

Report on the

**Fourth malaria border coordination meeting
between Afghanistan, Islamic Republic of Iran
and Pakistan**

Islamabad, Pakistan
29 September–1 October 2009



**World Health
Organization**

Regional Office for the Eastern Mediterranean

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1. INTRODUCTION

The fourth border coordination meeting between Afghanistan, Islamic Republic of Iran and Pakistan was held in Islamabad, Pakistan, from 29 September to 1 October 2009. The meeting was organized by the World Health Organization (WHO) Regional Office for the Eastern Mediterranean. The objectives of the meeting were to:

- review the progress made and problems encountered in the implementation of malaria control and elimination strategies;
- review implementation of the previous border meeting recommendations, and discuss achievements, challenges and the way forward for coming years;
- develop a framework of a joint proposal to GFATM Round 10 for malaria control in bordering areas for three countries;
- update countries with new developments on monitoring drug efficacy;
- review results of antimalarial drug efficacy studies and discuss about progress of PIAM-net establishment.

Dr Khalif Bile, WHO Representative in Pakistan, delivered the opening remarks on behalf of Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean. He said that people living in border areas were at greatest risk of malaria and also had the lowest access to health care as security problems increased the challenges. Therefore; there was a need for strong political commitment, open and transparent lines of communication, and joint coordination and cooperation in border areas. He referred to the recommendations of the three past border coordination meetings particularly regarding the establishment of a functional border coordination mechanism, which was not yet in place. He mentioned the emergence of artemisinin-tolerant malaria parasites that had been reported from the Thailand–Cambodia border. This highlighted the need to maintain and strengthen surveillance activities for monitoring parasitic response to artemisinin with emphasis on the border areas, conduct joint research among the three countries to better understand vivax malaria, and correctly estimate the magnitude of the problem. Finally, he referred to the network involving Pakistan, Islamic Republic of Iran and Afghanistan for malaria (PIAM.net) that was established last year to facilitate information-sharing on the malaria burden, particularly at the border areas.

The Chair was shared on a rotating basis. The programme and list of participants are included as Annexes 1 and 2, respectively.

2. UPDATE ON ACHIEVEMENTS AND CHALLENGES OF IMPLEMENTATION OF ROLL BACK MALARIA IN THE REGION

Dr Hoda Atta, WHO/EMRO

According to the *World malaria report 2008*, 50% of the world's population live in areas at risk of malaria (3.3 billion) with 881 000 deaths and 247 million cases annually, of which 92% are falciparum malaria. The Eastern Mediterranean Region ranked third after Africa and South-East Asia in terms of burden, where 55% of the population (295 million) live at risk, with 8.1 million estimated cases (76% P.falciparum) and 38 000 deaths annually. To achieve Roll Back Malaria (RBM) targets and Millennium Development Goals (MDGs)

related to malaria and the new goal in the global malaria action plan “near zero for all deaths by 2015” universal coverage is needed by the end of 2010. Currently, coverage of key interventions (ITNs, ACTs) is increasing, although the gap is still huge. Poor surveillance data make it difficult to measure the real incidence of malaria and monitor its trend. With the current speed of scale up, most high-burden endemic countries, might not achieve the RBM target of universal coverage or the targets of the MDG.

The key programmatic and health system challenges are: weak capacity of the control programme, limited coverage and low quality of laboratory services, weak malaria surveillance systems and weak structures to deliver the interventions to marginalized and inaccessible populations. Malaria-endemic countries need to implement immediate measures to strengthen programme capacity down to the district level. National programmes should have qualified, competent, trained focal points for treatment, diagnosis, entomology/vector control, epidemiology for monitoring and evaluation and surveillance, IEC, training, research and other activities. In a decentralized system, the structure must be repeated in priority provinces/districts for malaria.

