REPORT

"Protect, Prevent, Treat":
African Regional Workshop on coordinated approaches to pneumonia and diarrhoea prevention and control

Nairobi, Kenya, 25-28 January 2011

CONTENTS

List of Abbreviations

ACT	Artemisinin-based Combination Therapy
AMREF	African Medical and Research Foundation
CHWs	Community Health Workers
CAH	WHO Department of Child and Adolescent Health and Development
CHAI	Clinton Health Access Initiative
CHNRI	Child Health Nutrition Research Initiative
CIDA	Canadian International Development Agency
DHS	Demographic and Health Surveys
EPI	Expanded Programme on Immunization
ETAT	Emergency Triage Assessment and Treatment
GAPP	Global Action Plan for the Prevention and Control of Pneumonia
GAVI	Global Alliance for Vaccine and Immunization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HMIS	Health Management Information Systems
iCCM	Integrated Community Case Management
IMCI	Integrated Management of Childhood Illnesses
IVB	WHO Department of Immunization, Vaccines and Biologicals
KPA	Kenya Paediatric Association
MCHIP	Maternal and Child Health Integrated Programme
MDG	Millennium Development Goal
MICS	UNICEF's Multiple Indicator Cluster Survey
MNCH	Maternal, Newborn and Child Health
MSH	Management Sciences for Health
ORS	Oral Rehydration Salts solution
PCV	Pneumococcus Conjugate Vaccine
RDT	Rapid Diagnostic Test
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Acknowledgements

The World Health Organization acknowledges the valuable contributions of the many people who assisted in the preparation/organization of this workshop, and in the development of this report, especially the Ministry of Health and government of Kenya for hosting the workshop and the Bill and Melinda Gates Foundation for funding it.

Executive summary

To support and facilitate the implementation of activities for the control of pneumonia and diarrhoea in children under five years of age living in developing countries, a series of four regional workshops is being organized by the World Health Organization (WHO) in collaboration with ministries of health, the United Nations Children's Fund (UNICEF) and other partners. The workshops are intended to facilitate the introduction or scaling up of effective interventions through coordinated action at country level. This report describes the first workshop that was held in Nairobi, Kenya, 25-28 January 2011.

Jointly organized by WHO's Departments of Child and Adolescent Health and Development (CAH) and Immunization, Vaccines and Biologicals (IVB) at Headquarters and the WHO Regional Office for Africa and funded through a grant from the Bill & Melinda Gates Foundation (BMGF), this four-day workshop brought together approximately 100 participants from eight countries (Ethiopia, Ghana, Kenya, Malawi, Nigeria, Uganda, the United Republic of Tanzania and Zambia), as well as representatives of a wide range of international organizations, bilateral organizations, research institutions and non-governmental-organizations (NGOs) active in the area of child health[1]. The country teams included focal points from ministries of health responsible for child health/the Integrated Management of Childhood Illness (IMCI), the Expanded Programme on Immunization (EPI), nutrition, malaria, and health systems/health policy.

The objectives of the workshop were:

I. To orient participants to the concepts and practical principles of the Global Action Plan for the prevention and control of Pneumonia (GAPP)[2] and the seven-point plan for comprehensive diarrhoea control outlined in the WHO/UNICEF publication "Diarrhoea: Why children are still dying and what can be done"[3], their relationships with existing programmes and the benefits of putting greater emphasis on these two illnesses; and provide technical updates on integrated community case management (iCCM).

II. To analyse opportunities and obstacles to implementation, share lessons learned/best practices, and identify solutions, including policy issues, to increase coverage of pneumonia and diarrhoea prevention, treatment and control interventions at all levels.

III. To foster collaboration and linkages across programmes by identifying and developing country-specific actions for practical application of the GAPP and diarrhoea control strategy to strengthen existing child survival and primary health care programmes.

IV. To define the resources and technical assistance needed to ensure that coordinated actions and processes are implemented, and agree upon a set of indicators for monitoring and reporting.

V. To increase awareness of and build capacity for communications and advocacy at country level to improve implementation of pneumonia and diarrhoea prevention, control and treatment interventions within the context of child survival programmes.

[1] WHO, UNICEF, BMGF, the United States Agency for International Development (USAID), the Global Alliance for Vaccine and Immunization (GAVI), USAID's Maternal and Child Health Integrated Program (MCHIP), Program for Appropriate Technology in Health (PATH), Management Sciences for Health (MSH), Save the Children, the Clinton Health Access Initiative (CHAI), Sabin Institute, World Vision International, the African Medical and Research Foundation (AMREF) and the Kenya Paediatric Association. See Annex 2 for full list of participants.

[2] www.who.int/child_adolescent_health/documents/fch_cah_nch_09_04

[3] www.who.int/child_adolescent_health/documents/9789241598415

Prior to the workshop, a template was developed and distributed to country teams to support the preparation of situation analyses. This covered organizational structures, coordination mechanisms, programme budget and funding, training and supervision, Health Management Information Systems (HMIS), community structures and personnel, performance of programmes, gaps, opportunities and challenges. This helped to ensure that all country presentations were of high quality, and facilitated cross country comparison and sharing of experiences.

After brief statements by representatives of USAID, BMGF, and the WHO Representative for Kenya, Dr S.K. Sharif, Director of Public Health and Sanitation, Ministry of Public Health and Sanitation, Republic of Kenya, officially opened the workshop. Dr Sharif stressed that effective, high-impact interventions for pneumonia and diarrhoea control exist and are affordable, and called for strong coordination of implementation at country level.

Introductory sessions at the workshop included presentations on: the strategies and framework to "Protect, Prevent, Treat" pneumonia and diarrhoea; iCCM and a tool kit for its implementation; creating behaviour change and demand and an integrated framework for pneumonia/diarrhoea communication activities; and strengthening the supply chain.

During the workshop, intensive country team group work focused on national policies/strategies and strategic plans:

(i) to find out if key pneumonia and diarrhoea prevention and control interventions have been included;
(ii) to identify the main problems hindering implementation of proven intervention packages;
(iii) to propose realistic solutions; and
(iv) to identify opportunities for scaling up key pneumonia and diarrhoea interventions.

The country team group work was assisted by facilitators (WHO/UNICEF/USAID/Save the Children) who used a Facilitators' Guide specifically developed for the workshop. During the country team group work, coordinated actions were identified with an emphasis on fostering linkages between programmes.

Coordinated plans of action produced by the country teams during the workshop, focused mainly on coordination, capacity building, advocacy and communication, strengthening private sector involvement, monitoring and evaluation/data management, and supply chain logistics. In all countries, the key interventions for pneumonia and diarrhoea prevention and control were included in existing national policies and strategies, including community case management. However, coordination was identified as a challenge by most countries, and participants expressed a strong willingness to work together across programmes. In many cases, however, the authority to make the necessary changes to facilitate this was largely beyond the control of the workshop participants. Nevertheless, with the current momentum among governments, donors and partners towards more coordinated and integrated efforts for pneumonia and diarrhoea control, the process started at the workshop will likely find traction in countries.

At the close of the workshop, applying selection criteria (introduction of new vaccines within the next year; implementation of iCCM; and a supportive environment of government, donors and partners), workshop facilitators selected two countries -- Kenya and Zambia -- for more intensive follow-up and additional technical support within the scope of this initiative.

