



**KeNAAM**

Kenya NGO's Alliance Against Malaria

# East Africa

## Regional Malaria CSO's Consultation

26th – 29th March 2017

Amber Hotel, Nairobi, Kenya

# East Africa Regional Malaria CSO's Consultation

Held on 26th – 29th March 2017  
Amber Hotel, Nairobi, Kenya

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# Abbreviations and Acronyms

ACSM	Advocacy, Communication and Social Mobilization
ACT	Artemisinin-based Combination Therapy
ALMA	Africa Leaders Malaria Alliance
APCASO	Asia Pacific Council of AIDS Service Organizations
BCC	Behavior Change Control
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CHV	Community Health Volunteer
CRG	Community Rights and Gender
CSO	Civil Society Organization
CSR	Corporate Social Responsibility
CU	Community Unit
DRM	Domestic Resource Mobilization
FBO	Faith Based Organization
GF	Global Fund
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoK	Government of Kenya
HMIS	Health Management Information System
ICCM	Integrated Community Case Management
IDPs	Internally Displaced Persons
IEC	Information Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IPHA	International Public Health Advisors
ITP	Intermittent Preventive Treatment
KeNAAM	Kenya NGOs Alliance Against Malaria
LLIN	Long Lasting Insecticide Treated Nets
M&E	Monitoring and Evaluation
MACIS	Malaria and Childhood Illness NGO Secretariat
MARPs	Most At Risk Populations
MiP	Malaria in Pregnancy
MoF	Ministry of Finance
MoH	Ministry of Health
MP	Malaria Policy
MPR	Malaria Programme Review
MSP	Malaria Strategic Plan
NGO	Non-Governmental Organization
NHIF	National Hospital Insurance Fund

NMCP	National Malaria Control Programme
PR	Principal Recipient
RAME	Reswau access aux médicaments essentiels
RBM	Roll Back Malaria
RDT	Rapid Diagnosis Tests
SBCC	Social Behaviour Change Communication
SMEOR	Surveillance Monitoring Evaluation Operation Research
SR	Sub-Recipient
SSR	Sub-Sub-Recipient
TA	Technical Assistance
TANAM	Tanzania National Malaria Movement
TB	Tuberculosis
TNCM	Tanzania National Coordinating Mechanism
NSA	National Strategy Application
VHT	Village Health Teams
WMD	World Malaria Day





# Executive Summary

The **East Africa Regional Malaria CSOs Consultation** held in Nairobi, brought together 50 participants from over 35 Civil Society Organizations (CSOs) working on malaria in Kenya, Uganda and Tanzania; guests from the National Malaria Control Programme (NMCP); technical experts/consultants as well as bilateral partners.

The organizers conducted an evaluation for the workshop from the set out expectation at the beginning of the Consultation. Results from this evaluation show that the objectives and expected results were largely met as contained in Appendix 3 of this report.

During the opening session, the Vice-chair of the Kenya Coordination Mechanism, Dr. Samuel Mwenda stated that there has been strengthened CSO engagement since the relationship with the Global Fund begun. Towards this end he emphasized the need for CSOs to focus on how best to sustain the gains already made in the malaria response. On his part, the KeNAAM Chairman Dr. Maurice Odindo emphasized on the need for the removal of barriers between countries, and CSOs at large so as to work towards strengthening partnerships. Kate Thomson the GF-Head CRG department highlighted the role of the department within GF and the investments being undertaken within malaria and wider CRG Special Initiative.

Effective malaria programming was the theme for the day 1 presentations which started with sharing of the role of the CSO's which anchored around the CSO's as the strongest link for malaria control programs to move to next phase of malaria delivery continuum. The role the networks have played in carrying out malaria in the region was shared by the 3 networks; KeNAAM,

Macis and TANAM. Their role especially around CSO's coordination, advocacy and communication has catalysed gains recorded in the region on malaria control. The day ended by having CSO's GF Principal Recipient share their experiences and innovations in running malaria grants in the region.

Day 2 started with a group discussion with participants identifying the barriers for effective malaria programming. They highlighted governance, service delivery, resources, gender, human right and information system as key barriers. This provided a basis for the next session which provided comparative analysis for malaria investment in the East Africa region. Participants with experience in domestic resource mobilization shared their country experiences which then led to a discussion by CSO's currently implementing advocacy work on health. The key issue that come out was the role of CSO's to be involved in County budget making process while at the same time working with the national and sub-national level structure to keep track of the resources already allocated to malaria and health.

Day 3 provided the participants with a reflection of how they can leverage partners in delivery of malaria program at the community level. The Kenya NMCP highlighted the need for coordination of partners and implementation of the policies by every partner so as to have impact within the communities they work. This was reiterated by Head CRG at GF urging partners to roll out the activity and where there are gaps the CRG Strategic initiative can support through a request of the required technical assistance.







# Background

Successful response to malaria and health rests on the meaningful engagement of all actors, including civil society and particularly vulnerable and marginalized populations. At the same time however, communities often lack access to knowledge and information necessary to play an active role in malaria programming and tackling health issues. Moreover, the impact of malaria programs is often limited because they pay insufficient attention to barriers related to human rights, gender and other inequalities and exclusions. There also remains significant limits to the meaningful engagement of, and effective investment in, communities/civil organizations which are potentially well placed to help address these programme gaps. There are few technical assistance opportunities for communities/civil society, under resourced networks, in particular for vulnerable and marginalised populations and inadequate regional platforms to facilitate communication and coordination.

## The Need

In order to ensure that the malaria and health programs commitment to community engagement is maximized - significantly increased investments are necessary. This is to ensure communities on the ground are adequately supported to mobilize effectively, so that they can contribute to the design and delivery of programmes that address social determinants of health.

## Focus of the Workshop

The workshop was geared towards learning from experiences and similar programs that have been implemented in the region. This new knowledge and skill was geared towards helping participants reach communities in need, hold service providers to account, and advocate for appropriate new sources of investment in responses to malaria, particularly in contexts where reliance on donor support is decreasing.

Global financing mechanisms such as the Global Fund recognizes that strong community systems are critical to effective responses to the three diseases and the fulfilment of the right to health of populations most affected by HIV, tuberculosis and malaria. Such investments are particularly critical given the neglect of these communities in many national responses.

## Workshop Objectives

The overall objectives of this Consultation were as follows:

1. To strengthen the capacity of CSOs working on malaria to participate on networking, advocacy and partnership in malaria control programs.
2. To strengthen the capacity of CSOs working on malaria in advocacy for Domestic Resource Mobilization.
3. To share experience amongst Malaria CSO's in Kenya, Uganda and Tanzania.

Participants cited their expectations of the Consultation; they are summarized as follows:

- As malaria implementers in Kenya, Uganda and Tanzania, develop best practices on how to coordinate better.
- Gain knowledge on domestic financing and come up with ways to effectively utilize limited resources to maximize impact.
- Understand the use of traditional medicine therapies towards the treatment of malaria and the overall reduction of the cost.
- Identify the structural issues on funding.
- Identifying and addressing gender and human rights barriers in the prevention and treatment of malaria and how best to reach the people that need them.

# Welcome Remarks



**By: Dr. Samuel Mwenda,**  
**Vice Chair, Kenya Coordination Mechanism**

In his remarks, Dr. Mwenda stated that the health sector in Kenya is now devolved, with counties dealing with health service delivery, the private sector providing private for private and private not-for-profit health services as well as Faith Based Organizations (FBOs), CSO, and NGOs all contributing to over half of the health services in Kenya.

The inter-agency coordinating committees in Kenya, he noted, cuts across various diseases programmes and health system strengthening areas thereby giving space for stakeholders to be a part of coordination structures for the various diseases. Towards this end, he lauded KeNAAM for being a credible voice for CSOs in Kenya.

On malaria prevention, control, appropriate diagnosis and treatment, Dr. Mwenda pointed out that CSOs have been in the forefront in mobilization and creating community awareness on malaria treatment and the importance of data and evidence in tracking the malaria response. Kenya's CCM, he stated, has evolved over the years and improved on its governance structures as well as seen the involvement of non-state actors in its structures including having representation from the counties, KCM, ICCs, NGOs, communities affected or those living with or affected by diseases, FBOs, private sector (formal and informal), key populations, and the academia.

In Kenya, a lot of gain has been made since the relationship with the Global Fund begun, particularly in strengthening CSO engagement; in this regard, KeNAAM is making contributions towards the application process to the Global Fund. This meeting, he stated, is an opportunity to learn from each other as well as come up with strategies as a region on how best to address the issues they face as well approaches that would help scale up the achievements.

In conclusion, he emphasized the need for CSOs to focus on how best to sustain the gains already made in the malaria response by;

- i. building on the positive lessons learned in order to address the existing gaps,
- i. stepping up advocacy towards increasing domestic resource mobilization and ensuring they

- are appropriately allocated, with value added,
- i. building on the efficiencies and the importance of data and evidence to track CSOs performance as well as the resources being used in the malaria response,
- i. ensuring that the health insurance sector moves towards covering treatment for malaria as well the other diseases, and v) setting aside resources towards promoting prevention.

### **Dr. Maurice Odindo, KeNAAM Chairman**

Dr Odindo noted that the Workshop is a unique opportunity for the stakeholders to come together and join hands towards a malaria free Kenya, East Africa and Africa. He emphasized that this is attainable and possible. The Workshop, he said, seeks to share experiences and help build partnerships and bring stakeholders together around malaria programming.

In closing he stressed on the need for CSOs to learn from the mosquitoes by removing barriers between countries, institutions and work towards strengthening partnerships.

### **Kate Thomson, Global Fund, Head, Community Rights and Gender Department**

Kate Thomson began her remarks by thanking the organizers and participants from KENAAM, TANAM and MACIS.

The Global Fund, she said, is founded on the principles of community engagement and partnership with all partners who include communities most affected by the diseases, government, FBOs, or the private sector. Towards this end, community engagement and the full participation including programming of all the different and relevant partners is essential.

The CRG department within the Global Fund was created with the understanding that to end the epidemics and to strengthen the community systems and responses then the barriers or obstacle related to human rights, gender, marginalized groups, key populations, etc. will need to be adequately addressed

The new Global Fund Strategy 2017-22, she stated, focuses, more than ever before, not only on ending epidemics but on recognizing that one cannot make progress without also addressing key elements such as human rights related barriers to services, gender considerations, strengthening of community responses and systems, and importantly, putting those most heavily impacted, including those most marginalized and left behind within the disease responses at the centre of its efforts.