Innovative strategies should be developed to deliver comprehensive prevention, diagnosis and treatment package for marginalized groups (e.g. border and remote areas, residents of insecure areas, immigrants, refugees, nomads). Strong partnership with civil society organizations, the private sector and community is needed to scale up delivery of services. Governments should revisit the policies, legislation and practices that hinder free access and also should address cross-border issues.

3. UPDATES FOR ANTIMALARIAL DRUG MONITORING, STATUS OF RESISTANCE TO ACTS AND ITS CONTAINMENT STRATEGIES

Dr Marian Warsame, GMP/WHO/HQ

The updated WHO Protocol 2009 for monitoring drug efficacy reflects the following changes: rescue treatment to patients with parasitological treatment failures at all levels of malaria transmission, PCR genotyping to distinguish between recrudescence and reinfection and Day 3 clinical marker for artesunate tolerance. Inclusion criteria slightly adjusted to allow more patients. In high transmission areas the criteria are: parasitemia ranges from lower limit of 1000/µl to upper limit to 250 000/µl, a history of fever in the last 24 hours, and age from 15 years onwards. Low-to-moderate transmission area: maintain the sentinel sites if you get 4–5 patients/week over 6 months, reduce the parasitemia lower limit to 250/µl (reliability of microscopy) and history of fever over last 48 or 72 hours. In low to very low transmission areas: use multicentre approach of a one arm study, monitoring every three years and in between trends use molecular markers if known and validated (chloroquine, mefloquine, SP). If in vivo monitoring is unfeasible, use only early warning tools (molecular markers or in vitro tests).

Major differences of *P. vivax* protocol with falciparum protocol are: inclusion criteria Parasitemia >250/µl, history of fever 48 hours, chloroquine blood concentration to be measured on D0, D7, D failure, D 28, with 100/µl blood on filter paper. The definition of treatment failure includes: clinical deterioration due to *P. vivax* illness requiring

hospitalization in presence of parasitemia; the presence of parasitemia and axillary temperature ≥ 37.5 °C any time between Day 3 and Day 28; the presence of parasitemia on any day between Day 7 and Day 28, irrespective of clinical conditions.

The recent data of ACT treatment efficacy showed prolonged parasite clearance times along the Thai/Cambodian border following treatment with some ACTs. This might reflect the emergence of *P. falciparum* tolerance to artemisinins. However, efficacy of ACTs still remains high in most studies.

4. COUNTRY PRESENTATIONS ON ACTIVITIES CONDUCTED IN 2008–2009: ISSUES, CHALLENGES IN BORDER AREAS

4.1 Progress and challenges towards malaria control in Afghanistan

Dr Najibullah Safi, National Malaria and Leishmaniasis Control Programme Manager MoPH-Afghanistan

In Afghanistan a total of 81 574 confirmed cases were recorded in 2008, of which 4355 (5.6%) were falciparum cases. Such cases are continuously decreasing since 2002. High proportion of cases are from bordering provinces with Pakistan as 284 197 clinical and confirmed cases were recorded (60%), 8742 from bordering provinces with Islamic Republic of Iran and 174 184 from other provinces. The programme has major achievements in recent years with financial resources from GFATM, USAID and technical support from WHO. National strategic plan 2008–2013 and updated treatment guidelines developed. The diagnostic facilities were strengthened with establishment of 14 quality assurance centres and establishment of 101 microscopy facilities in 101 basic health centres. Since 2007, more than 1.5 million LLINs distributed in 14 target provinces and about 200 000 beds net were retreated. Entomology units were established in national malaria control programme and Nangarhar. Improvements have taken place in the surveillance system, where 735 health facilities and 9500 health posts are reporting malaria cases. Malaria indicators survey was completed in November 2008. Key challenges encountered are insecurity, lack of motivation, insufficient coordination among stakeholders and an unregulated private sector. Due to the low coverage of laboratory facilities only 15% of total malaria reported cases are confirmed by microscopy.

