria!

V Partners Forum

Cameroon

18-19 November 2005

The Fifth Forum meeting of the global Roll Back Malaria Partnership was held

Under the patronage and chairmanship of
His Excellency Paul Biya, President of the Republic of Cameroon,

and under the guidance of a steering committee composed of the following:

The President of the organizing committee for Forum V,
Mr Olanguena Awono, Minister of Health of the Republic of Cameroon

The President of Forum V and Chairman of the Roll Back Malaria Board,
Professor Eyitayo Lambo, Minister of Health of the Federal Republic of Nigeria

The Chair of the Roll Back Malaria Board subcommittee for Forum V, Billy Steward, United Kingdom

The Executive Secretary of the Roll Back Malaria Partnership,
Professor Awa Marie Coll-Seck

On 18 and 19 November 2005 Forum V brought together in Yaoundé (Cameroon) all partners of the Roll Back Malaria Partnership. The assembly consisted of over five hundred Partners from all continents and from all sectors and constituencies engaged in the fight against malaria.The puropose of Forum V was to share practical experiences in implementing ther Global Strategic Plan 2005-2015 aiming at rapid scale-up of malaria control and learn from experience on resolving implementation bottlenecks. The Forum V outputs culminated in the Yaoundé Call to Action identifying action in support of harmonization and alignment as the central element for success.

The Forum V Yaoundé Call to Action affirms that "all participants to the Fifth Roll Back Malaria Forum commit themselves, as RBM partners, take forward the actions agreed at Forum V and to implement the RBM Global Strategic Plan 2005 – 2015, holding each other accountable to its resource needs, targets and timelines. The participants put strong emphasis on the following priority actions.

National governments should continue to develop national plans for scaled up action, linked to health and development plans, through participatory mechanisms, establish broad based national coordinating mechanisms and scale up programmes.

In supporting national governments all other RBM partners, consistent with principles agreed in Paris in March 2005[1], should base their overall support on countries' national strategies and implement, where feasible, common arrangements at country level for planning, funding, disbursement, monitoring, evaluating and reporting to government on activities, progress and impact.

RBM Partners shall rapidly establish monitoring mechanisms to ensure mutual accountability to these commitments, and joint review of progress towards them"

This report summarizes all the actions agreed at the Fifth RBM Forum.

We invite all those who share our commitment to engage in this Call to Action.

The Chair

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[1] Paris Declaration on AID Effectiveness

Organization of the Forum V meeting

Programme

Day 1, Friday 18 November 2005

Plenary Introduction Session Forum V

Chair: Prof. Eyitayo Lambo, Minister of Health, Federal Republic of Nigeria
Chairman of the RBM Board
Co-chair: Mr Urbain Olanguena Awono, Minister of Health, Cameroon
Chairman of the Forum V Organizing Committee

Speakers: Prof. Awa Marie Coll-Seck, Executive Secretary RBM Partnership
Objectives Forum V, the Yaoundé Call to Action

Billy Stewart, Department for International Development, United Kingdom
Presentation of Forum V methodology

Constituency meeting
The seven constituencies meet in separate rooms with their respective Board members

Closing Ceremony of 4th MIM Conference
Opening Ceremony of Forum V
Under the Effective Chairmanship of His Honour Ephraim Inoni,
Prime Minister of the Republic of Cameroon

Welcome remarks by Chair Forum V Organizing Committee
Mr Olanguena Awono, Minister of Health,
Republic of Cameroon

Communities perception in the fight against malaria
Milly Katana, Uganda

Maximizing impact by addressing gender
Yvonne Chaka-Chaka, UNICEF Ambassador

RBM Partnership Board Chair,
Professor Eyitayo Lambo, Minister of Health
Federal Republic of Nigeria

The Global Fund and support for implementation
Michel Kazatchkine, Vice Chair
Global Fund to fight Aids, Tuberculosis and Malaria

The Global Malaria Response to date
Dr Anarfi Asamoa - Baah, Assistant Director General
World Health Organization

Parallel Sessions
Sharing experiences and learning from each other on scaling up delivery

1) Scaling up effective malaria prevention
Chair: Dr Gerhard Hesse (Bayer)
Co-Chair: Dr Alan Court (UNICEF)
Rapporteur: Don de Savigny (STI, WIN)
Panelists: Sam Ochola (Kenya), Simon Kunene (Swaziland), Juliana Yartey (WHO), Melinda Moree (MVI), Nguon Chea (Cambodia)

2) Scaling up effective timely treatment
Chair: Jean-Marie Kindermans (MSF)
Co-Chair: Peter Bloland (CDC, USA)
Rapporteur: Robert Ridley (WHO/TDR)
Panelists: Allan Schapira (WHO), Silvio Gabriel (Novartis), George Amofah (Ghana), Chris Hentschel (MMV), Bernard Pécoul (DNDI)

3) Scaling up demand creation and effective use
Chair: Hetherwick Ntaba, Minister of Health of Malawi
Co-Chair: Paul Ehmer (USA)
Rapporteur: Richard South (GSK)
Panelists: Desmond Chavasse (PSI), Oumoul Khayry Sow (Solidarité et Entraide, Senegal), Marie Chorr (Nova Scotia-Gambia Association), Melanie Renshaw (UNICEF)

4) Strengthening delivery system
Chair: Steven Phillips (ExxonMobil)
Co-Chair: Antoine Kabore (WHO)
Rapporteur: David Kim (WEF)
Panelists: Sylvia Masebo, Minister of Health (Zambia), Edugie Abebe (Nigeria), Julius Ombogo (CFW Shops, Kenya), Gikapa a Gudijiga (Sanru, DRC)

Plenary Feedback and Discussion
Chair: Regina Rabinovich (Gates Foundation)
Co-Chair: Prof Tang Linhua (CDC, China)

Session ajourned
Drafting Committee meeting for "Yaoundé Call to Action"

Day 2, Saturday 19 November 2005

Parallel Sessions:
Sharing experiences and learning from each other on result oriented investment

5) Harmonization for Impact
Chair: Stewart Tyson (DFID)
Co-Chair: Dorothée Akoko Kinde, Minister of Health (Benin)
Rapporteur: Chris White (AMREF- Kenya)
Panelists: John Chimumbwa (EARN), Soji Adeyi (WB), Brad Herbert (Global Fund)

6) Global and regional advocacy
Chair: Stephen O'Brien MP (UK)
Co-Chair: Wenceslaus Kilama (AMANET)
Rapporteur: Sylvia Meek (Malaria Consortium)
Panelists: Richard South (GSK), Carol Hooks (MVI), Kevin Starace (UN Foundation), Billy Stewart (DFID, UK)

7) Financing: Matching requirements for impact
Chair: Jacques Baudouy (WB)
Co-Chair: TBD
Rapporteur: Magda Robalo
Panelists: Mabingue Ngom (Global Fund), Maimouna Diop Ly (AFDB), Maryse Pierre-Louis (WB), John Paul Clark (USAID)

8) Monitoring & Evaluation
Chair: Pascal Villeneuve (UNICEF)
Co-Chair: Bernard Nahlen (Global Fund, MERG)
Rapporteur: Mark Young
Panelists: Samuel Owusu-Agyei, Deputy Minister of Health (Ghana), Mark Grabowsky (Red Cross, USA), Ed Browne (Kumasi Univ, Ghana)

Plenary feedback and discussion
Chair: Anarfi Asamoa - Baah (WHO)
Co-Chair: Osman Abdallah, Deputy Minister of Health (Sudan)

Lunch
Drafting Committee meeting for "Yaoundé Call to Action"

Plenary Closing Session

Presentation of the "Yaoundé Call to Action" by the Chair of the drafting committee

Plenary Discussion

Coffee Break
Drafting Committee meeting for "Yaoundé Call to Action"

Closing Ceremony

Under the Patronage of His Excellency Paul Biya,
President of the Republic of Cameroon
Under the Chairmanship of His Excellency Paul Biya,
President of the Republic of Cameroon

Under the Effective Chairmanship of His Honour Ephraim Inoni, Prime Minister of the Republic of Cameroon

The "Yaoundé Call to Action"
Professor Eyitayo Lambo, Minister of Health of the Federal Republic of Nigeria
Chair RBM Partnership Board

Presidents and agency heads in attendance
Responding to the "Yaoundé Call to Action"

M Philippe Baetz
Vice President Sanofi-Aventis

M Brad Herbert
Chief Operations Global Fund

Dr Lee Jong-wook
Director General , World Health Organization

Closure of Forum V

His Excellency Paul Biya,
President of the Republic of Cameroon

Goals of Forum V

The Fifth RBM Forum, the General Assembly of global Roll Back Malaria Partners, aimed at the endorsement of the RBM Global Strategic Plan, and more specifically at renewing the participants' commitment towards accelerated scaling-up for impact (SUFI):

- To make an all-out push to achieve Abuja targets in Africa, and to increase coverage elsewhere;
- To achieve malaria-related Millennium Development Goals;
- To strengthen health systems through the implementation of strategies to fight against malaria.

Forum V participants were expected and encouraged:

- To interact and share experiences across constituencies and countries;
- To provide a common vision of how to address identified bottlenecks;
- To jointly identify concrete actions to accelerate the scale up of malaria control and to address capacity gaps, culminating in The Yaoundé Call to Action;

Participants

Forum V was attended by **over 500 participants** from 7 different constituencies: endemic countries (19%), multilateral development partners (10%), OECD donor countries and foundations (8%), NGOs (21%), private sector (18%), research and academia (13%), as well as by parliamentarians, artists and representatives of the Global Fund and the RBM Partnership secretariat.

Methodology

Forum V was designed to ensure that each participant had an occasion to share practical experiences with others across constituencies and countries; that participants had a means of identifying collectively the priority activities required to implement the Roll Back Malaria Global Strategic Plan 2005-2015; that the way forward outlined in the Yaoundé Call to Action was collectively owned by Forum V participants.

Participants at Forum V shared experience rather than opinions or beliefs. During eight parallel sessions they discussed:

1) scaling up effective malaria prevention
2) scaling up effective timely treatment
3) scaling up demand creation and effective use
4) strengthening delivery systems
5) harmonization for impact
6) global and regional advocacy
7) financing: matching requirements for impact
8) monitoring & evaluation.

Four parallel sessions took place on November 18th and four parallel sessions took place on November 19th.

