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Report 2nd wave Country Consultation on GMAP2 "Action and Investment to defeat Malaria (AIM)" in Ethiopia
14th November 2014

Prepared for

Roll Back Malaria Partnership

Submitted by:

Swiss TPH **Swiss Tropical and Public Health Institute**

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Abbreviations

ACT	Artemisinin-based Combination Therapy
AIM	Action and Investment to defeat Malaria
FMOH	Federal Ministry of Health
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GMAP	Global Malaria Action Plan
HDA	Health Development Army
HEW	Health Extension Worker
ICCM	Integrated Community Case Management
IRS	Indoor Residual Spraying
LLIN	Long Lasting Insecticide Treated Nets
M&E	Monitoring and Evaluation
MNCH	Maternal/Neonatal and Child health
P. falciparum	*Plasmodium falciparum*
P. vivax	*Plasmodium vivax*
PHEM	Public Health Emergency Management
PMI	President's Malaria Initiative
R&D	Research & Development
RBM	Roll Back Malaria Partnership
RDT	Rapid Diagnostic Test
ROI	Return on Investment
SBCC	Social Behaviour Change Communication
SDG	Sustainable Development Goals
SOP	Standard Operating Procedure
Swiss TPH	Swiss Tropical and Public Health Institute
WHO	World Health Organization

1. Introduction

The first of the 2nd wave country consultations was held Ethiopia. The consultation was convened by the National Malaria Programme of the Federal Ministry of Health of Ethiopia. The President's Malaria Initiative (PMI) provided the funding and local technical support.

The participants had received the 1st November 2014 draft in advance of the meeting. On the actual day of the consultation an abridged version of chapters 1-3 was used. The call for action and chapter 4 were reviewed in their entirety. Six different groups were formed to review chapter 4. Each group looked at a different section in detail. The table on the links between malaria and the SDGs was not included in the review. In addition to the group work, each participant was provided with an individual feedback form. It is anticipated that this form will be used to guide the feedback process during the public, online review and the consultation therefore provide a good opportunity to field test the approach.

The consultation was facilitated by Dr. Nicolaus Lorenz, of the Swiss TPH/Deloitte AIM Consultant Team. It was conducted back-to-back with a stakeholders meeting to "Strengthen Malaria Monitoring & Evaluation and Operations Research for enhancing Decision Making" (November 12-13). On 14th November a full-day consultative meeting took place with the same participants, complemented by some additional representatives, mainly from the private sector. The venue was the Dire International Hotel in Adama.

Over forty participants from different stakeholder groups took part in the consultation.

The objectives of the meeting were to provide country stakeholders in Ethiopia with the opportunity to:

- Help set the agenda for the next iteration of the Global Malaria Action Plan
- Discuss, comment and provide suggestions for improving the draft AIM document

2. Malaria Situation in Ethiopia

The information presented here draws on a near final draft of an "Evaluation of the Impact of Malaria Control Interventions on All-Cause Mortality in Children less than five years of age and Malaria-Specific Morbidity and Mortality in All Ages in Ethiopia 2000-2013", Federal Ministry of Health (FMOH) approval still pending and on information provided in the World Malaria Report 2013.

Malaria endemicity is low in Ethiopia; however still 60% of the total population are at risk of malaria. *P. falciparum* is most prevalent, although *P.vivax* causes approximately 40% of outpatient disease. The transmission situation varies widely from no transmission at all in parts higher than 2000m to high transmission areas. Contrary to other countries in sub-Saharan Africa malaria-associated morbidity and mortality occur in persons older than five years. The strategy is based on long lasting insecticide treated nets (LLIN), but also on indoor residual spraying (IRS). Ethiopia has made substantial progress in fighting malaria in recent years. Artemisinin-based combination therapy (ACT) and rapid diagnostic tests (RDT) use has increased dramatically. As a consequence there has been a substantial reduction of malaria associated deaths among all age groups.