4.2 Update on the malaria situation and malaria control measures in the Islamic Republic of Iran

Dr.Ahmad Raeisi, Malaria programme manager, Islamic Republic of Iran

There has been a gradual decline in malaria cases since 1995. In 2008 a total of 11 460 malaria cases were reported, all confirmed, of which 90% were vivax. More than 70% were autochthonous cases. 90% of malaria cases were recorded in three provinces. The malaria burden in 2008 decreased by 27%, in comparison to 2007. Falciparum cases are only 10% (including 2% mixed infection). This figure is 20% in areas with frequent cross-border population movement with Pakistan while it is 5% in other non-bordering areas. The programme is aiming at malaria elimination by 2025. The national malaria elimination plan developed in accordance with MDGs goals and the National Plan of Development of the

country. A phased approach is developed based on stratification of districts at malaria risk displayed in Table 1.

Table 1: Distribution of at risk districts according to status of the programme

		Current condition		Number of districts in each phase by the end of the year			
		No. of districts	No. of population	2010	2015	2020	2025
Intensified control		5	446 113	0	0	0	0
Pre-elimination		8	851 139	5	1	0	0
Elimination		22	3 221 220	19	11	5	0
Preventing of re-introduction	High risk	49	7 117 686	60	72	79	84
	Low risk	271	61 245 372	271	271	271	271
Total		355	72 881 530	355	355	355	355

4.3 Malaria situation in Pakistan and activities at the border area

Mr Aslam Khan, NMCP manager, Islamabad Pakistan

Total malaria cases in 2008 (clinical and confirmed) were 4.5 million. Only 104 454 cases were confirmed of which 24% *P. falciparum*. The incidence was highest in Federally Administered Tribal Areas followed by Baluchistan. The burden of malaria border districts and agencies represents 37% of the total country burden. Round 7 of GFATM includes support to the seven bordering districts in Baluchistan and the three bordering agencies in Federally Administered Tribal Areas by RDTs, LLINs, ACTs. 81 microscopy centres were established/made functional in border area districts/agencies.

There is ongoing drug efficacy monitoring in three sentinel sites in border area. IEC activities are being strengthened. World Malaria Day was commemorated in Baluchistan and Federally Administered Tribal Areas on 25 April of 2008 and 2009.

Main challenges are poor district capacities, limited diagnostic facilities, weak surveillance activities and the deterioration of the security situation in Federally Administered Tribal Areas and Baluchistan.

R7 GFATM phase 1 project is under implementation in Pakistan. The goal is to reduce the burden of malaria in 19 high endemic districts of the three highly endemic provinces of the country. Objectives are to: improve early diagnosis and prompt treatment services, scale up coverage of LLINs, strengthen and build management capacity of national malaria control programme to coordinate, plan, implement and monitor effective curative and preventative interventions nationwide. The target areas are: Baluchistan - nine districts (Zhob, Mastung, Sibi, Kech, Noshki, Gawadar, Naseerabad, Loralai, QilaSaifullah); Sindh - four districts (Khairpur, Thatta, Tharparkar, Dadu); North-west Frontier province - three districts (Bannu,

Mardan, L. Marwat); Federally Administered Tribal Areas - three agencies (Khyber, Bajaur, Kurrum Agency).

4.3.1 Experience from the district

Dr Taj Baloch EDO Health District, Kech, Balochistan

In 2008 there were 3426 malaria cases, of which 1972 (57.5%) were falciparum. The major challenges at district level include: compromised skills of health facility staff and care providers in case management of malaria; scarcity of resources (local resource limitation); unethical promotion of drug prescription by pharmaceutical industry leading to irrational use of antimalarial drugs; low district capacity in field entomology and vector control; lack of coordination between the district health team and the implementation organization; and low coverage of control interventions.

