Great Lakes Cross Border Malaria Initiative Meeting Report

April 22nd -24th 2019

Secretariat of EAC

Contents

1. INTRODUCTION

1.1. Background

In accordance to the relevant provisions of Chapter 21, Article 118 (a) of the Treaty on the establishment of the East African Community (EAC), with respect to regional co-operation and integration on health, the Partner States to cooperate and take joint action towards the prevention and control of communicable and non-communicable diseases and to control pandemics and epidemics of communicable and vector-borne diseases such as HIV-AIDS, cholera, malaria, hepatitis and yellow fever that might endanger the health and welfare of the residents of the Partner States, and to co-operate in facilitating mass immunization and other public health community campaigns

Based on this EAC Treaty mandate, the 9th Ordinary Meeting of the EAC Sectoral Council of Ministers of Health which was held in Zanzibar City of the United Republic of Tanzania on 17th April 2014, noted that both The "East African Community (EAC)" and the "International Government Authority on Development (IGAD)" are among the recognized African Regional Economic Communities (RECs) under the African Union and some of the Member States of the IGAD are also Partner States of the EAC. There was a need to jointly explore opportunities and agree on the scope of possible collaboration in the identification, design, formulation, resource mobilization and implementation of various regional health projects and programmes in the Eastern Africa region, including Malaria Prevention and Control under the Roll Back Malaria (RBM) Framework and other common priorities. In this regards, in August 2018, WHO/AFRO in consultation with WHO/Country offices and National Malaria Programs from EAC Partners States and DRC developed a concept note for Great Lakes Malaria Collaborative Initiative. Finally a joint effort comprising EAC Secretariat, MOH/Rwanda and its technical partner Society for Family Health (SFH) and WHO/Rwanda led to the organization of the Malaria Cross Border initiative meeting on above mentioned dates.

1.2. Convening of the meeting

The Eastern African Community (EAC) and Democratic Republic of Congo (DRC) held a cross border malaria control initiative meeting from 22nd to 24th April 2019 in Marasa Hotel Kigali Rwanda, the current chair of the EAC Health Ministers and the meeting was sponsored by SFH, a Partner of MOH Rwanda in prevention of malaria. The members of Organizing Committee were:

- The East Africa Community Secretariat
- The Ministry of Foreign Affairs in Rwanda
- The Ministry of Health Rwanda
- The World Health Organization/Rwanda Office
- The Society for Family Health
- The USAID through Presidential Malaria Initiative

1.3. Objectives and expected outputs

The first meeting of EAC and DRC aimed to:

a) Review country progress, impact and gaps in malaria control in cross-border regions including high-risk areas for malaria epidemics;
b) Agree on a framework for future collaboration and harmonization of malaria policies/strategies and implementation of malaria control interventions across borders to accelerate progress towards malaria elimination
c) Agree on a joint cross-border plan of action that addresses the: −
    i. scope of activities to be implemented
    ii. timing of implementation
    iii. resource requirements and opportunities for resource mobilization
    iv. inter-country and regional joint review and coordination mechanisms, terms of reference and operational guidelines
d) Define activities for capacity building and technical assistance

The following was expected from that meeting:

- Framework of Collaboration/Policy Elaboration: Intercountry coordination mechanisms and a regional coordination mechanism
- List of cross-border zones in the Great Lakes Region prioritized for malaria cross-border activities
- Roadmap of key next activities and timeline
- List of activities for capacity building and technical assistance

1.4. Participants

The EAC Secretariat invited seven countries in which the Governments were represented by the country National Malaria Control Programs, Country WHO representative, Presidential Malaria Initiative (PIM) from each country, 1 representative of Roll Back Malaria (RBM), 2 representative of African Leaders Malaria Alliance (ALMA), 2 representative of Society for Family Health as shown in participants list below (Table 1).

Table 1: Participants by respective Country or organization

Country/ Organization	Definition	Attended
East Africa Community	By expertise	2
Ministry of Health	3 persons per country	20
MOH Rwanda (Hosting)	Group Facilitators	4
WHO/National Program Officers Malaria	One per country	7
WHO/AFRO staff	By Expertise	4
PMI	One per country	3
Society for Family Health (SFH), Rwanda and SC Johnson	Financial and technical support	4
RBM Partnership Staff	By Expertise	1
ALMA Staff	By Expertise	2
Total		46

2. OPENING CEREMONY

2.1. Remarks from Chair of EAC Sector Council of Ministers of Health

Hon. Minister of Health Rwanda Dr Diane Gashumba was the guest of honor and she is leading the Council of Ministers of Health in EAC.

The Honorable Minister opened the meeting and welcomed all participants to the meeting and said: "***All the countries in the Great Lakes Region are aggressively pursuing national malaria control strategies aiming at ending malaria within their respective borders. However, countries targeting malaria elimination cannot achieve their targets as long as high transmission remains within the region***". She reminded all participants that the overall objective of the meeting was to strengthen the regional initiative for malaria control and elimination in EAC countries and the Democratic Republic of Congo

Honorable Dr Diane urged the participants to define and strengthen the framework of collaboration, coordination and determine the key actions for next step. Hon Minister acknowledged the support from EAC Secretariat, WHO/AFRO, WHO/Country office and Society for Family Health in the whole process to organize the meeting

2.2. Remarks from World Health Organization (WHO/AFRO)

Dr Sillah said "Though malaria incidence is still high in region, the WHO has vision of "a world free of malaria" by 2030 and defined a global technical strategy for Malaria (2016-2030) with the objective to reduce incidence and death due to malaria by 90% of 2015 levels by 2030"

He quoted WHO Director-General as follow "***We need to change course and improve how we combat malaria, particularly in those countries with the highest burden. The status quo will take us further off track and have significant negative socio-economic consequences beyond malaria***." Said Dr Tedros Adhanom Ghebreyesus

He reminded that strong political commitment, sustainable financing, increased multisectoral and regional collaboration hold the key to further progress and WHO strongly support EAC initiative to bring together 7 Great Lakes countries to review and address their challenges in the prevention and control of Malaria in the sub-region and particularly to address inter- country barriers that may interfere with the achievement of optimal impact in malaria prevention and control in the region.

2.3. Remarks from Eastern Africa Community (EAC)

Dr Katende said "***One of the key challenges in the fight against malaria is that malaria has been seen as a country specific problem only and not as a regional (or sub-regional) issue***"

The EAC Cross border malaria initiative was recommended since 2014 but different challenges prevented the way ford, the meeting should serve as an opportunity for strengthening the regional initiative for malaria control and elimination in Great Lakes region.

Dr Katende recommended that the meeting should be a technical forum for sharing experience of all ongoing malaria control interventions in each country ,challenges in general and particularly those faced to address movement of people across borders especially from malaria hotspots areas in inter-borders Districts, identification of adequate and harmonized policies ,strategies and malaria control measures for a joint plans of action in Cross-Border districts, required budget for assuring synchronized and synergized implementation between concerned countries in the region

and finally the meeting will review and propose suitable governance mechanisms to ensure effective operability of the initiative for the coming five years

2.4. Remarks from Roll Back Malaria (RBM)

Gen (Dr) Kaka Mudambo explained that RBM Partnership is the global framework for coordinated action against malaria. It will continue to mobilize for action, resources and forges consensus among partners. RBM's overall strategy aims to reduce malaria morbidity and mortality by reaching universal coverage and strengthening health systems and partnerships. The Zero Malaria starts with me campaign provides a platform for raising funds to support malaria work and engage everyone from the Head of State to community members and keep malaria high on the political agenda.

2.5. Remarks from African Leaders Malaria Alliance (ALMA)

Mr Samson Katikiti ensures that ALMA will continue to leverage their collective knowledge and influence to bring about action and accountability as they fight one of African's most devastating disease by providing a forum to review progress and address challenges in meeting the malaria target; implementing a monitoring and accountability system through the ALMA Scorecard for accountability and action to track results, identify bottlenecks, and facilitate appropriate action; identifying and sharing lessons learned for effective implementation of national programs.

3. AGENDA

The main topics covered during the meeting through presentations, brainstorming and group discussion were:

- Perspectives and strategies for the control of Malaria in the Great lakes region
- Country malaria epidemiological profile, proposed strategies and interventions for Malaria Control with focus on potential risk factors
- EAC Malaria action framework.
- WHO Guidance on cross border Malaria initiatives and related terminologies
- Cross border situation analysis and define prioritized cross-border Malaria interventions
- High Burden High Impact (HBHI)-Country Briefing: Uganda Experience
- Key recommendations and next step

3.1 WHO/AFRO Perspectives and Strategies for the control of Malaria in the Great Lakes Region

The presentation was facilitated by **Dr Elisabeth Juma WHO/AFRO**

The Global Technical Strategy for malaria 2016-2030 highlighted the three pillars of border malaria which are:

1. **Ensure universal access to malaria prevention, diagnosis and treatment.** The core interventions for malaria prevention are ***mosquito nets*** - Long-Lasting Insecticidal Nets (LLINs) and ***Indoor Residual Spraying*** (IRS). However there are other supplement interventions like larva control and environment management. The universal coverage by at least one of the core interventions is recommended and both (IRS and LLINs) can be combined for mitigating resistance. All suspected malaria cases should have a parasitological test (microscopy or RDT) to confirm the diagnosis and treated by ACT for uncomplicated cases except pregnant women in their first trimester. For severe malaria cases, the first option should be artesunate injectable for at least first 24 hours until patient will be able to tolerate oral medication. To maximize the coverage, the countries should involve private sector in health service.
2. **Accelerate efforts towards elimination and attainment of malaria free status.** This requires quality and impactful implementation of interventions to achieve elimination and prevent re-introduction of transmission. The countries should detect every infection, implement targeted measures for tracking both parasites and vectors, eliminate all parasites from humans, and manage the risk of re-establishment through imported malaria and setting up the epidemiological surveillance system.
3. **Transform malaria surveillance into a core intervention in areas of high and low transmission and those targeted for elimination.** The countries in burden reduction (control phase) should be in trouble of reaching all cases for surveillance but those in pre/

elimination phase should follow all suspected cases with or without symptoms, including people from countries with malaria. These in control phase should report on malaria cases (simple and complicated), death due to malaria and malariometric indicators (Annual parasite incidence, Test positivity rate, Annual blood examination rate).

