



**Sothern African Regional Network  
SECRETARIAT**

**E-mail:** [boitumelo.lesaso@gmail.com](mailto:boitumelo.lesaso@gmail.com)  
**Website:** [www.rollbackmalaria.org](http://www.rollbackmalaria.org)

**Telephone:** +267 71469947

---

## **Report of the SARN Diagnostic Mission to Zimbabwe**

**Gaborone**

**Botswana**

## **EXECUTIVE SUMMARY**

SARN carried out a Diagnostic mission to Zimbabwe to conduct a diagnosis of the program performance/achievement of GMAP targets and milestones, carry out partner landscaping, identify gaps in the resource envelope, identify bottlenecks, create a forum for selling the Business Plan, support completion of 2014 Roadmap, include Zimbabwe in piloting the management tool. The method of work included courtesy calls to MoH senior officials and discussions with NMCP team/donor organisations and implementing partners.

The diagnosis showed high commitment to malaria elimination by the government at all levels from the Health facilities, district and provincial levels, the PS and Minister. Government provides HR and financial resources and there exist inter-departmental and inter-ministerial linkages with the NMCP. The partnership is broad based and made up of Private Sector, Research and Academia, NGOs, Civil Society, community, religious organisations, Government institutions and multilaterals who are committed to support the program and they all link into the One National Plan. The however, there is lack of engagement of the Pvt sector extraction industry and some of the corporates (banks, mobile phone operators). The annual plan is not accompanied by an annual scorecard to track individual partner achievements and there is no platform to share progress with partners outside Zimbabwe.

There exists well defined information sharing and joint decision platforms which include: weekly, bi-weekly, monthly, quarterly, bi-annual and annual meetings between NMCP and partners, CCM sub-committee, thematic area technical committee/sub-committee, PMI implementers, MoH donors (MODO), and Annual Malaria Conferences which are used for review of implementation of one work plan, grants management and resource mobilization.

In terms of operations, the current Malaria Strategic Plan (MSP) ends in 2017 however, no end-term evaluation was carried out in 2012 and since then, it has been extended without the evaluation. There exists an annual workplan which has weaknesses in several areas and requires review to ensure it is evidence based and that all partners feed their activities into the plan Implementation: All partners believe that implementation is going well, however, due to shortage of human resource, some activities are not completed on schedule while others are still to be implemented. The NMCP is taking advantage of the expertise within the partnership to cover the HR shortage. Grant management is going well with the Grant rated A1 and implementation of the GMAP targets is on schedule with universal coverage having been achieved in IRS, LLINs, ACTs and RDTs. A shift from bottlenecks impeding grant implementation to knowledge management/insecticide resistance/QA & QC was observed.

**Going forward**, due to the observed shift in the bottlenecks, SARN will be supporting the Strengthening of knowledge management (Quality information = quality decisions + results), grant making, program reviews, business marketing, end-term review of malaria strategic plan, preparation of the SADC Health Minister meeting and the SADC Malaria Events. Help complete 2014 Roadmap – to have a complete published record and include Zimbabwe in piloting the management tool and the tool for landscaping partnership.

## 1.0 BACKGROUND

The SARN held its Annual Review and Planning Meeting (ARPM) in July 2014. During the meeting all Constituencies outlined gaps, program performance/achievement of GMAP1 milestones/targets/objectives, TA needs and challenges that are either impeding progress or threatening the achievement of milestones. Insecticide resistance in Eastern Zimbabwe and a surge in imported malaria continue to present huge challenges. Replenishing the resource envelope remains a priority for Zimbabwe hence the need to arrange for the PS's engagement with the partners for him to sell the Business Plan. The Annual Malaria Plan requires strengthening and the Roadmap upload is erratic. SARN and RBM Secretariat have embarked on an **in-country Partner Landscaping Exercise** with a view to strengthening the in-country RBM partnership and rope in more players to support the National Malaria Strategic Plan (MSP) – the one Plan (Annual Malaria Plan). This will ensure that all partners support the **One Plan**, maximize on individual organizations comparative advantages, remove duplication of efforts while ensuring that all partners report their activities to the NMCP. The mission also aimed at strengthening the in-country partnerships engagement in various activities and support the generation of evidence based data and information for the NMCPs to embark on evidence based planning and decision making. Another important activity is the support required from partners for the NMCP to give the final push towards achieving the GMAP/MDG targets in the remaining months towards 2015.