In each parallel session, the 100 participants were seated at round tables of about 10 people. The session started with a panel launching the discussion on the theme. Then, the participants shared their experience at each round table. They were asked to come up with 5 experience-based action points which in their opinion were feasible in the short or mid term, and would have great impact on rolling back malaria. Room facilitators reminded participants of the ground rules, namely that everybody would have an opportunity to be heard and that experience, rather than opinion was to be shared. A room rapporteur collected the action points from the different tables and summarized them into 10 action points as a first synthesis emerging from the room's collective experience. Participants then prioritized 5 action points that the room rapporteurs shared back in the plenary. (cf. Figure 1).

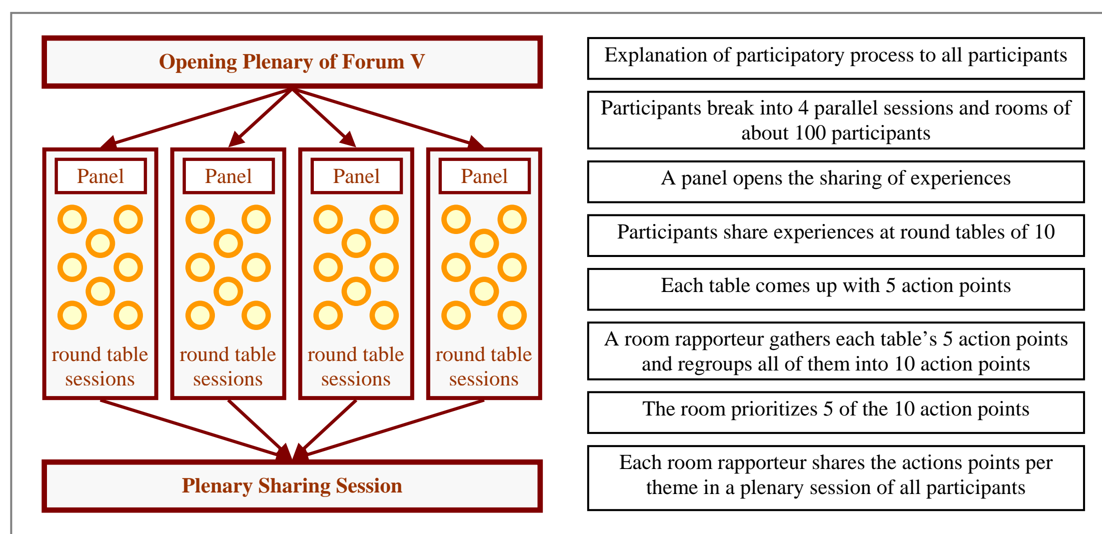

Figure 1: *Modus operandi* of parallel discussion sessions

An Editing Committee open to all met after each plenary session to synthesize the action points in the Yaoundé Call to Action.

Outcome

The participants very much appreciated the methodology of the forum. Discussions among participants at the round tables of the different parallel session were lively and contributed to a rich stream of proposed actions. There was a strong interest of all participants to attend the plenary sessions and learn about the 5 action points of the other parallel sessions presented by each theme's rapporteur. The modus operandi of the parallel sessions generated a strong sense of joint ownership of each of the proposed action points.

The RBM Partners have committed themselves to take forward the actions agreed at the Forum, including priority actions, and to implementing the key recommendations of the *Yaoundé Call to Action* and the RBM Global Strategic Plan 2005 -2015, holding each other accountable to its resource needs, targets and timelines.

Actions agreed at Forum V of the Roll Back Malaria Partnership

The Fifth RBM Forum plenary sessions discussed and agreed upon the following actions:.

Mainly:

- **Three Ones**: harmonization for one national plan, one coordination, one M&E
- **Performance:** gap analysis and closing the gap
- **Accountability**: monitoring outcomes at global and country levels

as critical workstreams in support of Scaling Up for Impact (SUFI)

With emphasis on:

National leadership: countries own programs, countries coordinate donor contributions
Inclusive partnerships, support to RBM partnership
Demonstrable donor commitment and alignment
Higher priority for malaria

And more specifically:

One national plan, performance-oriented, including:

- Integration of programs
- Smoother procurement and supply chain: financing, T&T, logistics, management, delivery to end user
- Local production capacity
- Quality assurance / consumer protection: regulatory and surveillance capacity; pharmacovigilance
- Financial management capacity: monitoring MTEFs, accounting, auditing
- Capacity to implement new policies, policy changes
- Integrated vector control, including IRS to be recommended, supported, guided where applicable
- Community involvement and Behavioural Change Communication for demand creation and effective use: multi-sectoral, existing competences and networks, joint planning and coordination, multiple communication methodologies
- Strengthen systems and human resources
- Technical support and technology transfer by in-country, subregional or global partners
- Zones of conflict, hard-to-reach areas

Funding:
- Free or highly subsidized access and commodities, particularly for children and pregnant women: global subsidy mechanisms such as airline tax, advance purchase commitment, bulk procurement
- Predictable funding
- Funding flexible and simpler
- Procurement procedures: simplify and harmonize, involve countries in design, build capacity, allow outsourcing
- Additionality of funding
- Funding for technical support
- Enhanced financial information streams

One M&E plan:
- Integrate malaria M&E with all other M&E systems in broader HIS; plug malaria indicators into other M&E programs; include private sector and non-health actors
- Focus M&E on coverage and impact: key indicators, disaggregate data, MERG for brokering consensus
- Build human capacity for M&E from community upto national, including NGOs; strong M&E capacity with multilaterals
- Financial resources for M&E: allocate 5 to 10 % of malaria budgets to M&E
- System monitoring: tracking resources, program management, system-wide bottlenecks and program distortions due to scale-up

Global quality assurance/consumer protection
- Standards: update, streamline (WHOPES), publicize
- Testing systems: durability in field conditions (LLINs)
- Packaging and labelling
- Support to regulatory and surveillance, and pharmacovigilance capacity

R&D
- Upstream: innovation (vaccine, paediatric formulations, pregnancy)
- Downstream: implementation research, health systems research

Global and regional advocacy:
- Wide spectrum: champions, politicians, corporate responsibility, events, field visits, networks, (sub)regional organizations, cross-border partnerships
- Consensus: on arguments, messages, actions; between public and private sector; within research
- Products and tools: clear strategy; epidemiological and economic evidence; business case; success stories; language
- Networking and collective action
- Accountability: track commitment and performance; civil society activism using constructive dialogue, no adverserial advocacy

Eight Thematic Sessions

The Fifth RBM Forum plenary sessions discussed and agreed upon these actions which were identified in eight Thematic Sessions.

1) Scaling up effective malaria prevention

Chair: Dr Gerhard Hesse (Bayer)
Co-Chair: Dr Alan Court (UNICEF)
Rapporteur: Don de Savigny (STI, WIN)
Panelists: Sam Ochola (Kenya), Simon Kunene (Swaziland), Juliana Yartey (WHO), Melinda Moree (MVI), Nguon Chea (Cambodia)

- Integration/Harmonization
  - The "Three Ones": each country one plan, one coordination, one M&E system
  - Prioritize malaria in hierarchy, and also in conflict torn and hard-to-reach areas
  - Integration of preventive treatment and bednets into antenatal care and immunization programs
  - Smoothened procurement and supply chain
- Quality Assurance: standards and testing systems, packaging and labeling
- Technology support for integrated vector control, ITNs, IRS, community participation
- Research: product innovation, health systems and implementation research
- Monitoring and evaluation
- Accountability at global and country levels with focus on outcomes

Integration and harmonization

The Three Ones
Countries adopting the "Three Ones", i.e. one national plan for malaria control, one broad partnership mechanism for coordination of the implementation and one monitoring and evaluation system, would go a long way to helping not just prevention but everything else we do in malaria control.

Prioritizing malaria
Many countries need to give a higher priority to malaria control, especially those where the malaria control program is too far down the hierarchy to have the authority and the agility to move fast when the resources are there. This is particularly true for preventive interventions in zones of conflict and in hard-to-reach areas.

Programme integration
We need to get much better at integrating delivery points of preventive interventions, such as Insecticide Treated Nets (ITNs) and Intermittent Preventive Treatment (IPT), into existing programmes such as the Extended Programme for Immunization (EPI) or Antenatal Care (ANC). We need to take advantage of their increasing coverage and actually help improve their coverage. This way only will we be able to *"catch up, keep up"*, a proven strategy for scaling up prevention, revolving around a rapid catch up of coverage by any means, but in a way that ensures the continued delivery of those interventions. There is a lot of progress that is probably relatively easy to make on that front.

Smoothing the procurement and supply chain
Integration also will result in smoothing the whole procurement and supply chain, all the way from financing over taxes-and-tariffs and logistics to the final end user.

Quality assurance

Reduce fragmented procurement
Fragmented procurement practices push big pulses of demand on the private sector and may stretch quality at the end.

Better standards and testing systems
We need better in-factory and in-field testing of ITNs and IRS, especially of LLIN's durability under field conditions. Many more new products are about to be available and we need to learn how to measure their long-term durability.

Packaging and labeling
Adequate packaging and labeling will also help improve quality.

Technology support for integrated vector control, ITNs and IRS.

New products and technologies
The utilization of new products and technologies can be improved by better technology transfer, particularly with IRS, and by streamlining the WHO Pesticide Evaluation Scheme process so that we can bring these new technologies online faster.

IRS guidance
There is increased interest today in understanding and considering IRS. There is already a RBM consensus statement on ITNs and IRS for guidance on choices of when and where. This needs to be expanded and much more practical guidance must be made available. IRS should be recommended and supported where applicable.

Community participation
Technical support is also required for improving community participation and the acceptance and appropriate use of ITNs and/or IRS.

Research and Development
On the supply side we need to continue with product innovation, for example new drugs for the preventive treatment of pregnant women. At the same time, if we are going to be integrating ITNs and other programs better, then we need to do a better job on health systems research. There are system constraints for which we need innovations out there, ways in which we can get systems to work better, to be stronger, to host these interventions and deliver them more effectively.

Monitoring and evaluation
Monitoring and evaluation are considered absolutely vital to guiding the scale-up of prevention, but also for the sake of accountability. To report back on outcomes and results requires that we are able to measure them.

Accountability
It is important that we report back to the populations of endemic and donor countries on outcomes and results both at global and country levels. Where did we start from? Where are we now? What's the gap? How to cross that gap?