For supporting elements include the harnessing innovation and research on new tools and approach for vector control, new diagnostic testing tools for detection of low parasitemia, new treatment regimen, malaria vaccines and surveillance approach.

For health strengthening the countries should increase international and domestic financing, ensuring a robust health sector response; strengthening health workforce and malaria expert base; ensure sustainability of malaria responses and improvement of government stewardship; ***Cross-border collaboration of malaria programs and strengthening of multi-sectoral collaboration*** and encourage private sector participation and engagement with non-governmental organizations.

3.2 The EAC and DRC Malaria Action Framework

Dr Michael J. Katende who led the group discussion on the framework presented to the participants the EAC and DRC Malaria Action Framework

a) Vision

A malaria free African great lakes region

b) Goal

The goal is to reduce malaria morbidity and mortality by 50% by 2023 in the region and districts adjoining international boundaries

c) Strategic Objectives

a) To strengthen regional coordination of policies and implementation of malaria programmes to accelerate progress towards regional malaria elimination targets'
b) To promote collaboration and harmonization of malaria policies/strategies and implementation of malaria control interventions to accelerate progress towards elimination.
c) To elevate and to maintain the regional elimination agenda at the highest political levels.
d) To promote a regional peer performance review and accountability framework to review and maintain the momentum towards elimination.
e) To mobilize resources (domestic and international) and ensure long term sustainable financing and to strengthen the attainment of individual country targets and regional goals

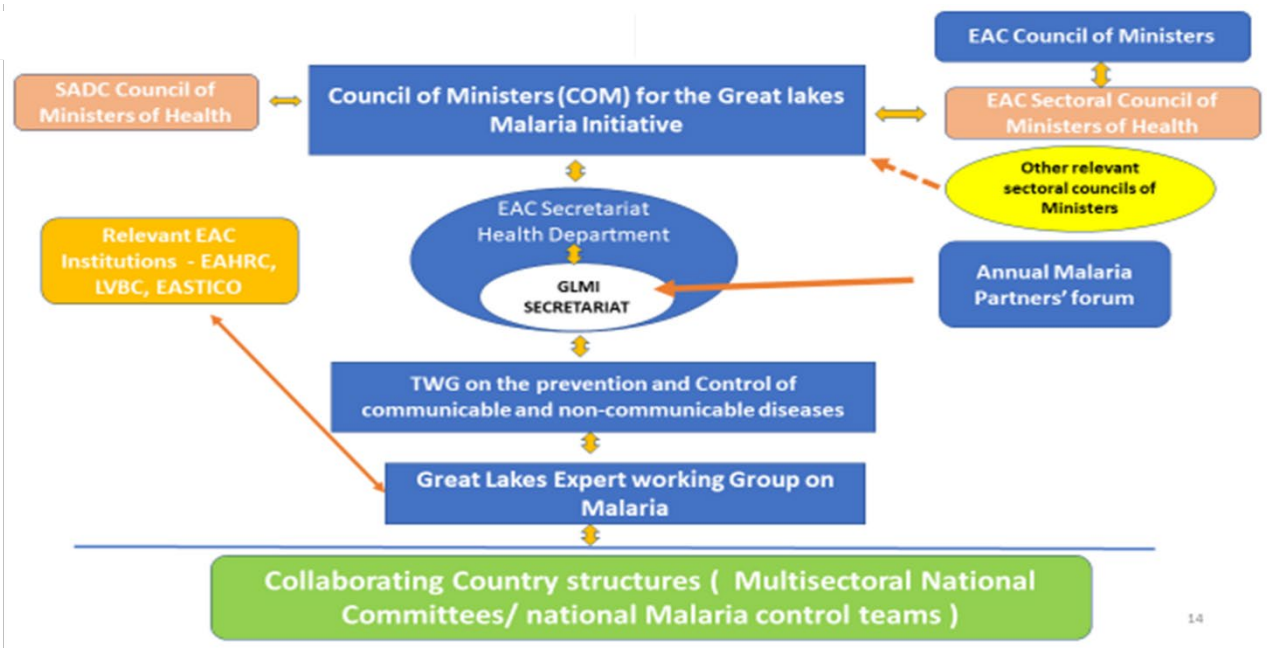
From Group discussion the following were the decisions:

- The name should change from EAC and DRC cross-border malaria initiative to ***Great Lakes Cross Border Malaria Initiative*** and it will:
    - Include Burundi, DRC, Kenya, Rwanda, South Sudan, United Republic of Tanzania, Zanzibar, Uganda
    - Focus on cross border malaria collaboration for preventing duplication but enhance what countries planned and are implementing.

- Framework of Collaboration/Policy Elaboration
  - EAC Sectoral Council of Ministers of Health (include DRC)
    - Stakeholders such as WHO, RBM, Global Fund, ALMA can attend
  - EAC Secretariat Health Department (hosting the Great Lakes Malaria Initiative (GLMI))
    - Great Lakes Malaria Initiative Secretariat
  - Sectoral Committee on Health (Include DRC)
  - Technical Working Group on the prevention and control of communicable and non-communicable diseases (include DRC on discussions on malaria) considering:
    - Member states representatives on malaria to sit in this technical working group when they meet.
    - Great Lakes Malaria Expert Working group
      - To develop TORs for Great Lakes Malaria Expert Working Group
    - *Stakeholders Forum for malaria (on the margins of RBM Partnership meeting)*
  - EAC Secretariat to work on formal working arrangement with DRC at the regional level. (likely to include working with the Africa Union)

The team suggested that the implementation and coordination of Great Lakes malaria initiative should be as below.

Graph 1: Proposed Implementation and Collaboration/Reporting Structure

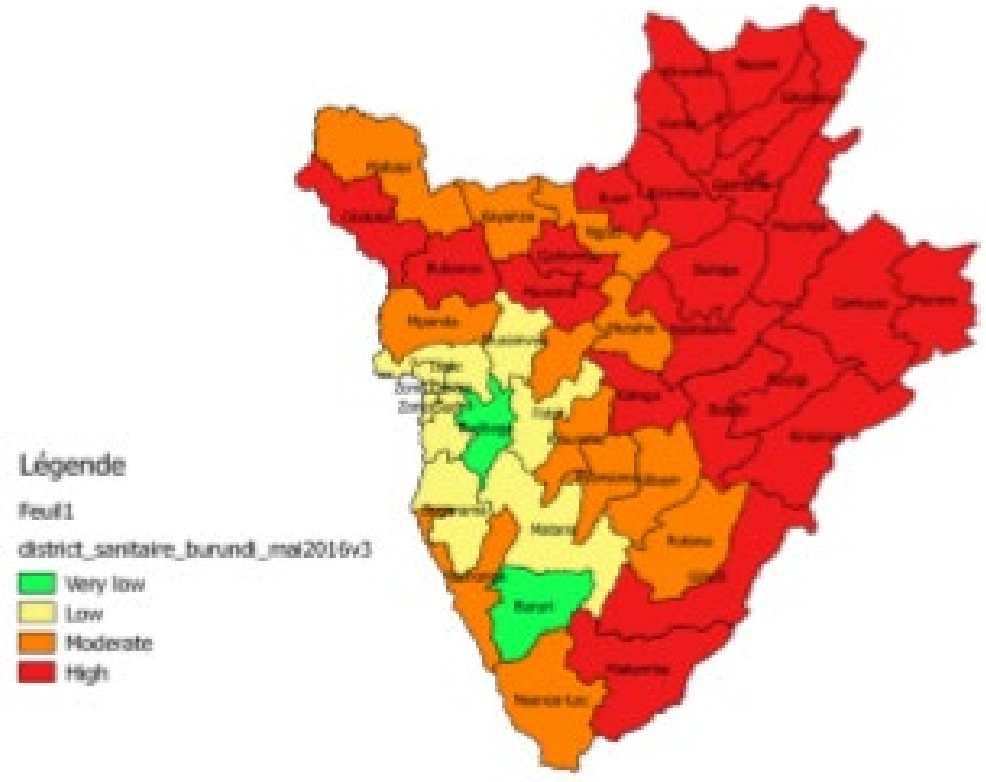


3.3 Country Malaria Epidemiological Profile, proposed strategies and interventions

3.3.1 BURUNDI

Malaria is a major cause of morbidity and mortality in Burundi particularly among children less than 5 years of age. All of the country's populations live in areas of high malaria transmission. In 2017, malaria was the first cause of morbidity with incidence of 815‰ and prevalence of 27%[1]. Malaria represent 45% of outpatient consultation but 50% for under five children. Plasmodium falciparum is the main parasite while main vectors are *Anopheles gambiae* and *An. funestus*. Between 2015 and 2017, the country faced a severe malaria epidemic, with more than 19.7 million cases and more than 9,000 deaths. The Government of Burundi declared the malaria epidemic in March 2017 and developed a response plan in collaboration with local and international health sector partners and brought the epidemic under control[2].

