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GMAP2 "Action and Investment to defeat Malaria (AIM)" Regional Consultation Report
AFRO-Harare

Prepared for

Roll Back Malaria Partnership

Submitted by:

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Abbreviations

AIM	Action and Investment to defeat Malaria
ALMA	African Leaders Malaria Alliance
AU Commission	African Union Commission
CAMA	Corporate Alliance on Malaria in Africa
DFID	Department for International Development
GMAP	Global Malaria Action Plan
GNP	Growth National Product
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Nets
M&E	Monitoring and Evaluation
MOU	Memorandum of Understanding
NDHS	National Demographic and Health Survey
NEPAD	New Partnership for Africa's Development
OECD	Organization for Economic Co-operation and Development
PMI	President's Malaria Initiative
R&D	Research & Development
RBM	Roll Back Malaria Partnership
RDT	Rapid Diagnostic Test
ROI	Return on Investment
WHO	World Health Organization

1. Introduction

1.1 Consultation Overview

A total of 29 participants took part in the two day AFRO Regional Consultation held in Harare, Zimbabwe. Participants came from ten countries in the region (Ghana, Kenya, Mozambique, Nigeria, Republic of Congo, South Africa, Tanzania, Zambia, Zimbabwe) France and the USA. The meeting was facilitated by Dr. Nicolaus Lorenz, Dr. Sally Stansfield, and Ms. Molly Loomis, with assistance from Dr. Alastair Robb, Dr. Vanessa Racloz, and Dr. Andre Tchouatieu.

Conference participant list, agenda, and selected responses from group presentations are included as Annexes to this document.

1.2 Consultation Objectives

There were three main objectives for the consultation:

- Increase participants' awareness of the second Global Malaria Action Plan "Action and Investment to defeat Malaria" (AIM) purpose, process, and relationship with the Global Technical Strategy
- Validate feedback on the current GMAP and desires for AIM
- Gather participants' input on key topics of AIM

The key topics of the consultation aligned with the main sections of the AIM draft outline. They included:

- Developing a business case for malaria reduction and elimination
- Mobilizing people and resources for a malaria free world
- Accelerating action on the pathways to elimination – overcoming common bottlenecks and addressing highest priority issues
- Aligning GMAP2 with Global and Regional level mechanisms, processes, programs, etc.

1.3 Meeting Structure and Approach

The consultation was structured to first create a shared understanding of the AIM in the context of the original Global Malaria Action Plan (GMAP), the process of developing the Global Technical Strategy, and the current status of the fight against malaria. The meeting used a participatory approach to engage participants and solicit inputs for the AIM document. Plenary presentations provided an introduction and background information for key topics. Small group sessions allowed the participants to explore each topic in depth, examining both current realities and recommendations for the future.

Each of the three small group sessions addressed one of the main topics of the AIM document: Developing a business case for malaria reduction and elimination; Mobilizing people and resources; and Accelerating action on the pathways to elimination. In each session, participants worked in groups to respond to key questions on each topic. Their responses were posted on the wall for a Gallery Walk, during which each group reviewed the responses of other groups. After the Gallery Walk, the participants came together for a plenary discussion to analyse key points that emerged.

In previous consultations held in Panama and Brazzaville, participants were divided in small groups based on their constituency: Government; Private Sector; Civil Society; Development Partners; and Research/Academia. Participants' feedback from the Panama consultation indicated that there was too much time spent working in constituency groups, and not enough time discussing issues in cross-constituency groups. In response, the working group sessions were restructured for the Harare consultation. The second group work session was conducted in multi-constituency/multi-sectoral groups, and greater time was allocated to the plenary discussion for each session, to allow for more intersectoral/interconstituency analysis and discussion. For the first and third sessions, participants worked in constituency groups.

2. Results and Actions

Selected results from the group work are presented in Annexes 1-3. Each Annex contains an overview of the session and the questions discussed. The responses to some questions are presented as bulleted lists from each constituency group; other responses are presented as a narrative summary to better capture the discussion.

3. Analysis of Key Themes and Implications for AIM

Several major themes emerged from the group work during this consultation. Each of these themes is presented below, along with the implications for AIM. The themes are presented in Box 1. Many of these themes are consistent with themes that emerged in other consultations. Data has been a priority topic in all three consultation. The diverse range of constituencies' motivations for investment, and the relative lack of clarity about other constituencies' motivations, has emerged as a consistent theme. The importance of a domestic response was raised in both AFRO consultations. Lastly, the need to shift from a health-centric perspective of malaria to a multisectoral perspective was a significant topic across all three consultations. The importance of "Performance" and "People" received much greater attention in this consultation. Other themes from Brazzaville and Panama consultations (e.g. Leadership's role; elimination; refocusing accountability) were present, but less central to the Harare consultation.

Box 1: Major themes from Anglophone AFRO Regional Consultation

- Data as a critical factor in the response
- Motivations for investment as opportunity and conflict
- Domestic investments as an essential priority
- Moving multisectoral solutions from idea to action through research and advocacy
- Performance must be monitored
- People matter

Data as a critical factor in the response

The value of data was a recurring theme throughout all sessions of the consultation. Participants stressed the need for data to make the business case, and recognized that many types of data were needed to target the case to diverse audiences. In some cases, existing data indicators and data collection systems were in place and could be leveraged. For example: Government, Development Partners, and Civil Society highlighted current data collected on health indicators for malaria and some program indicators. Private sector noted existing productivity and financial data collected. In other cases, participants acknowledged that new indicators would need to be established and new types of data collected. For example: economic indicators, collaboration indicators, and qualitative data around "softer" indicators such as measuring image/recognition (Private Sector, Research/Academia) and the dignity of overcoming malaria (Civil Society).

Participants also noted challenges associated with data (e.g. it was of poor quality, not widely shared or used). For the Research/Academia group, there was a need to both fight data protectionism, and fight data piracy. Civil Society, Development Partners, and Government viewed data as a critical way to hold themselves accountable, hold others accountable. They also noted the value that all groups placed on recognition for contributions and achievements, and saw data as necessary to validate contributions and recognize achievements. Private sector and Development Partners viewed transparency of data and sharing of data as critical to an effective response, particularly a multisectoral or multi-constituency response.

- ***Implications for AIM:*** AIM could address the need for timely, correct, and transparent data in two key ways. It could present indicators that speak to the business case for various audiences. It could also present mechanisms to share data for various purposes once the business case is made. AIM could also highlight the many practical measures suggested by participants around data.