Some experience based action points:

- HE Ms Dorothée Kinde-Gazard, Minister of Health of Benin: "Clear messages on how to handle chemical products were key to the success of large scale community based net dipping campaigns in Benin"
- Dr Nguon Chea, national malaria control program (NCMP) manager for Cambodia: " We invested in local capacity to manage malaria prevention programs and were surprised to see that the surveillance system based on community participation proved to be more effective than GIS for monitoring malaria interventions."
- Dr Simon Kunene, NCMP manager of Swaziland and malaria focal point for SADC: "The success of IRS in South Africa should invite us to revisit IRS and recommend it where it is appropriate."
- More experiences and proposed actions, on scaling up effective malaria prevention

2) Scaling up effective and timely treatment

Chair: Jean-Marie Kindermans (MSF)
Co-Chair: Peter Bloland (CDC, USA)
Rapporteur: Robert Ridley (WHO/TDR)
Panelists: Allan Schapira (WHO), Silvio Gabriel (Novartis), George Amofah (Ghana), Chris Hentschel (MMV), Bernard Pécoul (DNDI)

- National plans for scale-up
- National partnerships for consensus and coordination, linked to regional/global networks
- Enhanced regulatory and monitoring systems (pharmacovigilance)
- Make treatment free or highly subsidized to end-user
- Research both on new formulations and operational research on M&E, post-regulatory effectiveness
- Strengthen capacity of treatment services and make them user-friendly

National Plans
All recognized the absolute requirement to develop national plans for scale-up. Those plans should anticipate and plan for what to do with new drugs and tools well before they come online. They should provide for financing, logistics, forecasting, procurement and distribution, including how to get the products beyond the main health facilities to communities for use in home management of malaria. Within that context they should plan for information, education, communication. The success stories that were presented invariably had strong plans and the disaster stories didn't have strong plans.

National partnerships for consensus and coordination
Also came up the need for building national partnerships for country coordination and building consensus with a large number of stakeholders, so that everybody feels ownership of the process of scale-up. National partnerships should be able to rely upon strong regional and global networks supporting national activities.

Regulatory and monitoring systems
In-country regulatory and monitoring systems should be enhanced to effectively ensure that the quality of drugs and types and formulations match with international standards and national policy. There is a lot of stories about certain companies pushing single drug formulations when the national policy is combinations. Monitoring systems should also include safety pharmacovigilance.

Free or highly subsidized
For scale-up of effective use it was felt imperative that drugs be made available for free or at low cost to the end user, with first priority to young children and pregnant women.

Research
As for malaria prevention research is also a strong component of the scale up of treatment, both operational research, e.g. to inform community use on issues like integrated management of fever, and more upstream research on badly needed pediatric formulations and new drugs for pregnancy.

Strengthening the capacity of treatment services
The scale up of malaria treatment is largely dependent on the capacity of health systems and e human resources to deliver and to deliver in a user-friendly way and therefore requires generic strengthening of systems and human capacity. National plans should encompass delivery through the private sector, including the informal one, as well as the public sector.

Some experience based action points:

- Merlin Willcox from the NGO RITAM: "In Bandiagara, Mali, the case fatality rate for severe malaria was reduced from 40% to less than 10% by providing free, good quality treatment and collaborating with traditional healers to ensure early referral."

- Uganda considerably improved access to quality ACT's at community level through home based management of uncomplicated malaria using pre-packaged antimalarials delivered by trained community volunteers.

- Examples from many countries illustrate how preliminary consensus and joint planning between all stakeholders involved, as in Ghana, Indonesia and Liberia, and strong political commitment, as in Ghana, Uganda and Zambia, are key to a successful change of drugs policy. To inform policy change towards Coartem as first line treatment Zambia had timely planned and conducted efficacy and compliance studies. Ghana developed a communication strategy to support the outreach of its new drugs policy. In the absence of such a strategy Tanzania's new drugs policy was sidelined by media campaigns on adverse drug effects.

- African governments engage more and more in regional networks, as there are EANMAT, WANMAT, HANMAT, CANMAT, EARN and WARN, for sharing and learning from each other's experiences with drugs policies.

- More experiences and proposed actions, on scaling up effective and timely treatment

3) Scaling up demand creation and effective use

Chair:	Hetherwick Ntaba, Minister of Health of Malawi
Co-Chair:	Paul Ehmer (USA)
Rapporteur:	Richard South (GSK)
Panelists:	Desmond Chavasse (PSI), Oumoul Khayry Sow (Solidarité et Entraide, Senegal), Marie Chorr (Nova Scotia–Gambia Association), Melanie Renshaw (UNICEF)

- Multi-sectoral approaches
- Harnessing existing community competencies and networks
- Joint planning and coordination
- Ensure services and commodities are accessible and affordable
- Multiply communication methodologies

Multi-sectoral approaches

Messages on malaria can reach the community by joining efforts with other healthcare programmes, such as the integrated management of childhood illnesses (IMCI) or immunisation programmes (EPI), and with other sectors like the agricultural sector or community development. There are many examples of working with the Ministry of Education to ensure that up-to-date information on malaria prevention and treatment is incorporated into the school curriculums, to be used by the school children themselves and taken to their families and communities.

Harnessing existing competences and networks

Another approach is harnessing existing community competences and networks, using innovative and multiple entry points. Some microfinance groups are reaching deep down into poor rural communities and can channel education and behavior change and even ITNs. One can also work with women's groups, or with women chatting around the well, rural savings banks and traditional networks around community leaders and elders.

Joint planning and coordination

It is very important that all the actors working on malaria in a country jointly plan their communication strategies and coordinate their activities so that we can reduce gaps and counteracting overlaps.

Ensure services and commodities are accessible and affordable

There is no sense in creating a demand, letting people know that there are effective tools to protect or treat them, if those tools are not accessible or affordable for people where they live.

Multiply communication methodologies

Together with the traditional IEC materials and tools such as radio and TV slots and posters, we must develop and deploy participatory communication methodologies and a broad spectrum of approaches which altogether, in a package, will reach all the people in the affected communities in a repeated way so that the messages are heard again and again, in different ways from different sources.

Some experience based action points:

- Desmond Chavasse of the NGO PSI: "In several countries we noticed that school curricula contained outdated malaria information. We worked with the Ministries of Education to update curricula and teacher training on malaria."

- In Kenya, a youth group is engaged ineducating communities through drama and songs in public places like schools, markets, passing information about malaria. These peer groups go on counseling people and identifying vulnerable groups to teach and show the need for them to benefit from interventions like IPT, ITN etc.

- In West Africa the NGO Freedom from Hunger successfully promotes behaviour change through existing microfinance systems, Malaria Credit with Education; income generating activities; small businesses; village development committees.

- To promote ITNs, IPT and case management the NMCP of the Gambia engaged village development committees and health clubs. The committees in turn identified village dipping agents and made them responsible for sensitizing villagers to the benefits of ITNs. This has led to significantly increased demand and use of ITNs.

- More experiences and proposed actions, on scaling up demand creation and effective use

4) Strengthening delivery system

Chair: Steven Phillips (ExxonMobil)
Co-Chair: Antoine Kabore (WHO)
Rapporteur: David Kim (WEF)
Panelists: Sylvia Masebo, Minister of Health (Zambia), Edugie Abebe (Nigeria), Julius Ombogo (CFW Shops, Kenya), Gikapa a Gudijiga (Sanru, DRC)

- Address community based delivery systems
- Develop local capacity for consumer protection, manufacture, supply chain management
- Better information for better decisions
- Comprehensive treatment delivery
- Country ownership and coordination through inclusive partnerships

For strengthening delivery systems, we better shift focus to that level where the transaction takes place, the point of service delivery, which is at community level. To address **community-based delivery** adequately, we need to strengthen its components: training, monitoring and supervision of local workers and systems.

Countries must have the capacity to ensure that malaria commodities are of sufficient quality without necessarily always having to bring in outside assistance. This requires to develop in-country capacity for **consumer protection**, quality assurance and market surveillance for counterfeits.

If we really want commodities to reach the end users in a timely fashion and we truly want country ownership, then **countries need to own production capacity** for these commodities. Sumi Tomo showed the way by transfering its ITN technology to AZ in Tanzania.

Cutting across all areas is the need for developing capacity in **supply chain management**.

More rigorous analytical studies and a **better use of information** will help us make better decisions on where our resources and efforts need to be put.

All components of effective treatment, i.e. diagnosis, drugs and ancillary medicines should be delivered as **one integrated and comprehensive treatment**.

There is an acknowledgement that unless countries can truly own the programs at country level, then coordination or harmonization are not possible. This requires donors to allow for processes where the **countries own the programs and coordinate donor contributions** at the country level, in line with the principle of the "Three Ones".

If governments need to set comprehensive frameworks that others can buy into, they need to recognize that others out there can often deliver services more effectively than they can, particularly in reaching the most difficult and vulnerable groups. So it's really about creating an **inclusive partnership** that will bring in the missions, state providers, civil society, NGOs and private sector.

All the presentations appear to indicate that the proposed action points are all crosscutting and clearly prefigure a **holistic program approach** that needs to be taken.

Some experience based action points:

- UNICEF's Idrissa Souare reports how mastering the technology of impregnation of mosquito nets in a Guinean locality has enabled more than 50% of the population to use insecticide treated mosquito nets.

- Dr Garba Abdu, USAID Child Survival Program manager in Nigeria: "Until recently 70% of drugs in some segments of the Nigerian market were fake or substandard. After building capacity for pharmacovigilance its implementation improved the situation significantly."

- Edugue Abebe, Federal Ministry of Health of Nigeria: "For sustainable access, cost and delivery of quality drugs and commodities to the communities, franchising as is done with global companies in other sectors, can be introduced with major in country pharmaceutical manufacturers. Capacities exist in Nigeria, South Africa, Tanzania etc to manufacture these commodities and such franchising projects as the pilot one in Ondo State, Nigeria, are true development and poverty reduction projects."

- More experiences and proposed actions on strengthening delivery system

5) Harmonization for Impact

Chair: Stewart Tyson (DFID)
Co-Chair: Dorothée Akoko Kinde, Minister of Health (Benin)
Rapporteur: Chris White (AMREF- Kenya)
Panelists: John Chimumbwa (EARN), Soji Adeyi (WB), Brad Herbert (Global Fund)

- National Level Leadership
- Support to RBM Partnership at all levels
- Multi-partner planning and coordination
- Implement one M & E system
- Demonstrable donor commitment

Harmonization has become crucial for malaria-endemic countries, but equally for their development partners. All too often new initiatives are bypassing existing mechanisms and systems. So the question is not so much do we need harmonization or why, but how do we achieve it, not just as an ideology, but in a real practical sense: harmonization for scale-up with coordination and rigorous M&E systems, where we use a common language and agree that funding should be performance based.

Of all action points aiming at harmonization, **national leadership** clearly appears to be the cross cutting main issue, to which all other action points relate to.