Burundi Malaria incidence in 2017

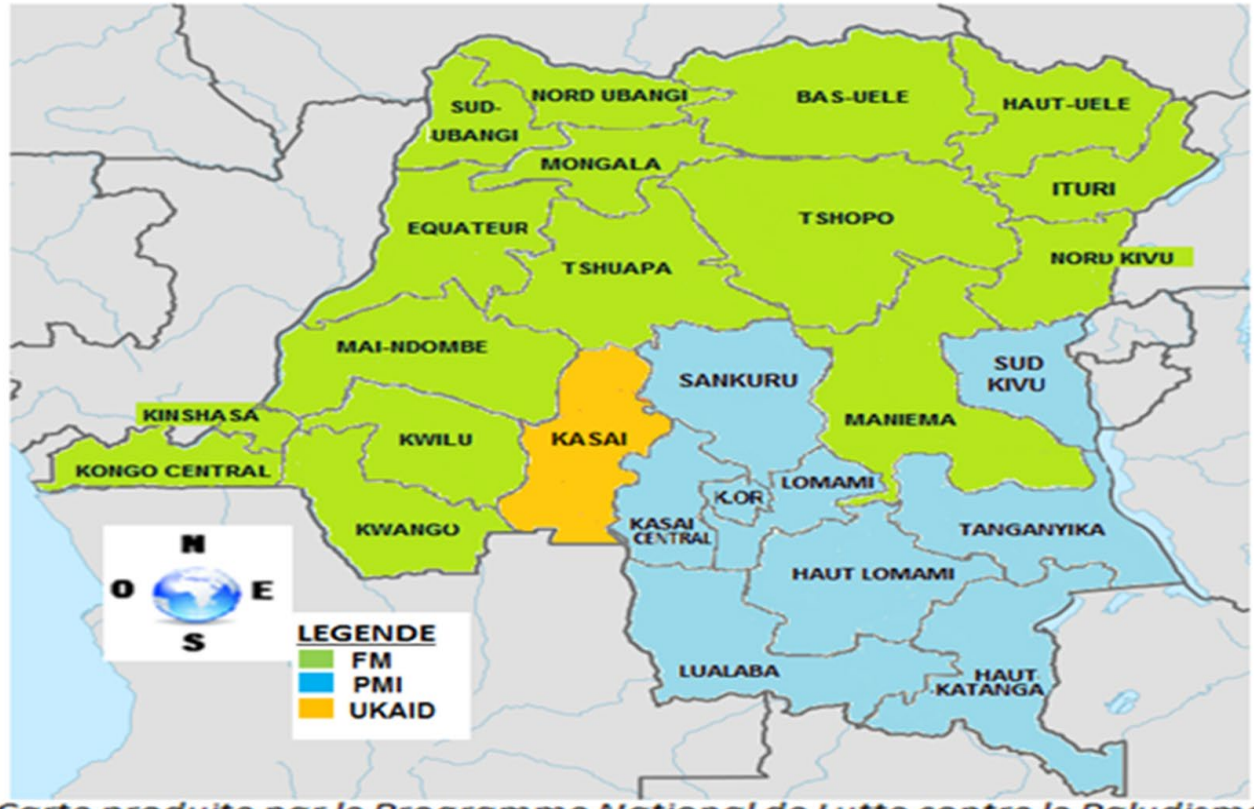


Source: National Program for malaria control, Strategic Plan 2018-2023

[1] Burundi Malaria strategic plan 2018-2023.
[2] Burundi Snapshot Malaria (Septembre 2017) UN Office for the Coordination of Humanitarian Affairs 2017.

The probable factors of malaria increase in Burundi were many but, the recent strategic plan highlighted that 80% of epidemic episodes occurred near to marshland with rice cultivation and dams for water collection used in agriculture.

3.3.2 DEMOCRATIC REPUBLIC OF CONGO



Carte produite par le Programme National de Lutte contre le Paludisme

The second biggest country in Africa and is bordered by 5 among 6 countries of EAC with 177‰ of malaria incidence in 2018. Malaria is the first cause of consultation, admission and death in DRC. The probable factors associated with the malaria situation in DRC are:

- Repetitive conflicts in the country which cause population movements and displacement
- Emergence of resistance on used insecticide
- No complying with protocol and guideline of Indoor Residual Spraying (IRS) due to the irregularity of funds
- Low budget execution mobilized for prevention and surveillance activities.
- Difficult data and information sharing due to weak internet connection
- Hard to reach population due to geographical location

Suggested solutions:

- Expand the IRS in other region and start larviciding wherever possible
- Choice the IRS product which is effective and respect of rotation
- Start resistance surveillance

- Respect of time for mass campaign for LLINs
- Develop a strong network by internet for getting information on time
- Mobilize funds for research and quick interventions when the malaria increase is very high.
- Integration of private sector in malaria prevention and care

3.3.3 KENYA

Overview of Kenya

National Malaria Control Programme – Komesha Malaria, Okoa Maisha

Kenya borders with 4 among 6 countries of EAC and the whole population is considered to be at risk with the difference coming at the epidemiological zones of the country. In Kenya, malaria accounts for 13% of out patients department (OPD) and 3-5% of inpatient deaths. The children 6 months to 14 years were found as population at high risk including pregant women. The probable factors contributing to malaria increase were high temperature, high level of humidity, high rainfall and low immunity. The main interventions implemented in Kenya were:

- Case management (CM)
- Intermittent preventive treatment in pregnancy (IPTp)
- Long-lasting insecticidal Nets (LLIN)
- Indoor residual spraying of insecticide (IRS)
- Monitoring and Evaluation
- Epidemic preparedness and response (EPR)

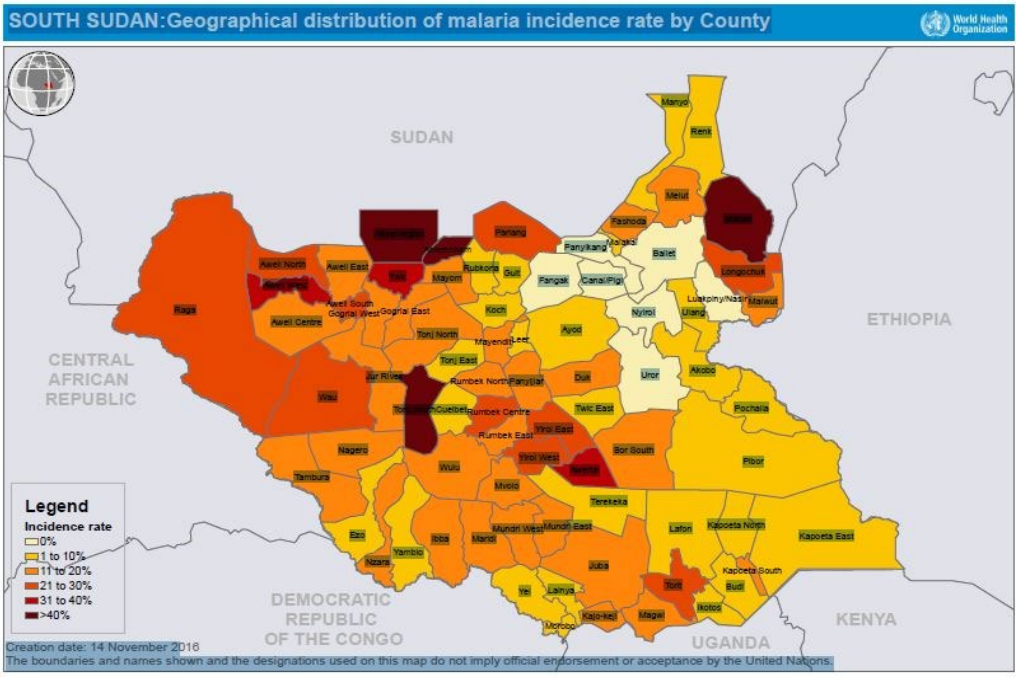
- Advocacy, communication and social mobilization (ACSM)
- Larval source management (LSM)
- Malaria Vaccine: Piloting in the lake endemic region

The main challenges and proposed solutions in Kenya were:

- Low funding (domestic, donor) proposed advocacy for more c funding, develop and implement resource mobilization strategy
- Low utilization of key malaria control interventions by the communities in endemic areas and should improve the SBCC
- Inadequate data for decision making build capacity on data collection, analysis and feedback mechanisms on malaria inpatient and mortality data including private sector and insecticide resistance.
- Emerging resistance to insecticides
- Lack of alternatives insecticides
- Overall Health systems challenges

3.3.4 SOUTH SUDAN

The South Sudan borders with 2 among 6 countries of EAC but with DRC on big part of country. All population is at high risk of malaria which last year was the leading cause of morbidity and mortality accounting for 45% outpatient consultation, 30% of admissions and 20% of health facility deaths, current prevalence stands at 32%.