In order to maximize the benefit of this initiative, and to improve advocacy and communication for child health, pneumonia and diarrhoea prevention and control, the workshop included a half-day capacity building session on advocacy and communication. Communication specialists from the WHO Regional Offices for Africa and South-East Asia, UNICEF HQ/Regional Office, and PATH co-facilitated this interactive session. The session included a refresher on communication basics, the process for identifying a single, overarching communication objective, performing a stakeholder analysis, and developing targeted key messages. In addition, case studies were presented, including the innovative advocacy and communication activities undertaken by the Kenya Paediatric Association (KPA) in a presentation by KPA President, Dr Fred Were.

The workshop also provided an opportunity for:

(i) A briefing on mechanisms and indicators for monitoring and reporting, including the Millennium Development Goals (MDGs), the Countdown to 2015: Tracking progress in maternal, newborn and child health, Demographic and Health Surveys (DHS)/Multiple Indicator Cluster Surveys (MICS), CCM Global Benchmark indicators, and the Canadian International Development Agency (CIDA)/UNICEF Catalytic Initiative.

(ii) An update on the operational research agenda to support the GAPP/diarrhoea control strategy.

(iii) An overview of possible funding opportunities: GAVI highlighted the opportunity for using health systems strengthening (HSS) funds to support coordinated action plans with a joint GAVI-Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) tranche of HSS funding becoming available in August 2011, as well as funding for new vaccines; the BMGF representative highlighted its support for research that complements country efforts; the Sabin Institute representative explained its advocacy support with parliamentarians; USAID and UNICEF highlighted linkages with their ongoing country support, with particular emphasis on support to iCCM through the President's Malaria Initiative.

In summary, the workshop successfully achieved its objectives. The collaboration between programmes was strengthened, and the participation of colleagues from the WHO Regional Office for South-East Asia enabled forward planning for the regional workshop to be held in Dhaka, Bangladesh.

Recommendations

WHO staff from headquarters and the Regional Office for Africa and partners will follow up on the implementation of coordinated actions identified by country teams. WHO will send a letter to WHO and UNICEF country representatives of the eight participating countries providing a short briefing on the workshop and requesting their support to ensure the implementation of coordinated action plans.

WHO will communicate with the two countries selected for intensified follow-up. Mapping of CAH and IVB activities and available support is to be done in collaboration with the African Regional Office in order to coordinate efforts and seek efficiencies.

Introduction

Background

Millennium Development Goal (MDG) 4[4] can only be achieved with intensified efforts to reduce the burden of the major causes of child deaths: pneumonia, diarrhoea, malaria, malnutrition, and neonatal problems. There is concern at the lack of adequate progress towards reducing morbidity and mortality from these conditions in low-resource settings.

Of the estimated 8.8 million child deaths that took place in 2008, an estimated 1.6 million were due to pneumonia and 1.3 million to diarrhoea -- more than any other disease. In spite of their huge toll and the availability of safe and effective interventions, relatively few resources have been dedicated to tackling these problems. Mortality due to these illnesses is strongly linked to malnutrition, poverty and inadequate access to health care. More than 98% of all pneumonia and diarrhoea deaths in children occur in 68 countries (the "Countdown to 2015" countries[5]). The burden that pneumonia and diarrhoea place on families and health systems in resource-constrained settings exacerbates inequalities. While the direct cost of treatment with antibiotics or oral rehydration salts (ORS) solution and zinc may be modest, the overall cost for a low-income household to access treatment can be very high, with indirect costs such as lost work time, transportation and out-of-pocket expenses. Reducing the burden of these diseases will not only make a key contribution to the achievement of MDG 4, it will also contribute to achieving MDG 1[6].

Despite the opportunities for impact, implementation of actions to prevent and control pneumonia have thus far been uneven and service delivery remains largely uncoordinated. Only 54% of children with cough and difficult or rapid breathing in developing countries are taken to a qualified health care provider. Despite the essential role of antibiotics in reducing child deaths from pneumonia, only 19% of children under five with clinical signs of pneumonia receive antibiotics. Only 82% of children receive their first routine dose of a vaccine against measles (one of the diseases associated with severe pneumonia), and which requires coverage levels of >90% to interrupt transmission of the disease. There has been a significant reduction in measles deaths as a result of large-scale measles vaccination campaigns, but 2010 was characterized by wide-spread outbreaks, particularly in Africa. Not all countries have introduced vaccination against other causative agents of severe pneumonia, such as *Haemophilus influenzae* type b (Hib), although there has been recent progress in this area.

In developing countries, only 39% of children under five with diarrhoea receive the recommended treatment (ORS with continued feeding) to prevent dehydration and worsening nutritional status, and this level is dropping. Furthermore, the newly available rotavirus vaccine is only beginning to be introduced in a few countries.

This situation must change. Unprecedented opportunities have arisen in recent years with renewed momentum for primary health care and efforts to strengthen health systems capacity; the availability of integrated approaches such as IMCI at all levels; iCCM; and the introduction of vaccines against Hib, *Streptococcus pneumoniae* (pneumococcus) and rotavirus.

[4] Target 4A: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate
[5] www.countdown2015mnch.org
[6] Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger

With accelerated implementation of strategies to deliver high-impact interventions, the number of pneumonia and diarrhoea deaths can drop substantially.

There is a good deal of overlap between pneumonia and diarrhoea control interventions, and coordinating these interventions will create synergies that will further contribute to the achievement of MDG 4. Exclusive breastfeeding, hand washing with soap, immunization, adequate nutrition, appropriate home-based care, prompt care-seeking and standard case management are common to the prevention and control of both illnesses. Resources and improved coordination approaches for service delivery are necessary to achieve scale-up in developing countries.

Purpose

The intent of the Nairobi workshop was to review programme efforts related to the implementation of pneumonia and diarrhoea control interventions in high-burden countries in Africa, and ensure/facilitate coordinated implementation to increase coverage within ongoing, integrated approaches to child survival (See annex 1: Agenda).

Participants

Participants consisted of teams from eight countries (Ethiopia, Ghana, Kenya, Malawi, Nigeria, Uganda, United Republic of Tanzania, and Zambia) comprising focal points from ministries of health for child health/IMCI, EPI, nutrition, malaria, and health systems/health policy, as well as programme managers for child health and child health related programmes, planning officers, deputy commissioners of health. They also included representatives of WHO, UNICEF, BMGF, USAID, GAVI, MCHIP, PATH, MSH, Save the Children, CHAI, Sabin Institute, World Vision International, AMREF and the Kenya Paediatric Association. The CAH Regional Advisers and Communication Officers from the WHO Regional Offices for Africa and South-East Asia also participated (see Annex 2: List of Participants).

Objectives

The specific objectives of the workshop were:

- To orient participants to the concepts and practical principles of the GAPP and seven-point comprehensive strategy for diarrhoea control, their relationships with existing programmes, and the benefits of putting greater emphasis on these two illnesses; and provide technical updates on iCCM and implications for the health system.

- To analyse opportunities and obstacles to implementation, share lessons learned/best practices and identify solutions, including policy issues, to increase coverage of pneumonia and diarrhoea prevention, treatment and control at all levels.

- To foster collaboration and linkages across programmes by identifying and developing country-specific actions for practical application of the GAPP and diarrhoea control strategy to strengthen existing child survival and primary health care programmes.

- To define the resources and technical assistance needed to ensure that coordinated actions and processes are implemented, and agree upon a set of indicators for monitoring and reporting.