Apart from domestic funding there is major external funding of the programme coming mainly from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and PMI.

3. Comments for the Call to Action

The Call for Action was considered as useful and overall well written. It was recommended to focus on the success and as far as Ethiopia is concerned on the efforts towards malaria elimination.

Participants also underlined the importance of referring more clearly to the quality of interventions and the role of research and technology. It was suggested that the role of endemic countries and their efforts could be more strongly acknowledged. In particular, the important role of communities as equal partners to the others mentioned should be stressed.

The benefits of malaria control for other vector borne diseases could also be elaborated. Either here, or elsewhere in the document, the challenges faced during implementation of the first GMAP (weak surveillance, entomological issues, logistical problems *etc.*) could be elaborated with suggestions on how AIM will address them.

4. Additions/Clarifications needed for Chapter 1:

It would help to have a stronger justification on why AIM is needed when there is now also a Global Technical Strategy. The text is not clear enough. As the draft strategy was not available there was some debate around the formulation of targets, or the way milestones should be formulated. It was suggested that incidence should be defined on the basis of confirmed/diagnosed rather than clinical cases; that subnational elimination targets should be mentioned and not just national elimination (i.e. Ethiopia). The measuring of progress for countries that have sub-national elimination targets but will not reach nation-wide elimination by 2030 should be clarified. The basis for selecting the elimination targets was also questioned and information on the underlying assumptions was requested (e.g. referencing GTS). Along the same line the assumptions for the quantification of LLIN, insecticides, ACT, RDTs etc. should be spelled out. The role of Social Behaviour Change Communication (SBCC) in the list of success/gains is missing and should be included.

5. Additions/Clarifications needed for Chapter 2:

The business language, and in particular the emphasis on the case for investment was well received. However, it would help to provide explanation/definition of terms like "ROI". The chapter should emphasize how investing in malaria brings economic benefits around poverty reduction, tackling inequalities. Also the positive effects of progress in fighting malaria for improving maternal and child health could be mentioned. Benefits of malaria investments on other sectors, health system, communicable diseases, other development sectors i.e. tourism, education should be made more explicit. Along these lines benefits, like an increase in school attendance, tourism, foreign investment, level of productivity at individual and community level should be mentioned. Also *P.vivax* should be explicitly mentioned *P.vivax* diagnosis and treatment strategies have to be taken into account in a context like Ethiopia, where *P.falciparum* and *P.vivax* co-dominantly exist.

There are important Ethiopian examples showing the potential of community engagement; The Health Development Army or the Health Extension Programme could serve as models for community engagement and mobilization (cost effectiveness of this sort of health worker infrastructure).

It is not clear to what extent the chapter should refer to other cross cutting interventions/services that may be cost effective – i.e. investments in health workers at a platform to decrease malaria and other health areas; savings due to SBCC –i.e. earlier treatment and diagnosis

The assumptions behind the costing of the global targets, as well as the cost-benefit analysis were also questioned and need to be explained. It was suggested that the document should be clearer about the negative impact that resource constraints will have on achieving the targets, whilst also outlining that the targeted reductions are cumulative and not incremental.

It was further requested if the global cost-benefit estimates could be broken down to country level and if these figures could also be made available somewhere[1].

In addition, more information was thought to be needed to explain why the 2007 baseline was selected for comparing the costs of inaction. It was raised whether the costs of inaction could be provided for each time period/milestone target and whether additional loses/impact on other development sectors – i.e. education, foreign investment, tourism, etc. could be taken up in the cost benefit analysis.

[1] This request is being discussed by the costing team and will be followed up.

6. Additions/Clarifications needed for Chapter 3:

Chapter 3 needs to be clearer about linking malaria with the sustainable development agenda in order to advocate for funding. The funding needed to implement AIM should be presented by year.

Some participants did not fully understand what is meant with “shifting political context”. However participants accept that there is a need for strong political commitment, stronger government systems, and responsive public sector implementation/good governance.