**Group Photo of the Zimbabwe Mission Partners**

## 2.0 MAIN OBJECTIVE

The purpose of the diagnostic missions was to conduct a diagnosis of the program performance/achievement of GMAP objectives, targets and milestones, embark on partner landscaping, identify and reach consensus on challenges and gaps in the

resource envelope and use the data/information for evidence based planning and decision making, support the program to review and strengthen the Malaria Annual Plan, Roadmap, resolve identified or existing bottlenecks and to create a forum for selling the Business Plan.

### 3.0 MISSION TEAM

The mission team was made up of: SARN and RBM Secretariats.

1. Dr. James Banda
2. Col. (Dr) Kaka Mudambo

### 4.0 CALENDAR OF EVENTS

Day of the week	Action	Outputs
<b>Monday 18 August 2014</b>	<ul style="list-style-type: none"> <li>• Work with NMCP</li> <li>• Courtesy calls on, NMCP, WR (WCO),</li> </ul>	<ul style="list-style-type: none"> <li>• Review of developments, achievements, failures for the period 2011 to 2013.</li> <li>• Review of Roadmaps 2011 to 2013</li> <li>• Review of 2014 roadmap and implementation</li> <li>• SWOT analysis</li> <li>• Programmatic needs assessment</li> <li>• Partner expectations</li> <li>• SADC Malaria day events, ministerial session and RBM Board member dinner</li> <li>• Update on cross-borders</li> </ul>
<b>Tuesday 19 August</b>	<ul style="list-style-type: none"> <li>• Work with NMCP,</li> <li>• Work with funding and implementing partners: PMI, PSI</li> </ul>	<ul style="list-style-type: none"> <li>• Updating of the country roadmap and annual work plan</li> <li>• Review contributions by various partners</li> <li>• Discuss harmonization at strategic, operational and implementation levels</li> <li>• Review monitoring and evaluation arrangements and reporting</li> <li>• Review the role and expectations of and for RBM</li> <li>• Review the business case for resource mobilization, partnership expansion and management strengthening.</li> </ul>
<b>Wednesday 20 August</b>	<ul style="list-style-type: none"> <li>• Courtesy call to Minister, PS, Reproductive Health, Director EDC</li> <li>• Work with Funding and implementing partners: Plan International</li> </ul>	<ul style="list-style-type: none"> <li>• Review provincial/regional, district and community level action for fit with NMSP.</li> <li>• Capture examples of success stories of Win –Win partnerships</li> </ul>
<b>Thursday 21 August</b>	<ul style="list-style-type: none"> <li>• Courtesy call to Principal Director Planning/M&amp;E</li> <li>• Mission team work on report and preparation of presentation for the partners/all stakeholders dialogue/</li> </ul>	<ul style="list-style-type: none"> <li>• Partnership building</li> <li>• Resource mobilization</li> <li>• Multi sectoral action</li> <li>• Partner commitment to on going implementation</li> <li>• Prepare draft findings for presentation during all stakeholders meeting</li> </ul>