Motivations for investment as opportunity and conflict

The expected return on investment varied by constituent group. There was some alignment of expected returns (e.g. all groups cited better health, reduction in malaria, and recognition as important returns). However, the relative importance of these shared expectations varied across groups, and many expectations were unique to each group. For example: Private Sector was focused on financial gain and recognition from other players as a real partner, Government prioritized political gain, and Research/Academia highlighted personal and professional gain.

The response to these different expectations also varied by constituent group. Whereas some groups were critical of other groups' expected returns, others' accepted the differences as reasonable. Still others saw the different expectations as a way to leverage collaboration and generate action. For example, Development Partners questioned Government's priority for election results, and noted that lowering Malaria morbidity and mortality did not seem a priority action in other sectors. Civil Society noted that Government's focus on political return gave greater power to their votes. While all groups noted the importance of understanding other groups' incentives, Civil Society in particular noted the opportunity to leverage that knowledge to help achieve their own goals.

> *"Sometimes we don't know what we expect or understand the true value of our role. Often the concept of Return on Investment is not clear."*
>
> *Civil Society Participant*

- ***Implications for AIM:*** Collaboration between constituent groups and sectors is likely to be easier when groups understand others' expected returns on investment and can identify opportunities for a "win-win" proposition, in which both their and the others' expected returns are met. This win-win proposition strengthens the business case, facilitates consensus on actions, and can increase negotiating power. AIM can help audiences understand the rationale for each groups' expected returns and reduce resistance when one group's expected returns is different from another groups. By highlighting opportunities, rather than conflict, AIM can help constituent groups leverage these opportunities for collaboration.

Domestic investments as an essential priority

There was a wide range of investments noted by participants, and a high level of synergies between these investments. For example, Research/Academia, Private Sector, and Development Partners all invest in capacity building. Both Government and Civil Society are focused on service delivery. Participants noted the need to leverage these investments better (manage and maximize resources) and coordinate more effectively to gain efficiencies in the response. They also emphasized the need for greater domestic investment, and provided suggestions to make this a reality. For example: Civil Society identified an opportunity to use the African Union to mobilize and harness the resources of wealthy Africans, and to leverage the burgeoning African movie industry to create a social movement for malaria. Private Sector suggested using alliances like the Corporate Alliance on Malaria in Africa (CAMA) to increase Private Sector investment in malaria. Research/Academia noted that without domestic funding, external partners will continue to drive the research agenda.

- ***Implications for AIM:*** Investments seemed to be linked to concepts of empowerment and ownership. Greater investment was tied to greater ownership and greater power of decision-making and accountability. Understanding your investment was the first step to understanding the value you brought to the response, and to other stakeholders engaged in the response. Conversely, not understanding the value of our investments weakened our position. By demonstrating the value of all types of investments (not just financial), and highlighting the link between investment and power, GMAP2 can help national groups take greater ownership over the response, and hold one another accountable.

Moving multisectoral solutions from idea to action through research and advocacy

Participants highlighted prevention as a priority area for multisectoral collaboration, particularly prevention among hard to reach populations. They also identified natural areas of intersection between stakeholder groups as important opportunities for multisectoral collaboration. For example, participants noted that Military/Defence, Extractive industries, and Government agencies for housing, water, and agriculture, all have mandates aligned to malaria control/elimination and can take on a more active role in the malaria portfolio.

Many participants noted that frameworks are in place to support multisectoral action. However, according to participants, many of these exist on paper only. Civil Society noted that countries are often successful at setting up coordination mechanisms that everyone respects during emergency situations; however, this intense collaborative effort diminishes after the acute emergency recedes. Participants raised questions of how to make this work in reality, and about the role that in-country leadership had to play to make different sectors to work together. They also recognized the need to bring successful partnerships to scale, and noted proven strategies and success stories that could serve as a model for multisectoral collaboration on a larger scale.

Advocacy in general, and gaining the support of champions in partner institutions in particular, were seen as essential to make multisectoral action a reality. Other practical suggestions focused on systemic and institutional mechanisms. These included: joint planning, harmonizing goals, and assigning clear roles and responsibilities. Participants also recognized the relatively limited data around multisectoral action, and emphasized the need for operations research to better understand what works and what does not.

> *"In Madagascar, the malaria program flourished during the political crisis because we were able to mobilize 30 partners through joint planning. Every month, NMCP coordinated a meeting with technical representatives and partners. The participants provided information to the NMCP Manager, who made a decision and took it to the Minister.*
>
> *Success was based on dynamic leadership, the culture of the group, and a champion. Poverty increased, but the malaria program improved its outcomes and convinced the Global Fund to continue funding programs in Madagascar despite the political instability."*
>
> *Development Partner Participant*

- ***Implications for AIM:*** AIM can present practical suggestions to facilitate multisectoral collaboration, along with case studies and success stories where this worked, for example in Madagascar. AIM can also include suggestions for operations research that might be studied to improve collaboration across sectors. Country consultations will offer other opportunities to gather examples of multisectoral collaboration. The document review should include further analysis to see if data already exists around operationalizing multisectoral collaboration.

Performance matters

The importance of measuring performance was central to many discussions in the consultation. Participants noted the need for performance measures as a way to ensure value for money (Development Partners), as a way to convey their value-add (Civil Society), and as a way to hold themselves and others accountable (Government, Civil Society, Private Sector, and Development Partners). Participants also recognized the need for performance-based funding models that could be taken to scale, and highlighted some examples that might serve as models. For example, Development Partners noted existing performance-based programs in Rwanda. Civil society made a clear link between making the business case, generating performance data, and successfully engaging and securing investment from stakeholders.

> *"With a business case, you will know what to expect and will know if you're on track or not. Performance monitoring – documentation of what we have produced (outcome level) – that's data that can "sell". It is an important advocacy tool for visibility."*
>
> *Civil Society Participant*

- ***Implications for AIM:*** AIM can incorporate performance measures (indicators and data collection mechanisms) into the presentation of the business case. It can also provide

examples of performance-based programs that might be taken to scale, and illustrate how performance data is linked to effective advocacy efforts.