During the last Global Funding cycle, one of the things done to ensure the meaningful engagement of community and civil society organizations (CSOs) in the roll-out of the Funding Model (2014-2016), the Global Fund Board approved a Special Initiative, the CRG SI (Community Rights and Gender Special Initiative) of US \$15 million with the following three primary components:

1. Providing short-term technical assistance for country dialogue and concept note development on human rights and gender as well as community; provision of technical assistance on human rights, gender and community systems strengthening by 34 CSOs selected through open tender bid.
2. Long-term capacity development of key populations networks as well as looking at the capacity development and partnership development of advocacy networks and more recently towards supporting engagement of community malaria related grants.
3. Regional civil society and community communication and coordination platforms in each of the regions where the Global Fund is present. This has enhanced civil society and community coordination as well as communication across all three disease areas and HSS. The civil society led platforms work closely with bilateral and multilateral partners on technical support and quality assurance.

As part of the second element of the Global Funds CRG SI, in September 2016, four organizations were selected as a part of the Community, Rights and Gender Special Initiative to reinforce the meaningful engagement of civil society and communities affected by malaria. From October 2016, these organizations have worked towards



conducting national and regional level work with the aim of increasing the impact of the Global Fund's investments in malaria. Their overall objectives are as follows:

- To increase meaningful representation and inclusion of civil society and community voices in Global Fund processes related to malaria within and across the proposed program countries.
- To enhance the understanding and analysis of human rights and gender-related barriers, key populations and community responses in the context of malaria.
- To contribute to the inclusion of community-centred, rights based, and gender-transformative interventions within country and regional Global Fund-supported malaria programs.

The successful entities, which were selected via a competitive process, included;

- i) Asia Pacific Council of AIDS Service Organizations (APCASO)
- ii) Reswau access aux médicaments essentiels (RAME)
- iii) International Public Health Advisers (IPHA)
- v) Kenya NGO Alliance against Malaria (KENAAM)

The following are snapshot of what's been done by the different groups:

#### APCASO:

1. Support the newly formed regional Malaria Civil Society Platform to perform its function as a regional advocacy group particularly for human rights and gender-related barriers, key populations and community responses in the Greater Mekong Sub-region malaria response.
2. Support the Malaria Civil Society Platform partners to more effectively engage and input into the regional malaria programme, particularly to the current regional and country dialogues and grant applications.
3. Build the regional malaria CRG knowledge base through developing, packaging and disseminating information materials in the context of malaria.

#### RAME:

1. Contributing to the development of a guide for civil society mobilization and advocacy on issues concerning gender and human rights.
2. Training at least 30 representatives of people

affected by malaria, through work with CCMs from six countries in the African francophone region on social mobilization techniques and advocacy for integration of gender issues and human rights in the fight against malaria.

3. Developing and sharing information on training modules for mobilization and advocacy on the inclusion of gender and human rights into national responses against malaria.

#### IPHA:

1. Conduct a landscape analysis of current community, rights, and gender stakeholders and activities relevant to Global Fund malaria grants.
2. Leverage identified resources to develop relevant training materials.
3. Convene appropriate stakeholders in a facilitated training session and workshop to identify key barriers and elements critical to success.
4. Develop a set of CRG engagement modules to help countries in identifying "who," educating individuals "how," and facilitating "what" can be done; and 5. Document lessons learned and present an actionable path forward.

#### KENAAM:

1. Strengthen the capacity of communities to engage in, and mobilize around, the Global Fund funding model and associated processes
2. Further support the participation of regional health civil society and communities in advocating for increased investment in domestic resources for malaria in three countries: Kenya, Uganda and Tanzania
3. Enhance the participation of civil society and communities in regional, national and sub-national malaria programs, in particular in high malaria endemic counties in Kenya
4. Participate in the development of core modules for strengthening community engagement and promoting greater attention to human rights and gender barriers in malaria programs.

In closing Ms. Thomson said that the Workshop acts as a platform for learning from each of the country experiences in advocacy, networking, partnership for malaria control, as well as advocacy for domestic resource mobilization.

# Plenary Discussions

The following were the key discussion outcomes:

## Key Malaria Populations:

It is really about identifying who is being marginalized and left behind and not receiving services; who is facing barriers towards accessing prevention or treatment of malaria. Identifying key malaria populations is about determining who is not getting the services and why they are not getting them. It is about ensuring that those that have been left behind are accessing services.

## The role of the academia in malaria prevention:

Their huge role is at the CCM level. It also comes down to the individual country network or platforms, and whether there is a need to involve the academia e.g. in operational research

## Climate change and malaria:

The effects of climate change exposes areas to malaria. Research has revealed that as a result of climate change, some highland areas of Uganda that were not previously exposed to malaria are now increasingly exposed. As the vision of zero tolerance to malaria is pursued, the effects of climate change as a factor should be brought to the fore including the development of new tools to fight the scourge, particularly in zones where malaria was never present.

## Key challenges faced by KeNAAM in implementing malaria interventions:

- How communities respond to malaria remains a challenge.
- Behaviour change communication on use of LLIN's: There still remains a disconnect between use and possession of LLIN's by the community. They need to be educated more on the benefits of their use.
- Devolution in Kenya: With the health sector devolved, the counties are now in charge of their respective health priorities.

## A case of community involvement in malaria prevention:

In the case of Kenya, communities want to play a greater role with regards to malaria control. In Malindi, a local community has taken up an initiative towards vector control within their community to control malaria by setting up interventions at the larval stage of mosquitos by working with the local county council as well as hotel owners. This approach has had a tremendous impact in the area with regards to malaria control.



# DAY I



# Session I:

## Effective Malaria Programming: Key Challenges And Opportunities For Malaria CSOs

*Session Chair: Dr. Maurice Odindo*

### 1.1 The roles of CSOs in combating Malaria – The Strongest Link

The core malaria interventions currently can be categorized as follows:

- Prompt and effective case management using Rapid Diagnostic Tests and Treatment with the use of Artemisinin-Based Combination Therapy (ACT)
- Intermittent Preventive Treatment of malaria in pregnancy
- Integrated Vector Management
- Other cross cutting interventions including Advocacy, Communication and Social Mobilization, Effective Programme Management, M&E, Partnership and Collaboration.

These are the key interventions for malaria control at the moment; extent of implementation however is variable. CSOs come in through the following levels, National, Regional, and District level of operations

#### National Level

- Have a coalition of CSOs organized into a good structure, e.g. National Executive, Secretariat, etc. that would effectively coordinate the CSOs response to malaria.
- Looking at collateral activities that eventually determine the direction of malaria control in the country. NGOs/CSOs must participate fully in the development of National Strategic Plans, setting up of Standards, Development of Guidelines, Procedures, National level proposals and Advocacy activities.

- Participate to step down National Strategies, Standards, Guidelines, Policies and Procedures to the regions, provinces or districts as they are the key communicators
- Contribute and support the government to effectively carry out its functions

#### Regional Level

- Step down the adapted National strategies, Standards, Guidelines, policies and Procedures to the regional levels
- Contribute to and support the regional government to effectively carry out its functions

#### District Level

- Develop a database of all active CSOs, NGOs acting or operating at the district and community level for purposes of ensuring quality control.
- Need to be rigorous towards ensuring that every member has well-structured systems in place, especially around finance and audit issues including proper documentation. Quality control should also be carried out at this level.
- In this regard the following activities can be taken up:
  - » Coordinate the community response to malaria at the district level.
  - » Carry out monitoring and evaluation, data collection and reporting on issues at the community level as well as providing effective feedback.

- » Implementation of policies
- » Use guidelines and strategies on malaria prevention, treatment and home management.
- » Mobilize human and financial resources for effective and sustainable activities on malaria issues at this level.
- » Coordinate the FBOs and the CBOs involved in Malaria activities at the District level
- » Advocacy to stakeholders at the District and Community levels within the public and Private sectors as well as the Traditional Institutions for sustainable multi-sector involvement at the Local government level
- » Strengthen the capacity of stakeholders at the District level on M & E, Social Mobilization and record keeping

- » Training of Community Health Workers/PMVs
- » Community entry and mobilization
- » Record keeping and provision of feedback into the HMIS to the State Ministry of Health
- » Attend meetings on the WDC on malaria issues and provide feedback to stakeholders

#### What are the roles of CSOs in:

- Improving case management
- Promoting the use of LLINs
- Promoting ITP of MIP
- Promoting Environmental Management Activities
- Facilitation Information, Education and Communication of Positive Behaviour Change
- Facilitating partnership
- Operational research

**Table 1: CSO Activities & Roles**

No.	Activity	Role
1.	Improving case management	<ul style="list-style-type: none"> <li>• Health education in various relevant for a.</li> <li>• Sensitization/public enlightenment on new policy and appropriate treatment for malaria.</li> <li>• Distribution of antimalarials within the community.</li> <li>• Formation of health clubs/malaria societies within secondary schools.</li> <li>• Capacity building for healthcare providers, laboratory scientists and community oriented resource persons, e.g. PMVs</li> <li>• Advocacy to improve support for appropriate case management subsidy on drugs, community involvement in management of primary health facilities.</li> <li>• Operational research – Health seeking behaviours, home management and herbal remedies used in the management of malaria.</li> </ul>
2.	Promoting the use of LLINs	<ul style="list-style-type: none"> <li>• Promoting the use of LLINs through IEC/BCC in various relevant for a.</li> <li>• Sensitization/enlightenment on the use of LLINs.</li> <li>• Distribution within the community (free, subsidized or cash)</li> <li>• Formation of health clubs/malaria societies.</li> <li>• Advocacy to improve support for use of LLINs, prescriptions of LLINs at health facilities.</li> <li>• Operational Research.</li> <li>• Record keeping, feedback and monitoring/tracking of LLIN use and impact.</li> <li>• Supportive supervision.</li> </ul>