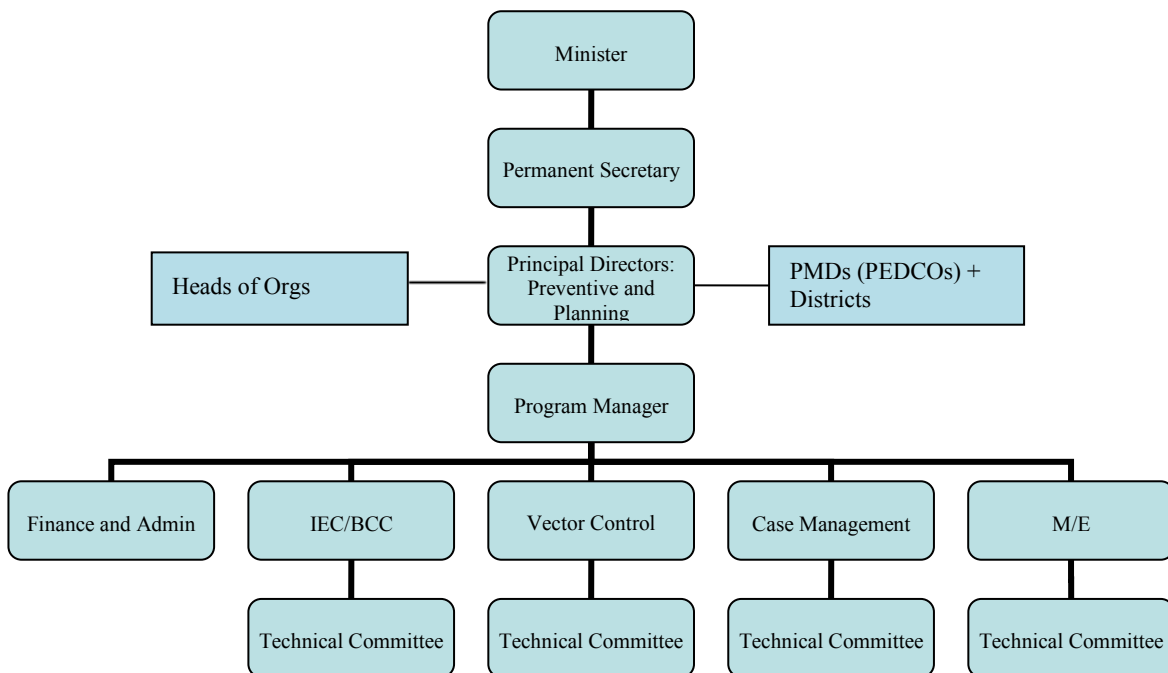
	marketing/development	
<b>Friday 22 August</b>	<ul style="list-style-type: none"> <li>• Work with NMCP</li> <li>• Partners/all stakeholders meeting</li> </ul>	<ul style="list-style-type: none"> <li>• Follow up on gaps in information</li> <li>• All stakeholders meeting</li> <li>• Finalization of mission report.</li> </ul>

## 5.0 MEETING WITH THE MINISTRY OF HEALTH

The NMCP Participants were:

1. Dr. Joseph Mberikunashe (Program manager)
2. Mr. Andrew Tangwena (M/E)
3. Dr. Stanford Mashaire (Case Management)
4. Mrs. Fortunate Manjoro (IEC/BCC)
5. Mr. Chauke (Vector Control)
6. Mrs. Emerly Chitate (Finance manager)
7. Mr. Wonder Sithole (Data manager)

### 5.1 MOH-CC ORGANOGRAM



### 5.2 Reporting Lines

In terms of Malaria reporting, the lowest entity in the NMCP reporting line are sub-committees which report to Technical Committees which in-turn report to their respective four Thematic areas (Vector control, Case management, M/E, IEC/BCC and the fifth component is Finance and Administration. The Thematic areas report to the Program Manager who heads the NMCP. The Program Manager reports to two Principal Directors (PDs) one for Preventive aspects and the other for Planning/M&E. The Principal Directors report to the Permanent Secretary (PS) who in-turn reports to the Minister of Health. However, there times when the Program manager reports directly to the Permanent Secretary. At Provincial Level there are Provincial Medical Directors (PMDs) who report directly to the PS. Below the PMDs are District Medical Officers (DMOs) who report to the PMDs. The lowest entity in the District is the Health Facility which reports to the DMO. Each province now has Provincial Disease Control Officers (PEDCOs) who report to the PMDs and although they are funded by Malaria, they also deal with other disease areas. In most Health Facilities are Village Health Workers (VHWs) who work at community level and report to the Health Facility. The PS also interacts with the Heads of Organizations such as WHO, PMI, PSI, CHAI, Plan International and UNICEF, Principal Director Preventive and Principal Director Planning and M/E.

### **5.3 Reporting Frequency**

All levels from the Minister to sub-committees hold meetings at different frequencies (weekly, monthly Quarterly, Bi-annually and annually).

#### **Management Meetings:**

**Weekly:** The Minister holds Ministerial meetings every Monday, the PS every Tuesday and the NMCP Management meeting in which the NPOs participate is also held weekly.

**Monthly Meetings:** Two monthly meetings are held: one by the CCM-subcommittee and the other by the Grants Management Committee.