People matter

Throughout the consultation, participants highlighted the importance of communities and people. Civil Society noted the impact of malaria on individuals in terms of health care costs, loss of wages, and emotional stress of illness and of losing loved ones. Investments from most constituencies' addressed this burden. Private sector, Government, and Civil Society all provided services to directly reduce morbidity and mortality in communities. Civil Society's expected return on investment included reduction in health costs and lost wages; Governments' expected return included citizens' satisfaction.

People and communities also played a central role in the response to malaria. Civil Society saw the collective power of individuals and communities in holding Government and Private Sector accountable through voting and participation on advisory boards. Government and Civil Society recognized the power of champions to drive change, for example: community leaders can galvanize community actions, national opinion leaders can influence policies, and movie stars and celebrities can change social norms. Similarly, the Development Partners identified an action step to "work with people of influence to advocate for malaria". Research/Academia noted the importance of nurturing individuals to become the next generation of malaria researchers.

Participants identified several ways to engage people and communities in the AIM process and in the response to malaria. For example, one could build on existing contacts of social scientists to facilitate access to affected people to conduct research, or marketing organizations could be contracted to collect data on affected populations' ideas, concerns, and coping strategies. Community leaders could galvanize groups of affected individuals to speak with politicians to advocate for greater response to malaria.

- ***Implications for AIM:*** It is critical to increase engagement of malaria-affected individuals and communities in the response to malaria. The AIM development process can support that engagement by increasing their participation in country consultations and capturing their perspective through other mechanisms (e.g. community conversations, key interviews). The AIM document can highlight the benefits of engaging people and communities as a central part of the response. It can also provide practical suggestions (based on the findings from the consultations) on how best to engage them.

4. Evaluation

Before the wrap up and way forward session participants were asked to complete a 20 question evaluation either online or on paper that examined their experience during the AIM Regional Consultation in Zimbabwe. All participants elected to complete the survey online. Seven participants (24% of those attending) provided responses which were analysed using an online tool. A summary of the outcomes of this evaluation are below, including recommendations based upon the responses from participants to further improve the Regional Consultation process.

Overall, participants were positive in their feedback on the consultation. The majority of participants (100%) either strongly agreed or agreed that the objectives of the Regional Consultation were clearly communicated and met. In addition, 86% agreed that the Regional Consultation was well organized and that the time allocated to the plenary and the breakout sessions was appropriate. The majority of respondents (86%) thought that the sessions provided ample opportunities to participate and provide input, and all respondents thought the discussions were helpful for the development of AIM. In addition, all respondents thought the conversations during the breakout sessions provided information that is relevant to the development of the AIM.

The participants noted that the following issues should be given attention in AIM:

- Accelerating to Elimination
  - Make it clear to every constituency that just controlling malaria is not good enough and malaria elimination should be the goal for all
  - Elaborate the elimination pathway, further delineating the control/consolidation phase so that progress can be measured in that phase
  - A district rather than national focus for elimination
  - Elaborate supportive elements such as procurement and supply management
  - Emphasize behaviour change at all levels
- Mobilizing Resources
  - Use the opportunities for raising additional resources for malaria control and management such as Global tax reforms
  - Per capita investment should be the basis for estimating cost of malaria control
  - Make the business case for malaria based on a complex of economic and other considerations
- Engaging and Holding Stakeholder Accountable
  - Need for a multisectoral approach to malaria control programming.
  - Sufficiently take up the contributions from country consultations process and ensure that communities play a strong role in the country consultations
  - The importance of WHO in providing guidance and technical assistance
  - The need to stress accountability across the board for all stakeholders, not just countries implementing programmes
- Using Data
  - Quality data to inform all aspects of malaria programmes/data collection, processing, sharing and use must use the full potential offered by mobile technologies (e.g. every single positive is immediately notified by SMS)
  - AIM should include in the surveillance and response, a specific section on all aspect of data management

3. Next Steps and Recommendations

Overall, the consultation went well. Because each consultation will be unique—in terms of its size, range of participants, languages, regional culture, and context of the epidemic and response—not all lessons learned in Harare will translate to other consultations. However, many lessons do transfer and must be taken into consideration as we finalize the standard approach to regional consultations and country consultations alike. Below is a summary of recommendations to inform future consultations.

- **Continue to refine presentation content to clarify key concepts like business case and return on investment.** This was the first consultation conducted only in English. There was some discussion about the appropriateness of terms like “business case” and “return on investment”, which were associated with private sector. This indicated that this was not primarily a question of language but one of “culture”, and highlighted the need to further socialize it. Importantly, while participants have initially reacted to the terms business case and ROI, by the end of the consultation they seemed more comfortable with it, and did not think that there were better terms to replace these.

  The presentation in Harare highlighted that the business case was not only economic, and that there could be a humanitarian, or a political business case. This seemed to

make participants more comfortable with the term. However, in future consultations, more effort can be made to link the elements of a business case to the thought process we use to drive decisions and discussions we engage in every day. This will help socialize the concept.

- **Refocus discussion for Working Group 2 on resource mobilization.** In Panama, the questions for Session 2 focused primarily on mobilizing *people* across a *multisectoral* response. While this is important, it eclipsed a more general discussion on how to mobilize resources (including funding, supplies, and people) both within and across sectors. Because the participants of regional consultations have been primarily within the health sector but represent multiple constituencies, the discussions around working cross-constituency have been more productive than discussions around working multisectorally. In future consultations, it will be more effective to focus Working Group 2 on mobilization of resources in general, highlighting both multisectoral work and cross-constituency work. We anticipate that country consultations will have more representation from non-health sectors, and will be a better forum for discussions on mobilizing multisectoral resources and people.
- **Allocate more time to Gallery Walk and Plenary Discussion.** In this consultation, we formalized the process of the Gallery Walk – we walked around with our small groups and used specific questions to analyze the responses. Then we asked them to identify a few keys points from their analysis for the plenary discussion. This worked well – more participants participated actively in the Gallery Walk, the analysis was richer, and the plenary discussion was more engaging. This process should be adopted for future consultations. The main challenge we encountered was that this formal process takes more time than allowing people to conduct a Gallery Walk individually and doing a simple report-back in plenary. In future consultations, we will adjust the agenda to allow more time for the Gallery Walk and Analysis, and for the Plenary Discussion. We will also refine the directions so the three steps of the process are clearly presented.

Annex 1: Results of Breakout Session I: Developing a business case for malaria reduction and elimination

The first working group session focused on understanding the elements of the business case that are already in place, and the actions that need to be taken to strengthen the business case. The questions required participants to look at their own case for investment (what they invest, their expected returns, and how they measure those returns), and then explore the case for other constituencies' investment. The specific questions are in the box below.