- To increase awareness of and build capacity for communications and advocacy at country level to improve implementation of pneumonia and diarrhoea control, prevention and treatment within the context of child survival programmes.

Expected outcomes

- A **common understanding** of the concepts, general principles and technical tools for the GAPP and diarrhoea control strategy, the advantages and implications for the health system, and how to effectively advocate for implementation with all relevant players at country level.

- Development and identification of **coordinated actions** for incorporation into national plans for the prevention and control of pneumonia and diarrhoea in participating countries.

- Identification of **required resources and technical assistance** to support coordinated actions and processes, and identification of possible funding opportunities (such as the GFATM and GAVI health system strengthening windows), and using the introduction of new vaccines as a platform for accelerated pneumonia and diarrhoea control efforts.

- Information to assist in the **selection of two demonstration countries** to document the key determinants of successful implementation and the impact of joint strategies.

Opening Session

The following is a summary of remarks made during the opening session of the workshop.

a) Dr Douglas Holzman, BMGF

This workshop comes at a timely moment to spearhead the work that will be critical to achieving the MDGs. It is vital that all stakeholders take up their responsibility, using the available tools and taking advantage of new opportunities such as the introduction of new vaccines, to achieve agreed goals in spite of the challenges.

b) Ms Lilian Mutea, USAID, Kenya

The emerging collaboration is encouraging and vital for progress to be made, especially in the countries where the achievement of the MDGs is under threat.

c) Dr Abdoulie Jack, WHO Country Representative, Kenya

This workshop is opportune and an illustration of the unity that will be essential on a global scale in order to achieve the MDGs. Nearly 40% of childhood deaths are due to pneumonia and diarrhoea. However, two-thirds of pneumonia deaths are avoidable with high coverage of interventions such as immunization.

This -- the first workshop to be convened in the region on improving prevention and control of pneumonia and diarrhoea through common synergistic interventions -- brings focus to the significance of working together, which is vital to tackling the health systems challenges that contribute to the lag in achieving the MDGs. On top of the various initiatives that are underway in countries such as Kenya, it will be important to take advantage of the emerging momentum to enhance achievement by strengthening coordination and harmonization. Unity, better coordination, support of NGOs, communities and partners will be vital in harnessing opportunities.

d) Dr S. K. Sharif, Director of Public Health and Sanitation, Ministry of Public Health and Sanitation, Republic of Kenya

Although Kenya has made substantial progress, it still lags behind, and like most African countries, may be delayed in meeting the MDGs. There is a need to scale-up high impact interventions. Kenya will be the first country to introduce the pneumococcus conjugate vaccine (PCV) in February 2011.

It is important to work with other sectors, such as water/sanitation and education, which play a vital contributory role in improving health.

Despite the challenges of working across programmes and implementation plans, the achievement of global goals hinges on partnerships (national, regional and international). There is a need to synergize the work of multiple committees and programmes.

Session 1: "Protect, Prevent, Treat: an overview": An integrated framework for the prevention and control of pneumonia and diarrhoea

The objectives of the session were:

(i) to orient participants to the concepts and practical principles of the GAPP and seven-point comprehensive strategy for diarrhoea control, their relationships with existing programmes, the benefits of putting greater emphasis on these two illnesses and the implications for the health system; and

(ii) to update participants on integrated community case management (iCCM) including available tools and frameworks for implementation.

Presentation 1: Understanding the concept and principles of GAPP

Dr Shamim Qazi (WHO/CAH) gave an overview presentation on the Global Action Plan for the prevention and control of Pneumonia (GAPP) and the seven-point comprehensive strategy for diarrhoea control. He explained that pneumonia and diarrhoea account for one third of all childhood deaths each year. The 10 countries with highest pneumonia mortality are the same 10 with highest diarrhoea mortality. In Africa, pneumonia and diarrhoea cause 37% of child deaths each year. MDG 4 can only be achieved with an intensified effort to reduce child deaths due to pneumonia and diarrhoea. Since pneumonia and diarrhoea are caused by multiple pathogens, no single intervention can address the entire burden. A set of 16 complementary interventions of proven effectiveness address the diseases, and many help control *both*. Yet, they have generally not been well implemented, and coverage across the interventions remains uneven.

It is necessary to establish better coordination and create synergies and efficiencies for the scaled-up delivery of selected interventions through existing programmes (EPI, IMCI, CCM, Safe Motherhood, Child Nutrition, HIV prevention, Environmental Health). These joint approaches can include (but are not limited to):

- Joint review of policies and strategies;
- Joint planning;
- Joint advocacy and social mobilization;
- Harmonization of processes for procurement and management of supplies and for logistics; and
- Development of synergies in processes for monitoring and evaluation.

Over 5.3 million deaths due to pneumonia and diarrhoea can be averted around the world from 2010 to 2015 if the coverage of the interventions can be increased to 90%. The intensification of efforts to reduce pneumonia and diarrhoea deaths is the surest way of achieving MDG 4. It is therefore essential that actions by multiple players to improve pneumonia and diarrhoea control are initiated or strengthened. The introduction of PCV, *Hib* and rotavirus vaccines, the important progress made in improving case management and availing new treatment options, and the renewed interest in creating synergies between programmes provide new opportunities for pneumonia and diarrhoea control.

Presentation 2: Updates on integrated Community Case Management (iCCM) including the toolkit

Joint presentations were made by Dr Mark Young (UNICEF), Dr Diaa Hammamy (USAID) and Dr Emmanuel Wansi (MCHIP) to share updates on iCCM implementation and available tools and experiences.

Dr Young gave an update on the status of iCCM implementation. He mentioned that multi-country reviews have demonstrated that community health workers (CHWs), provided with adequate training, supervision, tools, and logistical support, can correctly identify and appropriately treat children with:

- Diarrhoea: using low-osmolarity ORS and zinc;
- Pneumonia: using antibiotics (amoxicillin, co-trimoxazole); and
- Malaria: using rapid diagnostic tests (RDTs) and Artemisinin-based combination therapies (ACTs).

iCCM is an important strategy for providing programmatic support to front-line health workers to diagnose and treat *all three* of these common childhood killers in communities lacking easy access to health facilities. Despite the demonstrated benefits of iCCM, there has been little progress on iCCM in Africa to date.

Dr Hammamy reiterated USAID's role in supporting countries to roll out iCCM. USAID's Child Survival and Health Grants Program (CSHGP) contributes to 17 iCCM projects in 12 countries (Afghanistan, Benin, Burundi, Ethiopia, India, Liberia, Nepal, Niger, Rwanda, Sudan, Uganda and Zambia). Seven of the 17 projects are implementing iCCM (malaria, diarrhoea, pneumonia), while others focus on a single disease area. USAID's total CSHGP investment in these projects is $28 million (2006-2014), and the CCM components of the projects are estimated at $14 million. Overall, USAID contributes around $30 million to iCCM through CSHGP, the President's Malaria Initiative, and bilateral projects.

Community Case Management Interagency Task Force

An update was also given on the work of the CCM Interagency Task Force including the development of the iCCM benchmark matrix, which is a tool for programmatic planning, implementation, and scale-up.

The iCCM benchmark matrix includes:

- Eight key systems components for CCM programmes:
    1. Coordination and policy setting,
    2. Costing and financing,
    3. Human resources,
    4. Supply chain management,
    5. Service delivery and referral,
    6. Communication and social mobilization,
    7. Supervision and performance quality assurance,
    8. Monitoring and evaluation and health information systems.
- The benchmark matrix makes reference to three phases of implementation, including:
    1. Advocacy/planning,
    2. Pilot/early implementation,
    3. Expansion/scale-up.