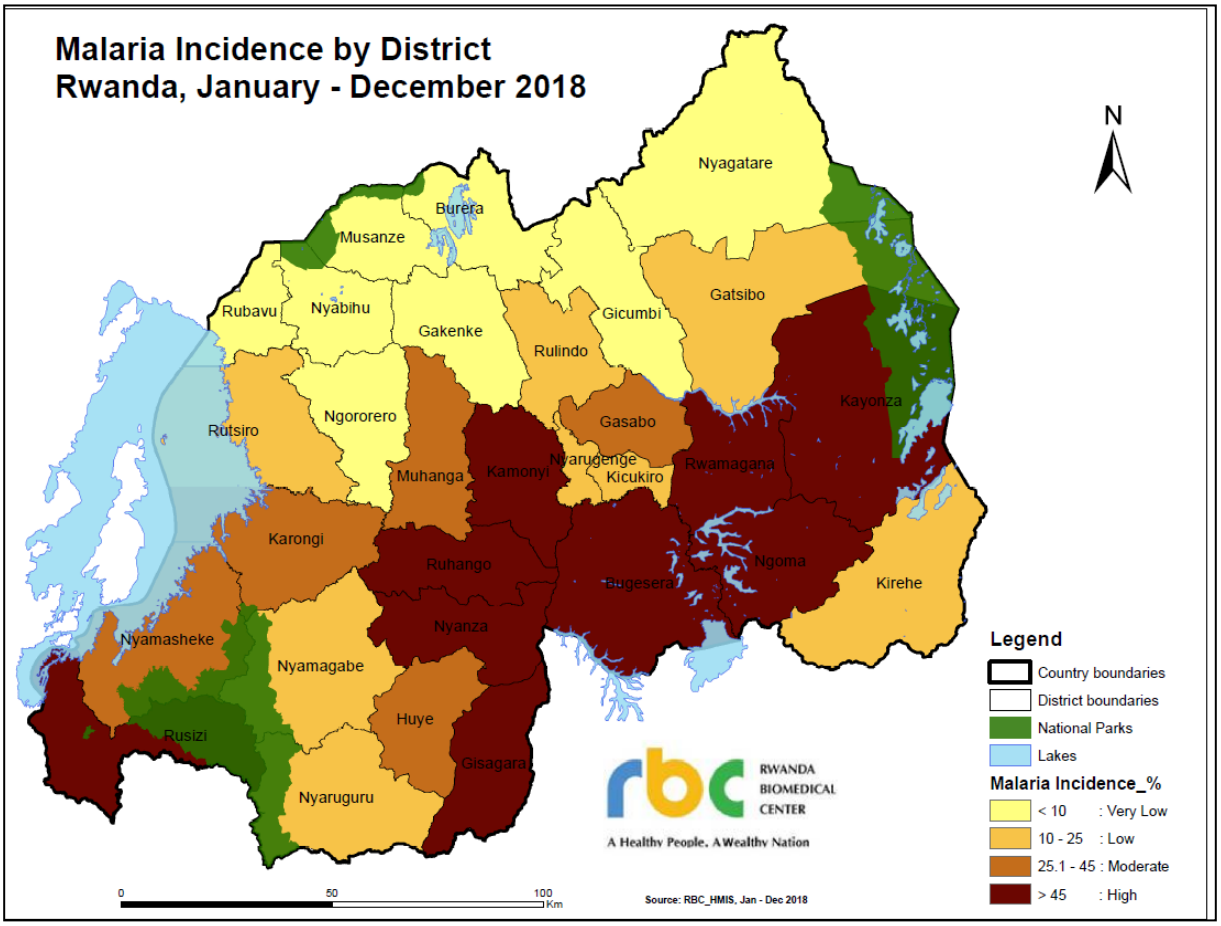
Since 2013 there was an up resurge of malaria incidence and probable causes were:

- Climate, hot and humid with 7 to 9 months of rainfall
- Population movement and displacement
- Poor access to health services
- Poor physical infrastructure
- Instability

The interventions for malaria prevention in South Sudan were:

- Mass & routine LLINs distribution for correct and regular use by everyone;
- Indoor residual spraying (IRS) in targeted areas (IDP and Refugee camps) and emergency settings
- Larval and environmental management (LSM), where breeding sites are few and can be found
- Chemo prevention in pregnancy

3.3.5 RWANDA



The malaria incidence increased since 2013 and the most recent was still high (340‰) even though reduced compared to the incidence of previous year. The malaria remain the first cause of consultation and hospitalization.
The probable causes of malaria presented were:

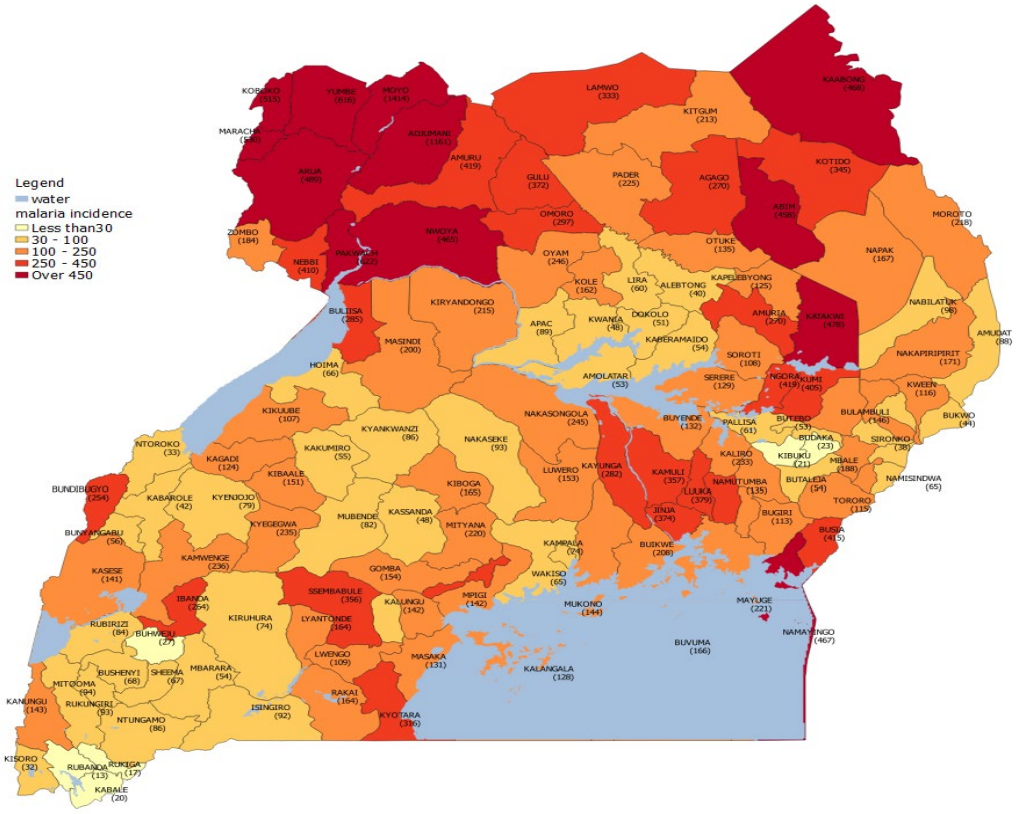
- Wide-spread insecticide resistance to **Pyrethroids** (LLINs and IRS)
- Significant drop in ITN coverage (43%) as reported in the 2015 DHS report
- Low coverage in IRS due to shifting from an affordable insecticide to expensive classes as a solution to mosquitoes resistance
- Increased rainfall pattern and temperature in 2012 creating favourable conditions for mosquitos to grow
- Land use change (marshlands for rice and vegetables with breeding sites)
- Population movement, particularly refugees camps in Eastern Province
- Changing in behaviour (outdoor, earlier, Zoophagic) and species composition of mosquitoes

The main program challenges highlighted were:

- Budget limitation to cover Indoor Residual Spraying for malaria control in all 15 high malaria burdened districts for a proper malaria control in Rwanda (only 5 of 15 districts sprayed in 2017/2018)
- Increased work load for CHWs due to HBM (60% of malaria burden)
- Inexistence of cross-border malaria control strategies for integrated regional malaria control
- Lack of Outdoor Control Interventions

3.3.6 UGANDA

Malaria incidence map of Uganda by district in 2018.