3.	Promoting IPT of MIP	<ul style="list-style-type: none"> <li>• Sensitization/public enlightenment to promote awareness and create demand for IPT through IEC/BCC in various relevant for a.</li> <li>• Capacity building of healthcare providers</li> <li>• Establishment and sensitization of Community level Model Caregivers</li> <li>• Advocacy to improve support for use of IPT at health facilities.</li> <li>• Operational research.</li> <li>• Record keeping, feedback and monitoring /tracking of IPT use and impact.</li> <li>• Supportive supervision</li> <li>• Pharmacovigilance</li> </ul>
4.	Promoting Environmental Management Activities	<ul style="list-style-type: none"> <li>• Sensitization/Public Enlightenment to promote awareness through IEC/ BCC in various relevant for a.</li> <li>• Formation of health clubs/malaria societies in schools.</li> <li>• Capacity building of health care providers.</li> <li>• Establishment and sensitization of Role Model Caregivers.</li> <li>• Advocacy to improve support for environmental management at community levels.</li> <li>• Operational Research.</li> <li>• Record keeping, feedback and monitoring.</li> <li>• Supportive supervision.</li> <li>• Participation of CSOs during environmental sanitation days in homes and markets.</li> <li>• Fumigation of schools, homes and offices.</li> </ul>
5.	Facilitation Information, Education and Communication of Positive Behaviour Change	<ul style="list-style-type: none"> <li>• Taking part in the development, field testing and finalization of IEC materials</li> <li>• Adopt the general IEC material as would be approved by NMCP</li> <li>• Translate into various languages in their various areas of operation and actively take part in dissemination.</li> <li>• Collaborate with Regional and District level stakeholders in mass mobilization activities for health, in general and malaria in particular.</li> <li>• Effectively monitor and evaluate the usage, outcomes and impact of the IEC materials and provide feedback to NMCP and the RBM partnership</li> </ul>
6.	Facilitating partnerships	<ul style="list-style-type: none"> <li>• Facilitation of the formation of partnerships at the community level with relevant stakeholders.</li> <li>• Strengthen and support CSO Networks to advice and guide implementation of interventions by NGOs and foster network and linkages.</li> </ul>
7.	Operational Research	<ul style="list-style-type: none"> <li>• Identification or research needs and priorities</li> <li>• Involvement in researchers on use of herbal remedies, communication strategies, health seeking behaviours, community needs and roles.</li> <li>• Dissemination of information on research outcomes.</li> <li>• Bridge the gaps between the traditional medical and orthodox practitioners.</li> <li>• Collaborating with research institutions and institutions of higher learning on malaria research.</li> <li>• Proposal writing, resource mobilization and documentation.</li> </ul>



## Summary

1. He indicated that CSOs are the strongest link; we could also be in many cases be the 'missing link'.
2. CSOs need to understand or define the role they can best play during the next GF implementation period
3. CSOs need to examine their own ideas and develop a checklist in the different programmatic areas (as an organization or a member of the organization) they are involved in at the various levels.
4. CSOs need to define the critical roles CSO can effectively play so that their contributions can be felt.

## 1.2 Plenary Discussion

The following were the key discussion outcomes:

- Other approaches that can be used as key malaria interventions:
  - » Holding public actors accountable towards helping reduce waste when carrying out the interventions, e.g. i) budget tracking, ii) where implementation plans are being drawn CSOs should be keen enough to determine whether they are any loopholes, iii) public criticism or whistle blowing.
  - » Analysis of the national policy environment towards identifying or coming up with particular methods that can be used to advocate for pro-poor and inclusive approaches, which are critical for malaria control.
  - » CSO's should help track technical issues about malaria, e.g. fully understanding the implication of a report and the issues that may arise.
- Being a country led concept, the Global Fund allows for Principal Recipients to take charge of the grants they have received and determine the strategies and level of flexibility of their implementation, e.g. allowing an organization or individual to carry out the activity, as well as operations research.
- The changing landscape in malaria prevention and control requires a change in the approach interventions are carried out, e.g. involvement of communities.
- Much needs to be done so that community engagement and rights based approach can be done in a more effective way.
- The Global Fund's The New Funding Mechanism: Delegations of CSOs and NGOs should be fully present at meetings and discussions around the new funding mechanisms; actively involved right from the start, e.g. through lobbying.
- With the funding from GF reducing by the year, CSOs should start documenting their activities, build strong internal structures as well as capacity, towards reducing their overhead costs, so that in the event of a funding reduction, their activities would still go on, the results of which can be used to obtain funding from other donors.
- There is need for discussions around how CSOs can be sustained beyond the Global Fund's fund cycle, e.g. its structures.
- We need to adopt simple ways of communicating the malaria message.

# Session 2:

## The Role Of Country Networks For Effective Malaria Programs

**Session Chair:** Mercy Musomi

*In this session, the Networks from Kenya, Uganda and Tanzania shared their experiences on the programs they have been running on effective malaria control.*

### 2.1 Tanzania:

~ Beatrice Thadeus Minja, TANAM

The strategic areas of TANAM's strategies, which include:

- Improvement of documentation and dissemination of best practices
- Improve coordination with other partners
- Establish a sustainable programme for retaining its community members through several social enterprises

It plays several roles in malaria programming and has achieved a lot through its solid and decentralized structures working with over 100 NGOs and CBOs including over 1000 community health workers country-wide. In this regard, it has mobilized foreign as well as local resources, empowering community actors into ITN distribution as well as in IRS. Towards its end, TANAM has reached over 50% of Tanzanian's on malaria awareness as well as empowered community groups who focus on malaria.

TANAM has also helped raise the malaria prevention effort at all levels as well as made effective use of the by-laws linked to malaria vector control thereby transforming and influencing political leaders and technical personnel in developing the current Malaria Strategic Plan 2014/2020 with the focus on malaria elimination. TANAM's efforts in malaria control compliment the country's Malaria Strategic Plan.

### 2.2 Uganda:

~ Dr. Patrobas Mufubenga, MACIS

The main aim of the MACIS network in Uganda was to coordinate NGOs activities and maximize their impact on malaria and childhood illnesses in the country. With its Vision being to see a vibrant and capable civil society towards being a key player in eradicating malaria and childhood illnesses as well as maternal health.

MACIS seeks to provide sustainable leadership and coordination of CSOs towards promoting the government recommended interventions in malaria and childhood illnesses as well as advocate for evidence based best practices and policies at all levels.

MACIS currently has an open membership consisting 453 organizations who are spread around the country. To avoid competition and confusion with government, MACIS has aligned its efforts to that of the government at every level, i.e. harmonizing CSO activities with those of the government

The network seeks to bring both the strong and weak CSOs together towards the common objective as well as to share resources, share best practices and learn from each other.

The impact MASIS has had on effective malaria programming:

- It has coordinated CSO efforts to influence the policy agenda

- It has strategically positioned different CSOs at different levels so that they can influence decision making
- MACIS contributes to enhance information generation at community level, as well sharing and harmonized reporting
- The network has harmonized the following operations; fostering partnerships, sharing for efficient and effective malaria programming, creating awareness on malaria including engaging in the malaria agenda.

Some of the challenges include:

- Inadequate resources
- High expectations of CSOs from the networking
- Infiltration by wrong elements who have different agenda's

Next steps:

- Create a credible network through accreditation of its membership
- Continue strategically position its members in country processes

- Manage the transition process from over-dependency on donors to sustainability

## 2.3 Kenya:

~ Edward Mwangi, KeNAAM

Started informally in 2001 with 7 NGOs, KeNAAM has grown with now over 90 organizations under its umbrella. Its membership is made up of NGOs, FBOs, CBOs as well as the private sector.

KeNAAM compliments the Ministry of Health as well as the county government and with membership in the National Malaria Control Programme, Child Health and the Global Fund structures.

With its Vision being a Malaria free Kenya, KeNAAM is committed to scaling up effective malaria interventions and addressing related diseases and conditions among vulnerable communities in Kenya; this is carried out under its five pillars<sup>1</sup>. As a malaria network, KeNAAM focuses its interventions in the four malaria epidemiological zones in Kenya.

KeNAAM, together with TANAM and MACIS is implementing the CRG project. The Table below shows the Objectives of the project and each of the activities by Objective:

**Table 2: CRG Project Objectives and Activities**

No.	Objectives	Activities
1.	To strengthen the participation of Health Regional CSOs in advocating for improvement of investment of Domestic resources for Malaria in selected region in Kenya, Uganda and Tanzania.	<ul style="list-style-type: none"> <li>- Work with Malaria National Networks in Kenya, Uganda and Tanzania</li> <li>- Carry on consultancies on domestic malaria investment in sub-National level in Kenya, Uganda and Tanzania</li> <li>- Hold a 3 day Regional Meeting on increasing domestic/malaria health investment</li> </ul>

<sup>1</sup>1) Maternal Child Health, 2) Community Health Systems Strengthening, 3) Policy Advocacy and Knowledge Management, 4) Management Support, 5) Capacity Building for Partners

2.	To strengthen the participation of CSO's in Regional, National Malaria and sub national program in the high malaria endemic counties.	<ul style="list-style-type: none"> <li>- Mapping of Regional malaria CSOs partners</li> <li>- Develop malaria CSOs Regional Accountability platforms in malaria endemic regions in Kenya</li> <li>- Facilitating monthly Malaria Round Table Forums</li> <li>- Strengthen feedback mechanisms from national, regional, county and community level and vice versa</li> </ul>
3.	To participate in the development of modules for strengthening community engagement and promoting greater attention to human rights and gender barriers in malaria programmes	<ul style="list-style-type: none"> <li>- Participate in the validation of IPHA-created tools for strengthening community engagement and promoting greater attention to human rights and gender barriers in malaria programmes.</li> </ul>

The following are KeNAAM's plans going forward:

- Leveraging CSO's strengths to deliver malaria and health intervention
- Working on cross border malaria issues
- Develop KeNAAM New Strategic Plan 2018-2022
- Participating in the upcoming Kenya MPR, MSP &MP
- Resource mobilization for malaria and CSO's members

## 2.4 Plenary Discussions

The following were the key discussion outcomes:

- *On production and importing of Nets from Tanzania:* There have been efforts towards standardising qualification of medical products across East Africa. This would allow countries to import these products from each other without the need of further testing them in their respective countries. This in the long run would help reduce the cost of funding the health sector.
- The main challenge in the traditional medicine sector is lack of standardization. This needs to followed-up towards helping use inexpensive and yet effective drugs which then would move towards, e.g. domestic resource mobilization for malaria.