Support to the Roll Back Malaria Partnership at all levels is important for its role as the multiple stakeholder platform where multithematic issues can be discussed and that helps raise the profile of malaria, but also for its role as the body for international leadership and coordination, prerequisite to addressing national leadership, with its sublayer of subregional networks which in turn support that national leadership process.

Harmonization requires that there be **one national malaria control plan**, fully owned by the ministry of health and widely supported by all the important stakeholders outside the ministry. The ministry should therefore **involve all important stakeholders in the planning process**, including private sector and NGOs. This planning process needs to be vertical as well as horizontal, meaning that planning not only has to be cross multisectoral and multipartner within countries, but should also be in relation with the regional and global networks.

Harmonization also requires **one coordination mechanism**, country owned and country led, but again, as with the planning, inclusive of all partners.

There is a desperate need to implement **one monitoring and evaluation system**, allowing to measure and evidence performance, responding to the strongly felt need for performance based funding and evidence based advocacy.

The **donor community is enjoined to commit** in a demonstrable way to all the issues raised here. There has to be measurable adherence to the idea of national ownership and to the principle of the three ones, the one national integrated plan, the one coordination mechanism, the one M&E system.

Some experience based action points:

- The experience of a project team in a Tanzanian district illustrates well the need for harmonization. 20 percent of their time was burdened with dealing with visiting missions and 40 to 50 percent with writing reports in relation to these missions.

- Experience with effective harmonization was described by Dr. John Chimumbwa of EARN, the East African Roll Back Malaria Network. EARN is working with 12 countries in the region. Each of those countries has a yearly work plan and from those yearly work plans, the EARN annual planning meeting generates a joint work plan, which is designed around the individual technical assistance gaps, identified by those countries, and then a broad base of partners within that network helps to address those gaps.

- Many more experiences with joint planning and/or coordination under national leadership were exposed by DRC, Guinea, Rwanda, Tanzania, Uganda and Zambia.

- More experiences and proposed actions, on harmonization for impact

6) Global and regional advocacy

Chair: Stephen O'Brien MP (UK)
Co-Chair: Wenceslaus Kilama (AMANET)
Rapporteur: Sylvia Meek (Malaria Consortium)
Panelists: Richard South (GSK), Carol Hooks (MVI), Kevin Starace (UN Foundation), Billy Stewart (DFID, UK)

- Use a Spectrum of Approaches
  - Champions, events, pride, field visits
- Consensus
  - Politicians, networks, regional organizations, cross border, public-private, research
- Products & Tools
  - Evidence, economic case, success stories, clear plan, packaging, language
- Creating Capacity and Using Collective Action
  - Give voice, different approaches, networks, media, local groups
- Accountability and Commitment
  - Activism, parliamentarians, constructive dialogue, pressure, track performance

A wide spectrum of approaches

The role of advocacy is multiple, so a variety of strategies are needed in order to address awareness, accountability and fund raising. One effective approach is identifying high profile champions and celebrity advocates, like sports people, musicians, politicians and actors. Another is using events such as Africa Malaria Day or a World Malaria Day, the World Swim for Malaria and Drive against Malaria. Corporate responsibility strategies often encourage a sense of pride. When employees can feel they are doing something good, they can spread the message widely. Another way to engage Northern partners is to create the opportunity for them to go and see the problem for themselves, to see a child suffering from malaria.

Consensus

Advocacy will fail unless some consensus can be garnered around the arguments, messages or actions to promote. It is important to rally politicians from different tendancies behind a common malaria objective, to set up networks or linkages between networks or between subregional and regional organisations, such as ECOWAS and the African Union, or partnerships between neighbouring countries. On a similar note public sector and multilaterals should be brought to reduce their suspicion against the private sector, while the research community should foster more consensus on strategies and privilege communication on strategies on which there is consensus.

Products and tools

Effective advocacy requires good evidence of the burden of malaria, both the epidemiological data and the economic and business case, the latter being of particular interest to the regional economic communities and national politicians. It is very important to have a clear plan and strategy when you are approaching funding bodies and well presented, well documented success stories Obviously good information and appropriate language is essential and there should be some global resource for keeping and disseminating success stories from all sources.

Creating capacity and using collective action
To bring more people on board, to enable more effective community action, to ensure its consistency and sustain involvements collective actions is very effective.So is networking, for example linking schools with malaria programs, or strengthening the capacity of media to act as advocates themselves, of local groups, traditional leaders, and
community radio was mentioned, and football came back again.

Accountability and commitment
Advocacy can enforce accountability. It can also trigger civil society activism, currently underfunded. But adversarial advocacy can discourage major partners and must be balanced by constructive dialogue, which can create a favorable environment for the involvement of private sector and civil society, and for the sustained engagement of parliamentarians, maintaining pressure to keep political will alive. We should also do more to track the performance of multilateral institutions and national governments to ensure accountability and consistency.

Some experience based action points:

- Community radio stations in Zambia are spreading malaria information and education to communities.

- Traditional leaders in Dakar have advocated for malaria through integration in polio campaigns.

- In Kenya and Zambia the public sector set up effective partnerships with the private sector, with Barclays bank in Kenya and with breweries in Zambia.

- Regional organizations such as ECOWAS and OCEAC were found ready to engage their member states to scale up malaria interventions

- More experiences and proposed actions, on global and regional advocacy

7) Financing: Matching requirements for impact

Chair: Jacques Baudouy (WB)
Co-Chair: TBD
Rapporteur: Magda Robalo
Panelists: Mabingue Ngom (Global Fund), Maimouna Diop Ly (AFDB), Maryse Pierre-Louis (WB), John Paul Clark (USAID)

Summary Report to the Plenary: the slides

1. Long term predictable financing
2. Flexible and simplify financing
3. Enhanced capacity for impact of funding
4. Additionality of funding
5. Information and Networking

Long term predictable financing
Donor commitment for five or ten years to funding countries' strategic plans appears to be a minimum. One way to mitigate the risk is to *diversify sources of funding*. A more fundamental way would be a *global subsidy,* for which the feasibility and the mechanisms, such as an *advance purchase commitment,* need to be further explored. Subsidized malaria commodities clearly will increase public and private sector coverage rapidly. Therefore countries should not wait and develop mechanisms at their level for subsidizing commodities and defining clearly which population groups will have priority access.

Flexible and simplified financing
Money comes with many strings and countries need better *information on the flexibility* of funding for country implementation. Countries must be aware of types and levels of flexibility and must *advocate for more flexibility*. Adequate *technical support* leads to more robust grant proposals. Countries should also be allowed more *flexibility in outsourcing services* and technical support. Today some of the monies are linked to services by very specific institutions or groups.

Enhanced capacity for impact of funding
Procurement processes vary from donor to donor and very often they are too complex. Countries should be *involved in the design of procurement procedures*. Principal Recipients of Global Fund funding should be able to move quickly and *outsource procurement* if that capacity lacks. Impact of funding requires many other capacities to be strengthened: *financial management*, monitoring of Mid-Term Expenditure Frameworks (MTEFs), accounting and auditing, *implementing new policies.* Enhanced *local production* of malaria commodities obviously will reduce the mismatch between demand and supply. Facing all those challenges there remains a strong feeling though that unless we all *work together to ensure free treatment*, there is no way this increased funding is going to make an impact. Still then the communities would have to be involved and well sensitized, which in turn requires to build in-country capacity to reach and sensitize the communities. To strengthen all these capacities countries obviously need technical support. So turning accrued resources into impact at country level requires increased funding for technical support agencies.

Additionality
Three major actions are necessary to guarantee the additionality of funding. First, the World Bank and the International Monetary Fund should, as agreed from the onset, push governments to respect the additionality of the increased funding and not to displace funds between areas, diseases or sectors. Second, donors need to assume collective responsibility for coordinating funding. Third, it should be clearly publicized that additional funds for malaria are not affected by budget ceilings or constraints of fiscal space.

Information and networking.
More and better connectivity and communication lines will improve financial information and transparency, reducing gaps, asymmetry and conflicting information. Data collection systems at country level need to be updated and the capacity to collect data on malaria strengthened.
Various subregional networks exist, strengthen and fund them, so that finance people can learn from each other and provide support to each other and to countries in trouble.

Some experience based action points:

- Burundi started a large scale implementation of ACTs, but is concerned now on whether they will be able to continue since they failed to secure funding from the Global Fund Round V.

- Kenya remained reluctant to switch to ACTs because they were not sure of sustained financing for ACTs.

- As many countries and partners have been advocating for, the Global Fund allows for reprogramming now of approved proposals.

- A lack of adequate communication lines between the supply and demand side for ACTs and nets has generated a flow of conflicting messages. The industry is saying "We are sitting on drugs and nets, we are not getting orders". Countries are saying "We cannot put orders forward because there is a supply shortage of nets and drugs"

- More experiences and action points on financing: matching requirement for impact

8) Monitoring & Evaluation

Chair: Pascal Villeneuve (UNICEF)
Co-Chair: Bernard Nahlen (Global Fund, MERG)
Rapporteur: Mark Young
Panelists: Samuel Owusu-Agyei, Deputy Minister of Health (Ghana), Mark Grabowsky (Red Cross, USA), Ed Browne (Kumasi Univ, Ghana)

Summary Report to the Plenary: the slides

- One M&E Plan
- Capacity Building
- Coverage & Impact
- System Monitoring

One M&E plan
Malaria M&E and the wealth of information from other systems should be integrated in one *broader Health Information System* at country level, including the Health Management Information System, demographic surveillance, vital registration, integrated disease surveillance, the DHS/MICS, household surveys, etc as well as data from the *private sector* and non-health actors. This would improve the *coherence* of information and its relevance for all partners. It would assist with joint *reporting back* on progress and success of malaria programs.

We should look at *synergies* with other programs, utilize other surveys and monitoring tools, plug in some key malaria indicators into national surveys e.g., or into routine M&E from antenatal care and immunization, particularly in the context of program integration with malaria.

The *Health Metrix Network* has recently been established to assist with this integration effort.

Capacity building for M&E at *all levels* of the system from community up to national, not forgetting the NGOs and strong M&E capacity within multilaterals like WHO and UNICEF. Capacity building requires adequate *resources, both human and financial*, and countries could allocate 5 or 10% of the budget to M&E on a regular basis.

Some *community structures* can be prepared to collect useful data which can then be linked into routine HMIS and vital registration. At the same time these community structures may improve delivery of services.

A continuous *information loop* from top to bottom and bottom to top within the M&E system will enhance the feedback capacity.

Information on **coverage and impact** is very important to guiding the scale up and reporting back on progress and success and securing sustained financial flows.