The malaria incidence in Uganda was 190‰ in 2018. The risk factors highlighted as causes of malaria high burden were:

- Climatic and weather conditions that is conducive to dual seasonal transmission seasons
- Human factors: knowledge attitude and practices that impedes positive response against malaria and health problems at all levels – HH, HF, Technical, Policy and Sectoral levels.
- Economic limitations at individual, household and HFs, corporate and governmental levels
- Weak health system and infrastructures
- Poor intersectoral collaboration and inter-programmatic coordination
- Resistance development to hitherto efficacious malaria interventions (Anopheles and P. falciparum)

The challenges to resolve above mentioned risk factors were:

- Political conflict, civil unrest and social / cultural conflicts

- Socio-economic interests and pursuits – Agriculture, Trade, Mining, Tourism, Cattle ranching, etc.
- Climatic changes leading to drought and famine
- Religious e.g. 03 June Annual Martyrs Festival at Namugongo
- Defence e.g. Military personnel on missions

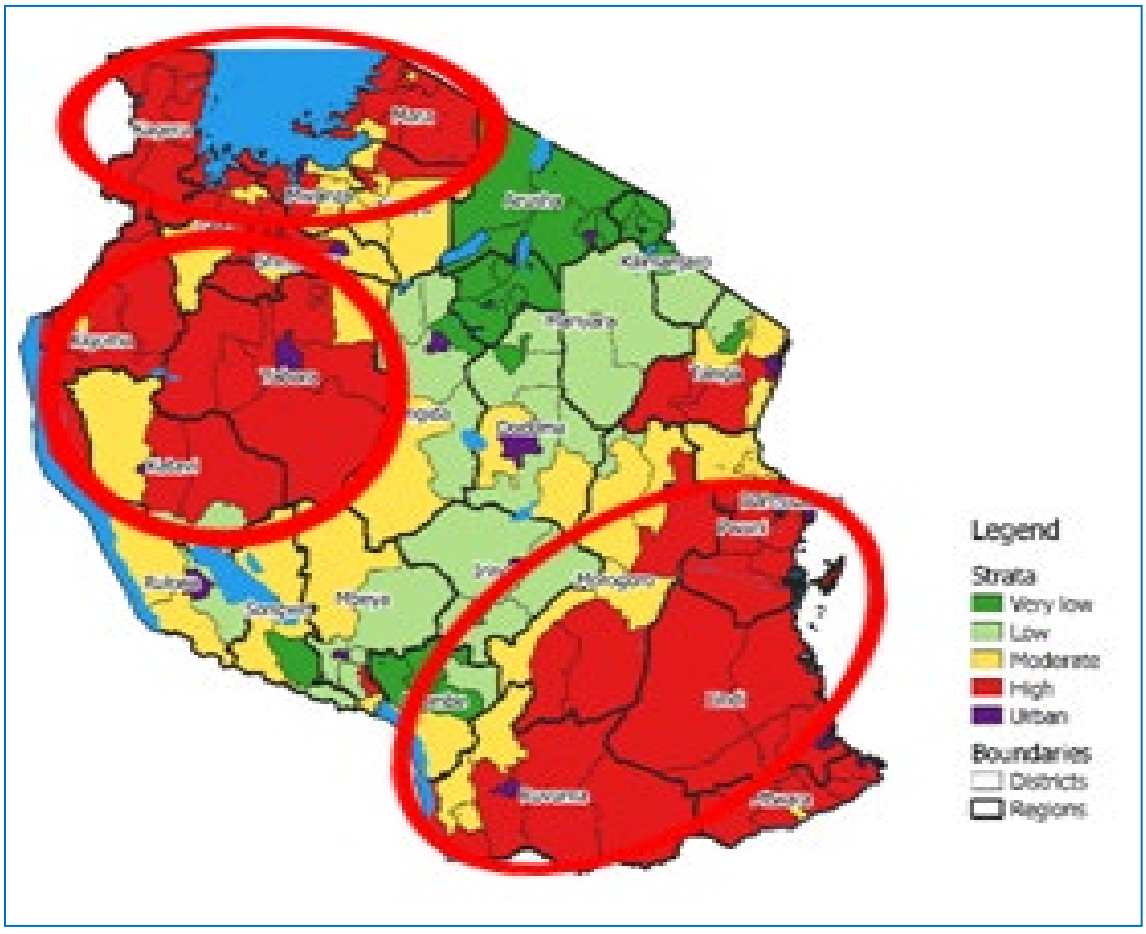
The country representative were suggesting Mass Action Against Malaria (MAAM) as an approach guided by the principle of **reaching Everyone wherever they live, work and recreate** and where malaria response becomes everyone's business. In addition to that there was a need of:

- Updated National Malaria Prevention and Elimination Policy 2019
    - Cross border Malaria Response has been incorporated
- Cross border Malaria - Uganda and Environs:

Understanding the magnitude & applying evidence to appropriately manage

3.3.7 TANZANIA MAIN LAND

Map of Tanzania Main Land stratified by level of endemicity 2018



Countrywide, malaria was still the leading cause of morbidity and mortality for all age groups but with high heterogeneity. Burden is mostly seen in the West, Lake and Southern zones but the low/very low prevalence in the Central corridor overtime. (See the map above). Some facts about malaria transmission in Mainland Tanzania were presented and detailed as below:

- Evidence of decreased malaria occurrence in the country (>50% decrease in prevalence in the past 15 years).
- More than half of the population lives in low transmission areas (pfpr <10%); half of them in very low transmission areas (pfpr <1%)
- One third of the country is consistently demonstrating to be in very low transmission areas.
- School age children and young adults are the most affected groups in terms of parasites prevalence.
- Data shows that in the past 5 years, malaria burden in health facilities is decreasing.

The main vector control interventions were providing LLINs, IRS in high transmission area and larvae source management. However some challenges were:

- Dependency for resources from partners for implementation of core intervention
- Insecticides Resistance
- Heterogeneity of transmission
- Outdoor bite
- Human resource in hard to reach areas
- Data management

3.3.8 TANZANIA ZANZIBAR

The Zanzibar region is in pre-elimination phase for more than ten years with malaria incidence below than 3 per 1000. The vector control interventions used there are LLINs, IRS. There are still challenges which probably continue to be barrier to eliminate malaria, such are:

- Scattered distribution of local cases with lack of supporting evidence for disease transmission
- Imported malaria cases: a threat for malaria transmission
- Evidenced through case investigation at household level
- Inadequate funding sources to achieve elimination goal

3.4. Summary of probable factors of current malaria situation within Great lakes

The Probable factors of malaria transmission increase by Country were summarized in below table

Table 1: Summarized Probable factors of malaria increase by country

Risk Factor	Burundi	DRC	Kenya	Rwanda	South Sudan	Tanzania ML	Zanzibar	Uganda
Population movement and displacement (in and out)		x		x	x		x	
Climate change	x	x	x	x	x	x		x
Mosquito behavior change				x		x		
Resistance to insecticide	x	x		x		x		x
Low coverage of IRS	x			x			x	
Low coverage or usage of bed net	x	x		x		x	x	
Environment change (Rice cultivation, mining, quarries)	x			x			x	
Weak health system and infrastructure		x			x			x
Insufficient fund (Domestic or out of country)	x					x	x	x
Weak involvement of private sector	x	x						
Data availability and utilization		x				x		
Insufficient behavior change of population	x					x	x	x

The $_{X}$ sign equals to presence of highlighted challenge (Source: Presentation of countries), MOH Burundi was not represented

Expectation of countries from Great Lakes Cross Border Malaria Initiative

- Learning from other countries malaria control strategies
- Understand factors related to malaria burden across the region
- Identification/Mapping of malaria hot spots across the region
- Prioritization of malaria control interventions for joint action plan/implementation
- Designing cross border collaboration framework for malaria elimination
- Advocate for resources mobilization
- Connecting with Malaria Experts from the region
- Clear involvement of Other Public Institutions, Private Sector, Civil Society and Community

3.5. Group work session

3.5.1. Methodology

The group discussion was organized based on existing Basins in Great Lakes Region plus a coordination team:

- Coordination team which included representatives of Managers of malaria program, WHO/AFRO representative, RBM, ALMA, EAC, SFH and Sc Johnson representative.
- Nile Basin which comprised four countries: Kenya, South Sudan, Tanzania and Uganda
- Eastern Congo Basin include 3 countries which were DRC , Burundi and Rwanda

The form used to collect information was designed into excel and gathered data on names of border districts per country, the malaria burden, interventions to control or eliminate malaria, challenges and threats.

The Coordination team was tasked to define the framework collaboration, resource and key steps after Kigali Meeting.

3.5.2. The output from coordination group

a) Name of this collaboration will be "Great Lakes Malaria Initiative"

- Focusing on cross border malaria collaboration
- Burundi, DRC, Kenya, Rwanda, South Sudan, United Republic of Tanzania, Uganda

b) The Framework of Collaboration/Policy Elaboration

- EAC Sectoral Council of Ministers of Health (add meeting involving DRC)
    - Stakeholders such as WHO, RBM, Global Fund, ALMA can attend
- EAC Secretariat Health Department (hosting the great lakes malaria initiative)
    - Great Lakes Malaria Initiative Secretariat
- Sectoral Committee on Health (add meeting involving DRC)
- Technical Working Group on the prevention and control of communicable and non-communicable diseases (add meeting involving DRC on discussions on malaria)
    - Member states representatives on malaria to sit in this technical working group when they meet.
    - Great Lakes Malaria Expert Working group
        - To develop TORs for Great Lakes Malaria Expert Working Group
    - *Stakeholders Forum for a for malaria (on the margins of RBM Partnership meeting)*

- EAC Secretariat to work on formal working arrangement with DRC at the regional level. (likely to include working with the Africa Union)

c) Meetings

- Meetings of the initiative will meet twice a year in line with the statutory meetings of EAC on health
- Great Lakes Malaria Expert Working Group can meet at least twice a year but, in the beginning, might meet more often as the Initiative is developing.
- Need focal points in member states for coordination as well as the cross-border areas for effective coordination.
- Next scheduled EAC statutory meetings planned for October