Other points raised included:

- Under the biological factors: the behavioral change of mosquitoes leading to more ecologically adaptive vectors needs to be emphasized
- Participants appreciate that improved housing is mentioned as a way to fight malaria.
- Capacity building is a necessity at all levels. The text mentions only subnational levels.
- Recognizing and rewarding innovation to encourage the private sector to invest more in R&D.
- There is a need to develop innovative SBCC strategies via multiple channels for the uptake of interventions; better maps it identify hot spots and foci of local transmission
- Need also to document failures of existing interventions and to draw lessons learnt for the second generation GMAP.
- The bolded sub-headings should be more concise.

7. Additions/Clarifications needed for Chapter 4:

A general comment that was made included that there are too many actions and that the document should rather focus on the most critical actions. It was also clearly expressed that some actions will have to change along the 2016-2030 timeframe. The actions relate to where a country/setting is on the continuum e.g. some countries may go from control to pre-elimination or elimination and need to reinforce or re-orientate its programmatic actions).

7.1 Partnering to achieve the broader development agenda

The actions proposed in this subchapter are generally considered to be useful; however it would be necessary to provide guidance on how conduct a stakeholder analysis. There is room to improve the input on incentives for different constituencies. Strengthening leadership for malaria partnerships should include the empowerment of youth and women. By standardising approaches it will become easier for countries to work together in regional initiatives.

7.2 Mobilizing resources for malaria

It is thought to be necessary to clarify which constituencies are expected to contribute and that a funding gap analysis should be called out as a specific action.

Many participants supported the need to increase domestic funding as compared to donor funding. In particular, it was suggested to highlight that countries need to become independent from external support and that communities should progressively be able to finance malaria control services themselves.

The target of Abuja declaration (increase government funding for health to at least 15%) has been set previously and some countries have achieved it. It was raised that it could be helpful to acknowledge those countries that have achieved the target, and encourage others to continue to aim for it. The potential to integrate malaria funding with other programs like ICCM, MNCH, and climate should be explored.

Uncertainties and emergency situations should be considered and options on how to deal with them should be presented. Participants recommended including some advice on how the media can be involved in awareness-raising.

Possible case study: In Ethiopia the Health Development Army and Health Extension workers (a total of 39,000) are contributing to the malaria control program. These initiatives show the commitment of the government to sustain malaria control efforts and to integrate malaria in the delivery of health services a primary care level. They are engaged in case management, vector control, and epidemic monitoring and response.

7.3 Improving policy and governance

Participants acknowledged that there is a need to stress the importance of political commitment. On the technical level countries need to adopt new tools faster once they have some level of endorsement from WHO.

Weaknesses of regulatory policies are a major obstacle and legislation needs to be more comprehensive. There should be banning of counterfeit/substandard drugs, banned insecticides, and inappropriate water management schemes. In addition it is recommended to involve communities and frontline health workers in the crafting of policies and strategies. There is a need for regular Policy Review/Evaluation and amendments if necessary. There should be sound evidence for any policy and strategy shift. It should be highlighted that there is a need to align poverty reduction policies with environmental, climate change, water and land use and social development policies including gender.

7.4 Strengthen and integrate in health systems

Governance is vital for strengthening health systems. Care should be taken that in addition to civil society representation also vulnerable population are adequately represented in governing bodies.

Stock outs are an issue, and solutions like networking of facilities to redistribute drugs and supplies should be mentioned. The potential to get communities involved in the disposal of expired drugs should be explored. The retention of skilled personnel should be addressed, and the potential of various incentive mechanisms could be presented.

Integrated Community Case Management has seen success in Ethiopia and could be used as a case study. Disaster preparedness should be taken up.

7.5 Putting people at the centre

It is good that the empowering of communities has been taken up in the document. One should refer to community participation also in the broader development sector and education sector. A possible example is the work of the Anti-malaria Association in Ethiopia.