Malaria M&E should therefore focus on coverage and impact and this requires a minimum package of core standard indicators and fewer indicators that are consistent over time and collected in a timely manner, all data appropriately disaggregated by socioeconomic status, age, gender and location. The choice of the key indicators and the way to measure and tabulate require consensus and this is

where the RBM M&E Reference Group, MERG, comes in strongly as the global forum for consensus.

It is recognized that there are *different timeframes* for measuring coverage and impact. Coverage can be measured more frequently. Impact, particularly mortality, can only be measured more infrequently. Both are important. Both need to be captured and reported on, but within different time frames.

A major challenge to malaria M&E remains how to monitor *diagnosis*, not just measuring coverage of treatment, but also trying to measure how patients are diagnosed. This is particularly sensitive for fever based diagnosis and treatment. As programs scale up and malaria burden reduces, how to capture the actual diagnosis of fever patients and link this to treatment?

System monitoring is about developing methods and systems to monitor the broader health system issues. First and foremost of challenges here is *tracking resources*, financing and disbursement, and trying to check whether resource allocations were actually consistent with the disease burden. This is more particularly of interest at the district level where the implementation is carried out.

Other challenges are to develop indicators to *monitor program management*, to keep track of *system-wide bottlenecks* to program scale up, like human resources or supply: where are the bottlenecks and how are they impacting on program scale up? How can we better assess the bottlenecks?

Finally, how to monitor the system wide effects of multiple program scale up? Are there distortion effects from scaling up of other programs? How is scaling up HIV/AIDS programs and ARVs affecting malaria program scale up? Is it in a positive way strengthening the system for delivery? Or is it in a negative way pulling human and financial resources away from malaria programs? We need to develop methods to track and monitor these possible distortion effects of scale up

Some experience based action points:

Constance Bart-Plance, MOH Ghana, reports: "We trained mothers and retired teachers, who did a good job collecting useful data. It proves one can build capacity for M&E starting from workers at the grass roots level including in-built feedback mechanisms so that beneficiaries can benefit from the data that is collected. Take good care to include clear definition of malaria into the capacity building efforts.

Solome Balkena from Uganda reports the experience they have with investing in improving data quality using existing tools e.g. HMIS to ensure inter-country comparability, including standardization of case definitions. This way they managed to diagnose clinically and treat successfully 90% of cases.

MOH Ghana subcontracted the monitoring of management performance to NGOs since the government is weak in this area. The contract included also supportive supervision *(Dr Constance Bart-Plance, Ghana)*.

Ghana developed a national M&E plan which includes public and private health providers, has clear supervising system and clearly defined roles and responsibilities in that plan, and develops good methods to monitor what is going on in the private sector. They recommend to engage a private sector person to coordinate the collaboration between public and private sector.

- More experiences and proposed actions, on monitoring and evaluation

ANNEX 1

The Yaoundé Call to Action, November 2005

Every thirty seconds a child dies of malaria, which means at least 3000 deaths a day and more than 1 million a year. Each death is an individual tragedy for the victim and a collective tragedy for the families, communities and countries affected.

In terms of lost opportunities and impact on development, it is estimated that African GDP is reduced by $12 billion per year because of Malaria.

We, the participants of the Roll Back Malaria Partnership Forum V, meeting in Yaoundé, Cameroon on 18-19 November 2005, express our commitment to work together to rapidly scale up action against malaria

Considering the magnitude of the disease, in particular its devastating impact on young children and pregnant women, and its economic consequences in Africa

Acknowledging that the implementation of effective interventions has enabled some countries to reduce the illness and death caused by malaria , we note with concern that the targets of the *Abuja Declaration on Roll Back Malaria in Africa of* April 2000 have not been achieved

Recognizing that these successes can be replicated provided sustained funding is available and is complemented by national leadership and mobilization of adequate human resources at all levels of the health system

Alarmed that current levels of global spending on malaria control are only 20% of the estimated $3 billion needed annually, and deeply concerned about the lack of long term predictability of funding that is provided.

Acknowledging that adequate investment in, and incentives for, research and development are required to ensure new and effective medicines, diagnostics , vaccines, vector control tools and strengthened health systems

Building on all previous commitments and targets to roll back malaria, and recognizing that increased global attention to development and poverty reduction as expressed in the Millennium Development Goals, has created an unprecedented opportunity for rolling back malaria

Aware that the effects of malaria reach far beyond health and that the response requires the involvement of society as a whole .

Emphasizing the importance of national leadership for a single coordinating authority , a single national plan and a single monitoring and evaluation framework

Our duty is to the people and communities that suffer most from malaria, but whose voices are all too often not heard. High level commitment and action is needed by all partners led by the principle of local ownership of the challenges and solutions for reducing the devastating impact of malaria.

Therefore, it is with a sense of urgency that we commit ourselves, as RBM partners, to take forward the actions agreed at the Yaoundé RBM Partners Forum, including the following priority actions, and to implementing the RBM Global Strategic Plan 2005 – 2015, holding each other accountable to its resource needs, targets and timelines:

- *National governments* should continue to develop national plans for scaled up action, linked to health and development plans, through participatory mechanisms, establish broad based national coordinating mechanisms and scale up programmes.

- *In supporting national governments all other RBM partners,* consistent with principles agreed in Paris in March 2005[2], should base their overall support on countries' national strategies and implement, where feasible, common arrangements at country level for planning, funding, disbursement, monitoring, evaluating and reporting to government on activities, progress and impact.

- *We shall rapidly establish* monitoring mechanisms to ensure mutual accountability to these commitments, and joint review of our progress towards them

We invite all those who share our commitment to engage in this Call to Action

[2] Paris Declaration on AID Effectiveness

ANNEX 2

Thematic sessions:
Summary reports to the plenary and Actions captured in the rooms

1: Scaling-up effective malaria prevention

Summary report to the plenary (slides)

- Integration/Harmonization
  - The "Three Ones"
  - "Catch-up; Keep-up"
  - Programme integration, e.g. ANC+, EPI+
  - Priority of malaria in country programming
  - Prioritizing conflict areas, hard to reach areas
  - Smoothing procurement/supply chain – e.g. financing, logistics
  - Taxes & tariffs

- Accountability
  - Global & country levels; focus on outcomes
    - where have we started?
    - where are we now?
    - where are we going?
    - what is the gap?
    - what do we do next?

- Quality Assurance
  - Improve quality by:
    - Reducing fragmented procurement
    - Clear standards and testing systems
    - Tech transfer and tech assistance for IRS and ITNs
    - Streamlining WHOPES process
    - LLIN durability under field conditions
    - Packaging

- Technology support
  - IRS recommended and supported where applicable
  - IRS guidance
  - Improving community participation and acceptability / appropriate use of ITNs and / or IRS

- Research and M&E
  - Systems and implementation research
    - E.g. vector resistance monitoring
  - Product innovation research
    - across all interventions, e.g.; new drugs for IPT

Action points captured in the Room:

Develop one national plan for coordination and M&E:
RBM EARN achieving quantifiable success *(Chris White)*

Put in place the complete structure for vector control at the government level:
Company involvement in 30 countries in Africa towards individual protection of employees (medication/bednets). *(Thierry Clement, Total)*
Development of strategies; individual protection focus; massive bednet distribution; no country capacity to manage the interventions, no anti-vectoral structure; we need laboratories. *(Lucien MANGA, WHO)*
Water, sanitization/sewage systems have degraded over the years, creating breeding grounds for mosquitos *(DRC Ministry of Health)*

Use non traditional channels to reach communities
Community Cascade System

Facilitate community competencies through alternative approaches and existing competency
In twelve countries (Benin, Cameroon, Cambodia, Tanzania, Kenya, Nigeria, Togo, Uganda, DRC, Guinee, Sierra Leone and the Gambia) communities are working towards malaria competence: they are improving local responses to Malaria. *(www.aidscompetence.org; http://health.groups.yahoo.com/group/malariacompetence)*

Strengthen local capacity for management of prevention programs
Cambodian surveillance system based on local community participation was more effective than GIS program to target malaria interventions *(Cambodia MoH)*

Involve existing community structures to promote ITNs, treatment etc
Malaria in School Curriculum

Scale up ITNs in emergency situations and for remote populations
In Northern Uganda ITN delivery has been directed according to the local situation. Free/heavily subsidized nets are delivered to the northern region whereas commercial distribution occurs in urban areas. *(Richard Allen, MENTOR)*
Similar experiences in Congo and DRC

Develop clear messages on how to handle chemical products
Campagne communautaire de masse d'imprégnation de moustiquaires - Actions en Coeur de Benin *(MOH Benin)*

Community should be the key for all environmental aspects (spraying, impregnating)
Good results with Impregnating curtains in Ghana; as a complementary strategy to ITN *(Margaret Gyapong, Ghana)*

Support innovations and technology development/transfer for LLIN to address in particular procurement and global capacity, and emerging insecticide resistance.
Several experiences reported *(WHOPES, Jolines, ANMA (African Net Mosquito Association); NETMARK)*

Revisit IRS and recommend it where it is appropriate
Succes in South Africa *(Simon Kunene – Swaziland)*

Improve IPT coverage
IPTP now nation wide implemented in Ghana, high acceptance. Problem due to high acceptance and shortage of SIP. Same problem in the 5 other countries that have country wide implemented IPTp *(Ambrose Misdre, UNICEF)*

IRS: Teaching people a correct application, Choosing appropriate insecticide
Works in South Africa and Southern Africa using DDT. Works well in Kenyan Highlands *(Margaret Gyapong, Ghana)*

Renforcement des mesures d'hygiène et d'assainissement du milieu
Raffraichir les règles élémentaires d'hygiène environmentale. Désherbage des alentours de maisons. Pratique systématique de la destruction des gites larvaires. Pratique de l'éducation communautaire pour le changement comportemental *(Essomba Ebola Charles, Cameroun)*

Adapt treatment of malaria to the resistance mapping – avoid generalizing solutions.
Prophylaxis within Total is used only for short stays; their challenge is that they have nothing to use for children/infants.
Financial structure realities on the ground make it impossible to implement the strategies that are discussed
Segmenting market for drugs in order to develop availability of lower priced, generically branded drugs
Problems of resistance levels that vary within a country
Differing ecological realities
(Total – Thierry Clement)

Simplify tender/procurement procedures for essential drugs
GF procedures slow procurement of essential drugs. *(Dr Pierre Lokadi Opetha, MoH DRC)*
Net purchases for Cameroon took 1-2 years to complete from time of tender to completion of purchase order *(Cameroon MoH)*