We should plan to have one Expert meeting before October

Table Proposed calendar of meeting, members and frequency

Level of Meeting	Team Members	Frequency
Council of Ministers Meeting	Ministers of Health	Twice a year
Sectoral Committee Meeting on Health	Senior MOH Officials (expanded to include other related Ministries, Departments and Agencies)	Twice a year
Technical Working Group on Communicable and Non-communicable diseases meeting	MOH Experts including malaria experts	Twice a year
Malaria Expert Working Group Meeting	NMCPs (expanded to include experts from other related Ministries, department and agencies as per need) Partners	At least twice a year
Joint Annual Review and Planning Meeting	NMCP Partners	Once a year

d) Resources

- Coordination (to include among other things)
  - Funding
  - Capacity Building
- Implementation (to include among other things)
  - Funding
  - Capacity Building

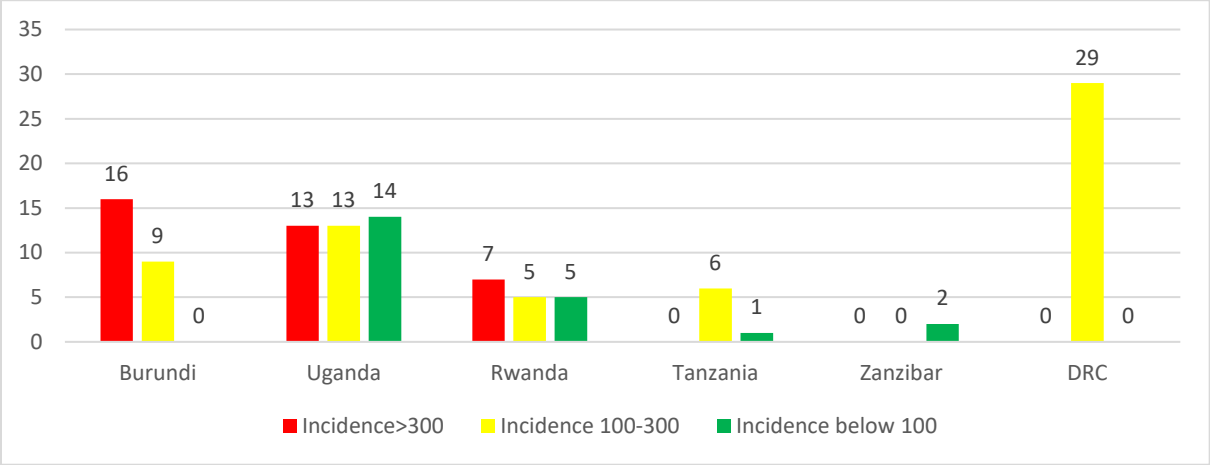
e) In the Interim

- Framework development
  - Country consultation
  - Regional validation
  - Technical support (expert/consultants seconded)
- Setting up of Secretariat (to be hosted by the EAC Secretariat)
    - Starting with existing staff
    - Secondment from countries
    - Secondment from partners
    - Financing of staff position
  - Focal point in member states for coordination (national, subnational, local level)
- Support for the following
  - Framework for collaboration (staff and funds)
  - MOU for Collaboration for the Initiative (staff and funds)
  - Funding proposal development (Staff and funds)
  - Strategic Plan for the Great Lakes Malaria Initiative (staff and funds)
  - In country consultations on the initiative (Staff and funds)

3.5.3. The output of Nile and Eastern Congo Basins

a) Malaria burden on borders

Graph 2: Distribution of malaria incidence on border districts per 1000 of population



The analysis of data provided on second day showed that:

- The participants identified 144 border districts in Eastern Africa Community and DRC. Among them 120 had information on malaria burden (incidence) therefore classified into graph. For South Sudan and Kenya incidence was grouped in other way which could not be merged with others.
- Among 120 district, 30% of them are in high endemic zone (Incidence >300/1000), 52% in moderate zone (Incidence between 100-300/1000) and 18% are in low endemic zone (Incidence < 100/1000).
- Burundi, Rwanda and Uganda have big proportion of border districts with high incidence 64%, 41%, 32% of all borders districts respectively.
- All districts in DRC were classified according to malaria burden of province which was limitation as the last is big and need micro stratification.
- The deep analysis to merge interventions and districts on border will be done during joint Great Lakes Cross Border Strategic Plan elaboration.

b) Key intervention to control malaria on border district

Intervention	Burundi	DRC	Kenya	Rwanda	South Sudan	Tanzania ML	Zanzibar	Uganda
Distribution of Long Lasting Insecticide Nets	x	x	x	x	x	x	x	x
Indoor Residual Spraying	x	x	x	x	x	x		x
Test and treat (Case management)	x	x	x	x	x	x	x	x
Social Behavioral Change Communication (SBCC)	x	x	x	x		x		x
Surveillance, M&E (SME)	x			x	x		x	
Epidemic preparedness and response					x			
Larval source management	x			x	x		x	
Malaria Vaccine: Piloting in the lake endemic region			x					
Intermittent preventive treatment in pregnancy			x		x			
		x				x		
	x					x	x	x

c) Opportunity

- All countries in EAC and DRC are mainly funded by Global Funds and PMI, this can be a stepping stones to harmonize the policies, guidelines and intervention within Great lakes region.
- Same vector control interventions can help harmonization of implementation
- Innovations such as repellants, larviciding, paints, larval source management,
- Malaria incidence, prevalence, mortality at sub national level
- Existence of SADC members where the Cross-border initiatives for malaria control and elimination have been successfully implemented.

d) Proposed interventions

Based on the challenges and expectation of countries below were suggested as interventions to overcome the cross-border malaria problem

- Protocol harmonization and mapping health facilities to mitigate the imported malaria caused by population movement and displacement
- Synchronize vector control interventions like mass net distribution done along the entire border; synchronize the scheduling of mass net distribution (joint planning, data sharing, sharing info on type of nets to be distributed,etc.); synchronize quality control and use of standardized specifications for nets procured
- Improving synchronized timing of malaria control activities within Great Lakes Region
- Conduct joint mapping of health services and risk assessments to inform responses best-suited to the situation and to optimize activities.
- Data sharing and coordination and it was advised that informal data sharing and coordination at the border district level is more efficient and effective.
- Advocate for preventive and early seeking behaviour

3.6. WHO Guidance on Cross-border Malaria Initiatives and Related Terminologies

The session was facilitated by **Dr Ebenezer Baba Sheshi WHO/AFRO**

Dr Baba presented the current WHO/AFRO guidance on malaria elimination and key terminologies to be taken into consideration during the situation analysis. Border malaria is a complex and multi-faceted issue; multiple factors can contribute to transmission in border malaria. Border malaria is often a common transmission focus that crosses an international border which shares a common ecology and is related to human populations, and frequent mixing malaria parasites and vectors. Control and prevention activities are not equal or optimized throughout the focus (e.g. differences in national malaria policies). It may also occur due to: (a) Political unrest, (b) Difference of social and economic development, (c) Weak surveillance and response systems, (d) Lack of access to health service or gradient in access to health care, and (e) As a result of remoteness, neglected, etc. The important fact to note also is that "There is not a one-size-fits-all" approach to address border malaria. Dr Baba explained that during the planning and management, WHO is recommending to use a border malaria analytical framework including: (a) the political context of the border, (b) the geography, environmental and natural features, (c) the population movements, (d) the health service availability and access, (e) the malaria ecology and on-going malaria interventions, (f) the existing cross-border collaborations. Dr Baba presented to the participants some examples of interventions to be implemented at cross border level:

- Joint (or coordinated) mapping and risk assessments;
- Conduct joint mapping of health services and risk assessments to inform responses best-suited to the situation and to optimize activities;
- Data sharing and coordination;
- Informal data sharing and coordination at the border district level is more efficient and effective;

- Improving synchronized timing of malaria control activities;
- The WHO should explore new modalities for scaling up cross-border coordination and collaboration with neighbouring countries in order to treat these areas holistically and fairly. The concept of "Special Intervention Zone," developed for onchocerciasis elimination, should be considered.