**Quarterly Meetings:** Several Quarterly meetings are held and these are: Partners meeting chaired by the NMCP: Thematic Technical Committee meetings (Vector, control, case management, IEC/BCC, Surveillance monitoring and evaluation) also chaired by the NMCP: Quarterly review meeting (Prov, districts) and the PMI implementers meeting.

**Bi-annual Meeting** also known as the Ministry and Donor Organizations (MODO) meeting and this is coordinated by the Principal Director for Planning and M/E.

**Annual Malaria conference:** The NMCP organizes one annual meeting which is attended by all partners/stakeholders, Minister, PS, principal directors, provincial, district and health facility levels. The NMCP also invites neighbouring countries/cross-border districts including SARN-RBM Secretariats to attend the meeting.

## 5.4 M/E Moto

**The M/E has a Moto which is:** Quality Information: Quality Decisions and Quality Results

**Tools:** The NMCP has several tools at its disposal and these include:

- Malaria Strategic Plan which ends in 2017 (MSP – 2017). No end-term evaluation was done
- Annual Malaria Work plan (WP)
- Business Plan
- Monthly Generic Reports (Districts):

**Reporting:** Weekly surveillance report (generated by facilities): Weekly manager's report to the PS: Monthly Generic reports (Districts): but no NMCP monthly report): Annual Malaria Report

**Tracking:** The PS sends a monthly letter to the PMDs to prompt/remind them on timeliness, frequency and quality of reporting. Monthly updates and upload of Roadmap by the NMCP serve as tracking both for the NMCP, SARN Secretariat and RBM secretariat.

**Budget/Financial Management:** There are three main investors: Government of Zimbabwe (GOZ), GF and PMI. The GF funds are co-managed by the GF and program manager (the NMCP is a sub-recipient) but some activities such as Procurement is done by the Principal Recipient (PR). PMI funds are co-managed by the PMI and program manager. The GOZ funds are managed by the program manager.

There are meetings for discussing GF and PMI investments but there is no specific meetings for tracking spending of Govt Money (general discussions covering Malaria, TB and HIV and other projects are carried out during the MODO, but these are not detailed). The Anglican and Methodist Churches also provide funding for malaria in some districts but there are no specific meetings where these investments are discussed.

**Other investments:** Hippo Valley (Sugar Producer) is providing a complete malaria program within its Sugar plantation.

**Prospective investment:** ECOBANK and Public Service Medical investment (PSMI) have expressed their intention to become some of the investors. The program manager is in the process of negotiating with these potential investors. RTI and Health Information are supporting the SMS project which started with ECONET providing handsets to Health Facilities.

**PR-ship is in transition:** The current PR is UNDP however; the MOH has requested the GF that the PR be returned to the Ministry. In response, the GF has agreed on condition the Ministry meets the required conditions. The GF is currently assessing the Ministry after which a final decision will be taken.

### **Partner Mapping (Listing)**

WHO, GF PMI (PMI Implementers: PSI, MCHIP, JSI Deliver), PSI, Plan International, CHAI, Anglican Church, UNDP (PR), Anglican Church (operating in Victoria Falls and Binga district) and Methodist Church (operating in Chimanimani and Mt. Darwin districts)

**Private Sector include:** Hippo Valley and PSMI

### **Cross-borders Initiatives**

ZAM-ZIM (Zambia and Zimbabwe)

Zimbabwe IRS support to Mozambique in the North East district that borders Mozambique where they will spray a 10 km buffer Zone into Mozambique (2014 – 15)

### **Discussion with the Permanent secretary**

- The program manager's post is not on the current organogram but, the NMCP is recognized by the leadership of the Ministry as a **Special Program** that should have maximum flexibility and access. The weakness in this arrangement lies in the fact that collaboration with other Heads of projects or program seems to suffer.
- The **Good news** is that the PS indicated that document for the Program Manager's elevation to Deputy Director is now with the Health Services Board (HSB).

### **Discussion with the Minister of Health**

Zimbabwe should be included in the RBM management tool, implement the RBM performance template and its integration into the roadmap

### **Discussion with Reproductive Health**

The ideal scenario is for them to know who does what and involve all stakeholders in the development of guidelines. To strengthen maternal deaths audit, there is need for holding joint systemized training workshops.