In each phase, benchmarks for each of the eight key systems components are available to guide programme planning and implementation through a health systems approach.

Dr Wansi gave an update on the iCCM Toolkit and experiences with implementation of iCCM in the region.

The toolkit is organized around:

- Policy/advocacy/planning;
- Implementation;
- Monitoring and evaluation; and
- Logistics.

Experience with implementation of iCCM in Senegal and the Democratic Republic of the Congo (DRC) highlighted the following key points:

- Empowering the intermediate level is challenging, but key to ensuring quality support and mobilization of peripheral resources, especially in a decentralized system.
- Engaging district-level and community health centres requires advocacy and investment.
- Frequent drug stock-outs are a major problem with CCM, sometimes independent of the situation within the health system.
- Implementation of IMCI at the health facility level does not constitute a paramount condition for the launch of case management programmes at community level.

The conclusions of this presentation were as follows:

Policy: although policy gaps exist for all conditions, supportive policy does exist and change is possible. More effort is needed for supportive policies for the CCM of pneumonia.

Scale of implementation: CCM of pneumonia and diarrhoea lag behind CCM of malaria (probably due to the availability of resources through GFATM and the President's Malaria Initiative).

Integration: integration and working across programmes has been initiated and is promising for implementation led by ministries of health.

MoH concerns: the top five priorities are incentives/motivation for CHWs, policy change, quality of care, integration and supply, and logistics.

The profiles of CHWs are variable, from substantially trained, salaried health workers to community volunteers with limited training.

Presentation 3: Creating behaviour change and demand: Integrated framework for pneumonia/diarrhoea communication activities

In this presentation, Dr Osman Mansoor (UNICEF) emphasized the need for a coordinated communication approach to encompass the entire spectrum of what is required to make a difference. While it is important to achieve synergy in the interventions against diarrhoea and pneumonia, the role and power of communities and individuals to reduce diarrhoea and pneumonia deaths also needs to be acknowledged. Healthy actions play a key role in all interventions since “protection” is mainly about behaviour. The core of all interventions for

pneumonia and diarrhoea is therefore based on what people do. Communication should be aimed at informing communities in order to elicit healthy actions.

A proper communication framework encompassing coordination, capacity and change needs to be cultivated. The planning steps of the communication framework should entail:

- Analysis;
- Design;
- Implementation; and
- Evaluation.

Presentation 4: Strengthening the supply chain

An overview of the problems related to the "supply chain" was given by Ms Lora Shimp (MCHIP). At present, supply chains are characterized by insufficient government funding and duplication. In addition, often donors bypass the government and create new parallel systems. There is a need for donors and governments to develop central coordination mechanisms to simplify and harmonize systems.

There is also a need for consideration of product requirements, such as vaccine temperature sensitivities, cold-chain maintenance and integration to strengthen the supply chain. This will require:

- strong political will;
- supportive policies;
- adequate funding;
- improved health worker capacity;
- clear definitions of responsibilities for monitoring;
- building on existing primary health care structures; and
- segmentation.

Service providers need to look beyond commodities and consider other important elements like communications, training, and surveillance.

Five preconditions for successful Supply Chain for Community Case Management (SC4CCM) were presented:

1. Necessary, usable, quality CCM products are available at CHW resupply point(s).
2. CHWs, or persons responsible for CHW resupply, know how, where, what, when and how much of each product to requisition or re-supply and take necessary actions.
3. CHWs have adequate storage.
4. Goods are routinely transported between re-supply points and CHWs.
5. CHWs are motivated to perform their roles in the CCM product supply chain.

Preliminary findings from Malawi indicate that preconditions 1 and 4 are critical and drive product availability at the CHW level.

Ensuring the availability of medicines for treating diarrhoea and pneumonia at the national level requires the ability to forecast, to consider the reliability of information and balance that with actual needs. Various considerations such as regional workload, prevalence of disease, seasonal variations and regional changes are key determinants in forecasting.

Session 2: Increasing awareness and building capacity for communication & advocacy

The objective of this session was to increase awareness of and build capacity for communications and advocacy at country level to improve implementation of pneumonia and diarrhoea control, prevention and treatment within the context of child survival programmes.

Presentation 1: Kenya's experience with communication and advocacy

Experience from Kenya, presented by Dr Fred Were, President of the Kenya Paediatric Association (KPA), demonstrated the importance of effective advocacy for improving child survival. He presented data showing steady rises in EPI coverage associated with a decline in under-five mortality. He stressed, however, that much more needs to be done to ensure universal coverage, and that the role of advocates like the KPA is important.

Since 2006, the KPA has been actively supporting the Government of Kenya to enhance routine immunization at all levels. The organization has worked intensively to enhance health workers' knowledge of the importance of immunization – moving beyond the ward and into the community; to inform the public and promote demand; and to lobby the government and donors to ensure that immunization is included in their agenda. The KPA works to ensure that immunization remains prominent in the national media by holding public events. Through ongoing and effective advocacy, the organization has earned the respect and trust of the Government and partners and is regularly called upon to support work on a number of important child health issues.

The key messages from Dr Were's presentation were:

- The key to success is working with governments and other partners collaboratively, "going beyond borders", enlisting heroes and champions for the cause and actively passing the message verbally and visually – your message must be strong!

- The KPA stands by its belief that "people may care but don't know – so we must inform them; people may know but don't care – we must convince them with passion towards a simple and shared goal".

Presentation 2: Advocacy and communication for World Pneumonia Day and for diarrhoea prevention and control

In her presentation Ms Doune Porter (PATH/GAVI) emphasized the importance of advocacy and communication as an essential component of every public health programme. Effective advocacy and communication can make a crucial difference at *every* level:

- in seeking funding – donors must be persuaded of the value of the programme, especially in a time of economic constraints;
- the public in donor countries must also be convinced, so donor governments know their own stakeholders support programme funding decisions;
- national governments need to be persuaded to establish appropriate policies and to allocate their own limited resources to the programme;
- health workers should be encouraged to implement the policies effectively; and

- the community/public must be persuaded to demand/take-up the programme services.

Unfortunately the important role that advocacy and communications play is often misunderstood, and not taken into account as part of the strategic planning process. Public health experts often do not understand how little people know about their particular area of expertise.

World Pneumonia Day was launched on 2 November 2009 as a vehicle to put pneumonia on the global agenda. There was recognition that although 1.5 million children die globally from pneumonia there is a need to galvanize support around the problem and to offer solutions. At the time, there were very few voices championing the issue (unlike HIV and malaria, for example – programmes with strong champions and funding). World Pneumonia Day was established as a platform to engage decision-makers at the highest level and citizens at the grassroots level and to galvanize broad support for action to address pneumonia. Since 2009, the number of partners participating in the event has grown from four to 100.

Examples of national advocacy and communications activities for World Pneumonia Day

- The Cameroon Pediatric Association worked with the country's largest mobile phone company to send four million text messages about pneumonia;
- A hospital in Nigeria staged plays to raise awareness about the danger signs of pneumonia among parents, children and teachers; and
- A pneumonia rally and symposium in Bangladesh led to the establishment of a parliamentary action group to ensure MPs support the health sector.