3.7. High Burden, High Impact (HBHI): Uganda Experience

Presented by **Dr Bayo Fatunmbi** WHO/Malaria Advisor Uganda

Dr Bayo presented the current guidance on the High Burden High Impact approach which is a new effort to get back on track for the Global Technical Strategy (GTS) milestones launched in November 2018 by WHO and the RBM partnership. HBHI aims to reaffirm commitment and refocus activities in the highest burden countries to accelerate progress towards GTS goals through 4 response elements: **Pillar I:** Political will to reduce malaria deaths, **Pillar II**: Strategic information to drive impact, **Pillar III**: Better guidance, policies and strategies and **Pillar IV**: A coordinated national malaria response. All those pillars are embedded under an effective health system through a multi-sectoral response. The approach calls on high burden countries and global partners to translate their stated political commitment into resources and tangible actions that will save more lives. Grassroots initiatives that empower people to protect themselves from malaria, like the Zero Malaria Starts with Me campaign, can help foster an environment of accountability and action. We are moving away from a 'one-size-fits-all' approach to malaria. Through the more strategic use of data, countries can pinpoint where and how to deploy the most effective malaria control tools for maximum impact. WHO will draw on the best evidence to establish global guidelines. These guidelines will be continually updated and refined based on country experience and the development of new tools. High burden countries will be supported in adapting and adopting the global guidelines based on local settings. Countries will be supported to develop specific implementation guidance to ensure uptake and scale-up of policy. Key to success is a more coordinated health sector response complemented by other sectors, such as environment, education and agriculture. Aligning partners behind this country-led approach will ensure that scarce resources are used as efficiently as possible. The first wave of high burden countries includes Burkina Faso, Cameroun, DRC, Ghana, Mali, Mozambique, Niger, Nigeria, Uganda, Tanzania and India. Guiding principles are : (a) Country-owned , country-led approach aligned with the GTS, Sustainable Development Goals, national health goals, strategies and priorities; (b) Better coordinated support from in-country and external partners paired with increased transparency to ensure efficient responses; (c) Commitment from partners to share and jointly analyze data and (d) Support for enhanced domestic and international resource mobilization

4. KEY RECOMMENDATIONS AND NEXT STEP

The closing session was led by **Hon. Minister of State Dr Patrick Ndimubanzi** with Dr Jackson Sillah from WHO/AFRO, Dr Michael J. Katende from EAC, General (Dr) Kaka Mudambo from RBM and Mr Samson Katikiti from ALMA. On behalf of participants, Dr Aimable Mbituyumuremyi, The Rwanda Malaria Program Manager presented key recommendations and next steps as follows:

4.1. Key recommendations

- For the Collaboration Framework , the following were recommended:

1. Consensus was reached on naming the initiative as "***The Great Lakes Malaria Initiative" (GLMI)***
2. Finalize the GLMI Collaboration Framework
3. Maintain a political momentum with a focus on cross border malaria initiative : Country ownership and leadership
4. Equity in access of health services
5. Using the EAC existing framework and include DRC
   - GLMI to be hosted in the EAC Secretariat Health Department
   - Regional Malaria Expert Working Group
   - Multi-sectoral National committees and focal points
   - Annual Malaria Partners Forum
6. Review some TOR taking into consideration the Great Lakes Malaria Initiative

7. Strengthening communication between EAC and other regional economic bodies such as the SADC

8. EAC to establish a legal framework to ensure effective participation of DRC in this initiative through an MOU between EAC and DRC with support from the EAC Secretariat

9. Resource Mobilization at national, regional and international levels
   - Consistent Advocacy: Focused, Guided
   - Equity of funds allocation

10. Mapping Key Stakeholders (in country, regional and international) including Private Sector and Civil Society

- For the technical implementation, the following were recommended:

1. Development of a Great Lakes Malaria Initiative Strategic Plan
2. Strengthen mechanism for Information Sharing across the Region
3. Synchronize operations implementation at border districts
4. Harmonization of Operational Research Protocols and effective results sharing (where relevant)

5. Facilitate Knowledge and Expertise Sharing across the Region (Peer review, etc.)
6. Strengthen Regional Centers of Excellence on Malaria
7. Strengthen malaria emergency preparedness and response mechanism in border regions embracing an integrated approach where possible
8. Leverage on regional momentum towards the Universal Health Coverage

4.2. Next steps and timeline (Roadmap)

The following were presented as the next steps:

Activities	Timeline
Final Meeting Report shared	3rd May 2019
Hiring consultants for technical support by RBM and WHO	TBD
Framework for Collaboration	30th June 2019
Development of the MOU for Collaboration on the Initiative to be presented to the Council of Ministers meeting	30th June 2019
Draft Great Lakes Malaria Initiative Strategic Plan	31st August 2019
Submit the final draft documents to the Council of Ministers of Health for the GLMI for consideration and approval	October-November 2019
Development of the Joint Funding Proposal for the GLMI once approved by the council of Ministers	TBD

5. ACKNOWLEDGEMENT

The Minister of State expressed his great appreciation to all participants and particularly he recognized the valuable technical and financial support provided by SFH both in the organization of the meeting and also for their role in the fight against Malaria by providing social behavior change communication messages and availing supplement malaria intervention made of repellants. Thus, he gave a recognition award to SFH and Sc Johnson representatives.

The Managing Principal from SC Johnson/USA said: "My favorite country to visit in Africa is Rwanda, my Boss will be excited by this award of recognition and will be happy to work closely with Great Lakes Cross Border Malaria Initiative and our fully support is guaranteed".

The Executive Director of SFH in Rwanda said: "It is taking long working with the Ministry of Health in Rwanda but SFH is honored by this favor of working with Great Lakes Cross Border Malaria Initiative. We will continue to support technically and financially to make sure that this collaboration is functional"

6. ANNEXES

a) Detailed agenda

DAY 1	MALARIA PROGRAMME MANAGERS MEETING WITH SUPPORT OF TECHNICAL PARTNERS	
Time	**Topic**	**Facilitator/ Moderator**
08 :30-09:00	Registration	EAC-WHO/CO and SFH
09 :00-09:30	Welcome and opening remarks Opening speech	- Dr Michael K,EAC Secretariat - Dr Kaka Mudambo, RBM Partnership - Mr Samson Katikiti ,ALMA - Dr Sillah Jackson, WHO/AFRO - Hon Minister of Health Rwanda
09:30-09:45	Objectives, expected outcomes of the meeting	Dr Michael Katende Representative of EAC Secretariat
09 :45-10:00	WHO/AFRO perspectives and strategies for the control of Malaria in the Great lakes region.	Dr Juma Elisabeth WHO/AFRO
10:00-10:25	Group Photo and Tea break	RHCC(interview of Hon Minister with Journalists)
10:25-:10:30	Security Briefing	UNDSS-Country office
	SESSION I	CHAIR :Dr Sillah Jackson
10:30-10:45	EAC Malaria action framework	Dr Michael Katende Representative of EAC Secretariat
10:45-12:30	Country malaria epidemiological profile, proposed strategies and interventions for Malaria Control with focus on potential risk factors	- All countries (Burundi ,DRC, Kenya, South Sudan,Tanzania, Zanzibar,Uganda and Rwanda) - **Moderator** :Dr Spes B /WHO/AFRO
12 :30-13 :00	Comprehensive deployment of social marketing tools for Malaria control in Rwanda	SFH-Rwanda as MOH in Country Malaria Partner - **Moderator** :Consultant
13 :00-14 :00	**LUNCH**	
	SESSION II	CHAIR: Dr Juma Elisabeth
14 :00-14 :15	WHO Guidance on cross border Malaria initiatives and related terminologies	Dr Baba E.WHO/AFRO
14 :15-14 :30	Introductive presentation of the Framework Form collecting pertinent information for the control of Malaria within and between EAC +DRC Countries.	-Independent Consultant
14:30- 15:30	**Group work session 1:** Cross border situation analysis and define prioritized cross-border Malaria interventions	-Regional groups working session : *__Nile Basin__: South Sudan ,Uganda , Kenya ,Tanzania and Zanzibar **Moderator**: Consultant

		Facilitators: Dr Baba WHO/AFRO &RBM * **Eastern Congo Basin**: DRC , Burundi and Rwanda **Moderator**: Dr Jean d'Amour **Facilitator**: Dr Spes B. WHO/AFRO
14:30- 15:30	**Group work (Parallel session)** -Governance ,coordination and resource mobilization mechanism for Malaria cross border interventions	**Moderator** :ALMA **Members of the group work**: one rep from EAC-Countries +DRC +PMI representatives +WHO/AFRO and RBM Partnership
15:30- 16:00	Tea break	
16:00- 17:30	**Group work session 2**: Cross border situation analysis and define prioritized cross-border Malaria interventions	-Regional groups working session**(Con't)** : *__Nile Basin__: South Sudan ,Uganda , Kenya ,Tanzania and Zanzibar **Moderator**: Consultant **Facilitators**: Dr Baba WHO/AFRO &RBM * **East Congo Basin**: DRC , Burundi and Rwanda **Moderator**: Dr Jean d'Amour **Facilitator**:- Dr Spes WHO/AFRO
17:30-18:00	Facilitators ,Moderators +NMCP Managers meeting	
DAY 2 MALARIA PROGRAMME MANAGERS MEETING WITH SUPPORT OF TECHNICAL PARTNERS		
08 :30-08 :45	Registration	EAC-WCO and SFH
	SESSION III	CHAIR : Dr Kaka Mudambo
08 :45-9 :00	Day 1 wrap up	Kenya NMCP Manager
09 :00-10 :00	**Group work session 3(Con't)** : Cross border situation analysis and define prioritized cross-border Malaria interventions	-Regional groups working session : *__Nile Basin__: South Sudan ,Uganda , Kenya ,Tanzania and Zanzibar **Moderator**: Consultant **Facilitators**: Dr Baba WHO/AFRO &RBM * Eastern Congo Basin: DRC , Burundi and Rwanda **Moderator**: Dr Jean d'Amour **Facilitator**:-Dr Spes WHO/AFRO
10 :00-10 :30	Tea break	
	SESSION III(Con't)	CHAIR : Dr Kaka Mudambo