## **6.0 MEETINGS WITH PARTERS**

### **6.1 Summary of PMI Meeting**



## List of Participants

1. Dr. Gail Stennies (PMI – CDC)
2. Ms. Christie Billingsley (PMI – USAID)
3. Mr. Regis Magauzi (PMI – USAID)
4. Dr. James Banda (RBM Secretariat)
5. Dr. Kaka Mudambo (SARN Coordinator)

## Main Outcomes

PMI supports 4 main areas: IRS, IPTp, LLIN (Mass distribution with a shift towards adding routine distribution and LLIN durability studies) and Case management and diagnosis (Procurement and distribution of ACTs and RDTs, Therapeutic Efficacy studies (TET), QC/QA). There however remain challenges with RDT QC/QA and PMI are currently exploring use of the PEPFAR – CDC partner which has been successful elsewhere. TET were done in 2013 and 2014 using 6 sites and the data and samples are now with the National Institute of Health Research (NIHR) who now have some PCR and genotyping capacity (they are undergoing training in these technologies to boost their capability). PMI are also supporting strengthening of M/E and BCC

In January 2014 NMCP changed Treatment guidelines and included ASAQ as second line therapy for uncomplicated malaria: parenteral Artesunate for severe cases and Rectal Artesunate included for pre-referral use at the community level. The updating of the malaria treatment guidelines are being supported by a PMI partner and planned to coordinate with the updating of the national essential medicines list.

On-going strengthening of NMCP Coordination with Reproductive Health and MIP is an area that needs attention and is a necessity for malaria case management guidelines.

PMI funds and support is currently implemented through 5 partners (PSI, JSI Deliver, MCHIP project in Manicaland for Community Health Workers (CHWs), ABT Associates and they also support the University of Zimbabwe (UZ) MPH program.

Annually, the budget for PMI/Zimbabwe has been about \$14-\$15 million since it began regular activities in 2012. PMI prioritizes funds for commodities.

Development of the Insecticide Resistance Management Strategy (IRMS) will be done with joint support from PMI and WHO after October 2014 when allocated funds are available.

Since 2011, when Zimbabwe became a PMI country, the NMCP has strengthened in program ownership, management, delivery and has a strong leadership. However,

gaps in funding and programming time differences make coordination workload management difficult at times.

In addition, there is a shortage of human resources allocated to the NMCP; an inadequate amount needed to manage the large volume of work.

The PMI team does meet with the program manager bi-weekly, and ad hoc as needed, but do not meet with the PS regularly. However, the USAID Health Team Leader meets with the PS regular and carries issues forward. The PMI Malaria Operational Plan team did meet with the PS for a briefing in April 2014.

PMI also holds quarterly meetings with their 5 implementing partners and other partners also participate while NMCP takes the lead role in facilitating the discussion.

### **Failures and Delayed Implementation**

**Entomological Studies:** Two key entomological studies (entomological sentinel site assessment and insecticide resistance mapping) were delayed by 1 year.

The PMI-MOP dates are habitually done in all countries far in advance of implementation (18 months). This is determined by the PMI headquarters so funding can be planned for and requested in advance. The PMI country teams remain as flexible as possible and go through a reprogramming exercise to address unanticipated funding needs or shifting priorities. The different PMI schedule (fiscal year 1 October – 30 September) is different from the NMCP and GF fiscal years so coordination in planning can be challenging.

Harmonization of entomological surveillance was delayed due to discrepancies in the per diem rates, discouraging MOHCC and NIHR staff to work on PMI-funded activities. GF has higher rates (they decided to increase allowed rate as part of the current grant budget without input from other organizations) while the Bilateral agencies, PMI, and UN-Agents have lower rates determined by the Ministry of Finance.

**Diagnosis QA/QC:** In 2012 PMI had planned to allocate funds to a local diagnostic entity, ZINQAP, but after further review this was not possible in the immediate term because of strengthening needed in governance and administration recognized by another USG agency. There was no other local entity, as requested by NMCP, available with the same expertise as ZINQAP, so PMI asked a specialist from CDC/Atlanta to write a detailed description of what diagnostic support was needed to be added to the GF grant (new funding model) so GF might consider funding diagnostics. PMI is currently exploring other partners with diagnostic capacity that could be potential grantees/contractors in the future, such as the American Public Health Laboratory (APHL), which has a current relationship with CDC to support HIV/AIDS diagnostics in Zimbabwe.