The importance of SBCC is supported and acknowledged. Referring to Ethiopia the need for better coordination and marketing of SBCC efforts by FMOH is underlined. Once again the positive role of HDA and HEWs and grass roots organizations was mentioned.

Celebrities could become “malaria champions”. In particular religious community leaders or committees of religious leaders could be asked to endorse malaria leaders.

Attention should be drawn to the fact that technology most needed in Ethiopia (and probably in other countries as well) is not high tech. Much could be gained by using for example simple maps with grids at community level to target resources and interventions and SBCC and by sharing surveillance data promptly with partners at all levels.

The work of Public Health Emergency Management (PHEM) provides the framework for addressing domestic emergencies and could be a possible case study; UNHCR works with refugees along the

borders (Sudan/South Sudan) and responds when there are malaria outbreaks. However, the approach is very stand-alone and not very integrated. There is a need for a better WHO coordination for cross-border malaria issues. The example of polio could be referred to.

7.6 Innovate and strengthen/use the evidence

It is recommended to rephrase "Collect and analyse data to fill the information gap" with "Collect quality and useful data and analyze to fill the information gap"

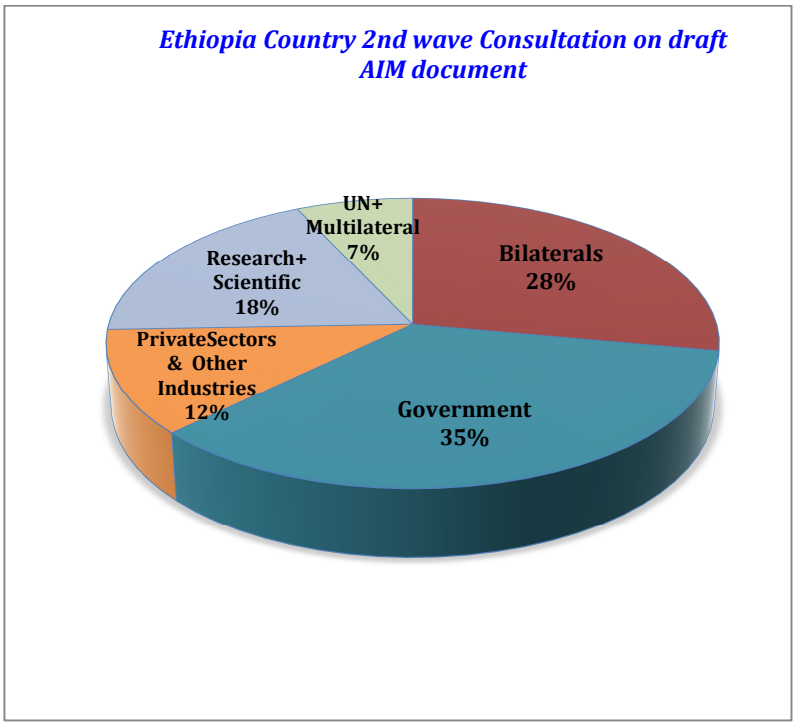
Additional actions such as the increase of the frequency and regularity of data collection, data quality assessment and reporting should be mentioned. It is recommended to rephrase the 3rd bullet to include archiving and dissemination.

Examples of innovative mapping could also be provided. In Ethiopia cases are visualized on maps of health facilities catchment areas. This "micro-cluster" technology makes use of spatial information in the data to define clusters of cases documenting foci of probable active malaria transmission. These dynamic maps represent a tool for HEWs to document and quantify areas within the community where malaria transmission is present, and allows them to prioritize their efforts at detection and prevention based upon data collected within the most recent 4-6 weeks to rapidly disrupt local malaria transmission events.

The Operational/Implementation Research – actions are useful. However, one should also mention basic research for new anti-malarial drugs, and new diagnostic tools and new delivery strategies. The need to strengthen capacity of national institutions to do research should also be stressed.