Working Group Session 1 Questions

1. What are you currently investing in the fight against malaria? Please consider the full range of investments, not just financial.
2. What do you expect in return for these investments?
3. Do you measure the return on these investments? If yes, how? If no, how could it be measured?
4. What are the five highest priority actions that you need to take in order to build or strengthen your business case for investing in malaria reduction or elimination?
5. Considering the investments and expected returns proposed by other constituencies, where do you see areas of alignment or potential conflicts of interest?

Summary of Each Constituencies' Investments, Expected Returns, and Measurements

Investments	Expected Returns	Measurements
Civil Society		
• Provide services, social mobilization and disseminate key messages to increase demand for and uptake of interventions • Advocacy, through newspapers, champions that bring visibility to the response • Political activity, by voting for candidates that take action against malaria • Economic inputs, through out of pocket expenses and by taking lower-paying jobs in NGOs that address malaria • Monitoring data for programs	• Better services and healthier population • Economic gain: reduced out of pocket costs; reduced work absences and associated financial loss; stronger local economies that contribute to global economies • Maximize, better management of existing resources • Recognition of the role we play: higher status of communities that contribute, greater dignity when we've taken control of our situation • A world without malaria	• Access to treatment/services • Cost effectiveness (service delivery and Out of pocket expenses) • Per capita investment in malaria • Level of participation/ownership (formal devolution of responsibilities to communities). • School and work absences • Qualitative studies (e.g. dignity, recognition, acceptability) • Involvement/investments of non-health sectors in malaria (e.g. number of meetings with multiple sectors involved)
Private Sector		

Investments	Expected Returns	Measurements
• Development and provision of malaria commodities • Investment in capacity building (e.g. commodity use; training for practitioners, program managers; technical support: M&E for drugs, RDT, vector control) • Investment in employee health • Innovation for new technologies (e.g. mobile phone – SMS for health) • Marketing and communication expertise for malaria advocacy • Supply chain expertise for malaria commodity distribution • Initiatives to gather the malaria community together (e.g. CAMA)	• Financial gains (spend on other areas of investment rather than malaria) • Increase in productivity • Better image/recognition • Increase market penetration (e.g. mobile phone network)	• Yearly financial reports (Growth and productivity indicators; Health expenditure figures) • Measuring image is a challenge (e.g. How can companies be recognized for investing in malaria?)
Government		
• Tax incentives • Prevention and treatment services and commodities • Health infrastructure • Human resources (salaries and training) • Health insurance schemes • Development of other sectors impacting malaria (e.g. educations, roads)	• Political visibility • Economic development • Job creation • Increased productivity • Attraction of Foreign Direct Investment • Tourism • Citizen's satisfaction • National pride and credibility • Decreased mortality and morbidity	• National statistics (e.g. tourism, economic indices, NDHS, MIS, etc.) • Research • Surveillance • Media reports • Parliament oversight report • Surveys • Election reports
Research and Academia		
• Exact funding not known. 2012 G-Finder report estimates ~$540M spent on malaria R&D. Only 3.2 % from LMIC countries. • Most African countries count well below the 2% GNP expenditure committed. • Limited capacity building (mostly externally funded). • There is some funding for operational research issues. • There are major issues with research agenda setting, which is largely steered from outside countries	• Personal career advancement • Translation of research into policy • Patents • Increased funding for research	• Publication number and impact factor • Citations/contributions to policy documents and national/global strategies • Peer recognition
Development Partners		

Investments	Expected Returns	Measurements
• Funding (e.g. PMI, DFID) for programs and research. Tendency to fund Global Fund over bilateral funding mechanisms • Technical support, human resources, capacity building • Strategic planning support • Health system strengthening • Resistance monitoring (drugs, insecticides) • Global advocacy • Support to meet international environmental standards	• Quality data • Partnership and participation from Ministries • Stability, country accountability, transparency, corruption management • Proper and efficient use of resources • Greater 'independence building efforts' from countries in their developmental agenda • Improved trade and access to markets	• Malaria burden • Impact evaluation (economic and scientific). Malaria in pregnancy, IRS, ITN, case management. Child mortality as indicator. • Economic ROI is more attractive than health outcomes. (e.g. DFID must show its ROI to demonstrate that tax payers' money was properly spent)

What are the highest priority actions for each constituency?

Research and Academia

- Respond to priority gaps in tools and knowledge and threats to malaria prevention and treatment
- Encourage countries to lead national priority agenda setting to respond to local problems and enhance the use of layers of evidence for decision making
- Nurture high caliber local researchers through the right institutional, mentorship and funding support
- Strengthen linkages and collaborations between researchers, policy makers, institutions and wider society to increase the use of research evidence for decision and increase the visibility of research to lever domestic and external funding
- Foster regional networks and collaborations of research and academia to allow for exchange of ideas and experiences to address common problems

Civil Society

- Increase advocacy. Help people understand the potential and added value of civil society, bring awareness that we need to make a business case.
- Generate and use data in a timely way to demonstrate value for money and the impact of what we contribute.
- Increase coordination (e.g. have planning session and agree on expected results/return, and organize efforts for greater cost-efficiency within and across sectors.
- Hold stakeholders accountable, especially local government and private sector who profit from and often pollute our environment.
- Create community demand for services and support program implementation, particularly around community health workers
- Build capacity in technical areas and financial/resource management
- Reward performance to help keep people motivated to stay involved and keep focused on the business the case.

Private Sector Priority Actions

- Encourage and communicate incentives for malaria investments
- Build local evidence and communicate economic impact of malaria investment – specifically workforce productivity
- Reinforce malaria advocacy in the private sector (e.g. trade unions)
- Encourage the development of CAMA-like institutions at local level
- Create a formal recognition platform for private sector contributions against malaria

Government Priority Actions

- Improve the production and sharing of data regarding the burden of malaria and the effectiveness of interventions, including through reports to citizens on progress towards control and elimination
- Create policies and facilitate dialogue among stakeholders to accelerate action for malaria elimination
- Leverage regional mechanisms, opinion leaders outside government, and other high-level voices (e.g., ALMA) to remove the barriers to intersectoral action
- Establish national research priorities and identify funding to address these
- Build capacity within government and other key institutions to develop the business case and to use evidence for advocacy

Development Partner Priority Actions

- Generate more macro and micro economic impact data on malaria
- Analyze resource allocation
- Harmonize goals and priorities
- Improve use and quality of data
- Identify both malaria and non-malaria gains in control efforts (i.e. social, political)

Annex 2: Results of Breakout Session II: Mobilising People and Resources

The second working group session focused on mobilizing a multisectoral and multi-constituency response, and generating greater investment in the response to malaria. There were three questions posed to participants (see the box below). They answered the first two questions in mixed constituency groups, and answered the third questions in their constituency groups.