5. MALARIA SURVEILLANCE IN LOW TRANSMISSION SETTINGS

Dr Ghasem Zamani, MO/RBM/EMRO

A low transmission area is where the slide positivity rate (SPR) is <10%. Such transmission settings may have a strong or weak surveillance system. In some countries the population at risk is a small proportion of the national population; however, the absolute number is as big as in Pakistan. Malaria surveillance in low transmission settings requires the establishment of functional malaria integrated systems at the district level with strong supervision to ensure reporting completeness, timeliness and quality.

This needs motivated, competent human resources with adequate and quality training and retraining, new tools and technology for diagnosis, analysis, reporting and limited and standard indicators with the possibility of separate analysis of data from different sources. Reports and feedback are provided monthly by district and annual update on malaria surveillance by foci for each district. A GIS-based database should be established at district level beginning with health facilities and then expanded for malaria foci when approaching pre-elimination and elimination stages, including use of geographical and meteorological data.

RDT and microscopy results should be registered, reported and analysed separately. Measurement of proportion of confirmed cases is important. Case-based surveillance of inpatient (severe) malaria cases and deaths should be analysed in less than 48 hours at all levels. Immediate reporting of malaria deaths to national level should be started. Introduction of case-based surveillance should be at district level by health facility and by ecological foci. Cases should be recorded/reported by actual age, gender, species, location, interventions used (LLIN or IRS, diagnosis by microscopy or RDT), date of onset of symptoms, date of seeking medical care, date of diagnosis and date of treatment. Introduction of the concept of epidemiological classification of cases should start at this stage.

Identification of malaria foci for planning interventions and preparation for elimination is mandatory. Active surveillance should be introduced in pre-elimination stage. The participation of the private sector in reporting is crucial and at the later stage, treatment should

be restricted only to the public sector. Additional needed data and validation may be done by conducting specific surveys and entomological surveillance with analysis and interpretation of IRS coverage at foci level.

Future planned regional efforts to strengthen malaria surveillance will include: developing the regional malaria information portal, updating malaria risk mapping in collaboration with KEMRI (<http://www.map.ox.ac.uk/data/>), updating district shape files for district-based mapping for reporting to WHO by district, strengthening the capacity of malaria monitoring and evaluation by recruitment of monitoring and evaluation officers in priority countries, organizing regional malaria surveillance and a monitoring and evaluation training Course, planned in 2010 using the new malaria surveillance and monitoring and evaluation guidelines.

6. REVIEW OF ACHIEVEMENTS OF PREVIOUS BORDER MEETING RECOMMENDATIONS

Dr Q. Kakar, WHO Pakistan

The first cross border meeting took place in Chabahar, Islamic Republic of Iran 20–22 July 2003. The second meeting took place in Peshawar, Pakistan, August–September 2004 and during this meeting a practical plan with specific activities was developed. The third meeting in Shiraz, Islamic Republic of Iran, 2007, resulted in the establishment of a network for cooperation named PIAM-net. Key achievements from those meetings include: establishment of functioning sentinel sites for the monitoring of antimalarial drugs efficacy, conduction of three country projects for determination of molecular epidemiology of vivax malaria, and conducting of training courses for entomologists with involvement of participants from Afghanistan and Pakistan in Bandar Abbas, Islamic Republic of Iran.

7. PROGRESS REPORT ON PIAM-NET PERFORMANCE

Dr Ahmed Raeisi, Cairman of the PIAM-net

The PIAM-net is in need of resources and some promises was made by the Chancellor of Tehran University of Medical Sciences who agreed to support activities with US\$ 200 000 and to host of joint malaria research congress (in July 2010). The main expected activities are to support drug efficacy monitoring, joint regional proposals; capacity of malaria research institutions upgrade malaria research infrastructure, that is essential to the effective conduct of malaria research, support study tour to some countries (e.g. Malaysia, Viet Nam) for increasing knowledge on new malaria vector control measures through collaboration with a private partnership, facilitating conduction of surveys in border areas, design MEWS sentinel sites in the border areas.