Small grants and resources are available to help grassroots organizations celebrate World Pneumonia Day. Information can be found at: www.worldpneumoniaday.org.

Ms Porter also spoke about advocacy and communications efforts in the area of diarrhoea. In March 2010, the Government of Kenya launched a national policy to strengthen the availability and uptake of proven health interventions to manage and control diarrhoeal disease. Despite the fact that diarrhoeal disease is the leading cause of child death in Kenya, many Kenyans have not taken adequate precautions against it, believing it a normal part of childhood. The policy was launched with a major media and communications push, stressing at both policy and public levels the importance of preventing and treating the disease and underlining the Government's commitment to do so. The launch of the policy was used to raise awareness about diarrhoeal disease and to create a platform for discussion around it. Through the effective engagement of the media, clear messages were given from the Government to the community on the prevention and treatment of diarrhoea.

The conclusion of the presentations is that advocacy and communications are an integral part of any successful public health programme.

Presentation 3: Communication and advocacy capacity building

A key objective of the session was to build capacity among workshop participants for effective advocacy/communications. A presentation was given and simulation exercises were led by Mrs Vismita Gupta-Smith (WHO/SEARO) and Mr Collins Boakye-Ayemang (WHO/AFRO). Topics covered were: key communications challenges and tips; setting a

single, overarching communications objective (SOCO); stakeholder analysis; and developing key messages. For each concept presented, participants were engaged in exercises to practice and develop skills.

Key tips for effective communications and advocacy

- Set a single, overarching communications objective (SOCO)
    a. How? What is the issue: What is new and compelling for the audience? What change do you want to bring about?
    b. Challenge – get to the point straight away, grab the attention of the audience.

- Think of your audience
    a. Do an analysis of who is who on your issue – Champions (active supporters); Silent Boosters (passive supporters); Avoiders (passive resisters); and Blockers (active resisters) – and decide who you will aim to reach.
    b. Put yourself in the shoes of those you are trying to convince. They will ask themselves "What's in it for me?" The message must be tailored according to the audience, simple and easy to understand.

- 7 Cs of public health communication:
    1. Command the attention of your audience
    2. Clarify your message – keep it simple
    3. Communicate a benefit
    4. Consistency counts – your figures and messages must remain consistent for credibility
    5. Cater to the hearts (and heads) of your audience
    6. Create trust
    7. Call to action – make sure that you are clear about what you want them to DO as a result of getting your message.

A pre-training questionnaire and an end-of-session evaluation were used to gather feedback from participants before and after the training in order to assess its effectiveness. Nearly all participants gave a strong positive response to the communication session and most indicated that they would be confident to use what they had learnt in the immediate future. The analysis of responses to the questionnaires has been useful in understanding the relevance of the training, and in identifying areas to be strengthened for future workshops.

Session 3: Monitoring progress, research priorities and funding opportunities

The objectives of this session were to share an update on progress towards the achievement of MDGs and the instruments available to measure progress, as well to provide a briefing on current research priorities and funding opportunities.

Presentation 1: Monitoring progress

Dr Young (UNICEF) gave an overview of the existing mechanisms for monitoring and tracking progress towards the MDGs both in terms of results of implementation and financial resources. These include the UN Secretary-General's Global Strategy on Women's and Children's Health – Commission on Information and Accountability (hosted by WHO), and the Countdown to 2015.

The key messages from the presentation and discussions were:

- Parallel systems should not be set up and monitoring activities should fit within existing national M&E platforms or plans;
- A focus on a limited number of key indicators to track progress is best;
- It is better to have a few high-quality data rather than many low-quality data; and
- There is a need to disaggregate data to sub-national and district levels to identify inequities and poor performing areas that require more support.

The importance of using data to inform programmes and make necessary programmatic decisions was underscored. This requires strengthening of routine data systems to track key process, output and outcome indicators. The possible sources of data are:

- Programme reviews;
- Health facility surveys (first- and referral-level);
- Quality of care assessments;
- Periodic large-scale household surveys, e.g. DHS, MICS; and
- Smaller "lighter" surveys for more frequent data collection.

The CCM Global Benchmark indicators for process and inputs, outputs and outcomes were introduced briefly.

Finally, the Monitoring and Evaluation of the UNICEF-CIDA "Catalytic Initiative" Programme was highlighted with a focus on key outcome monitoring indicators.

The key areas for documentation and monitoring of iCCM are:

- CCM Policy;
- CCM Implementation Strength;
- Utilization of CCM services; and
- "Point of Treatment" coverage for CCM.

Workshop participants emphasized the importance of data collection to show trends in terms of morbidity and mortality. Since iCCM improves access to timely treatment, the number of severe cases needing referral would be expected to decrease. Therefore, it was proposed to

have an indicator to measure severe cases in health facilities to appreciate the impact of iCCM. Participants also raised concerns about the multitude of reporting forms that busy health workers have to complete, emphasizing the urgent need to harmonize and reduce the number of reporting forms.

Drug quantification for iCCM was mentioned as a challenge since a precise estimation of incidence of diseases throughout the year is not available. The need to monitor the quality of care provided by CHWs when applying iCCM was also emphasized, to ensure the safety of the patient and avoid misuse of drugs and the potential risk of the emergence of resistance. It was noted, however, that the fear of seeing an increase in antimicrobial resistance following CHW authorization to provide antibiotics for treating pneumonia appears to be unfounded. Indeed, there is ample evidence that trained and supervised CHWs use antibiotics even more rationally than conventional health workers. It was concluded, then, that the authorization of trained CHWs to use antibiotics to treat pneumonia in the community will undoubtedly promote the rational use of antibiotics.

Presentation 2: Operational research agenda to support GAPP and diarrhoea control strategies

Dr Qazi (WHO) introduced the list of research priorities for pneumonia and diarrhoea, and described how it was developed using the Child Health Nutrition Research Initiative (CHNRI) methodology. Using this methodology, research questions aimed at better understanding the barriers to implementation, effectiveness and the optimal use of available interventions and programmes scored the highest.

The top five research areas/questions for diarrhoea are:

1. What is the acceptability and effectiveness of low-osmolarity ORS in clinics and in the community? How to improve it?
2. What is the effectiveness of zinc supplementation on the outcome and incidence of diarrhoea in the community?
3. What are the barriers impeding the appropriate use of ORS? How can they be overcome?
4. Design locally-adapted training programmes to orient health workers on IMCI.
5. What is the impact of IMCI in different population groups on the timely identification and treatment of acute diarrhoea?

For pneumonia, the top five research areas/questions are:

1. What are the main barriers to care-seeking and access to services for children with pneumonia in different contexts and settings?
2. What are the key risk factors predisposing a child to the development of severe pneumonia and hospitalization?
3. What are the main barriers to increasing coverage with available vaccines – *Hib* and pneumococcal – in different contexts and settings?
4. Study whether the coverage of antibiotic treatment can be greatly expanded, safely and effectively, if it is administered by community health workers?
5. What are the main barriers to increasing demand for/compliance with vaccination with available vaccines in different contexts and settings?