Working Group 2 Questions

1. What are the priority areas for multisectoral work? In other words, in which aspects of malaria reduction and elimination do we most need multisectoral action?
2. What are the most significant facilitators, or ways to overcome barriers to effective multisectoral action against malaria?
3. What actions can your constituency take to better mobilize people and resources within and across constituencies?

Question 1: "What are the priority areas for multisectoral collaboration?"

Responses to this question focused on two main topics: operational issues that needed to be addressed in order to make multisectoral action a reality, and programming areas where multisectoral action would have a significant impact.

Operational issues that need to be address to achieve multisectoral action:

- **Operations research.** The MAF is not operationalized. It's a political slogan, but it is not programmatic reality. It exists on paper, but we haven't been able to operationalize it. The big question that we need to work together on is "How do we do it?" We need to get the evidence for when it works.
- **Data.** Sharing data among stakeholders, particularly on programming. Alignment of reporting and harmonization of data collection. Information sharing, matching priorities and knowledge sharing.
- **Joint planning.** Strengthen or create collaborative and multisectoral planning platforms. Planning together in a common framework with a common objective, and harmonization of activities. There are multiple layers of implementation at country level. People are doing different things, or sometimes the same things, but are not talking to each other.
- **Situational Analysis.** We need to see what everyone is doing, what needs to be done, and then figure out what everyone's roles are (i.e. identify the mandate of each sector/partner). A successful example of mapping exist in the Democratic Republic of Congo.
- **Advocacy to engage other sectors.** Malaria is understood as a health/medical issue, which means that the doctor needs to deal with it. This isn't right; others need to be involved. We have the platform in most countries, but people don't see the need. The roles and responsibilities are established, but people don't follow it. We need advocacy to convince people to play their roles.
- **Develop leadership.** Country leadership is a critical first step. Then we can figure out platform and mechanisms to bring constituencies and sectors together. There are platforms we can leverage, so we do not need to reinvent things.

Programming areas where multisectoral action is a priority:

- **Education sector.** It's easy to reach a lot of people and conduct behavior change activities (e.g.

PMI is doing school based distribution of nets in Nigeria, Senegal). Work with Ministry of Education to adapt training programmes, curricula for diagnostic and case management and prevention.

- **Agricultural and extractive sectors.** Create more awareness around impact of agricultural irrigation, vector breeding sites. Workforce health/occupational health risk: mining areas are often particular risk areas.
- **Housing.** In Tanzania, the Ministry of Health and Social Welfare took an expanded view: if you provide subsidies for housing construction, you're improving health.
- **Hard to reach populations** (e.g. Prisons using IRS rather than bed nets)
- **Supply chain.** Use military services for transport.
- **Coordination** with regulatory bodies (for insecticides and other non-medical products).

Question 2: What are the facilitators for Multisectoral Action?

Responses to this question focused on four main types of facilitators: Availability of funding and other resources for malaria; Existing advocacy bodies/platforms; Partners with mandates aligned to malaria control/elimination; and Proven strategies and success stories to build upon. Discussion also highlighted critical barriers to multisectoral action.

Examples of **existing funding and other resources for malaria** focused primarily on public private partnerships. For example, the copper mining industry is collaborating with the MOH: industry covered the cost of indoor residual spraying and MOH provided technical assistance. The economic benefit of this partnership could be calculated and shown to the industry. Marathon Oil Company in Equatorial Guinea supports Malaria. MCP in Kenya initiated broad buy in of other sectors within national planning. In Eritrea, close collaboration with Military services helps ensures health services in the border areas.

Existing advocacy platforms and bodies highlighted governmental, regional, and multilateral, and global bodies. Regional and sub-regional economic bodies like the Lake Victoria Basin Initiative drive policies and work across partners. Parliament committees convene multisectoral meetings, and Heads of States advocate through entities like ALMA, AU commission, and NEPAD. Mechanisms such as malaria bonds can help convene private sector.

There are a **wide range of partners across sectors that have mandates aligned to malar**ia control/elimination and can take on a more active role in the malaria portfolio. Considering and articulating incentives for each partner will help engage them. Government agencies and departments that are naturally aligned to malaria control include those focused on: housing; water affairs; sanitation; environment/national resources; agriculture; education; roads/infrastructure; and tourism. Other partners include extractive Industries (e.g. Mining); local governments; Military/Defense; and community groups.

Throughout the discussion, participants noted **proven strategies and success stories** that could serve as a model for multisectoral collaboration on a larger scale. Strategic plans are in place and partners are working together. For example, Ghana has a multisectoral regional coordinator at the regional level – covers health, agriculture, and education. Uganda develop MOUs between NGOs, Governments, and Donors to make sure everyone knew what others were doing. Funding mechanisms like basket funding that DFID and others have contributed to were cited as examples to reduce competition between donors ("turf issues") and galvanize donors around the national strategy. PMI noted its work across constituencies (grants to civil society, procurement through private sector) and plans to fund activities directly through governments. Countries like Rwanda were highlighted as

examples of the strong governance that was needed, along with a clear evidence-based national strategic plan, and a clear financing framework. Someone in country must say "This is our country and our plan and you need to follow our plan".

Many barriers were also noted in the discussion.

- Competition was seen to undermine multisectoral collaboration: everyone is protecting their area, donors often push into areas where other donors are already working (turf issues), and it's difficult to share the recognition, because everyone wants to show that they did it.
- There is sometimes a lack of government leadership to execute the plan. For example, in Zambia, the government is understaffed and overworked, and health is not the priority. Technical working groups don't meet; there is not always a health desk for each ministry to link their activities to health programs. Health is not the priority in certain countries; it is a small piece of the domestic budget. Malawi estimated that they would have $2B for malaria, but developed a national plan that had a budget of $6B. That allows people to do things that are within the plan, but not highest priority. Sometimes in resource-constrained settings will accept any funding, even if it's not in the plan.
- Incentives and indicators – what we expect of people – don't always align with what we want them to do. We need new incentives to encourage collaboration, and we need to report on indicators for collaboration.
- In some cases, there is ignorance of the need to work together, lack of interest to work together, and lack of understanding of the multisectoral landscape.