- *Kenya on resource mobilisation and other potential sources of funding:* Kenya has access to funding from the Global Fund and DFID through WHO. Other opportunities for funding are, i) in the counties whereby their resources are based on what they see as priority, ii) the National Hospital Insurance Fund (NHIF), iii) the private sector, who have made it possible for certain projects to be implemented, e.g. the Safaricom Foundation being interested in handling aspects of vector control, or purchase of LLIN's. More needs to be done towards involving the private sector in malaria prevention and control.
- There are key potential areas for interaction and collaboration between the three country networks, from the activities highlighted. In this regard, there may be need to look into the idea of establishing a secretariat towards drawing the way forward so that activities can be handled by the networks collectively, rather than singularly.



# Session 3:

## GFATM Principal Recipient/Sub-Recipient Experiences In Implementation Of CSO Malaria Project

*Session Chair: Beatrice Minja*

### 3.1 Kenya – Amref Health Africa/Blue Cross

Amref health Africa has been the PR of the Global Fund malaria grant whose goal is to contribute towards the 2017 national goal of reducing the morbidity and mortality attributable to malaria in the various epidemiological zones by 2/3 of the 2007/8 levels. The project implementation period runs from 1st October 2015 to December 31st 2017 with a total budget of USD 12,155,880. The project coverage is 10 counties in the lake endemic regions of Nyanza and Western Kenya with focus on community based approach. Currently there are a total of 17 Sub-recipients of the grant

Towards supporting the SRs, the key activities of this grant, which uses a community approach are towards;

- i. Community case management of malaria,
- i. Link facility support supervision to ensure the 735 CUs functionality,
- i. School health promotion activity on net use (8 of the 10 counties),
- i. Supervision of health facilities,
- i. Piloting of community systems strengthening in terms of integrating the three diseases, malaria, TB and HIV,
- i. Data quality audits carried out for the national program in all the 47 counties in Kenya.

Key outcomes in terms of disbursing the funds to the SRs in the last reporting period are:

- All SRs have submitted their completed reports on time (SSR to SR)
- Support supervision provided to 89% of the sub-county health management teams
- Data quality audits done on 70% of the counties
- Amref has also been supporting operations research activities with currently 4 manuscripts under development
- Supporting quarterly review meetings with the SRs and ensuring that the malaria testing activities are going on well within the communities
- Working with the SRs towards developing self-sustainable measures with the community units whereby they are encouraged to come up with income generating activities so they can be self-reliant

Key challenges encountered include;

- i. Low absorption of funds by some of the SRs,
- ii. Some of the SRs disengaging before end of the funding period,
- iii. Specific county health care workers strikes.

### 3.2 Blue Cross - Perspective from an SR's point of view

The presentation by Eric Okoth highlighted the following two cases of what SRs are doing:

#### Case 1: Western Nyanza

Before the intervention of the CCM at a health facility in this region, the malaria in pregnancy registered cases was as high as 95. As a result of the community health units, and trained CHWs conducting the CCM activities at the community level.

#### Case 2: Siaya County

Demonstrated the effects of the impact of testing and treatment at community level vis a vis the work load at the community level – when CHWs do a testing and at the community level, a workload reduction is expected at the health facility. Community Health Workers in this county received stipends from the county government as a way of motivation.

### 3.3 Uganda – MACIS

Dorothy Balaba gave the MACIS experience on sub-recipient experiences in implementation of CSO malaria project. In its activities it has ensured that there is a CSO represented in each District of the country; the specific activities undertaken include:

- Routine Long Lasting Insecticidal Net distribution through Antenatal Care and immunization following the MoH protocols/Standard Operating Procedure in all districts
- Private sector training and adoption of MoH tools to facilitate reporting
- Training of Village Health Teams for routine distribution and Integrated Community Case Management)
- Community social mobilization for malaria prevention and treatment
- Integrated community case management of malaria

Key challenges encountered

- Varying capacities by CSOs to implement activities
- Inadequate human resources in CSOs as the Global Fund has limited resources to support administration
- Limited internal monitoring systems
- Limited appreciation by facility providers to report on LLIN distributed to beneficiaries
- Poor storage in most of the health units leading to drug damages
- Some of the health centres and communities are hard to reach
- Inadequate facilitation for the Health Village Teams (VHTs) who implement ICCM

- Delayed procurement of material/Equipment thereby creating delays in implementation at the community level
- Limited number of behavioural change communication activities conducted for the project
- Inadequate support to private sector monitoring and reporting

Key lessons learned:

- Forming of a consortium leads to a wider reach as well as learning from each other
- Setting up monitoring systems and peer orientation is critical as well as data capturing tools coupled with constant support supervision.
- Involvement of District Health Teams in Global Fund activities as well as support supervision improves ownership of the project.
- Involvement of VHT supervisors has improved VHT

#### Recommendations

- Need to form Strategic consortium through MACIS , this not only increases coverage but strengthens CSO capacity
- Increase the social behavior Change Communication activities for malaria prevention and treatment at community level
- Need to advocate for more harmonized reporting especially at the community level reporting
- Innovation around constantly engaging the community not only during the funding cycle.

### 3.4 Tanzania - Africare's

In his presentation Alfred Kalaghe, Africare stated that through its malaria programs across Africa, Africare is implementing SBCC activities that are increasing ownership and helping communities to do the following:

- Adopt correct use of Insecticide Treated Nets (ITNs) by households, particularly pregnant women and children under five years
- Intermittent preventive treatment of malaria in pregnancy (IPTp)
- Increased knowledge about transmission of malaria, malaria signs, care-seeking and treatment with ACT

Africare's integrated BCC strategy combines interpersonal communication, advocacy, social mobilization and mass media to disseminate evidence and research-based culturally sensitive core messages on malaria prevention and treatment to targeted audiences. It also uses mobile phone technology and other innovative approaches to deliver malaria specific information to the population.

Africare Tanzania implemented a two-year Malaria Program under Global Fund Round 4 (February-2006 to May-2008). The program involved the roll out of the government new malaria treatment policy with Artemisinin-based Combination Therapy (ACT).

Africare Tanzania led a partnership involving Plan Tanzania, PSI, TANAM, NMCP and 85 local CSOs to deliver the program. The roll out of the new policy covered 127 districts and all villages of Tanzania mainland.

Lessons learned from implementing Global Fund grants:

- Sensitizing and engaging local government leaders at community level (wards and villages) in the implementation of ACT policy roll motivated the leaders to support the initiative in their communities
- Sensitized district leaders in the extended PHCs increased support in disseminating correct and proper information on ACT
- DMOs and DIMFPs were supportive and quite instrumental in providing technical information on malaria treatment policy change, in particular, using ACT.
- Strategic Integration of Malaria interventions in Africare's Nutrition Programming is having significant impact in child hood stunting and maternal anemia.

### 3.5 Plenary Discussion:

The following are the key discussion outcomes:

- The role played by Africare Tanzania: Working with TANAM in a Sub-Recipient position, Africare's role was to manage the fund as well as to identify partners to work with, provide training, tools to carry out the activities as well as supervise them to do what has been agreed upon. Towards this end they were provided with resources as well as regular supervision being in place. Africare on its end, together with providing them with resources and monitor the reports being provided.
- Successes of Amref Health Africa/Blue Cross: Its successes around its M&E activities, procurement as well as reporting on the activities could be attribute to the following: i) before engagement of any Sub-Recipient, capacity assessment is carried out to ensure they are able to deliver on the project activities, ii) mentorship on GF procedures for them to understand what is required of them, iii) carrying out regular checks and supervisions, iv) tracking mechanisms – grant management information system to track programmatic and financial performance of SRs therefore allowing for remedial action to be carried out before a problem can get out-of-hand.
- The community health strategy is a health delivery strategy used by Amref Health Africa. It is the lowest level of the strategy starting from the community. This is a mechanism that divides the members of a community so that they are linked to the primary health facilities; each community unit is then served by community health volunteers.
- Social and Behaviour Change Communication: The 1000 parent kit rolled out by Africare this tool is used through peer support groups established in the community, comprising of pregnant and lactating mothers who need to listen and read the material. Modern technology of SBCC provides for much more engagement towards internalizing messages.
- There is need for the three networks to establish a strategy on how best to move forward in more effectively way by maximizing on the skills and specialties available such as implementation, technical skills, etc.



### Recommendations on net use

- There is no mechanism in place on the extent of use of mosquito nets hence the low usage rate. Investment in BCC therefore needs to be increased.
- Use of old LLIN's: There is need to encourage recipients on the alternative use of old nets (re-purposing).
- Need for research to be carried out on the extent on use of nets, their overall distribution, their correct use and their replacement.
- Need to have a concept on the tool to determine if the net being provided to a recipient is their first.



# DAY 2

# Session 4:

## Group Work: Barriers To Effective Malaria Programming And The Role CSOs Play

Session Chair: Matthew Greenall

*The focus of this session was on identifying existing barriers that exclude various groups of people within the communities from gaining access to malaria interventions thereby making them vulnerable.*

*Participants broke into 3 groups to identify the barriers and the issues associated. The table below lists provides the outcome of the group activity.*

**Table 3: Group feedback on barrier to effective malaria programming and the role CSO's Play**

Barriers	Issues
Vulnerability	<ul style="list-style-type: none"><li>• At the consumer level based on the agenda, their location, on issues of IDPs, access to education, pregnant mother. Hence making it a challenge to programme malaria interventions</li></ul>
Governance	<ul style="list-style-type: none"><li>• Economies not investing in malaria interventions</li><li>• Irregularities in access</li><li>• Low response</li><li>• Corruption</li></ul>
Limited financing	<ul style="list-style-type: none"><li>• Governments have no allocation for malaria.</li><li>• Lack of health insurance schemes.</li></ul>
Limited user friendly services	<ul style="list-style-type: none"><li>• Poor attitudes to patients</li><li>• Lack of commodities, nets and drugs</li><li>• As a result of poverty, people will not be able to access</li><li>• Beliefs, as a result of culture, having wrong perception on malaria interventions</li></ul>
Information systems	<ul style="list-style-type: none"><li>• Lack of awareness by people while others are misinformed on treatment approaches</li><li>• Health needs of the populace are not properly identified</li><li>• There is poor documentation e.g. on the needs of drugs and supplies such as nets, thereby leading to oversupply or undersupply</li></ul>
Cultures	<ul style="list-style-type: none"><li>• Communities exchange myths: Example in Kilifi, Kenya the local communities believe mosquito nets speak back to them, hence people get to avoid using them.</li><li>• Superiority of use – in the local communities the head of the home is presumed to have priority on use of the net leaving the most vulnerable in the house, child or pregnant wife exposed.</li><li>• Activities within the communities are mainly carried out at night thereby exposing most of them to malaria.</li><li>• As a result of peer influence – people use traditional methods to cure malaria such as boiling herbs and slaughtering chickens</li></ul>