Transfer production of commodities to African countries
Au Cameroun et au Benin il existe des industries du textile mais elles ne fabriquent pas les moustiquaires

Support technology transfer to countries
Experience with spray teams/IRS, ITNs/ LLINs *(Mike Coleman)*

Engage press in your efforts
Mieux sensibilisés, les journalistes deviennent le véritable vecteur d'information en s'engageant davantage dans la lutte contre la malaria. A Genève, un journaliste africain est devenu un des meilleurs représentants de la cause de la lutte auti malaria au sein de Nations Unies *(Ndoye Elhadj Gorgui Wade/Journalist www.continentpremier.info)*

Encourage operational research
Inclusion of operational research as part of global fund proposals *(Global Fund)*

2: Scaling Up Effective and Timely Treatment

Summary Report to the Plenary: the slides

- Development of national plans for scale-up
  - Financing; logistics, forecasting; procurement, distribution including HMM; IEC;
- National partnerships and country coordination for consensus
  - Link to Regional and global networks
- Enhanced regulatory and monitoring systems
  - pharmacovigilance
- Financing - subsidized / free to end-user
- Research to support scale-up – operational research – M and E, post-regulatory effectiveness and new formulations
- Capacity strengthening
  - User-friendly treatment services

Actions Captured in the Room:

Develop and implement comprehensive national communication strategies to support the dissemination of the new drug policy using ACT's
Ghana has just developed a communication strategy
Tanzania suffered from the absence of a communication strategy during change to SP as first line treatment. The media highlighted the adverse effects of SP

Strengthen national systems relating to forecasting, procurement, storage and distribution for anti malarias
Novartis receiving orders for multi million doses of Coartem without being aware of bulkiness (1 jumbo jet =1 million doses) of products and the need for adequate storage and distribution mechanisms *(Novartis)*
Stock-outs in some clinics in Zambia and overstocking in others

Plan with all stakeholders involved, ensure consensus
Examples in Indonesia, Ghana and Liberia *(MoH Indonesia, Ghana and Liberia)*

Work towards strong political commitment to policy changes
Good examples in Ghana, Uganda, Zambia

Prepare and plan for timely studies of drug effectiveness when licensing of new drugs is anticipated at national level
Zambia conducted a number of efficacy and compliance studies to inform policy change towards Courtan as first time treatment

Facilitate regional networks to strengthen implementation and policy coordination across borders
Members of EANMAT, WANMAT, CANMAT, HANMAT, EARN and WARN learn together and share experiences. *(K. Carter)*

Engage partners to facilitate highly subsidised quality ACT's to the private sector as a priority.
Monotherapy use in Zambia where ACT has become drug policy
Rwanda, 13 drugs and several monotherapies are already in the private sector while public facilities have not finished the change in drug policy

Strengthen capacity of health facility and laboratory workers for implementation of the new drug policy with high quality of care
Cascade system in Zambia, Ghana and Tanzania

Restore trust in public health care
It is often observed that there is a line at the religious-affiliated health facility while no one wants to use the public health facility (Cameroon) *(Dr Felix F.Tso S.mo, MOH, Cameroon)*

Training of traditional practitioners for timely referral to health facility.
Une collaboration menée par une ONG au Cameroun : Cité des Palmiers, à Douala *(Gaspard Zoubeudem, BCM Africa, Cameroun, et Raymond, OUM)*

Scale up use and access of quality assured diagnostics as a method to achieve more rational drug use
(Plan International)

Provide information, education and immunisation at community level
In one region of Cameroon; population 850,000 with 1 doctor per 15,000 inhabitants and 1 paramedic per 2,500 inhabitants with an estimated 2 to 4 cases of malaria per person per year, only 50,000 cases of malaria are registered. So data is not collected.

Improve access to quality ACT's at community level through home based management
Success stories from Tanzania and Uganda:
Tanzania , pre-referral treatment using rectal artesumate
Uganda, home based care for uncomplicated malaria using pre-packaged antimalarials delivered by trained community volunteers.
IRC in refugee and IDP camps

Make treatment for severe Malaria free at health facilities
In Bandiagara, Mali, case fatality from severe malaria was reduced from 40% to < 10% by providing free, good quality treatment and collaborating with traditional healers to ensure early referral. *(Merlin Willcox)*

Mettre en priorité le traitement des femmes enceintes et les enfants
Au Burkina Faso la quinine est gratuite pour les <5ans et femmes enceintes pour le traitement du palu grave *(Dr Jean Eure Ouedraogo, Director PNLP, Burkina Faso; Graciela Diap, DNDi)*

3: Scaling Up Demand Creation and Effective Use

Summary Report to the Plenary: the slides

Multi-sectoral approaches
- school curriculum
- IMCI
- EPI
- Agriculture
- Community development

Harnessing existing community competencies through innovative multiple entry points
- Microfinance
- Women's groups
- Traditional communication networks

Require all actors to plan together and co-ordinate activity

Increase accessibility & affordability of services and commodities

Multiple communication methodologies in a strategic manner

Actions Captured in the room:

Include malaria (including treatment) in school curricula
PSI works on teacher training with updated curriculum. PSI looked at school curriculum and noticed that info on malaria was totally outdated - worked with Ministry of Education to train teachers so appropriate info imparted. *(PSI, Desmond Chavasse)*

Involve all malaria actors in planning process
Zambia - NMCC - ZMF. All partners must work with NMCC - all NGOs have to go to ZMF for information *(Malama Muleba - ZMF)*

Involve secondary stakeholders - churches, community leaders and mayors
ITNs with immunization - measles/malaria; schools with clinics so children can be tested and treated; Brewery workers given on the job treatment for malaria so they do not miss work.

Promote partnerships at all levels
Partnerships help promote demand and effective use in Cambodia. Partnership has helped increase ITN coverage and also more availability of appropriate treatment of malaria at community level *(National Malaria Control Programme Cambodia)*
Au Cameroun, District de Sante de la Cité des Palmiers : Collaboration entre responables des communautés et praticiens de services de santé pour le diagnostic et la prise en charge du paludisme a résulté en une diminuition des case de paludisme grave *(BCH Africa, Tel 237 988 7395, BP 2032 Yaounde email: bch_africa@yahoo.fr)*

RACTAP, RAOTAPI II et autres reseaux *(Mr Ngono Jean Marie www.ractap.org Administrateurs RACTAP BP 3266 Yaounde tel 237 223 2431)*
Partneriat International AHDSEFCAM/Afro Aid Suisse est parti avec un de groupe de 10 femmes. Aujourd'hui 600 familles sont impliquees. Les activitees concernent le sensibilisation , d'assainissement et la prise en charge dans les famille du suivi et l'evaluation. *(Suzanne_apanda@yahoo.fr – BP 20628 Tel 778 4097)*

Involve Communities
Communities have structures that can help create demand and use of effective intervention eg in the Gambia they use village development Committees and Health Cub committees to promote key interventions (ITNs, IPT and Case Management) ITNs programmes are promoted by village dipping agents who are used during mass net retreatment campaigns. The dipping agents identified by the village development committee are responsible for community sensitization relating to the benefits of ITNs at community level. This has led to increased demand and use of ITNs. *(The Gambia National Malaria Control Programme)*
Benin : avec les relais communautaires il y a une prise en charge communautaire du paludisme *(MoH Benin)*

CCC (Communication pour le changement comfortement), comme la Commune Champion de Madagascar *(Mr Noe Rakotondrajaona, USAID, Madagascar; nrafzotondrajaona@usaid.gov)*

Renforcement des ONGs et autre organisations communautaires
Cameroun – country connection Mechanism (CCM) : Les ONGs se sont retrouves, ont elabore eux memes des criteres des candidatures (credible, methode d'audit, bilan d'activités) *(Viviane Nzeussue – International Federation of Red Cross; ifrccm10@ifrc.org ruissiov@yahoo.fr)*

Increase Malaria IEC
In Kenya, a youth group is used to educate the communities through drama, songs in public places like schools, markets, passing information about malaria. This improves people's knowledge, changes attitudes and improves skills. These peer groups go on counseling people and identifying vulnerable groups to teach and show the need for them to benefit from interventions like IPT, ITN etc. *(Kenya National Malaria Control Program)*

Share success stories
Village leaders and village volunteers – health education and discussion; bednets distribution free of charge; village volunteer monitor the use of bednets; bednets distribution - wet season,, high mosquito density; advantages, head lice reduce, bugs reduce, malaria reduced; more demand for bed nets; sustainability – stimulate discussion with village leaders and volunteers and users *(http://health.groups.yahoo.com/group/malariacompetence; Malaria Competence Group)*

Increase distribution of outlets eg ITNs at various levels eg 1) Health facility/hospitals 2) Community women's group 3) Private clinics/hospital
National Malaria Control Programme in Sierra Leone in collaboration with UNICEF distributed 96,000 nets from 2004 to August 2005 under the Child Survival Strategy Initiative. As a result there was increase coverage eg ITN of under five. The scale raised from 0 to 30% in three selected districts after a survey conducted in September 2005 at Household and Health Centre *(National Malaria Control Programme – Sierra Leone)*

Have communities in charge of distribution of impregnated bed nets
Association BCH et District de Sante de Deido :
Actions Menees – reinforcement des capacitees de la communaute; organization de la distribution de moustiquaires, couple avec la vaccination des enfants
Resultats – taux de distribution des moustiquaires eleve; taux de vaccination eleve; les responsables communautaires verifient eux-memes l'utilisation des moustiquaires *(Building Capacities for better Health in Africa tel 237 988 7395 bch_africs@yahoo.fr ;BP 2032 Yaounde)*

Change the culture of bed net use
"Fashionable", "Collective courage", "Tipping Point", "To let go to get others going", "Seeing is believing" *(Bart Knols, Ellen Van der Brugge)*

Build on existing community based finance systems
Micro finance systems – Freedom from Hunger in W Africa, Malaria Credit with Education; Income generating activities; Small businesses; Village Development Committees *(Marie Chorr, Ellen Van der Brugge, John Chimumbwa)*

Work on availability, accessibility and affordability of services
PSI clinic nets in Kenya has raised demand due to accessibility and affordability in clinics and are given to vulnerable groups. *(National Malaria Control Programme – Kenya)*
In Cambodia PSI sells Anti – Malaria Combination Therapy in the market through local drug outlets. *(National Malaria Control Programme – Cambodia)*
In Uganda, home packs are made available at village level for children under five years at free cost. *(National Malaria Control Programme – Uganda)*