Question 3: What actions can your constituency take to better mobilize people and resources within and across constituencies?

Governments:

- Invest national resources in obtaining quality data on disease burden across geographic areas
- Build capacity in developing a business case for malaria program
- Develop appropriate IEC messages for targeted advocacy for malaria
- Set appropriate policy to guide stakeholders participation in malaria programs and data sharing
- Incorporate all the above in national malaria action plans for business investment plan

Development Partners:

- Innovative fund resourcing
- Improving quality of funding management
- PMI should facilitate interaction, convene appropriate partners
- Global tax reform
- Develop an International malaria bond
- Work with people of influence (not only usual suspects i.e. religious leaders) to advocate for malaria

Civil Society:

- Document activities and outcomes. This can be a source of evidence for advocacy and lobbying. We need to be very thoughtful about what evidence is needed to convince stakeholders, and analyze that evidence to tailor messages to these groups.
- Quantify the impact of funding decisions in terms of mortality and morbidity.
- Coordinate with/deliver services to populations that the government can't reach because of political issues. Improve coordination across civil society organizations delivering the services.
- Support joint planning. In Madagascar, the malaria program flourished during the political crisis because we were able to mobilize groups (30 partners) through joint planning. Every month, NMCP coordinated a meeting with technical representatives and partners. The participants provided information to the NMCP Manager, who made a decision and took it to the Minister. Partners and Government agreed to work together and recognized this as a win-win situation. Success was based on dynamic leadership, the culture of the group, and a champion. Poverty increased, but the malaria program improved its outcomes and convinced the Global Fund to continue funding programs in Madagascar despite the political instability.
- Create a social movement. Be a voice for change, and hold groups accountable. Leverage Roll Back Malaria, ALMA, WHO, and local leaders to advocate. Roll Back Malaria in particular can play a heavier role at country level: it is recognized by Governments and is well respected. RBM can prioritize funding for countries without other partners, to help fund coordination meetings. WHO can play a role in technical areas.

Private Sector:

- Operationalize the multisectoral approach using the leadership of ALMA as the leadership for malaria should be at the heads of states and African leaders' level. This could be achieved through targeted advocacy by using the multisectoral framework document as a reference document to communicate and disseminate the idea.
- Come in as a coalition to face other sectors and take an active role in advocacy efforts by using private sector coalitions platform when they exist (e.g. chamber of commerce), or by creating theses coalitions where they do not exist.
- Lead innovation in housing to contribute in the fight against malaria i.e. Lake Victoria Basin Initiative.
- Play a role in the malaria component of the Nile Basin Initiative.
- Contract with NGOs to take part into the malaria battle.
- Use the Public Relation activities (breakfast, lunches etc…) as a platform for identification of joint priorities between different sectors. Avenues for exchanging experiences should be encouraged.

Research & Academia:

- Actively engage national programmes to identify data/evidence gaps, establish mechanisms/resources for filling the gaps, and consequently develop products to support national programmes.
- Establish or leverage research/academia platforms where data and research products and capabilities can be presented to the other constituencies to provide a forum for dialogue and exchange of ideas.

- Reform/revitalize academic institutions to undertake high quality research as key requirement for academic qualification and career progression to ensure a continuous pipeline of potential researchers.
- Harness private sector technology to develop operational research products for effective malaria control – e.g. mHealth.

Annex III: Overcoming bottlenecks to regional and country level action

The third working group session examined five questions focused on leveraging assets and overcoming barriers to accelerate implementation, and increasing accountability across all constituencies. Participants considered regional level and country level actions. Questions are included in the box below.

Questions for Working Group Session 3

- How could a regional or sub-regional response help to address the main challenges in progress towards malaria reduction and elimination goals in this region?
- What are the main implementation bottlenecks that prevent you from acting against malaria (at regional, country, or community level), even when you are engaged and committed to action?
- What are the top five priority actions that you must take in order to overcome implementation barriers and accelerate action towards malaria elimination in this region?
- To whom are you accountable when you implement activities against malaria? What actions can you take to strengthen accountability for your investments, actions, and performance towards the achievement of malaria reduction and elimination goals?
- What actions can you take to hold other constituencies more accountable for their investments, actions, and performance towards the achievement of malaria reduction and elimination goals?

Question 1: How could a regional or sub regional response help address the main challenges in progress towards malaria reduction?

The groups collectively identified multiple ways that a regional response is critical to malaria from a cultural, financial, political, and data perspective.

- **Mobilizing a cultural response.** We can leverage cultural movements such as the movie revolution and the growing importance of Nollywood and other African film industries. Movie stars and movie producers could advocate for malaria through their movies and through PSAs. We can use movies and celebrities across Africa to create a cultural shift and educate/make people aware that every death due to malaria is a failure because it's preventable. The movie makers are less bounded by politics – they can say things that WHO and Governments can't say.
- **Mobilizing domestic finances.** Regional initiatives would enable countries to better engage wealthy Africans like Mo Abraham or professional football players. The African Union could facilitate a platform to engage wealthy Africans to do what Bill Gates does – help them think health, think malaria. These rich people have very wide reach and influence: they have meetings with the presidents, and presidents want them to invest in their countries. These powerful individuals can invest their own resources and advocate for governments to invest more domestic funding (e.g. through matching or challenge grants).
- **Mobilizing a political response.** Regional efforts facilitate use of cross-country resources and platforms e.g. SADC, can support a common strategy, coordination, and sharing of good practices/ experiences. ALMA scorecard should be used as pressure system. This is particularly important to address cross border issues for regions that are moving towards elimination.
- **Mobilizing a data response.** Leveraging regional bodies and mechanism can help harmonize monitoring and evaluation data and tools, and support data sharing and harmonization to help programmatic issues. WHO, DFID, and others have supported the development of the African

Health Observatory, which has a platform for data sharing and mapping technology. Scientists can help monitor the epidemic when the MoH is not able to do the job. For example, Sub regional network have research and academia constituencies (e.g. "equineT"), and African health economists' network AFREA, address some malaria questions.

Question 2: What are the main implementation bottlenecks that prevent you from acting against malaria (at regional, country, or community level), even when you are engaged and committed to action?