10 :30-13 :00	**Plenary session 1**: Rapporteur of Countries sharing Nile Basin to present group work session . **QA/DISCUSSIONS**	Moderator :WHO/AFRO
13 :00-14 :00	Lunch	
14 :30-15 :30	**Plenary session 2(Con't)** Rapporteur of Countries sharing Eastern Congo Basin to present group work session **QA/DISCUSSIONS**	Moderator :PMI BURUNDI
15 :30-16 :00	Tea break	
	SESSION IV	CHAIR : Dr Kaendi Munguti
16 :00-17 :00	**Plenary session 3** Rapporteur of Group work session Governance ,coordination and resource mobilization mechanism for Malaria cross border interventions **QA/DISCUSSIONS**	Moderator :ALMA Rep
17 :30-18 :30	Cocktail at MARASA HOTEL	SFH
18 :30-19 :00	Facilitators, Moderators +NMCP Managers meeting	
DAY3 :MALARIA PROGRAMME MANAGERS MEETING WITH SUPPORT OF TECHNICAL PARTNERS		
08:30-08:45	Registration	EAC ,WCHO and SFH
	SESSION V	CHAIR: Dr Baba Ebenezer
	Day 1 wrap up	Tanzania NMCP Manager
09:00-10:30	**Plenary session 4** Governance ,coordination and resource mobilization mechanism for Malaria cross border interventions **QA/DISCUSSIONS**	Dr Michael Katende /EAC Secretariat as Presenter WHO/AFRO as Moderator
10:30-11 :00	Tea break	
11 :00 -12 :00	**Working group1 :DRC +BURUNDI +RWANDA** Define Implementation Framework for Cross border Malaria control based on agreed Governance ,coordination and resource mobilization mechanism	**Facilitators**: WHO/AFRO+RBM
	Working group 2: UGANDA+KENYA+SOUTH SUDAN+TANZANIA	**Facilitators**: ALMA &PMI Rwanda

	Define Implementation framework for cross border Malaria control based on Governance ,coordination and resource mobilization mechanism	
12 :00-12 :45	**Plenary session 5** Rapporteur for each group to present the framework **Q/A session**	**Moderator**: ALMA representative
	SESSION VI	Chair : Dr Michael Katende
12:45-1:30	**Closing session** : -Presentation of recommendations and next steps -Closing remarks	Rwanda NMCP Manager as Moderator -Independent consultant -EAC Secretariat -RBM -ALMA -WHO/AFRO -MOH/RBC Representative
13:00-14:00	Lunch	

b) List of Participants

SN	Names	Position	Institution/Country	Email Address
1	Dr Jackson Sillah	Medical Officer /Malaria	WHO/AFRO	sillahj@who.int
2	Dr Elisabeth Juma	Team Leader CDS Cluster	WHO/AFRO	jumae@who.int
3	Dr Ebenezer Baba Sheshi	Medical Officer /Malaria	WHO/AFRO	babae@who.int
4	Dr Spes Caritas Ntabangana	Medical Officer /Malaria	WHO/AFRO	ntabangana@who.int
5	Dr Dismas Baza	National Program Officer	WHO/Burundi	bazad@who.int
6	Dr Patrick Bahizi Bizoza	National Program Officer	WHO/DRC	bahizibizozap@who.int
7	Dr Joyce Onsongo, Kerubo	National Program Officer	WHO/Kenya	njorogej@who.int
8	Dr Lincoln Charimari	National Program Officer	WHO/South Sudan	
9	Dr Charles Katureebe	National Program Officer	WHO/Uganda	
10	Dr Ritha Njau	National Program Officer	WHO/Tanzania	njaur@who.int
11	Dr Daniel Ngamije	National Program Officer	WHO/Rwanda	ngamijed@who.int
12	Samson Katikiti	Senior Program Officer	ALMA	skatikiti@alma2030.org
13	Dr Kaka Mudambo	Coordinator East and Southern Africa	RBM Partnership	kakamudambo@gmail.com
14	Prof Eric Mukomena	Directeur PNLP	MOH/DRC	
15	Dr Narcisse Bolamba Basasila	Director of vector Control	MOH/DRC	narcissebassosila@gmail.com
16	Dr Stella Mambavu Bukasa	Director of Epidemiology and Surveillance	MOH/DRC	J3knyota@gmail.com
17	Dr Kiambo Njagi	Director of vector Control	MOH/Kenya	kiambonjagi@gmail.com
18	Dr Omar Ahmeddin	Director of Epidemiology and Surveillance	MOH/Kenya	
19	Dr Erjesa Waqo Dulacha	NMCP Manager	MOH/Kenya	
20	Dr Harriet Akello Pasquale	NMCP Manager	MOH/South Sudan	harrietpasquale@gmail.com
21	Mr Lemi Bakhit Sebit	Epidemiology and Surveillance Officer	MOH/South Sudan	bsslemi@gmail.com
22	Mr Constantino Ramigo Dogale	Vector Control Officer	MOH/South Sudan	cdoggale@gmail.com
23	Dr Anna Mahendeka	Surveillance and Monitoring evaluation officer	MOH/Tanzania	anna.mahendeka@yahoo.com
24	Mr Dismas Mwalimu	Head of Integrated Malaria Vector Control	MOH/Tanzania	dismasi@yahoo.com

25	Dr Faiza Abbas	NMCP Deputy Manager	MOH/Zanzibar	faisaabbas@yahoo.com
26	Dr Aimable Mbituyumureyi	NMCP Manager	MOH/Rwanda	aimable.mbituyumuremyi@rbc.gov.rw
27	Dr Emmanuel Hakizimana	Director of Vector Control	MOH/Rwanda	ehakizimana@gmail.com
28	Michee Kabera	Director of Epidemiology and Surveillance	MOH/Rwanda	michee.kabera@rbc.gov.rw
29	Dr Aline Uwimana	Director of Case Management	MOH/Rwanda	aline.uwimana@rbc.gov.rw
30	Melanie Mukantagara	Malaria Specialist	MOH/Rwanda	mntagara@gmail.com
31	Dr Liévin Nsabiyumva	Malaria Specialist	PMI Burundi	lnsabiyumva@usaid.gov
32	Dr Kaendi Munguti	Resident Advisor	PMI Rwanda	kmunguti@usaid.gov
33	Dr Monique Murindahabi	Malaria Specialist	PMI Rwanda	mmurindahabi@usaid.gov
34	Mr Manasseh Wandera	Executive Director	SFH Rwanda	mwandera@sfhrwanda.org
35	Gwamaka Lazarous Mwandwan	Ministry of Foreign Affairs	Tanzania	gwamaka.lazarus@nje.go.tz.
36	Dr Katende Michael J.	EAC Secretariat	PHO	MKatende@eachq.org
37	Dr Turate Innocent	Head of Department RBC	MOH/Rwanda	innocent.turate@rbc.gov.rw
38	Dr Umulisa Irenee	Senior Program Officer	ALMA	imulisa@alma2030.org umulisa5@gmail.com
39	Njoroge Josephine	National Program Officer	WHO/Kenya	
40	Janet Opio Apalamit	Chief of Party	SFH Rwanda	
41	Edward Komba	Ministry of Foreign Affairs	Tanzania	edward.komba@meac.go.tz
42	Naganza Aimee	SBCC Specialist	SFH Rwanda	anaganza@sfhrwanda.org
43	Putzer, Thomas C.	Managing Principal, Base of the Pyramid Group	Sc Johnson/USA	TCPutzer@scj.com
44	Dr Rutazaana Damian	Director of Epidemiology and Surveillance	MOH/Uganda	damianamanya@gmail.com
45	Ntege Charles	Director Vector Control	MOH/Uganda	charlesntege$7@gmail.com
46	Jonathan Kirabo			jkirabo@minaffet.gov.rw
47	Dr Ndahimana J. d'Amour	Consultant	Private	ndahimanaj@gmail.com

ENDORSEMENT

This to confirm that the we the undersigned participated in the East African Community and Democratic Republic of Congo Cross border Malaria Control initiative meeting from the 22nd to 24th April 2019 at **Marasa Umubano Hotel, Kigali, Republic of Rwanda**. This to confirm that the report contains information and represent the content and discussions of the meeting and here endorse the report for circulation.

Signed by Partner States' Heads of delegations on this 24th Day of April 2019.

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Dr Kiambo Njagi
Entomologist
National Malaria Control Program
Ministry of Health
REPUBLIC OF KENYA

P.O CSE CBA SOSIHA

.....

Prof Eric Mukomena Sompwe
Directeur
Program National de Lutte Contre le Paludisme
Ministere de la Sante
DEMOCRATIC REPUBLIC OF CONGO

.....

Dr Aimable Mbituyumuremyi
Head of Division
Malaria and Other Parasitic Diseases Division
Ministry of Health
REPUBLIC OF RWANDA

.....

Charles Dismas Mwalimu
Head of Vector Control
Preventive Health Services/National Malaria Program
Ministry of Health Community Development, Gender and Children
THE UNITED REPUBLIC OF TANZANIA

.....

Dr Harriet Akello Pasquale
Program Manager
National Malaria Control Program
Ministry of Health
REPUBLIC OF SOUTH SUDAN

.....

Dr Damian Rutazana
Epidemiologist/SMEOR/EPR Focal Point
National Malaria Control Division
Ministry of Health
REPUBLIC OF UGANDA

.....

REPUBLIC OF BURUNDI

GREAT LAKES CROSS BORDER MALARIA INITIATIVE MEETING FINAL REPORT 2019