**Documentation, Equipment & Historical Data:** PMI noted that there are sometimes delays in developing and sharing meeting minutes, documenting activities, and related information probably due to limited staff time and poor access to equipment/space/facilities such as internet. There is also a need to improve the historical data storage and create a library of knowledge for NMCP.

**Collaborating with other Government of Zimbabwe Offices:** Collaboration with other Ministry of Health and Government of Zimbabwe offices can be challenging and prevent activities from achieving optimal success.

LLIN routine distribution in collaboration with Ministry of Education is experiencing challenges due to delayed communication and delayed provision of data by the Ministry of Education as they await a formal request from the Ministry of Health.

Cross-departmental communication and linkages, such as with Reproductive Health office, require strengthening and this includes relations with the National Institute of Health Research (NIHR) especially on entomological activities and access to the Insectary (mosquitoes) by partners. Malaria partners would benefit from strengthening ties to NIHR and more regular communication with NIHR.

## **6.2 Summary of PSI Meeting**

### **List of Participants**

1. Ms. Lisa Norman (Country Representative)
2. Dr. Ngonidzashe Madidi (Director: Reproductive Health and Malaria)
3. Mrs. Joy (Malaria Manager)
4. Dr. James Banda (RBM Secretariat)
5. Dr. Kaka Mudambo (SARN Coordinator)

### **Main Outcomes**

PSI supports LLIN (Mass distribution) and LLIN durability studies) and Case management - they act as a conduit for resources to come through and they are a member of the Case Management Technical Committee. PSI has the capacity, experience and ability to investigate and follow up outbreaks and conduct follow up training in case management. In SBCC, PSI supports in mass media for IRS campaigns and LLINs distribution. The gap in SBCC lies in funding because there is no stand alone budget for SBCC in the current Concept Note Module because it is seen as a small component of each thematic area hence it is fragmented making it difficult to plan. In the past 3 years PSI has chaired the SBCC technical committee and in 2014 they are the Vice Chair.

1. In 2014 PSI are spearheading Routine distribution in which they have distributed 1.2 million nets (2014). They are an Implementing partner of the

PMI who have introduced the **Networks project** for a 1 year trial period for Routine distribution at the end of which it will be scaled up. This trial period involves several partners (NMCP, PMI, PSI, JSI and Ministry of Education). Schools are being used for net distribution and they work through the MoHCW and Education provincial officials. PSI Platforms are used for supporting both supply and distribution. A net durability study has also been introduced using new Guidelines developed by WHO and PMI. Because PMI cannot give funds directly to the Zimbabwe government, it creates both coordination and implementation challenges for the implementing partners. It would work much better if the NMCP had an expert to oversee the project implementation process.

2. The NMCP has registered important achievements especially that of moving some districts from control to pre-elimination. This is because the NMCP is managing to take advantage of the expertise in the in-country partnership to provide the required support in Human Resource gaps.
3. The NMCP has also managed to increase all thematic areas activities and linkages in the field.
4. There is need for elevation of the status of the program manager in the MoHCC structure because it attracts more funding.
5. While many meetings are conducted, most of them do not attract the participation of senior officials in both the Ministry and partners. There is need for this to change and ensure decision makers also interact.

### **Keeping Track**

- a. The PMI partners meeting is used for tracking progress: implementing partners are required to share progress made, challenges and share their concerns.
- b. Because there is constant movement of malaria expertise from one organization to another, it does not translate into improved performance and hence the need for the NMCP and partners to establish a harmonized **Plan Management Platform** to manage this recycling challenge.
- c. There is need to increase support to NMCP to monitor the surge in outbreaks and resurgence while ensuring there is no continued dependency on the GF and PMI funding alone.

### **Failures**

- a. A good number of local partners from the commodity producers have been lost because they cannot compete with the stringent procurement and supply requirements imposed by the GF and other donors.

- b. The approach to pre-elimination in which one province has been selected is risky because it is tied to funding rather than the actual ground reality since there are many other districts that now meet pre-elimination requirements but because they are scattered in different provinces, they have been left out.
- c. Partners should now concentrate on supporting the NMCP to fine-tune coordination, focus on rectifying weaknesses because the NMCP is depended on the GF and PMI (it is risky). The NMCP also need support to ensure they have information on their finger-tips.