8. CROSS-BORDER MALARIA CONTROL AND ELIMINATION PRINCIPLES: LESSONS LEARNT IMPLEMENTATION AND PROPOSAL CONTENT

Dr Sivakumaran Murugasampillay, Medical Officer, GMP/HQ

The cross-border control project is justified to address the needs and ensure rights of remote population living on the borders and minority groups such as nomads, refugees, migrants; when there is frequent movement of malaria infected people or movement of mosquitoes. The cross-border control project is needed to achieve the target of the total coverage and more important in situation of shift from control to elimination with more imported cases as compared to indigenous cases. He summarized the methods for coordination in such projects as follows: national joint meeting to share and exchange information, advocacy and joint planning and review meeting of border districts and provinces, focal points/communication link/hot line, bilateral or multilateral agreements or protocols or memorandums of understanding, sharing resources and expertise, harmonize drug and insecticide policies, target travellers, refugees, migrants and tourists, joint teams working across borders to deliver services such as IRS, LLIN, ACT and conduct surveys and building proposal to scale up.

An example of a border project is the Southern Africa Cross-border project 1997. Lubombo Spatial Development (LSDI) Malaria Control launched 1999 as a trilateral initiative between Mozambique, South Africa and Swaziland to open up area for eco-tourism, it was later supported by GFATM R2 and R5 and RCC. The main objective was to develop a regional malaria control programme and a regional GIS-based malaria information system. The plan includes activities for baseline survey, vector profile, KAPB, parasite prevalence, GIS platform, IRS programme and monitoring and evaluation. Another project is Trans-Zambezi Cross-Border 2008 by GFATM R8 and R9 to address the gaps and coordinate implementation of malaria strategies. The five country coordination mechanisms and malaria managers decided to make a regional effort to roll out successful strategies in LSDI into their 15 border districts (country driven).

Steps in developing cross-border proposals are: joint meeting between countries, seek seed funding or core start up funding, involve research and academic institutions, involve partners, intersectoral approach: local government/foreign affairs/home affairs/defence, joint meeting with border district and provinces, individual country concept note, multi-country concept note and share with funding partners. Other steps are formation of regional CCM and regional PR, rapid assessment on the needs and gaps in coverage in the border districts, cross-border strategic plan and costed, project proposal, work plan, performance framework, monitoring and evaluation plan.

Factor of success are: advocacy, high-level political and policy support, linking to development projects; technically driven by the Research Institute, WHO; private sector financing, government financing, GFATM funding. Key challenges are: countries move with different speed (Swaziland and South Africa low malaria problem and leading and Mozambique is slow); remote areas and access to difficult field malaria centres; minority

tribal groups uptake of interventions, community mobilization; main push was IRS and not enough LLIN for sustainability; not enough parasite control; no adequate focus on cordon sanitaire 2 km free area barrier; no adequate focus on migrants and travellers; highly demanding project and technical management.

9. KEY ISSUES FOR CROSS BORDER MULTI-COUNTRY/REGIONAL/ SUBREGIONAL PROPOSAL TO GFATM - R 10

Dr Hoda Atta, RA/RBM/EMRO

Applicants should explain the overall reason for why the interventions described in the proposal are most effectively managed through a multicountry approach (whether cross-border or a regional initiative) rather than a single country approach.

It is expected that RCMs will have members of the CCMs of each country targeted in the proposal, to further support cross-collaboration with national programmes and remove the potential for duplication of work. It is also expected that members drawn from CCMs come from different sectors, to assist the RCM to maintain a multisectoral approach to membership. The members of each CCM must endorse a RCM proposal. Principle recipient(s) could be existing regional or locally operating institutions, other multilateral or bilateral development partners.