Accessibility	<ul style="list-style-type: none"> <li>• Individuals with information on life saving approaches still shun on their usage, e.g. use of nets.</li> <li>• Interventions are not reaching the hard to reach areas where communities are isolated.</li> <li>• There is lack of lack coordination between the public and private sectors as well as with CSOs with regards to the approach taken on malaria intervention to communities.</li> <li>• Malaria interventions directed to communities takes the top-bottom approach thereby leaving out the targeted communities in as far as planning and execution is concerned.</li> </ul>
Gender	<ul style="list-style-type: none"> <li>• Community sensitization meetings are mostly attended by women; men need to be targeted more during mobilization.</li> <li>• Financing of medical treatment and purchase of nets: Women in the communities are reliant on their husbands for money for treatment and purchase of nets.</li> <li>• In health units, males nurses are used to examine women thereby making them shun from going to the clinics.</li> <li>• Children are more vulnerable especially if a net as nets provided to household's benefits the parents first before the children.</li> <li>• Women take more responsibilities in treatment processes in the homes e.g. hanging and caring for the nets. This responsibility is not shared</li> <li>• If subsidies are cut out by donors, women and children will be the most affected.</li> <li>• The most vulnerable group is pregnant or expectant mothers – they are most affected</li> </ul>
Human Rights	<ul style="list-style-type: none"> <li>• IDPs lack appropriate information on health care with regards to access to treatment.</li> <li>• Disability rights in terms of access to treatment and malaria.</li> <li>• The deaf are also limited to access of information or health services.</li> <li>• Access to health services: Health units within the rural areas tend to be quite far hereby making it hard for rural communities to reach.</li> <li>• In some communities politics determine the delivery of health service to the local populace.</li> <li>• Tribalism and discrimination acting as barriers to access to health services, e.g. in the case of Tanzania, Albinos fear moving out to access treatment.</li> </ul>

## Session Conclusion

1. Every context is unique and therefore who is vulnerable to a region cannot be generalized.
2. Each context should therefore identify who is vulnerable within their communities as well as the existing barriers to health service provision.
3. Identifying and breaking down the barriers is more critical than awareness raising.
4. Inequalities usually make everybody worse off.
5. CSOs and NGOs also need to proactively identify these barriers within the communities they operate in.

# Session 5:

## Domestic Resource Mobilization For Malaria

**Chair:** Kate Thomson

*The focus of this Session was on experience sharing by countries on domestic resource mobilization.*

### 5.1 Kenya

In his presentation titled “A Kenyan experience in context of devolved government on Malaria Domestic Investment” Mr. James Muraguri, CEO Institute of Public Finance Kenya delved into how the government has changed the management of its health system since the onset of the new Kenyan Constitution 2010 as well as how the government has been allocating money to counties on health. The following are the key facts of his presentation:

- As guided by the Public Finance Management Act, the budget process in Kenya (for both national and county governments) runs for a period of 28 months, starting from August of a specific year:
  - » August – April = Formulation
  - » May – June = Approval
  - » 12 months for Implementation
  - » Audit/Oversight across the year
- Each of these 4 stages is an opportunity for engagement for CSOs with government.
- The Kenyan budget has continued increasing over the years and through the Institute of Public Finance been able to determine the estimated monies allocated for communicable disease control and understanding the expenditure as well as understanding its source, i.e. the amount of money government is putting towards it.
- The presentation highlighted how the Institute of Public Finance tracks monies from government and donors are, including the amounts received and

used, e.g. for malaria control as well as putting to task the counties or relevant departments on the usage of the monies

- A key challenge is on tracking the expenditure by government on e.g. malaria
- On budget cycle the following are the key arrears where CSOs can be of influence:
  - » Sector Working Groups
  - » Budget Police Statements
  - » Budget Estimates
- For CSOs to engage or influence government on aspects of funding on any activity is between July-October of any year as well as in February.

### 5.2 Tanzania

In her presentation, Ms. Beatrice Minja, TANAM gave a report titled “rapid assessment for malaria investment in Morogoro and Pwani regions”. This report was from a study whose overall goal was to conduct a rapid malaria investment gender and human rights to understand the local context integration to end malaria through partnership Public Private Partnership (PPP). The focus of this study which was carried out through desk reviews, in-depth interviews, focus group discussions as well as by direct observation was as follows:

- To analyze the alignment of malaria control investments with the policy priorities as provided for in the respective Tanzania National Malaria Control Strategic Plans.

- To analyze the government resource allocation for Malaria Control in the FY 2013/2017 budget estimates
- To determine the extent to which the budget estimates for Malaria Plans are consistent with country health policy priorities.
- To determine entry point for advocacy by Malaria CSO to various decision makers to increase investment for malaria control and health.
- To share the consultancy results with CSOs through effective communication channels for building capacity and knowledge.

Her key findings revealed that indeed there is government investment in the fight against malaria e.g. having in place dispensaries in each village, with exception of a few, management of malaria services countrywide as well as the construction of a BTI (Bacillus Israeliasis), in partnership with the Cuban government.

With regards to investments in the malaria program by the government, not much is known about the amounts being invested by other partners, the spending of the same at the district and lower levels with little investments being felt at the lower level. The study also revealed the critical need for a strategic move to increase local resource budget by involving every sector of the economy. Also noted was the fact that other investments in the regions especially by CSO, Academia and private sector are not documented.

On gender and human rights it revealed that women seem to be burdened with activities related to malaria such as caring for the sick, preventive strategies and treatment. They were also found to be the ones paying for larvicides at home. A THMIS School Survey carried out in 2016 showed that malaria incidence now observed on school children (7-9) years was 44%. Women in rural were also found not to be knowledgeable of the consequences of malaria to pregnant women and children, meaning that they are deprived of their right to accurate information affecting their health.

The following were found to be barriers towards fighting malaria in the community:

- Some community members not using ITNS
- Lack of knowledge on malaria infection and complications
- Defaulting doses for malaria
- Drug stock outs.
- Weak documentation of program results and lack of quality data for sharing.

- Weak coordination among malaria stakeholders and implemented activities.
- Inadequate community involvement and participation in malaria control activities hence causing thereby impeding the eMalaria Strategy 2030.
- Women and especially women of reproductive age ,under five years and primary school children are more vulnerable to malaria than any one else in the community in all community settings.
- Weak men involvement in community based malaria interventions.

The study concluded that local malaria investments remain low in the country; towards this end there is need to increase investment in the sector including through the private sector. Advocacy for investment in the local production of the ACT drug may help bring about sustainable solutions to the drug stockouts. The aspect of gender and human rights violations including that of children will need to be addressed.

### 5.3 Uganda

*Mr. Byabasajj Abdallah* gave Uganda's experience with local authority investments at Sub National Level. Financing of the country's malaria control activities has mainly been from donors, including, among others, the Global Fund, UNICEF and DfID.

A research carried out by MACIS on "Sustaining malaria investment gains, and prospects of citizen's involvement in findings" revealed that the community have a receivership attitude towards health financing and expect the government to do everything and therefore have not supported any resourcing efforts. The study also showed that the private sector actors such as CBOs, INGOs, LNGOs, FBOs, Media Houses and the citizenry are willing to participate and, innovate solutions to support LG responses; they only need to be mobilized.

The following are some of the activities that have enhanced local resourcing within the communities:

- Local governments have mainstreamed the VHT work.
- Partnership with malaria intervention CSOs as well as on prevention services.
- Local ordinances in the control of malaria for community based health insurance schemes.
- Use of the media, e.g. radio. The government has set in place a policy for all media houses to provide free airtime (2 hours per week) for government



programs; including programs on malaria prevention is a way of raising resources.

- Establishment of local malaria spaces through the use of round table dialogues in which key health service delivery and performance issues including malaria are discussed, resulting in non-monetary resources from communities, e.g. volunteerism by VHTs.
- LGs are also innovating solutions towards local health financing through community-based health insurance.

### Recommendations:

- Engage communities in conversation/dialogue on key health issues including malaria and financing. Through this, contributions will be realized.
- Invest more in prevention, e.g. knowledge about how malaria is spread encourages uptake of appropriate preventive measures.
- Mobilize private sectors (through Corporate Social Responsibility - CSR) towards Malaria investments.
- Local governments should design mechanisms for generating local resources for malaria.
- Promote efficiency and minimize wastage e.g. encouragement of net repairs, better quantification of products to minimize wastage.
- Reduce the cost of doing business e.g. review the local government procurement procedures for crucial health commodities towards reducing the costs
- Concurrent use of multiple mobilization and advocacy channels at local government level towards obtaining resources from the communities.
- Local governments should promote user responsibility with Malarial Commodities such as ITNs, e.g. it should be the responsibility of the family to replace a worn out ITN. Pre-distribution education should therefore be packaged to include this aspect.

Subsidies should however be designed to target MARPs (most at risk populations) such as the elderly poor, IDPs and the terminally ill, through e.g. introducing a voucher system

## 5.4 Global Fund

*Mr John Ocheri, Senior FPM, The Global Fund, gave the Global Fund experience on advocacy for Domestic Resource Mobilization in Kenya. He cited government, out-of-pocket expenditure and high network individuals/s*

philanthropists as traditional sources for domestic funding for health. Other innovative fundraising approaches used include the establishment of, i) an HIV/AIDS Trust Fund expenditure derived levies, e.g. airline, and ii) use of a National Hospital Insurance Fund. There however is no initiative in place towards raising money for malaria.

He cited the following as the key challenges of domestic finance mechanism in a resource constrained environment:

- Value for money: As the resource landscape changes, focus is now more on improving health programmes efficiency and effectiveness which calls for both “more money for health and more health for money”- creating efficiency so one can obtain value for their money.
- Domestic Advocacy: Need for a convincing business and advocacy case for increased public commitment in programs of proven effectiveness.

Sustainability: As domestic funding may not be sufficient to address all the health needs, there is need for external resources in the short to medium term, hence the need to explore innovative domestic finance mechanisms

With global priorities changing donors are likely to reduce their funding. For countries like Kenya who have moved to a low-middle income status, there will be a decrease in the level of funding. The level of funding by African governments towards health still does not meet the expectations of the Abuja Declaration, as of 2014, the level of funding by Kenya was at 6.8% versus 12%.