### 6.3 Summary of PLAN Meeting

#### List of Participants

1. Mr. William Matane (National malaria Coordinator)
2. Mr. Nigel Murimiradzomba (Resource Mobilization Manager)
3. Dr. James Banda (RBM Secretariat)
4. Col (Dr.) Kaka Mudambo (SARN Coordinator)

#### Main Outcomes

1. PLAN is a Child Centered organization which supports 4 main sectors:
2. Health sector in which Malaria and Maternal Health fall. They operate in 10 traditional districts (Bulawayo, Tjolotjo, Chiredzi, Mwenezi, Kwekwe, Mutoko, Epworth, Mutare, Mutasa and Chipinge). They also have an additional 5 districts specifically for Malaria thus, they support a total of 15 districts in which they use the GF and their own resources. The 5 Malaria districts in which they distribute LLINs are (Umguza, Murewa, Gorominzi, Bubi and Mberengwa).
3. Plan supports and participates in 2 thematic groups: Vector Control and BCC. Using the GF funds, they have in 10 districts established the **Neighbour to Neighbour** mobilization and learning platforms and **School Health Masters** for coordinating training, competitions and identification of role players and malaria champions
4. Plan also supports strengthening of EPR
5. For any local funds they mobilize, their counterpart office in Canada (Plan Canada) then provide funding by matching with 10 – 15%. In 2014 Plan Canada supported with USD 35,000 which has been partitioned as follows:
  - a. USD 5,000 for CN development
  - b. USD 19,000 for Social Mobilization

- c. USD 9,000 for monitoring LLIN distribution activities (security to ensure there are no nets pilferages and for movement of distribution managers to supervise the distribution process)

## **Achievements**

- a. Support to Tjolutjo district together with other partners have moved the district to pre-elimination (<1/000).
- b. Plan together with other partners are contributing towards the development of national strategies, guidelines and CN
- c. They will now engage the NMCP towards establishing a team of partners that ensures monthly upload of the Roadmap.

## **7.1 Summary of WHO meeting**

### **List of Participants**

1. Dr. David Okelo (WR)
2. Mr. Jasper Pasipamire (NPO-MAL)
3. Dr James Banda
4. Dr Kaka Mudambo

## **Main Outcomes**

- a. WHO continues to provide technical support to NMCP and guidance to implementing partners.
- b. The NMCP is performing well and in the past five years has posted remarkable achievements leading to significant reduction in cases and deaths and from control to pre-elimination in several districts.
- c. Efforts should be put towards prevention of imported malaria, insecticide resistance, strengthening surveillance, M/E and reporting
- d. Support is needed towards achieving milestones and reporting in 2015.

## **8.0 PARTNER MAPPING**

There exists a broad based in-country partnership made up of the following organizations:

Private Sector, Research and Academia, UN Agents, NGOs, Civil Society, community, religious organisations, Government institutions and multilaterals as evidenced below to mention but a few - WHO, ABT, PSI, PMI, PLAN, MCHIP, JSI, Hippo Valley, HEDEC, Reagent Laboratories, IOM, PSMI, Anglican and Methodist Churches, Red Cross, CIMAS, Sanofi, PCD, CHAI, UMCOR, ZUNDINE, Hwanke Colliery, CHEMPLEX, Aryster, PCD, Stanbic, ECOBANK, National Health Trust Fund, Nets for Africa, Vestergaard, community (Traditional healers, chiefs and others)

## **9.0 NEXT STEPS**

Follow up during the NMCP Annual Meeting the following issues:

- Help complete 2014 Roadmap – to have a complete published record
- Include Zimbabwe in piloting the management tool
- Support efforts towards removal of insecticide resistance and strengthening QA/QC
- Appeal to the Zimbabwe partnership to continue helping in the tool for landscaping partnership
- Support program reviews, business marketing and grant making
- Support documentation of program performance/achievement of GMAP targets
- Support end term review of malaria strategic plan
- Plan for the SADC Health Ministers Meeting and the SADC Malaria Day events
- Discuss with the Board Member preparations for the Board meeting
- Follow up with the Minister on the Endemic Countries Board Member's forum (MEC)