The proposal should include answers to the key questions: what are the key gaps in border areas; what is meant by border areas?; are the population on the border marginalized, what are the political, social and economic factors behind this?; what is the malaria burden in border areas?; what about detailed malaria epidemiology parasite species, vectors, and resistance status; what is the size and characters of the population at risk? What is the population's access to, and coverage of, the main intervention?; health facilities delivering malaria services in those areas; what are the main challenges and those related to neighbouring countries; key partners/community/nongovernmental organizations serving those population. Gap analysis in the border areas is needed at the beginning. Proposals should focus on activities that can not be implemented except together, if an intervention can be done separately it can be funded from ongoing grant by reprogramming or explore possible funding by other partners.

10. GROUP WORK FOR DEVELOPING THE FRAMEWORK OF THE CROSS-BORDER PROJECT

The participant developed the concept note for the project. The goal of the project is to contribute to the improvement of the health status in border districts and mobile populations of Afghanistan, Islamic Republic of Iran and Pakistan through reduction of morbidity and mortality associated with malaria. The general objective of the project is to strengthen coordination and collaboration to harmonize and scale up, towards universal coverage, malaria. Control interventions/activities in the border districts between Afghanistan, Islamic Republic of Iran and Pakistan.

The specific objectives of the project are to:

- establish coordination mechanisms and collaboration among the three countries, including establishing a functional system for information-sharing on malaria in the border districts, provinces and at the national level
- provide evidence-based information to guide malaria control strategies in bordering districts and provinces
- increase community awareness and community mobilization in border districts and mobile populations on malaria and its control, including promoting use of LLIN in mobile populations
- improve access and facilitate provision of quality assured diagnostic and treatment facilities for mobile populations and those who cross the borders at certain points
- strengthen the capacity of malaria control programmes in the targeted districts through joint training activities.

11. CONCLUSIONS AND RECOMMENDATIONS

The fourth malaria border control coordination meeting between Afghanistan, Islamic Republic of Iran and Pakistan was held in Islamabad, Pakistan from 29 September to 1 October 2009. During the meeting the participants held detailed discussions on the prevailing malaria situation in bordering districts/agencies of the three neighbouring countries, current needs of the poor and marginalized populations living in the border areas at risk of malaria and challenges faced by the control programmes, particularly related to high population movement and poor coverage of quality health services.

Considering the deliberations and recommendations of the previous three cross-border coordination meetings and the Kabul Declaration on Malaria, signed in April 2006, the delegations of the three countries highlighted the urgent need for strengthening collaboration. With this in mind the following collaborative activities were agreed upon.

- The Chancellor of Sistan and Baluchistan University of Medical Sciences and delegates from the Ministry of Health and Medical Education, Islamic Republic of Iran during the meeting offered to support 10 centres with malaria microscopy in three bordering districts in Baluchistan with the Islamic Republic of Iran that are not covered by Global Fund grants (Round 7) through provision of the necessary staff training, laboratory equipment and consumables.
- The malaria programme manager of Afghanistan requested delegates from the Ministry of Health and Medical Education, Islamic Republic of Iran, to explore the possibility of providing fellowships for a master's degree in public health for selected Afghani participants, and the manager of malaria control programme of Islamic Republic of Iran promised to follow up the issue.
- The participants acknowledged the commitment shown by the governments of the three countries to implement the annual plan of action of the newly-established PIAM-Net. The meeting agreed to establish a secretariat for PIAM-Net with a chairperson for 2 years on a rotational basis. The current chairperson is the national malaria programme manager of the Islamic Republic of Iran, and the secretariat of the network will be hosted and supported by WHO and the Ministry of Public Health, Afghanistan.

For strengthening coordination of malaria activities among the three countries and at the border areas and ensuring that PIAM-Net is functional, the meeting recommended the following.