Plenary discussion highlighted the following key points:

- The CHNRI methodology used to identify priority research questions focused on issues that could have an impact on the achievement of the MDGs by 2015.
- In order to increase the use and coverage of ORT/ORS, the respective roles of ORS and home-made solutions in the management of diarrhoea should be clarified.
- The importance of defining new delivery strategies for ORS is important.
- Resistance to the use of antibiotics for community case management of pneumonia is based on the premise that it will increase irrational use of antibiotics and lead to antibiotic resistance. However, there is ample evidence that trained and supervised CHWs use antibiotics rationally, even more so than conventional health workers.
- The relationship between antibiotic *in vitro* resistance and clinical failure is not straightforward in pneumonia treated in the community and needs to be investigated.
- It was also emphasized that operational research should not only be a concern for researchers but for implementers as well, and that scale-up of interventions needs to be based on scientific evidence.

Panel Discussion: Funding opportunities

An overview of possible funding opportunities was presented in a round table discussion in which various organizations and agencies were represented.

GAVI's main support in this field is for the introduction of new vaccines, e.g. DTP-HepB-*Hib*, rotavirus and pneumococcal. There will be an application round for support to introduce new vaccines with the closing date of 15 May 2011. Joint proposals to GAVI and GFATM for health systems strengthening support are also possible.

The **Sabin Institute** supports national Ministry of Health officials through intensive briefings in their 'lobbying' of the Ministry of Finance and of Parliamentarians for increased domestic financing for immunization and integrated approaches to vaccine-preventable disease control.

The **Bill & Melinda Gates Foundation** supports global infrastructure development, and innovative financing mechanisms, works to achieve lower prices of vaccines and medical products and supports emerging vaccine manufacturers, all in an entrepreneurial spirit. The BMGF is "more than just vaccines" – the foundation supports the piloting, expansion and scale-up of broad, integrated health interventions.

USAID, together with UNICEF, WHO and BMGF, coordinates efforts for integrated community case management activities through a CCM Taskforce. Through USAID missions in countries, applications for funds from the President's Global Health Initiative can be made for support of CCM activities. USAID missions also provide technical assistance for health systems strengthening, and USAID/Washington runs a child survival grant programme. Through USAID/Washington, a number of health-related programmes and activities are supported, such as the Maternal and Child Health Integrated Program (MCHIP), the Health Care Improvement Program, SHOPS project for support of the private sector, and WASH+ for water and sanitation work.

The **United Kingdom** will soon provide funding for the implementation of its new reproductive and neonatal health strategies for developing countries. Funding opportunities may also be available through support for malaria programmes in developing countries.

UNICEF mainly provides technical assistance to countries and health programmes and assists in attracting funders and in mobilizing resources to improve child health. To overcome operational challenges in countries, UNICEF assists countries to synchronize national actions, to provide policy options, to work towards programme congruence and improved implementation.

The WHO Regional Office for Africa works with country programme managers and higher officials in ministries of health to increase domestic funding for integrated health programmes in the context of the Abuja Declaration targets to spend 15% of the national budgets on health. WHO provides mainly technical assistance, high-level expertise and guidelines to countries, but can also provide some catalytic or seed funding for innovative health programmes. It is to be noted that CIDA funding for maternal and child health work in the African Region (in the amount of US$ 50 million) will become available through WHO in the near future.

Session 4: Sharing and learning from country experience

The objectives of this session were:

(i) to analyse opportunities for and obstacles to implementation;

(ii) to share lessons learned/best practices; and

(iii) to identify solutions, including policy issues, that can facilitate increasing coverage of pneumonia and diarrhoea prevention, treatment and control at all levels.

Prior to the workshop, a template was developed and distributed to country teams to support the preparation of situation analyses. This covered organizational structures, coordination mechanisms, programme budget and funding, training and supervision, HMIS, community structures and personnel, performance of programmes, gaps, opportunities and challenges. The resulting situation analysis presentations were presented by the country groups in plenary sessions (see Annex 3 for presentations). The standardized template facilitated cross-country comparison and sharing of experiences.

Key messages from the country presentations:

- Diarrhoea and pneumonia are among the leading causes of death in children under five years of age.
- Progress has been made towards achieving MDG 4, but it is insufficient to reach the target by 2015. Unless the coverage of effective interventions for diarrhoea and pneumonia is increased to 90%, reaching MDG 4 will not be possible.
- More needs to be done to scale-up diarrhoea and pneumonia interventions in all countries.
- In general, policies and strategies related to child survival and child health are in place in countries. However, the implementation of these policies and strategies is sub-optimal.
- In several countries the policy of community pneumonia treatment by CHWs either does not exist or needs to be improved.
- Integrated community case management (iCCM) needs to be scaled-up to increase coverage for treatment of diarrhoea, pneumonia and malaria in the community.
- Although many programmes, civic society and private sector provide services towards child survival and child health, there is very little coordination or collaboration between them.
- There are few human and financial resources available to improve the quality of care at all levels of the health system and to increase coverage.
- In several countries the supply of ORS, zinc and antibiotics is inefficient, insufficient and ruptures of stocks are common.
- Public demand for services and care-seeking for diarrhoea and pneumonia is low in many countries.
- Motivation and incentives for health workers are essential for improving access to quality care, and to ensure the retention of workers.
- In many countries coordinating mechanisms exist, but vary in approaches and breadth – and there is also wider variation in organization of ministries of health.
- Although not in line with various commitments made (e.g. Abuja Declaration), governments are allocating more national funds to health. Ther is a need for more

- The current political environment - national and global - to accelerate action towards the achievement of MDGs is favourable (as indicated by ongoing policy dialogues for iCCM). This opportunity needs to be well utilized to implement interventions across the continuum of care.
- There are specific budgets for specific programmatic interventions such as malaria and EPI but no dedicated specific budget for child survival or child health
- Access to community case management care and definition of CHWs is variable from paid MOH staff to community volunteers.
- Advocacy and political commitment have been key to progress.
- All the countries represented in the workshop have plans for introducing the new vaccines (Rotavirus or pneumococcal).

Some of the **challenges** mentioned by countries included:

- Low coverage of some of the interventions, e.g. EBF, hand washing and sanitation due to lack of coordination and adequate involvement of all sectors.
- Low coverage of training in IMCI due to high attrition rate, inadequate funds, low donor interest due to no quick win.
- Policies do not support the use of antibiotics by CHWs.
- Health systems challenges (access to services, human resources constraints and shortage of drugs).
- Shortage of financial resources.
- Shortage and high turnover of skilled human resources.
- Inadequate access to health facilities.
- Lack of essential equipment and supplies.
- Inadequate programme coordination.
- Inadequate monitoring and evaluation system.
- Low care-seeking behavior in communities.

The country presentations highlighted the following **opportunities** for introducing or accelerating a coordinated action for pneumonia and diarrhoea control:

- Global and national political commitment to achieve MDGs.
- Country initiatives accelerating the expansion of Primary Health Care initiatives such as the roll out plan of the health extension programme in Ethiopia.
- Wide experience in implementing child health programmes.
- Introduction of new vaccines (Hib).
- Evidence for policy changes in CCM of pneumonia.
- Strong partnership for child survival.
- Availability of data for programme planning and for enhancing advocacy.
- Existence of funding opportunities.
- Willingness, commitment, interest and the realization that coordination and harmonization are essential ingredients for success.
- Experiences and best practices.

Session 5: Identifying coordinated actions

The objective of this session was to foster collaboration and linkages across programmes by identifying and developing country-specific actions for practical application of the GAPP and the comprehensive diarrhoea control strategy to strengthen child survival and primary health care programmes.