4: Strengthening Delivery System

Summary Report to the Plenary: the slides

- Strengthen community based delivery systems, including training, monitoring and supervision of local workers and systems
- Local capacity needs to be developed/strengthened in the following areas:
  - Consumer protection
  - Quality Assurance
  - Market surveillance for counterfeits
  - Local manufacture for new essential commodities
  - Supply Chain Management
- Countries and programmes should form a more rigorous analytical basis for more effective planning, trouble-shooting and management
- All components for effective treatment (diagnosis, drugs, ancillary medicines) should be employed in an effectively integrated and comprehensive service delivery approach
- Ministries of Health should be empowered to coordinate donor inputs, to facilitate most efficient and effective use of resources

Actions Captured in the Room:

Support technology transfer, franchising and other mechanisms to facilitate local production of antimalarial commodities including ACTS, ITMS and insecticides
For sustainability of programme ie access and cost and delivery of quality commodity drugs to the communities, franchising as is done with MacDonalds, Boots, M&S etc can be introduced with major in country manufacturers (pharmaceutical) as in pilot in Ondo State Nigeria. Capacities exist in Nigeria, S Africa, Tanzania etc to manufacture these commodities. This is a development and poverty reduction project. *(Edugue Abebe, FMOH, Nigeria)*
Mastering the technology of impregnation of mosquito nets in a Guinean locality has enabled more than 50% of the population to use Mosquito nets. *(Idrissa Souare,UNICEF- Guinee)*
Production of LLINs and ACTs in Tanzania

Build capacity at country level for consumer protection, including quality assurance, market surveillance to detect counterfeit or substandard commodities
70% of drugs in some segments of the Nigerian market were fake/substandard. After implementation of pharmavigilence the situation improved significantly. *(Dr Garba Abdu, Program manager, Child Survival, USAID, Nigeria; DR E Ebebe, Director, Public Health Federal ministry of Health, Nigeria)*
Experience in Guinea *(Dr. Sidiki Diakite IGSS – Guinea)*

Build capacity at country level for supply chain management, including demand forecasting, procurement and distribution
"Cold Chain Management System as A&I": Set up data base on demand based on real needs. Ensure storage capacity. Build and reinforce transportation network *(Rene Cazetian, Abiola Tilley-Gyada)*

Some bilateral agreements address migration of health workers and provide appropriate incentives to retain health workers

Coca-Cola distribution system to deliver services

Use fixed duration for tender process and make procurement orders well in advance
Process of procurement in practice in South Africa *(Daisy Mafubelu - Permanent mission of South Africa, Geneva, +41 22 849 5442 daisymafubelu@bluewin.ch)*

Develop a joint procurement system for all countries
Systems being experimented in Zambia *(Christoper Simoonga simoongachris@yahoo.com)*

Strengthen community based delivery systems, including training, monitoring, and supervision of local systems and workers
L'implication des agents communautaires permet d'augmenter le taux de couverture : De 6% a une localitie a Guinee a 38% ce converter en M11. Au Congo, 20% de couverture en 20 jours *(Idrissa Souare - Unicef Guinee; John Gikapa, RD Congo)*
Good experiences with community based agents as medicine vendors, volunteers or other community agents in the provision of quality malaria control commodities (drugs and ITNs) close to the home. *(John Paul Clark, USAID)*
Village volunteer program - is making use of existing trained staff to do incremental training on malaria prevention and treatment

Seek opportunities for planning or implementation within country context
Child health, measles campaign, opportunities for cross usage of drugs eg cotrimoxazole

Strengthen donor harmonization for impact through local existing aid policies and strategies
Zambia SWAPs, Aid policies and strategies, joint planning and implementation systems.

Conduct facilitated peer exchange of experiences and learning across countries and regions
Kenya had an exchange visit with Malawi and decided to adopt the Malawi approach.

5: Coordination for Harmonization

Summary Report to the Plenary: the slides:

1. National Level Leadership
   - Support to RBM Partnership at all levels
   - Multi partner planning
   - M&E
   - Donor Commitment
2. Support to RBM Partnership at all levels
   - Global and Sub-regional networks supporting Three Ones approach
     - Multi stakeholder platform to address multi-thematic effects
     - Advocacy
     - Profile
3. Multi-partner Planning
   - Support for one National Strategic Plan
   - Ownership by Ministry and inclusive of all other partners
   - Planning process needs to be horizontal as well as vertical
   - Coordination Mechanism
4. M & E
   - Implement one system
     - Strong emphasis on performance based funding
     - Evidence based advocacy
5. Donor commitment
   - Demonstrated commitment to measurable adherence to National Ownership and Integrated Plans

Actions Captured in the room:

Prioritize a strategic plan focusing on specific outcomes and with clear timeline that all donors, programs and funding then fit into
Experiences from Rwanda, Tanzania, Zambia

National Level Leadership should co-ordinate harmonization with all the partners at all levels from global to national, sub-national, and community.
An example of Southern Africa AED Regional Malaria Planning, with pooled work plans between donors and national partners. Needs-driven support results from this partnership planning.

Another example is the Tanzania malaria national plan (Ministry of Health- driven meeting), with donor fund at national level. All partners agree on their contribution e.g. ITNs. *(TANAM)*

Kenya, Tanzania and Zambia conducted stakeholder coordination at national level.*(KENAM, TANAM)*

There are also UNICEF experiences in 11 countries of West Africa on concentration/integration for increasing survival of children *(DRC, SASDE, Guinea, Benin)*

Encourage continuity of personnel to retain the effective work force for malaria programme – capability building and retention
In Eritrea – national malaria programme staff members have been part of the whole process and have remained in post.

Adopt a sector wide approach for health at country level to align partners and a strong RBM partnership within that Framework with clear targets, responsibility and accountability. Harness and harmonise players outside of and within the public health sector who have specific areas of expertise to bring to malaria prevention and control.
In Nigeria a fragmented approach by donors was adopted but Uganda has a functional SWAP.
Examples are the Tanzania Voucher Scheme, MIPESE countries, West Africa Credit Union Federations. A mix of methods/ approaches is used, and there is outsourcing of what can be done better by partners.

Donors should commit to country level planning and ownership, fund end points and allow country level programmes to establish the breakdown of funds to promote country empowerment.
GFATM supports Tanzanian National Malaria control programme, a clear response to country level initiatives.

International RBM partners and global initiatives should align to support and empower sub-regional RBM partners
In East Africa the RBM partnership works very well in coordinating but is bypassed by global initiatives and international NGOs

In-country malaria champion should support a strong RBM partnership.
Ex head of state supporting Guinea worm programme. Many malaria control programmes are at a low level in the hierarchy and not able to engage in high-level advocacy, such as in Ethiopia and Zambia.

Conduct in-country participatory needs-based planning to identify priorities and to assist in planning monitoring and evaluation of malaria nationally.
Several experiences related to strategic plans (bottom Up)

Acknowledge the contribution of different players in order to give them an extra boost in delivering planned activity.
Experiences from RDC, and Guinea

Ensure that monitoring and evaluation is in place and include system of assessment, analysis and action.
Experiences from RDC, and Guinea

Use the media to ensure communication is properly shared.
Experiences from RDC, and Guinea

Link pilot activity to discussion, policy making and strategy
Experiences from RDC, and Guinea

6: Global And Regional Advocacy

Summary Report to the Plenary: the slides:

1. Use a Spectrum of Approaches
   - Develop advocacy strategies to address awareness, accountability and fund-raising
   - Identify high-profile champions and celebrity advocates such as sportsmen, musicians, politicians and actors
   - Raise public awareness at global and country levels through high impact actions (eg Africa Malaria Day, and add a World Malaria Day, World Swim for Malaria, Drive against Malaria)
   - Encourage pride (eg in industry)
   - Use opportunities for northern partners to see the problem for themselves
2. Consensus
   - Engage politicians (eg The Gambia)
   - Develop networks for malaria advocacy
   - Create linkages among regional economic communities and African Union and bring them in as advocates
   - Develop neighbouring country partnerships (eg. Swaziland, Mozambique and South Africa)
   - Public sector and multi-laterals need to break down suspicion against private sector
   - Reach consensus among research community on strategies
   - Convey consensus for communication
3. Products & Tools
   - Evidence
   - Economic and business case (eg by involving regional economic communities and strategies as well as national politicians)
   - Success stories
   - Clear Plan and Strategy
   - Packaging information and use appropriate language
   - Global resource for keeping and dissemination of success from all source
4. Creating Capacity and Using Collective Action
   - Give voice to enable effective community action
   - Sustained
   - Consistency
   - Involve different approaches working together
   - Develop networks, eg linking schools and malaria programmes (Gambia)
   - Strengthen capacity of media to act as advocates
   - Strengthen capacity of local groups (traditional leaders, community radio, soccer players)
5. Accountability and Commitment
   - Fund civil society activism
   - Sensitise parliamentarians to raise the profile
   - Focus on creating favourable environment for private sector and civil society involvement (emphasis on constructive dialogue)
   - Maintain pressure for continuing political will
   - Track performance of multilateral institutions as well as national governments to ensure accountability and consistency

Actions Captured in the Room:

Coordinate R&D interventions with advocacy.
Adoption and exploitation of LLINS *(SiamDutch)*

Use existing opportunities for northern donor to visit endemic countries, health facilities, and communities to appreciate the efforts and impact of malaria response.
Presidents and political leaders visit Africa all the time and are sent to well-managed hospitals instead of being taken to visit problem communities. *(Dr Doumbia Seydou, Ghana, sedounbia@wsaid.gov)*

Raise public awareness at global and regional levels
Zambian Parliamentary Health Committee to create advocates within parliament. Africa Malaria Day, World swim for malaria, Drive against Malaria

Indentify Malaria Champions on high profile people to take malaria on as a pet cause
Nelson Mandela took on HIV and has been successful in delivering messages globally. Malaria needs a face that is recognized and respected both in and out of Africa. Head of State in Kenya shows a new commitment

Put in place mechanism for acknowledging success irrespective of who has achieved this.
Political commitment can only be measured by effective programmes. Examples of effective interventions e.g. 3 state initiatives (Swaziland, Mozambique, South Africa). *(GFATM programme - Ms Matcha., Civil Society)*

Sustain commitment to malaria through gathering and dissemination of success stories and effective partnerships. .
Last year RBM did 4 country success stories. Examples of effective partnership include partnership with Barclays bank in Kenya and with breweries in Zambia.

Use anthropological and journalistic approach to put a face on the statistics so that successes speak to the broader audience
Applied field research produces stories on local development which incorporate traditional local practitioners, generates local stories, and shows local investment.