Towards this end, the Global Fund involvement is based around its four strategic pillars, one of which is raising domestic financing through innovative mechanisms such as advocacy, and encouraging governments to allocate more money towards health. Specifically the Global Fund is working with governments towards:

- Leveraging Global Fund resources to encourage increased Government commitment to disease programs and related health systems strengthening.
- Improving data quality and accessibility for both domestic and international health funding.
- Identifying and addressing rigid budgeting practices, allocative inefficiencies that are obstacles to the reallocation of revenues towards health.
- Fostering effective dialogue between local health and finance officials -- creating space for discussion by empowering health officials and ensuring that finance has a better understanding of health issues.

- Supporting countries in establishing an acceptable “benchmark” on a country by country basis and discussions/support on innovative domestic resource mobilization tools.
- Nurture political leadership -- ongoing work on multi-dimensional advocacy and messaging to ensure health is given top priority at national and international levels (political will).
- Revisit and raise awareness on economic arguments for health, including how it makes macro-economic sense.
- Universal Health Coverage as the overall goal.

#### 5.4.1 Kenya’s experience on Global Fund Domestic Resource Mobilization (DRM):

On health financing, although the Kenya Government budget allocation for health has increased significantly in recent years from about US\$ 478 Million in 2009/10 to US\$ 1,102 million in 2013/14, total government expenditure in health still remains far below the Abuja target of 15% and one of the lowest in the African region (Global Health Expenditure Database, WHO). There is need therefore for increased domestic financing. Kenya is best placed to do this being a leading economic force in the region that has moved to lower middle-income level status. Kenya is also best placed to lead African nations in the bid to increase their domestic financing to meet the Abuja target. In its 2030 Vision, the country plans

to increase government expenditure in health from the current 6.8% (2012-13) to 12% by 2017/18. The country has encouraged developing country governments to actively contribute to the Global Fund Replenishment Campaigns, including pledging /contributing US\$ 2 million and US\$5 million for the last and current replenishment periods respectively. It has also proactively contributed US\$ 54 million for HIV, Tuberculosis & Malaria as part of its WTP/counterpart contribution (\$26 m for FY 2015/16 & \$28 m for FY 2016/17).

Kenya is one of the focus countries for the Global Fund’s domestic financing strategy and the Global Fund is working with Kenya towards this end including funding special initiatives to support it (e.g. the Gates funded DRM initiative for Kenya). Its private sector is keen to act in the area of health, including through the establishment of the Kenya public-private partnership (PPP) initiative for health in partnership with the Global Fund, private sector partners, and other stakeholders. It is hoped that these and many more initiatives will be achieved to complement Kenya’s efforts.

#### 5.4.2 Global Fund’s Initiatives in Kenya

The following Table lists out a Global Fund initiative in Kenya, showing the activities undertaken towards advocating for domestic financing:

**Table: 4: Global Funds Initiatives in Kenya**

<b>Activity 1:</b> Capacity Building and Technical Workshops for Parliamentarians and Civil Society related to Health Financing	Parliamentarians and Civil Society	Advocacy and Capacity Building: one per semester
<b>Activity 2:</b> Convene High Level Technical Meeting to agree on terms and progress of implementation plans for the private sector domestic financing initiatives and overview of health financing landscape.	MOH, MOF, Private Sector, Counties	Advocacy and Capacity Building
<b>Activity 3:</b> Support of identification, media visibility and capacity building of Champions of Domestic Financing.	MOH, MOF, Private Sector, CSOs, Parliamentarians	Advocacy and Capacity Building
<b>Activity 4:</b> Contribute to consultancy for developing an implementation plan for Private Sector Domestic financing initiative in Kenya.	Kenya MOH and Private Sector	Technical Assistance for accountability and oversight of Private Sector DF initiatives. E Emoluments X 6 months.

<b>Activity 5:</b> Contribute to consultancy to work with in-country stakeholders (Donors, GOK/Private sector, CSOs, etc) to make an overview of the funding landscape and programmatic gaps in 47 counties/mapping for both domestic and donor funding in Kenya-supplementing the National Health Accounts.	Kenya MOH, MOF, Private Sector, CSOs, Donors in Health sector	Technical assistance for accountability and oversight of Health budgeting and expenditure in Kenya. Emoluments X10 months
<b>Activity 6:</b> Fund Actuarial studies to support development of the universal health care system in Kenya.	Kenya in-country	Evidence-generation
<b>Activity 7:</b> Contribute to undertake an assessment on government health financing targets and the development of a sustainability plan for the health sector - Kenya	Kenya MOF & MOH	Generate evidence and data for accountability and oversight. Emoluments X 6 months

## 5.5 Plenary Discussion

The following were the key outcomes of the discussions:

- *Identifying and working with allies at the national or sub-national level – on government financing:*
  - » In Kenya, health has been devolved to the county level. The Public Finance and Management Act allows for the setting up of a County Budget and Economic Forum which is a board that is setup to work with the county Governor through nominated persons representing women, CSOs, FBOs, etc. The Governor on his/her part appoints someone to act on his behalf.
  - » Case Example: Kwale County has a functional County Budget and Economic Forum and through it, a lot more information has been obtained on the County.
- *Case of Tanzania:* When advocating for ACT, TANAM partnered with Tanzania Pharmacist Association to help reach out to investors in the private sector.
- *Having a common voice when talking to MOF and MOH.* There is need as CSOs to be more coordinated in our messages to government.
- *Expanding the network base:* There is need to consider joining the conversation around expanding the local revenue base so that more funding can be directed towards the health sector.
- *Creating a Malaria Trust Fund:* The malaria community should brainstorm towards e.g. promoting the issues of malaria to large organizations in the private sector with the purpose of raising capital from where a Trust Fund can be setup.
- Until a government audit has been carried out, it would be difficult to determine if there is money that is leaking from the system. The only way one can know the amount of money spent is through the Budget Review and Outlook Paper.

# Session 6:

## Group Work: Sharing Experiences On Domestic Resource Mobilisation

*This Session saw participants break into 3 groups to discuss what is needed to mobilise money domestically. The activity's emphasis was on sharing experiences that have worked in their organizations with regards to domestic resource mobilization activities.*

The following Table shows the experiences by country:

### 6.1 Group feedback: Experiences on domestic mobilization by Country

#### 6.1.1 Tanzania

##### Experience

##### General Experiences

- Previously people paid for health service, now there is cost sharing for health services. People pay an annual fee, which is determined by the Councils. This approach is similar to a health insurance cover.
- Use of the Committee Health Fund and use of Community Volunteers as a way of health financing.
- The White Ribbon Alliance is tasking the government to increase its allocation on health financing through strategic budget advocacy by engaging key personnel in government.
- Community engagements with local persons in order to raise funds for the running and operations of the health centres.
- Community health fund: Works towards increase access to health services. An annual fee has been set whereby the local community pay to receive medical services. This approach has yielded an increase to medical services including malaria. It is managed at the local level.

##### TANAAM

- Activity: Spraying with a larvicide - in one activity, 71% of house holds was reached while in another 33% of households was reached. Each household in the community is charged Tshs2000 for the spraying, which is done as whole in the community. Schools, businesses and hotels are charged a higher rate.
- The community came together to work towards increasing citizen participation in building dispensaries, case of Kisangiro Dispensary that was built by the community and then handed over to government to manage.

##### Pwani Development Promotion Agents

- Built capacity of 46 volunteers who spread malaria awareness messages through theatre and other forms of expression. 75% of households reached with information on malaria.



## 6.1.2 Uganda

### Experience

#### General Experiences

- Cost sharing and partnership. Some organizations use this approach in order to carry out some health activities
- MPs buying ambulances for communities as a way of gaining popularity
- Successful capacity building of CSOs on their role in public participation and budgeting as well as county government officials in budget development according to the governments requirements.
- Successful presence attending budget formulation processes and meetings at community level.
- Successfully submitted memoranda to duty bearers.
- CSOs who have been capacity built now attending TWG sessions at the county and sub-county level.

#### NAFCOM Foundation:

- Successfully hold meetings with the district health teams, which is a government agency. Through this they were able to mobilize and work with CSOs to each contribute, in kind or in cash towards ITN distribution exercises.

#### Wells Medical Centre - Uganda

- Carried out monthly training for village health teams.
- Established a community medical aid fund for the poor who could afford the cost of treatment.
- Successfully distributed treated nets; these efforts were supported by a variety of stakeholders 150 churches who mobilized funds for the kitty
- Through the Uganda Communication Commission the government gave a directive to the mass media to identify at least 2 hours per week to popularise development initiatives by the government including health programs. This has yielded interest by the citizenry to participate and has also built interest by corporate agencies to provide CSR.

## 6.1.3. Kenya

### Experience

- In Kuria County, members of a community contribute money towards a health a common kitty for health insurance whereby the sick are covered medically and also, in cases of emergency, ferried to hospital by ambulance.
- In Baringo County the mining activities create more harm than good. The excavations have led to increased malaria in the area. An innovative finance mechanism was developed whereby the local administrators are engaged towards having the contractors contribute monies towards health services and particularly in malaria control in the county.
- The Community Health Volunteers is an initiative by the communities and local counties to motivate the volunteers through paying them a total remuneration of Kshs 3000, with Kshs 1000 withheld and redirected to their savings account, case of Kitui County.
- A National Hospital Insurance Fund has been established. In it was Kenya piloted from the formal sector then broadened to cover the entire country; average citizens pay Kshs 500 per month. The Fund has also broadened the covering of illnesses e.g. cancer. This has increased access to health services

## Key Recommendations

- In Kenya need for focused advocacy with MCAs on health financing.
- Need for more focused discussions with politicians on health provision.
- Fund raise through sports.
- Engage the private sector more towards them help in improving the running of the health sector (Public Private Partnerships).
- Organize a Malaria Stakeholder Meeting with government leaders as a way of advocacy.
- Advocate for good governance, as it is a determinant for good health and service provision.
- Put in place internal institutional sustainability mechanisms that would help sustain the initiatives at the country level.
- The need to begin internal conversations between NGOs on the question of sustainability without donor funding. This should be a continuous conversation.
- Begin donor engagement around having them support sustainability mechanisms, e.g. supporting NGOs to build their own premises.