1. Countries should develop a joint proposal for strengthening cross-border coordination and submit it to Round 10 of applications to the Global Fund to fight AIDS, Tuberculosis and Malaria. The proposal should focus only on joint activities to strengthen cross-border coordination in malaria control in the border areas and also to cover the needs which created/induced by cross border population movements and should not address country-specific interventions.
2. Funding for urgent country-specific needs for increasing coverage of malaria prevention and control interventions should be sought from national resources, existing Global Fund grants, or bilateral and other international development partners. This is of particular importance in the border areas between Afghanistan and Pakistan, where the available Global Fund grants do not include the total needs of those populations, resulting in a sizeable gap.
3. Countries should finalize the draft proposal concept note for the Global Fund, and submit the final concept note for endorsement by the relevant country coordination mechanisms.
4. Each country coordination mechanism should assign a proposal development team to facilitate the development of the joint proposal following the time-frame agreed in the meeting. It was agreed that the focal point for proposal development will be the malaria programme manager of each country.
5. WHO should provide technical support for proposal development, as necessary.
6. The roles and responsibilities of the PIAM-Net network, chairperson, members and secretariat should be developed by the chairperson in consultation with other members, and then should be endorsed by each country. Further support for the network activities and structure should be pledged as part of the joint proposal for the Global Fund.

Annex 1**PROGRAMME****Tuesday, 29 September 2009**

08:00–08:30	Registration	
08:30–09:30	Opening Session	
	<ul style="list-style-type: none"> • Opening Remarks from WHO/EMRO • notes from countries' CCM chairpersons 	<i>Dr K. Mohamud WR Pakistan</i>
09:30–10:00	Update on achievements and challenges of implementation of Roll Back Malaria in the Region	<i>Dr H. Atta</i>
10:30–11:15	Updates for antimalarial drug monitoring, status of resistance to ACTs and its containment strategies	<i>Dr M. Warsame</i>
	Briefing on WWARN perspective and progress	<i>Dr C. Sibley</i>
11:15–11:30	Discussion	
11:30–12:30	Country presentations on activities conducted in 2008–2009, including drug efficacy monitoring, ACT and RDT implementation, prevention interventions	<i>Country Representatives</i>

Tuesday, 29 September 2009

13:30–14:15	Issues and challenges in border areas: experience from the field	<i>Focal Points from border areas</i>
14:15–14:30	Update countries on use of serological techniques for conduction of malaria surveys: value, limitations, sampling design and data collection, analysis and interpretation	<i>Dr H. Atta on behalf of Dr Chris Drakeley</i>
14:30–15:00	Briefing on EMRO future plans for strengthening malaria surveillance and monitoring and evaluation and <i>World malaria report</i>	<i>Dr G. Zamani</i>
15:00–15:30	Experience of establishing border collaboration project between Afghanistan and Tajikistan Strengthening laboratory services in the northern area of Afghanistan with support from USAID	<i>Dr W. Butt</i>
16:00–16:15	Review of achievements of previous border meeting recommendations	<i>Dr Q. Kakar</i>
16:15–17:00	Future of PIAM-NET: administrative issues, securing funds for PIAM-NET, and plan for future activities including drug monitoring, research, capacity-building	<i>Programme Manangers</i>

Wednesday, 30 September 2009

08:30–09:45	Briefing on different aspects GFATM grants:	<i>Dr S. Murugasampillay</i>
	- Different modalities of grants particularly multi-country proposal	
	- Experience of developing multicountry proposal in other regions	
09:45–10:00	Discussions	
10:30–11:00	Brief update on current GFATM malaria grants in each country	<i>PR of each grant</i>
11:00–11:30	Discussions	
11:30–12:00	Concept of joint proposal and development of framework	<i>Dr H. Atta</i>
12:00–12:30	Discussion and feedback from CCM	<i>Dr M. Motamedi</i>
		<i>CCM Chairs and Vice chairs</i>
13:30–17:00	Group work on development of a concept and framework for joint proposal	

Thursday, 1 October 2009

08:30– 10:00	Group work on development of a concept and framework for joint proposal (cont'd)
10:30–11: 30	Group presentation and discussion
11:30–12:30	Group work on development of recommendations
13:30–14:30	Conclusions and recommendations
14:30	Closing session

Annex 2

LIST OF PARTICIPANTS

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