Develop economic arguments to convince economic communities (both national and regional) by developing suitable advocacy tools for the mobilization of resources.
Regional organizations such as ECOWAS and OCEAC used to involve all countries in a given region. *(Dr. Joanna)*

Develop capacity for malaria advocacy at all levels, including at community level such as traditional leaders, religious leaders, and sports players
Community radio stations in Zambia have given information to disseminate to communities.

Traditional leaders in Dakar have advocated for malaria through integration in polio campaigns.

In Tanzania a planning tool was developed to help districts prioritise planning. *(Alex Mwsta)*

Strengthen capacity of media and involve them in the fight against malaria.
In Senegal communication programme is conducted at national level. Campaign messages broadcast at prime time include malaria stories in soap opera.

Involve the education sector (Schools) and link it with the community.
An example in The Gambia: the peer health education programme and the National School based education programme. *(Nova Scotia Gambia Association)*

Promote formation of interested network to stress common cause.
Successful example in Kenya *(KeNaaM, Kenya of NGO alliance against , a public private partnership)*

Enable and connect politicians so they can mobilize resources for malaria
Peer review in Gambia: touch points to keep legislators involved.

Improve accountability and management of multi-lateral stakeholders so that trust and transparency in partnership are improved, at both national and international levels.
The price of anti-retrovirals has only come down because there have been positive incentives to industry. Pressure, encouragement, and/or incentives will also be needed for malaria. From experience, there is a danger of isolating people who try to make a difference, so a general consensus is needed to minimize the risks for people taking decisions. *(Asamoah-Baah, WHO)*

Encourage investors at regional and national levels to produce mosquito nets, insecticides , anti-malarial drugs and standardized traditional medicines.
There are examples of Tanzania promoting the bed net factory, while Mali and Ghana have promoted production of standardized traditional medicine.

Sensitize parliaments in endemic countries and advocate for dedication of one day per year to malaria e.g. Africa Malaria Day
Work in Gambia by NGOs and national control program *(National Malaria Control Program/CIAM Gambia)*

Get decision-makers to commit to scaling up malaria through concrete action such as increasing the national budget.
Zambia has prioritized malaria. NMCC now has own directorate and has prominence. *(Malama Muleba, ZMF)*
There also is commitment from South African minister of Health to SADC.. *(Patrick Moonasar, South Africa)*

Fund civil society activism to ensure political accountability at national level as well as political commitment within countries.
GFATM experience has seen more activism for HIV but has also shown greater visibility at national level increases national confidence and therefore a regional profile. Experience in the region also shows that lack of civil society activism and national accountability affects decision on political process.

7 : Financing: Matching Requirements For Impact

Summary Report to the Plenary: the slides

1. Long term predictable financing
   - Need donor commitment for 5-10 yeras to support country strategic plan (e.g. Burundi funding for ACT's cannot be sustained – interruption of GFATM support; Kenya reluctance to switch to ACT's due to lack of confidence in long term funding)
   - Diversification of partners
   - Global and country subsidy for malaria commodities
     - Explore mechanisms and feasibility of global subsidy e.g. advance purchase commitment;
     - Need also for mechanisms for subsidy at country level
     - Increase coverage in public and private sector
2. Flexibility and simplification of financing
   - Information dissemination on current levels of flexibility of different donors (e.g. GFATM allows re-programming
   - Technical support for funding applications
   - Flexibility of govt. Out-contracting Detail of action
3. Impact of Funding requires enhanced capacity
   - Procurement
     - PR's to engage agents rapidly if they lack capacity
     - Involvement of countries in developing procurement procedures
   - Financial management
     - Capacity to monitoring MTEFs
     - Capacity for accounting and audit
   - Strengthen local capacity for producing commodities, ITN's etc.
   - Strengthen capacity for implementing new policies
   - Work to ensure free treatment
   - Community sensitisation
   - Increased funding for technical support agencies
4. Additionality
   - WB and IMF to push governments for additionality and not displacement
   - Donors to assume collective responsibility for coordinating funding (e.g. DRC
   - Publicise issue that additional funds for malaria are not affected by budget ceilings – fiscal space (press release, IMF engagement etc.)
5. Information and Networking
   - On financial and reporting mechanisms
     - Increase communication lines / connectivity to enhance knowledge of sources of finance e.g. Uganda rural hospital
     - Transparency addressing information asymmetry (supply and demand – conflicting information e.g ACT's and nets)
     - update data collection systems
     - Capacity for data collection on malaria
   - Networking
     - Strengthen financing of regional networks
     - Sub-regional networking and learning from each other

Captured In The Room:

Promote flexibility in various funding sources.
Experience of the GFATM which allows direct purchases from manufacturers.

Need longer-term donor commitment, such as 5-10 years, to support country strategic plan.
Burundi funding for ACT's cannot be sustained, interruption of GFATM support;
Kenya reluctance to switch to ACT's due to lack of confidence in long term funding.

WB and TMF should push framework for additionality and not displacement. Donors should assume collective responsibility for coordinating their funding.
Example of DRC with assistance from 4 donors EU, GF, USAID, and Belgium.

Renforcement des financements de la sensibilisation
'Exemple de AHDSEFCAM au Cameroun' *(Mme Apando Suzanne. AHDSEFCAM BP 20628 ~Tel 778 4097 suzanne_apanda@yahoo.fr)*
'La radio Rivale' en Guinée *(Mr Aboubaco Sidiki Diakine. Inspecto general de la sociate REpublique de Guinea BP 481 Tel +224 212976 or +224 45442 dialadam@yahoo.fr)*

Appuyer les organisations sous-régionales qui soutiennent les programmes nationaux dans la mise en oeuvre des activités de lutte contre le paludisme.
MIPESA, RAOPAG

Renforcer les capacités locales de production des intrants (moustiquaire, DDT, médicament)
Example of Tanzania

8: Monitoring &Evaluation

Summary Report to the Plenary: the slides

1. One M&E Plan
   - Integration with broader Health Information System at country level (HMIS, DSS, vital registration systems, IDSR, DHS/MICS, etc)
   - Involve private sector and non-health actors
   - Improve coherence and relevance for all partners
   - Joint reporting back on progress/success
   - Synergies with other programmes – utilizing other surveys and monitoring tools
     - National HH surveys (HIV/AIDS)
     - Routine monitoring – EPI, ANC
   - Health Metrics Network recently established to assist this integration effort
2. Capacity Building
   - Strengthen capacity for M&E at all levels of the system (national, sub-national, community, organizational)
   - Must be adequately resourced, both human and financial (e.g. certain% of health budget?)
   - Make use of community structures to collect and make use of data (link to HMIS, vital registration) – as a method to improve quality of services
   - Feedback system – information loop
3. Coverage & Impact
   - Minimum package of core standard indicators - fewer indicators, consistent over time and collected in a timely manner – disaggregate (SES, age, gender, location)
   - Regular reporting of progress and success to ensure sustainable financing
   - Recognize different timeframes for coverage and impact measurements
   - Diagnosis: a challenge in this era of programme scale-up – related to assessing impact in situation of reduced malaria burden
4. System Monitoring
   - Develop methods and systems to monitor broader "health system" issues:
     - Financing and disbursement – track resources (are allocations consistent with disease burden?)
     - Programme Management
     - Monitoring system-wide obstacles that may be impacting on programme scale-up (e.g human resources, supply)
     - System-wide effects of scale-up – possible distorting effects of other programmes

Actions Captured in the Room:

Deliberate investment in M&E as part of the strategic plan for malaria

In Cameroun efforts are made to integrate redesigned data collection tools with other health outcomes and develop human resource capacity. VSAT technology is used in all policies. *(Simon Kwake, Cameroun)*

Competitive contracting out of M&E in Ghana and Tanzania

Conduct M & E on 2 levels of action: the macro level and the micro level.
At the macro level:
- **develop indicators based on available tools**
- **get appropriate tool in order to have good and applicable indicators**
- **ensure feedback system from the base to the macro level and vice versa**

(Marlise Booman)

Build capacity for M&E starting from workers at the grass roots level including in- built feedback mechanisms so that beneficiaries can benefit from the data that is collected. Ensure that capacity building efforts include clear definition of malaria.
Ghana trained mothers and retired teachers, and were able to collect useful data. *(Constance Masto MOH Ghana)*

Define minimum package of M&E indicators to reduce burden on data collectors at the collection points. Ensure that indicators reflect a clear link between diagnosis and treatment
At present up to 90% are treated without diagnosis.

Implication du niveau communautaire dans le système de suivi et évaluation
SSBC – Système de suivi à base communautaire - Guinée

Encourage and expand M&E to include management performance and supportive supervision.
Specialized contracts to NGOs to monitor management performance where the government is weak in this area. *(Dr Constance Bart-Plance, Ghana)*

Renforcement des capacités techniques et materielles en matiere de suivi et évaluation
Les sites sentinelles non operationels. Le système national de Getoon (SNIS) faiblement efficient. (RDC/Guinée Equatoriale, Bioko)

Evaluation et renforcement dse systèmes de suivi et évaluation.
Les sites sentinelles, Burch-Burkina, RDC, Benin, Guinee

Harmoniser et bien définir les méthodes de collecte des indicateurs à utiliser pour évaluer nos actions. Adaptation entre activité planifiée et indicateur
Tracking Results Continuously (TRAC) Madagascar
makotondragaone@usaid.gov ; kkersay@gmail.com

Invest in improving data quality using existing tools e.g. HMIS to ensure inter-country comparability, including standardization of case definitions
Most cases diagnosed clinically *(Solome Balkena, Uganda)*

Ensure national M&E plan which:
- **includes public and private health providers,**
- **has clear supervising system and clearly defined roles and responsibilities in that plan,**
- **develops good methods to monitor what is going on in the private sector.**

Experience from Ghana: Engage private sector person to coordinate the collaboration between public and private sector.

Correlate outcome indicators to impact indicators through linking processes to outputs, impact and performances
ITN distribution and coverage in the M&M (malaria and measles) campaign was quite high. Getting the impact on malaria reduction in the respective areas is quite a challenge and there is a need to develop a tool to capture impact in these high coverage areas that might not have access to normal sentinel sites. *(Sylvia Khamaki Sylvia.khamaki@irdc.org)*

Implement active case and intervention coverage surveillance systems which:

- **capture conditions and disease burden in the community,**
- **complement passive surveillance through MMIS,**
- **need to be validated with existing DSS infrastructures.**

In Malawi: introduction of the community/village register that will be providing information on disease conditions (prevalence/ increases) and other interventions at community levels. *(Doreen Ali, National Malaria Control Program, Malawi)*