### 6.3 Recommendations on effectively engaging in the Budget processes

- CSOs need to understand or know the points of intervention to engage government on funding areas that need funding, e.g. malaria prevention and control.
- Need to understand the whole budget cycle, Formulation, Approval, Implementation, Oversight and Control and engage at least six months before the Budget is read.
- Need to engage government accordingly and advocate for resource mobilization when opportunity arises.
- Maximize the opportunity for engagement with government as sector working groups, where opportunities are made available for bidding whereby Ministries bid for funding from the central government e.g. for health issues

- Educate participants on the budget process of the 3 countries with regards to the budget approval process
- To influence budget processes and budget analysis there is need for strong collaboration, networking and sharing of information so that views from across the country can be aggregated and presented as the civil society's position.
- Need to mobilize communities to come up with their own initiatives towards malaria control in their settings
- Its important as we move towards advocating for more funding – we use alternative approaches such as changing the arguments such as linking the cost of not doing something in economic terms – showing evidence that can build an argument-change the rules of engagement and argue linking outcomes and impacts on economic gain

### 6.4 Summary of Key Areas

- Public Private Partnerships: Reviewing issues e.g. Corporate Social Responsibility (CSR), use of the media, philanthropy and investment by private sectors towards malaria commodities as part of sustainability efforts.
- Government supported: This includes registration at either the national or at sub-county level, use of insurance schemes such as the NHIF (Kenya), Community Health Fund (Tanzania) as well as other legislative frameworks such as the Community Development Fund (CDF) in Kenya as well as conditional grants by the national government
- Innovation: The Lotto foundation investment, insurance, social marketing and welfare
- Community innovation: Community contribution to their own welfare, case of Uganda's community medical aid
- Donor engagement especially on capital expenditure items for sustainability

# Session 7:

## Panel Discussion: Advocacy for Domestic Resource Mobilization in Africa

*Session Chair: Matt Greenall*

The Panel Discussion consisted of 5 discussants who each shared their experiences about their understanding of Domestic Resource Mobilization and what their respective organizations are doing in this regard.

The following were the discussants in the Session:

- Dr. Awadh Mky Nguluma – TANAM
- Susan Nanduddu – MACIS
- Emily Chepng'eno - World Vision
- Mokishon Turere – Malaria No More
- Ransom Fue - TANAM

**Question 1:** *What has been your aim in Domestic Resource Mobilization and what has been achieved?*

### **1) TANAM - Tanzania:**

Community contributing towards the construction of health facilities through provision of materials. The community is mobilized through educating them on the importance of having in place a health facility.

### **2) Malaria No More**

Is implementing a pilot to increase political and financial goodwill in two counties in both Kwale and Busia counties in Kenya towards making malaria an agenda item towards both government and the civil society. This is achieved by building the capacity of the two groups to first understand their roles and how serious malaria towards talking appropriate action.

County Executive: Trained to develop programme-based budgets that are aligned to the national provisions.

Civil Society Organizations: Creating the awareness on malaria through partnering with the National Malaria Control Programme. This ensures CSOs have clear Asks during the county meetings.

Kwale County: Members of the county assembly are informed of the status of malaria in the county right down to the area of representation where a members of the county comes from. This kind of pressure on them has led to them requesting for joint net distribution activities.

The proposals to the County governments should be clear, showing the sector being proposed for targeting and the implications that will arise as a result of the interventions.

### **3) MACIS**

The activity was to help build the confidence and competence (through mobilization and sensitization) of the rural community to engage in local government budget processes. The community chose the area of water and sanitation, health and education as their focus areas that need to be prioritized into the local government budget.

The health centre in the area caters for 15,000 residents with challenges of lack of electricity, adequate water, as well as drug stock-outs, etc. The program therefore took the initiative (by accident) to mobilize the community, health workers, the Catholic Church as well as politicians to fundraise towards lighting up the health centre. This community effort led to the lighting up of the maternity wards and the staff quarters.

#### 4) World Vision

The Citizens Voices and Action: This is a model used by World Vision to empower the community to understand what role they can play through the local government budget making process. The community has been able to form groups through which they review the policies that are in place and also review the data on health that is made available by the District Health Information Systems so that when the budget making process starts, they are in the know of the issues that they want prioritized. After the budgeting process is complete they also effectively and meaningfully participate in the follow-up of the activities.

The Channels of Hope: This is a model used to train faith leaders, who have a lot of influence in the community, to influence the small groups within their congregations with regards to health interventions and specifically monitor services rendered to maternal healthcare. Through this intervention, and use of available health data to determine the interventions, the women are empowered to raise their voices and ensure they receive the required services.

#### 5) TANAM

Sensitization meetings carried out in the streets to have people recognize and understand malaria and seek health services to guard themselves against it.

The programme carries out Larviciding and IRS activities in the community with each household paying a fee with coverage being as much as 71% of the community households. This approach therefore shows that the community collectively takes responsibility for their health.

### Plenary and Discussion

The following were the key outcomes of the discussions:

Engagement beyond budget making: Nairobi stands out as a model county that already has in place a budget set aside for malaria. There however is a disconnect between the allocation and implementation of the programme, however the details of how these allocated funds are used is not available. CSO's therefore needed to engage the local government even after the budget making process is completed, towards the implementation of the resources with focus on impact of the programme.

### Recommendations:

- CSO need to build relationships, do the analysis and provide adequate information that can be used for engagement with local leaders.
- National organizations, e.g. KeNAAM need to carry out higher-level engagement with Governors.
- Need for joint planning, networking between CSOs as well as jointly determining entry points to engage with the local governments.
- It is for the CSOs to identify the key players (allies) at the national government or in the counties who they can work with to ensure they get their resources allocated to malaria.
- Clear data on malaria is needed through which clear advocacy messages can be developed.
- Need for smart use of existing mechanisms as well as use of data.





# DAY 3

# SESSION 8:

## Panel Discussion By Technical/Development Partners On Domestic Malaria Control Investment Roles For Cso's And How To Scale-Up

*Session Chair: Edward Mwangi, KeNAAM*

The objective of this Session was to:

1. How can the National Malaria Control Programme (NMCP) provide the environment that the civil society can work and partner with?
2. What does Global Fund mean for the Civil Society and what are the available opportunities for them to partner with the Global Fund at the country level?

Dr. Jackie Kisia, National Malaria Control Programme, and Kate Thomson, Global Fund were the discussants in the Session. The following are the key highlights of their presentations:

### 1) Dr Jackie Kisia, National Malaria Control

#### Resource Mobilization

Developed in 2016 together with the civil society, traditional partners as well as the Ministry of Health, the Kenya Malaria Strategic Resource Mobilization Plan was the first in the Ministry of Health, which is aligned to the National Malaria Strategy. This was begun because only 60% of the programmes activities was funded. The idea was to develop a strategy whereby the remaining 40% is obtained through funding. Yearly reviews will be carried out as to how the resources have been spent; this will be documented and made transparent to all involved. There is also an M&E section within the Strategy that will help track the implementation of the Resource Mobilization process. This Strategy will be launched on 25th April 2017, the World Malaria Day.

#### Partnership

It works with all the 47 counties, including partners, the civil society as well as traditional partners such as the Global Fund, Presidential Malaria Initiative, UNICEF, WHO, KeNAAM, among others.

#### Partnerships at NMCP

All partners on board have the same mission and follow the NFCP principal. The opinions of those on board are respected, activities are mapped to avoid duplication, and partners are placed in areas according to the expertise. Partners are also included in the Technical Working Groups and discussions and agreements are made as a group.

#### The role of civil society in implementation of resource mobilization

CSOs can play the role of political goodwill in terms of advocacy at the government level so that more funds can be allocated to malaria. When advocacy is done at the government level that's when the government will allocate more resources to malaria.

### 2) Kate Thomson, Global Fund

#### Working with partners at the country levels

The Global Fund embraces an inclusive partnership level whereby communities most affected by HIV, TB and Malaria should always be at the table, as should a variety of other partners. This has been strengthened by additional requirements on the CCM including them

required to spend 15% of the funds they get on civil society engagement. Engagement should therefore be throughout the grant cycle.

The participation of civil society, NGOs, community groups, CBOs as implementers is critical to the Global Fund as working towards ending the three epidemics would not be possible without full engagement of community response and assistance as part of a broader system for health.

### **Working with partners at the global level**

The GF Board which has the same level of voting rights as the implementers and donor constituencies. Within the implementing constituency there are three constituencies made up of civil society, they include:

- Communities constituency-this is made up of people living with or infected by HIV, TB and Malaria
- Developed countries NGO delegation
- Developing countries NGO delegation

### **Community Rights and Gender (CRG) Strategic Initiative and how CSOs can participate**

In the last Global Fund funding cycle, the Board approved US\$15 million for this initiative, which came about as a result of advocacy from community and civil society actors involved in government structures. The purpose of the CRG is to bolster and strengthen community and civil society engagement in Global Fund related processes in particular relation to the Funding Model. The initiative will have 3 separate elements, which include:

- Provision of short term technical support at country level as requested by civil society and community: Its purpose is meaningful engagement in Concept Note funding requests and development as well as engagement in grant making throughout the funding cycle. The support is provided or led by civil society organizations as well as community groups who provide Technical Assistance.
- Longer term capacity development of other networks who are engaged in Global Fund related processes.

- Establishment of regional and civil society communication and coordination platforms towards bringing the voice of the Global Fund closer to communities and vice versa.

### **Technical Assistance provision with regards to the civil society**

To qualify for the TA, the civil society need to engage, in dialogue with communities as well as ensure voices of the marginalized are included in the conversations and have their needs well-articulated.

### **Plenary Discussion**

The following were the key outcomes of the discussions:

1. Developing and rolling out of the 2016 Kenya Malaria Strategic Resource Mobilization Plan by the civil society, partners as well as the counties was an eye-opener for all as they were not aware of the opportunities to get funding through this approach. Disbursement of funds however remains a challenge; new ways are being found on how best to work or engage with the counties since they are the ones implementing all the activities towards malaria reduction.
2. The CRG support initiative helps programme think through on whether they are delivering things effectively.
3. The Resource Mobilization Strategy has worked because of transparency in the way of doing of doing things; this is a good example and should be replicated.
4. Approaches towards strengthening interventions: When things are not working failing what it highlights the importance of having and building sustainable community feedback mechanisms so that they can be on-going, learning throughout the process of grant cycle; there is need for a strong feedback loop that is well embedded and which allow for correction when interventions are failing.