Participants noted several and significant barriers that need to be address in order to accelerate implementation. These fall into the following main categories:

Bureaucracy. Government noted the administrative and political barriers to engaging the broad array of partners required to accelerate action. Civil Society noted difficulties gaining permission to implement activities, and highlighted the impact individual relationships (positive or negative) can have on administrative processes ("A personality can make it very difficult to get where you want to go"). Private sector noted the lengthy approval process to bring new tools / innovations to market, and the challenges this creates when "Me too" products are introduced.

Lack of leadership. Research/Academia noted that Principal investigators often northern hemisphere based, and Money/donors is driving the agenda. Development partners noted poor management, but said that despite mismanagement, development partners are hesitant to take on a 'problem area' from government since the exit strategy (returning ownership) is usually unsuccessful. Civil Society noted that people are often good technically, and they are promoted to managers, but they don't have management and leadership experience.

Lack of data. Private Sector noted Lack of information on investment figures in malaria, which is tied to lack of transparency of companies implementing malaria control programs, which contributes to mistrust of the Private Sector. Civil society indicated that we can't trust the data we have. We say that XX children die, but we don't know if that number is accurate. Government participants pointed out that existing data are often not well shared and used, either within government or among other stakeholder groups.

Lack of Technical Expertise. Private sector noted that Lack of technical expertise / information, which is a potential barrier for new players to make malaria investments. Research/Academia noted that Linkages to higher capacity non-African universities hampers regional collaboration, fostering North-South interaction, rather than south-South collaboration.

Poor health systems and infrastructure. Development Partners and Civil Society noted several challenges related to health system, including issues with supply chain management, human resources, and a culture where you have to be paid extra to do your job. Infrastructure is also a problem. There is no internet to transmit data, and there are no roads to get to treatment centres, so there are long walks to treatment.

Lack of domestic funding. Government noted the lack of evidence and human and institutional capacity to mobilize domestic funding. Development Partners noted the lack of consistency/stability in funding mechanisms and amounts funding as a barrier. Research/Academic highlighted that the Malaria research network is weak, because it is not formalized and not funded.

Other barriers included lack of coordination, lack of incentives to invest, conflict and competition among stakeholders engaged in the response. Civil Society also noted the threat of political retribution for raising issues with government or trying to hold people accountable. Speaking out can be seen as anti-government behaviour; people are afraid for their families. It is challenging to work in opposition zones. Civil servants in particular are afraid of speaking up.

Question 3: What are the top five priority actions that you must take in order to overcome implementation barriers and accelerate action towards malaria elimination in this region?

Government:

- Strengthen leadership and policy for improved governance and accountability

- Use quality data (surveillance) to make business case for local and national resource mobilization
- Engage other sectors with powerful advocacy tools in a coordinated manner at all levels
- Invest in human and institutional capacity to improve program management
- Leverage RBM, regional and donor support to catalyze these transformations

Research and Academia:

- Strengthen South-South and Programme collaborations.
- Strengthen grant-management capacities
- Strengthen postgraduate training of malaria scientist to be competitive
- Lobby for a Regional Research Fund (SADC)
- Improve research translation into policy

Private Sector:

- Increase transparency on costs/margins from the private sector
- Generate development and support, commitment from alliances (i.e. CAMA)
- Institutionalize accountability mechanisms to hold companies to targets (CAMA)
- Advocate for product development partnerships
- Take initiatives to implement activities and/or private-private partnerships for innovation

Development Partners:

- Stronger technical support
- Create sufficient external and internal funding
- 'Enforce' accountability (more country ownership, more performance-based approaches)

Civil Society:

- Strengthen the information system. For example, introduce the DHIS2 tool and provide technical support to carry it out at community level using malaria as an entry point.
- Build capacity for leadership and communication, recognizing that there can be negative consequences for speaking out against government. For example, have meetings with ministries to promote dialogue rather that hold press conference that will be confrontational.
- Negotiate with private sector to increase services (e.g. work with MTN to have services where you need them).
- Introduce policies to protect civil rights to speak out. In Nigeria, civil society is leading efforts to introduce a bill for freedom of information (it's now in parliament). Civil society held meetings with friendly parliamentarians (champions) and engaged the press/media to push it forward.

- Conduct joint advocacy. Encourage private sector to advocate through their CSR activities/PSAs. Use social media to promote films, musicians that are promoting our messages. For example, Bayer Corporation is partnering with a Nigerian musician (Moawomi) to make songs about insecticide spray. Harness religious groups and religious leaders to advocate for malaria.

Questions 3 and 4: What actions can you take to hold your own and other constituencies more accountable for investments, actions, and performance towards the achievement of malaria reduction and elimination goals?

Government

- Improve communication with citizens (hold media briefings to better present information)
- Use data to assess and report performance of districts to citizens and other stakeholders
- Conduct joint planning to identify roles and responsibilities for other sectors
- Document and share good practice with other stakeholders
- Provide recognition and reward for performing sectors
- Conduct donor mapping to identify funding and other gaps and procurement patterns

Civil Society

- Provide feedback to Government on its performance through a social charter based on constitution, political manifesto, workplan or budget. We can develop the social charter (articulate clear expectations) and then publish results of how well the Government is doing.
- Review Government budget from an equity lens, advocate for special interest groups that need more support (e.g. physically disabled, women and children). Publish feedback.
- Vote for politicians that are committed to working on malaria, and publicly recognize them when they achieve targets.
- Clearly define our expectations at the start, so everyone knows what we are holding people accountable for from the beginning. Tie expectations to advocacy and communication efforts.
- The first mechanism of accountability is participation. Plan together with other constituencies and negotiate expectations and include them all in the plan. Conduct joint field visits, monitoring and evaluation visits, joint mid-term review
- Put a community representation on Private Sector Advisory Boards.
- Conduct internal and external audit/evaluation mechanisms

Research and Academia

- Make sure that all policy decisions should be based on evidence. Depending on the quality of governance, scientists can make their point and influence policy.
- Demand transparency from government
- Fight data protectionism, and fight data piracy. Allow data access; support knowledge transfer.