Using a series of worksheets and information from the situation analyses, participants worked in country team working groups to:

- Identify the pneumonia and diarrhoea prevention and control interventions that have been included in existing policies/strategies/plans;
- Identify the pneumonia and diarrhoea prevention and control interventions that need to be updated or included in existing policies/strategies/plans;
- Describe existing coordination mechanisms and linkages between the different child survival and child health-related strategies, policies and programmes;
- Identify major problems affecting implementation; and
- Develop recommendations for coordinated actions to scale-up pneumonia and diarrhoea prevention and control interventions.

The outcome of the group work was presented and discussed in plenary. This session provided opportunities for peer review of draft recommendations and next steps for country actions (see Annex 3: Coordinated approaches).

The key points that emerged from country plans included:

- Coordination mechanisms need to be either developed or reinvigorated in the form of technical working groups, coordination committees, etc. at the country level to increase collaboration across all child survival and child health-related programmes. Other programmes that have an indirect impact, such as water, sanitation and environment, also need to be further engaged in these coordination mechanisms. Where necessary, advocacy and lobbying need to be done to get these programmes more involved in child survival activities. In addition, the private sector needs to be included in coordination efforts.

- There is a proposal for some countries to institutionalize the high-level committees at ministerial level to increase coordination and increase resource flows to support the implementation of interventions for diarrhoea and pneumonia control.

- Creating an enabling environment is critical to ensure support for implementation of key child survival interventions. Thus, where there is a gap in supportive policies, such as the policy on the use of low-osmolarity ORS and zinc, or community case management of pneumonia, coordinated action from partners will be essential to facilitate policy dialogue.

- Advocating and lobbying for more resources to increase the coverage of pneumonia and diarrhoea interventions to policy makers and planners at ministries of health, finance, parliaments, donors, etc.

- It is important to have a national communication strategy that includes reaching out to the media, public, opinion and community leaders to increase awareness of and support for increasing coverage and utilization of effective pneumonia and diarrhoea interventions.

- Existing programmes provide additional channels for the delivery of effective interventions. These include the promotion of CCM through the malaria programme, improving supply and logistics for commodities like ORS, zinc, antimalarial drugs, RDTs for malaria and antibiotics through the health system strengthening initiatives.

- There is a need to identify the best ways of quantifying resource needs at the community level. This includes commodities and human resources.

- Although zinc and low-osmolarity ORS have been widely adopted for the treatment of diarrhoea, they are still not available in many countries. Partners should support and facilitate local production and technology transfer.

- To increase utilization and care seeking, quality of care should be improved at all levels of the health system, e.g. introducing Emergency Triage and Treatment (ETAT), improving and sustaining skills at community-, first- and referral-level facilities.

Conclusions

The workshop provided an opportunity for country teams and partners to jointly review national efforts for reducing morbidity and mortality from pneumonia and diarrhoea in children under five years of age in Ethiopia, Kenya, Ghana, Malawi, Nigeria, Uganda, the United Republic of Tanzania and Zambia.

Through the processes of undertaking situational analyses and preparing country presentations together, the workshop objective of fostering collaboration and linkages was initiated before the participants arrived in Nairobi. This preparatory work was taken to a higher level during the workshop through country and partner exchanges of ideas and experiences. The successful outcome was that country teams -- including programme managers, health system specialists, planning officers, directors of health services, commissioners of health and partners from the different levels -- made commitments and plans for coordinated action for the control of pneumonia and diarrhoea in children under five years of age.

Annex 1:

***"Protect, Prevent, Treat"*: African Regional Workshop on coordinated approaches to pneumonia and diarrhoea prevention & control**
Nairobi, Kenya, 25-28 January 2011

Agenda

DAY	SESSION	Responsible
Day 1: Tuesday, 25 January 2011		
08:30	Opening session Chairperson for session 9:30- 13:00 Co-chair Rapporteur- Olivier	Head, Department of Family Health T. Cherian
09:30	Overview of GAPP	S. Qazi/WHO
11:00-13.00	Technical Update BCC/Integrated framework for communication activities Strengthening supply chain Rapporteur- Vismita	Mark Young, UNICEF Diaa Hammamy , USAID Emmanuel Wansi Lora SHIMP
14:00-17.30	Chairperson: Co-chair Rapporteur- Osman Mansoor Country Presentations: Kenya, Ghana, Ethiopia, Malawi Wrap up of Day 1- Olivier + Osman	Mark Young Samira Aboubaker
Day 2: Wednesday, 26 January 2011		
08:30-10:00	Country Presentations Group 1**: Nigeria and Tanzania,** Ghana, Ethiopia Rapporteur: Tracy Group 2: **Uganda and Zambia** Malawi, Kenya Rapporteur: Phanuel	 Group 1- Diaa Group 2 – David
10:30 – 11:00	Feedback from parallel country presentations and discussions	Diaa, David
11:00 – 11:15	Introduction to country team work	Teshome
11:15-12.30	Country team work Ethiopia Kenya Ghana Malawi	 Diaa, Neena, David Emmanuel, Carsten, Josephine Osman, Olga, Mark

DAY	SESSION	Responsible
	Nigeria Zambia Uganda Tanzania	Tracy, Samira Dyness, Thomas Herbert, Qazi Teshome, Vismita Phanuel, Olivier, Collins
Day 3: Thursday, 27 January 2011		Chairperson: Osman Co-chair: Collins Rapporteur- Melissa Corkum/Josephine Namboze
8:30-9:00	Kenya's experience with communication and advocacy	Fred Were
9:00-9:30	Advocacy and communication for World Pneumonia Day and for Diarrhoea prevention and control	Doune Porter
9:30-10:30	Communication and advocacy Rapporteur: Melissa Corkum/Josephine Namboze	Vismita Gupta-Smith/WHO Collins Boakye-Ayemang/WHO
10:30-11:00	Tea Beak	
11:00-12:00	Working groups on communication Group 1: Ethiopia/Ghana Group 2: Kenya/Malawi Group 3: Nigeria/Tanzania Group 4: Uganda/Zambia	Facilitator for each group: - Christin Kisia - Suliman Malik - Rufus Eshuchi - Melissa Corkum
12:00-13:00	Group work plenary presentation	Vismita Gupta-Smith/WHO Collins Boakye-Ayemang/WHO
14:00-17:30	Country working group on coordinated action	
Day 4: Friday, 28 January 2011		
08:30-12:30	Country presentation Rapporteur: S. Qazi	Chairperson: P. Habimana
14.00-15:30	Mechanisms for monitoring implementation Rapporteur: T. Desta	Chairperson: S. Aboubaker
16:00-16:30	Operations research Rapporteur: S. Qazi	Chairperson: S. Aboubaker
16:30	Funding opportunities 5 minutes presentations by	Chairperson: S. Aboubaker

DAY	SESSION	Responsible
	USAID, UNICEF, GAVI/HSS, GFATM, BMGF Rapporteur: Mantel	
17:00-17:30	Wrap-up and closing remarks	S. Aboubaker

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25 - 28 January 2011, Nairobi, Kenya

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25 - 28 January 2011, Nairobi, Kenya

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Annex 3:

Outcome of country team group work

Country	Recommended Actions	Responsible	Date
KENYA	1. Gather evidence for antibiotics, Vitamin A and zinc use at community level through CHWs	DFH/CHICC	02/11
	2. Present CCM effectiveness evidence to ICC for endorsement.	Drs Kamenwa, Muriithi, Rakiro, Miheso, and Jane Koech	06/11
	3. Develop Ghantt charts to identify areas of overlap for joint activities.	DFH/MCHIP	04/11
	4. Hold meetings between divisions in DFH to review previous activities and plan upcoming activities.	DFH	05/11
	5. Advocate for CMEs for HWs on diarrhoea and pneumonia management.	DFH	06/11
	6. Commence adaptation of IMCI Computerized Adaptation &Training Tools (ICATT) and initiate revival of joint drug quantification meeting.	DCAH/WHO	06/11
	7. Lobby partners for supplementary funding of commodity gaps.	DFH/ICC	03/11
	8. Advocate with health managers for the revival of facility level supervisory meetings.	DFH	04/11

	9. Finalize CHWs curriculum, initiate the development guidelines for CCM and initiate adaptation of CCM training materials.	DCHS, WHO,DCAH, UNICEF, MCHIP	05/11
	10. Finalize the KAP survey/evaluations on child survival to inform communication strategies. (work in progress, funding available) – Short term. DCAH .	DCAH/UNICEF	04/11
	11. Finalise the CSD communications strategy.	DCAH/UNICEF	06/11
	12. Provide OJT and mentorship to health managers.	DFH	06/11
	13. Ensure the ongoing revision of HMIS tools include indicator for zinc.	DCAH/HMIS	Ongoing
	14. Ensure that the diarrhoea and pneumonia interventions are included in the AOP 7.(CCM training, HWs refresher training, CMEs).	DCH, WHO,UNICEF	05/11
	15. Organise meeting with Parliamentary Health Committee to sensitize them on the need to fund diarrhoea & pneumonia interventions at community level.	DCH, WHO, UNICEF, KPA	04/11
	16. Reactivate relationship with KEPSA.	DCAH/UNICEF	05/11
	17. Use communiqué on HII to lobby development partners for funding pneumonia and diarrhoea interventions.	DFH/WHO/UNICEF/USAID	04/11 Onward
GHANA	1. Briefing session for CHC members and other key stakeholders on the Nairobi workshop and way forward.	Child Health Coordinator and EPI manager	end 3/11
	2. Find out existence of WASH committee and lobby for representation of Child	UNICEF	15/02/11

	Health on the Committee. 3. Invite the MOE, Local Gov & RD, Min of Water resources and Works and Housing to serve on CH committee (If WASH Committee does not exist).	Child Health Coordinator	end 3/11
ETHIOPIA	1. Revitalize Child Survival Technical Working Group (CSTWG) and increase membership.	Director of FHD	end 3/11
	2. Identify reasons for non-availability of life saving case management medicines (zinc, low osmolarity ORS).	Director of FHD and CSTWG	end 6/11
	3. Advocate to policy makers to produce and/or procure medicines.	FHD, CSTWG, DACA, PFSA	end 9/11
	4. Develop concept note proposing options for production and procurement.	CSTWG	end 9/11
	5. Train supervisors in ICCM and supervisory skills.	ICCM partners.	end 3/11
	6. Review integrated Health Extension Worker supervisory checklist for CCM content.	ICCM WG	end 6/11
	7. Review supervision strategy to test alternatives. (medium term).	CSTWG	end 12/11
	8. Review HMIS indicators.	FHD, CSTWG	end 3/11
	9. Produce twice yearly bulletin reporting progress and use findings for advocacy.	CSTWG	end 6/11
	10. Participate in regional and national review meetings.	FMOH	on-going
	11. Advocate for and facilitate periodic household and health facility surveys.	FMOH, CSTWG	periodic

MALAWI	1. Update the ACSD policy to include emerging issues.	IMCI Unit	06/11
	2. MOH to form a coordination committee for child health activities.	DPHS	03/11
	3. Advocate for more resources to speed up the scale up ETAT.	ETAT/ARI Manager	12/11
	4. Develop the comprehensive communication strategy for child health.	ACSD/IMCI TWG	12/11
	5. Capacity building for data management and harmonization meetings for HMIS and programme coordinators.	IMCI Unit	12/11
NIGERIA	1. Strengthening informal communication including generation of a mailing list.	DPRS	2011
	2. Map out roles and responsibilities of different components within MNCH.	MNCH Core Technical Cmt	2011
	3. Leverage funds from Malaria, HIV and TB for integrated training on childhood illnesses including pneumonia and diarrhoea.	MNCH Core Technical Cmt	2011
	4. Mapping of the different States supply chain systems with the ultimate aim of integrating the supply chain system.	MNCH Core Technical Cmt	2011
	5. Train Role Model Caregivers in management of pneumonia and diarrhoea diseases.	NPHCDA/NMCP	2011

	6. Advocate for the inclusion of pneumonia and diarrhoea in Immunization Plus Days (IPD) communication and social mobilization plans.	Family Health	2011
	7. Advocacy to State, LGA Chairmen, Councillors of health and the private sector on training and supervision of health workers on the use of the National referral forms	DPRS	2011
	8. Engage the MDG office on the burden contributed by pneumonia and diarrhoea to under five mortality and present a proposal for funding of procurement and distribution of antibiotics, low osmolarity ORS and Zinc.	DPRS/MNCH CTC/NPHCDA	2011
TANZANIA	1. To identify communities with poor access and use existing REC framework and outreach services in order to provide care for pneumonia and diarrhea at community level.	MOH/Regions/Districts	12/11
	2. To provide integrated promotive, preventive and curative health services through Village Health Days.	MOH/PORALG/ CHMT/RHMT/ Partners	9/11
	3. To support establishment and sustaining of Media Alliance for Child survival.	MOH/Media institutions/Media Houses/Ministry of Comm/Comm Dev Gender and women	5/11
	4. Advocate inclusion of iCCM in the CHW curriculum/training guidelines in development under Primary Health services and Dev program (2007- 217).	RCH/TFDA/PSU	5/11

UGANDA	1. Develop framework to support integration of PPT Intervention across programmes.	MOH community and clinical health	2/11- 7/11
	2. Advocate for the implementation of the Framework for integration & resources.	MOH community and clinical health	2/11- 7/11
	3. Establish and operation of a Child Survival Coordination committee to oversee the implementation of the above framework.	MOH community and clinical health	2/11- 7/11
	4. Build capacity for planning and management at all levels (National , District & lower levels).	MOH Division of Child Health	2/11- 7/11
	5. Develop standards for quality of care at facility & community level.	MOH Division of Child Health	2/11- 7/11
	6. Harmonize the BCC components of the Child Survival strategy.	MOH Division of Child Health	2/11- 7/11
	7. Increase the capacity of the current EPI programme in preparation to operationalize the policy of new vaccine introduction (Rota & pneumococcal).	MOH/UNEPI	ongoing
ZAMBIA	1. To review the Comprehensive National Health Policy to ensure it encompasses the national community health workers and healthcare financing issues.	MOH directorate of policy and planning	2011
	2. Develop a comprehensive national plan for essential medicines and community needs.	MOH directorate of clinical care	2011

	3. Engage donors to support health system strengthening and priority child health programmes. Recommend for of an interministerial committee for the establishment of an SHI.	MOH directorate of policy and planning	2011
	4. MOH to increase budget allocation to the retention scheme. Advocate for increased funding of health sector by government and donors. Include health system strengthening in proposal to World Bank, GAVI and GFTAM. Expedite the financing and implementation of the national community health worker strategy.	MOH directorate of Human Resources and Administration	2011