# SESSION 9:

## Consensus and Action Planning for malaria CSO's in the East African region

*In this Session, participants worked by country groups. The goals of this activity were the following:*

1. To make programmes more effective and responsive to peoples' needs by:
  - » Doing more with the available resources
  - » Reaching the marginalized and excluded
  - » Addressing (gender and human rights)
  - » Sustaining national responses to malaria (and health for all)
2. The country groups were tasked to answer the following questions:
  - » What should networks do?
  - » What should CSOs do?
  - » What should this regional platform do?

### 9.1 Country Feedback

The following Tables shows the feedback of the country groups:

#### 9.1.1 Uganda

Make programmes more effective and responsive	Key Activities	Check points	Level of priority?
Network	1. Membership profiling	Specific	High Priority
	2. Strategically Identifying CSO's which are reaching marginalized groups and lobby them to integrate Malaria into their work	Specific	High Priority
	3. Identifying the strengths of different CSO's members and positioning them appropriately		
	4. Developing an advocacy agenda that can be disseminated at all levels		Medium Priority
	5. Resource Mobilization and identifying opportunities for funding for its members as a joint consortium		
	6. Capacity building for its members		
	7. Monitoring, Evaluation and Learning		



CSO	1. Identify pockets of marginalized groups and bring them to the forefront for redress		
	2. Advocacy for resource allocation at the District level		
	3. Replicating resource mobilization models that are proven to work		
Regional	1. Regional platform to lobby G.F to review the financing mechanism of CSO's to manage the transition.	Specific	High Priority
	2. Documenting and Sharing best practices of other countries on CSO operations	Specific	Low Priority
	<b>3. Sustain national responses</b>		
Network	Operational research to test different community based financing models for appropriateness		
CSOs			

### 9.1.2 Tanzania (TANAM)

Make programmes more effective and responsive	Key Activities	Check points	Level of priority?
<b>Network</b>	<ul style="list-style-type: none"> <li>• Advocacy for Strategic Collaboration among key institution (Ministry of water, Ministry of agriculture, Ministry of works, Minerals, Natural resources, Education)</li> <li>• Advocacy for increasing demands/coverage for services (ITN, PPTP, Case Management, IRS, Larviciding)</li> <li>• Strengthen Coordination and networking at National, Zone, Regional and District levels.</li> <li>• Conduct training to CSOs on Gender and Human Rights Principles.</li> <li>• Conduct National Forums for information sharing.</li> <li>• Strengthen network relationships with NMCP, MOH and other government organs.</li> <li>• Review Network advocacy and engagement Strategy.</li> <li>• Conduct M&amp;E and periodic reviews.</li> <li>• Documentation and Data management</li> </ul>		
<b>CSOs</b>	<ul style="list-style-type: none"> <li>• Track the use and consumer satisfaction for the services that are provided at the communities.</li> <li>• Track barriers to access services.</li> <li>• Mobilisation and sensitisation of the communities for best practices in using malaria tools.</li> </ul>		
<b>Regional (cross-country)</b>	<ul style="list-style-type: none"> <li>• Conduct Regional Forums for sharing experiences and learning.</li> <li>• Advocacy at regional East Africa Community Assembly meetings for raising the malaria profile.</li> <li>• Regional Resource Mobilisation for responding to common malaria and health issues in EA.</li> <li>• Exchange visit.</li> <li>• Advocate for Regional Malaria Alliance among EA-CSOs</li> </ul>		

### 9.1.3 Kenya

Make programmes more effective and responsive	Key Activities	Check points	Level of priority?																								
Network	<b>Programme I:</b> Prevention: Vector control, laticiding, MIP a) <b>Strengthen level I:</b> Functionality of Community Health strategy b) <b>Programme II:</b> Case management: treatment, diagnostic a) Encourage local manufacturers of commodities ie diagnostics, RDTs  <b>Programme III:</b> Crosscutting: SMEOR, ACSM, Programme management a) Incorporate research to inform policy b) Preparation and participation in WMD activities c) To Strengthen malaria surveillance by communities- ID-ing/reporting outbreaks d) Involvement of private sector in malaria control (Public Private Partnerships) e) Engage Government/ private agencies that breed malaria- agriculture, water, roads f) A malaria events calendar g) Development of stakeholder engagement strategy h) A network communication strategy	SRA, 1-2 year with periodic reviews	High Priority																								
		SRA, 5 years, with midterm review,	High Priority																								
		<table><tr><td>a) S</td><td>R/A</td><td>12 Months</td></tr><tr><td>b) S</td><td>R/A</td><td></td></tr><tr><td>c) S</td><td>R/A</td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr></table>	a) S	R/A	12 Months	b) S	R/A		c) S	R/A																	High Priority
		a) S	R/A	12 Months																							
		b) S	R/A																								
		c) S	R/A																								
CSOs	Preparation and participation in WMD activities																										
Regional (cross-country)	a. South-south collaboration b. Development of a stakeholder engagement strategy: reaching out to regional blocks c. A communication strategy d. Cross border initiatives- joint net distribution																										

# Closing Remarks



29 - 29 March 2017; The East Africa Regional Malaria CSO's Consultation meeting participants pose for a picture after the four day meeting held between at Amber Hotel, Nairobi Kenya.

~ Dr. Maurice Odindo

Thanked all participants for making time to attend the Regional Consultation. The conference brought out the best in everybody in looking at malaria control from a singular point of view.

The following are the key outcomes from the conference:

- Sharing of common issues in our activities, including working with the communities, raising of financial resources at the local and national level
- **Building various channels for communication:** There is potential to conduct activities together at both the local and international levels as well as at the regional level.

- **Our strengths;** Us as CSOs being the strongest link and in some cases, the missing link in key issues. Therefore problems that may look impossible can be resolved.
- Maximizing on the available opportunities using our knowledge and strengths, e.g. the CRG initiative can then help us as CSOs to build our community groups in our respective countries.

He ended his remarks by challenging CSOs to strengthen each other and work together work towards making maximum use of the available opportunities.

**Thank You!!**

# Appendix

## Appendix 1: List of Participants

NO	Name of Participant	Organisation	Email
1	Alfred Kalaghe	Africare	
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# Appendix 2:

## Results of the end of Workshop Questionnaire

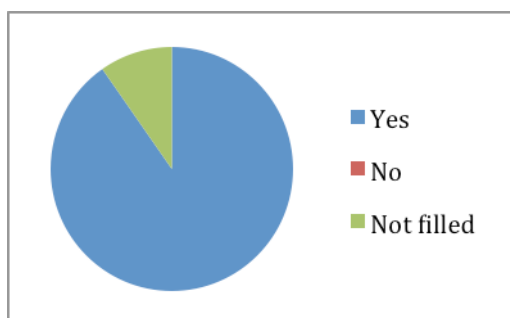
Venue: Amber Hotel

Date: 27th – 29th March 2017

Out of 40 questionnaires, 31 were filled and returned.

1. Have you learnt anything that you did not previously know at this workshop?

Yes - 28 No - 0 Not filled - 3



2. Please rate the workshop component using the following scale:

5 = Strongly Agree 4 = Agree 3 = No Opinion 2 = Disagree 1 = Strongly Disagree

NO.	WORKSHOP COMPONENT	Strongly Agree (%)	Agree (%)	No Opinion (%)	Disagree (%)	Strongly Disagree (%)	Invalid (%)
i)	The workshop objectives were clearly spelt out.	48	35	6	0	0	6
ii)	The workshop lived up to my expectations.	32	58	3	0	0	6
iii)	The content was relevant to me/my job.	55	32	6	0	0	6
iv)	The workshop stimulated me/my learning around Malaria.	48	32	6	6	0	6
v)	The group discussions were relevant to me	45	42	3	3	0	6

vi)	I was actively involved in group discussions	39	48	3	0	0	6
vii)	The sessions were well paced within the allocated time	13	61	10	6	0	6
viii)	The panel discussion were well moderated	29	48	13	0	3	6
ix)	The information presented to me was mostly very new to me	19	19	19	39	3	6
x)	There was sufficient time scheduled for discussions	6	58	19	10	0	6

3. Please circle a face, which most describes your level of satisfaction with the workshop:

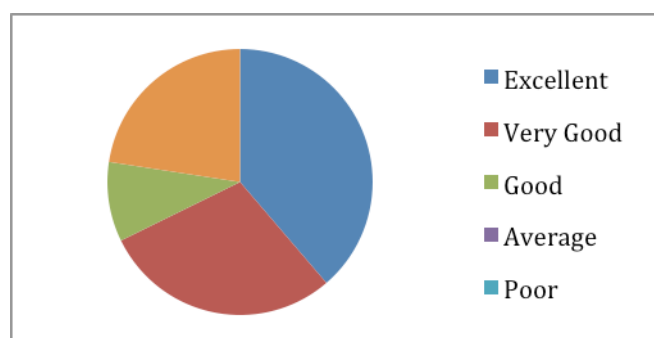
😊😊😊	😊😊	😊	😊😬	😬	Not filled	
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Average</b>	<b>Poor</b>	<b>1</b>	
32%		42%	16%	6%	0%	3%

4. What recommendations would you propose on topics in future workshops?

- Resource mobilization
- Climate Change, Regular workshops yearly.
- Provide more time to finish tasks at hand.
- Rotation of workshops across East African countries
- Workshops to be done twice a year
- Include study site visits

5. How do you rank the accommodation and venue provided during the workshop?

😊😊😊	😊😊	😊	😊😬	😬	Not Filled
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Average</b>	<b>Poor</b>	
39%	29%	10%	0%	0%	23%



Please comment/give suggestions:

- Allocate more time to view the city,
- Good accommodation,
- Next time book guests to travel at daytime.

6. How would you judge the arrangements/communication you received from the Secretariat before the workshop?

😊😊😊	😊😊	😊	😊😄	😄	Not Filled
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Average</b>	<b>Poor</b>	
32%	32%	10%	6%	-	16%

Please comment/give suggestions:

- Timely, Proper communications on logistics to be made, Communicate earlier, communicate all information regarding workshops during weekdays.

7. The logistics for the workshop were well executed

😊😊😊	😊😊	😊	😊😄	😄	Not Filled
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Average</b>	<b>Poor</b>	
19%	45%	16%	6%	0%	13%

8. What was most valuable about this workshop?

- Good accommodation
- Proper Networking,
- Exposure,
- Resource mobilization discussion,
- Synergy,
- Learning new ways to tackle malaria.