Private Sector

- Increase transparency to promote accountability
- Institutionalize accountability mechanisms to hold companies to targets (CAMA)

Development Partners:

- Increase transparency (overheads) of Development Partners
- Conduct performance measure reviews (scorecard, such as OECD donors), based on specific region and activity
- Align accountability measures with business case
- Improve Development Partners' use of data to highlight input – output process
- Establish internal accountability measures (reviews, audits, world health assembly, regional committees) for Development Partners
- Establish performance-based funding mechanisms for fund recipient, and introduce the threat of changing recipients for those who do not perform
- Use media and civil society to influence relationship with government
- Use Development Partners' respective board membership positions more to improve accountability and performance
- Identify what works where and link it to technical guidance
- Development Partners should both support and challenge each other (e.g. make disagreements between WHO recommendations and government actions more public).

Annex 4: AFRO Agenda for the Consultation on the Global Malaria Action Plan 2

Day 1

09.00-09.20	Welcome and Introductions	Dr. David Okello / WHO-Zim Dr. James Banda / RBM
09.20-09.30	Housekeeping/Security	Dr. Gitonga Kathurima WHO-Zim
09.30-09.45	Update on the Global Technical Strategy process and outcomes of Harare consultation	Dr. Issa Sanou WHO-AFRO
09.45-10.00	AIM	Mr Alastair Robb DFID, AIM Task Force
10.00-10.15	Objectives, focus areas for the consultation	Dr. Nicolaus Lorenz AIM Consultant Team
10.15-10.30	Feedback on review of GMAP (findings from pre-consultation questionnaire)	Dr. Sally Stansfield AIM Consultant Team
10.30-11.00	Coffee break	
11.00-12:45	Breakout Session I: Developing a business case for malaria reduction	Ms. Molly Loomis AIM Consultant Team
12.45-13:45	Lunch & Gallery Walk	
13.45-14.30	Breakout Session I: Gallery Walk, Analysis	Ms Molly Loomis AIM Consultant Team
14.30-15.00	Plenary / Report back	Ms Molly Loomis AIM Consultant Team
15.00-15.15	Introduction to RBM/UNDP Multisectoral Action Framework	Prof. Munodawafa WHO-AFRO
15.15-15.20	Africa Progress Panel	Short video
15.20-16.15	Breakout Session II: Mobilising people and resources. Group work **across** constituencies	Dr. Sally Stansfield AIM Consultant Team
16.15-16.30	Coffee break	
16.30-17.15	Breakout Session II: Gallery Walk, Analysis in **constituency groups**	Dr. Sally Stansfield AIM Consultant Team
17.15-17.45	Plenary / Report back	Dr. Sally Stansfield AIM Consultant Team
17.45-18.00	Wrap up	Dr. Nicolaus Lorenz AIM Consultant Team

Day 2

09.00-09.30	Welcome and status summary	Dr. Sally Stansfield AIM Consultant Team
09.30-10.30	Plenary discussion: Making AIM work at global, regional, and national levels / Country Consultation input	Dr. Sally Stansfield AIM Consultant Team
10.30-11.00	Coffee break	

11.00-12.00	Breakout Session III: Accelerating action on the pathways to elimination	Ms Molly Loomis AIM Consultant Team
12.00-12.30	Gallery Walk	
12.30-13.30	Lunch	
13.30-14.15	Breakout Session III: Analysis Question	Ms Molly Loomis AIM Consultant Team
14.15-14.45	Plenary / Report back	Ms Molly Loomis AIM Consultant Team
14.45-15.00	Evaluation of consultation	Dr. Nicolaus Lorenz AIM Consultant Team
15.00-15.15	Wrap up and next steps	Dr. Sally Stansfield AIM Consultant Team
15.15-15.30	Official closure	Dr. David Okello / WHO-Zim Dr. James Banda / RBM
15:30-16.00	Coffee break	

Appendix 2: Overview of working group members

Country	Name	Organization
Tanzania	Mr Maximillian Mapunda	WHO Country Office
Zambia	Ms Chilunga Puta	MACEPA/PATH
Nigeria	Rotimi Sankore	Africa Health Human & Social development
Nigeria	Ms Chidi Ezigbo	Friends Africa
Tanzania	Dr Ntuli Kapologwe	Dodoma District Medical Officer
Nigeria	Dr Nnenna EZEIGWE	MoH
Tanzania	Dr Mandike Renatha	MoH
Tanzania	Bubelwa Ephraim	XXXXXXX
Zimbabwe	Regis Magauzi	PMI
Ghana	Melinda Hadi	Vestegaard Frandsen
Kenya	Edward Mwangi	Kenya NGO Alliance Against Malaria
Tanzania	Nick Brown	A-Z Textiles
Uganda	Mr Kabanda David	Center for Health Human Rights & Development
Congo	Kalu Akpaka	WHO AFRO
Congo	Kinvi E Boniface	WHO AFRO
Switzerland	Abraham Mnzava	GMP/HQ
Switzerland	Erin Shutes	GMP/HQ
Tanzania	Dr. Mohammed Ally	NMCP Manager
Zanzibar	Dr. Abdullah Ali	NMCP Manager
Ghana	Dr Fred Binka	Regional Expert
South Africa	Dr Rajendra Maharaj	Regional Expert
South Africa	Dr Halima Mwenesi	Regional Expert
Zimbabwe	Christie Billingsley	PMI
	Regis Magauzi	PMI
Zambia	Mark Maire	PMI
Mozambique	James Colburn	PMI
Switzerland	James Banda	RBM
Switzerland	Vanessa Racloz	RBM
	Alastair Robb	DFID/GMAP2 TF
Switzerland	Nicolaus Lorenz	SwissTPH
USA	Sally Stansfield	Deloitte
USA	Molly Loomis	Deloitte
France	Andre Tchouatieu	Sanofi / GMAP Task Force
	Davidson Mundowafa	UNDP
	Abraham	GMP
	Maragret Gyapong	GTS Steering Committee
	Lesong Conteh	GTS Steering Committee
Kenya	Abdisalan Noor	GTS Steering Committee
Congo	Sanou Issa	WHO AFRO
Congo	Diarra Tieman	WHO AFRO
Ethiopia	Dr Hiwot Solomon TAFESSE	NMCP Manager
UK	Dr Sylvia Meek	Regional Expert
Switzerland	Mike Lynch	GMP/HQ
Congo	Ameneshewa Birkinesh	WHO AFRO

Country	Name	Organization
Congo	Sambo Luis Gomes	WHO AFRO
Congo	Kasolo Francis	WHO AFRO
	Gail Stennies	PMI
	Abuchahama Saifodine	PMI