8. Assessment of the success of the consultative process

The country consultation was successful in bringing together various important stakeholders in Ethiopia engaged in fighting malaria. Government and bi- and multilaterals representatives constituted the most important groups. It is noteworthy that there was a comparatively strong presence of the R&D community and the Private Sector. Unfortunately, no representatives from civil society attended.



9. Conclusion

Overall, the consultation went very well, thanks to the excellent preparation of the FMOH and its development partners, in particular PMI.

The feedback obtained was positive overall and the working groups considered the document to be useful and on track to meet their expectations. There were numerous constructive comments. A preliminary analysis of the individual feedback forms confirms this view. It is particularly encouraging that numerous participants believed that the document will be useful for programmes at country level.

The report of the consultation will be posted on the RBM website and circulated to all participants.

10. List of Participants at the consultation on GMAP2 Action and Investment to defeat Malaria– November 14, 2014

NO.	Name	Organization	Responsibility
1	Meseret Assefa	Federal Ministry of Health	Officer
2	Mebrhatom Haile	Federal Ministry of Health	Officer
3	Gezahegn Tesfaye	Federal Ministry of Health	Advisor
4	Hailemariam Lemma	Federal Ministry of Health	Expert
5	Brook Tesfaye	Federal Ministry of Health	M&E Officer
6	Hiwot Solomon	Federal Ministry of Health	Malaria team leader
7	Asnakech Tadesse	Federal Ministry of Health	Secretary
8	Seife Bashaye	Federal Ministry of Health	
9	Alemayehu Worku	Addis Continental Institute of Public Health	M&E Specialist
10	Yemane Brhane	Addis Continental Institute of Public Health	Director
11	Seblewongel Lemma	Addis Continental Institute of Public Health	Senior Public health
12	Honelgn Nahusenay	Addis Continental Institute of Public Health	Program Manager
13	Dinsa Bedada	Sugar Corporation	Health Officer
14	Dr. Emawayish Teseno	Alert Center	Clinical
15	Dr. Meshesha Balkew	Aklilu Lemma Institute of Pathology	Researcher
16	Dr. Delnenasaw Yewhalaw	Jimma University	Researcher
17	Dr. Mekonnen Yohannes	Mekelle University	Researcher
16	Dr. Yemane Yihdego	Abt/IRS	Chief of Party
18	Samuel Girma	ICAP	Malaria Clinical Team Leader
19	Tesfay Abera	ICAP	Director MLDM Project

20	Dr. Gunawardena Dissanayake	USAID/PMI	Team Leader
21	Sheleme Chibsa	USAID/PMI	Malaria Advisor
22	Hiwot Teka	USAID/PMI	Malaria Advisor
23	Joseph Malone	CDC/PMI	Resident Advisor, and CDC Medical Officer
24	Asfaw Getachew	MACEPA	STA
25	Asnakew Kebede	PATH-MACEPA	SPU
26	Dereje Muluken	UNICEF	Health Specialist
27	Estifanos Bayabil	Health Development Ati-Malaria Association	Program Coordinator
28	Abere Mihrete	Health Development Ati-Malaria Association	ED
29	Aleme Wogi	TFHP	Malaria Advisor
30	Ahmed Ali	SPH/AAU	Instructor
31	Agonafer Tekalegn	MC	CD
32	Seifedin Beredin	Adami tulu Pesticide Processing S.Co	Entomologist
33	Goitom Mehari	Tigray Regional Health Bureau	Expert
34	Musa Ali Hussen	Afar Regional Health Bureau	Malaria Officer
35	Kemaladin Alfeki	Benishangul Regional Health Bureau	Malaria expert
36	Abdi Aliyi	Harare Regional Health Bureau	DPEC
37	Nebiyu Negussu	Somali Regional Health Bureau	Expert
38	Tsehaye Tewabe	Amhara Regional Health Bureau	Expert
38	Kebede Abelit	Dire Dawa Regional Health Bureau	Malaria Focal Person
39	Bayeu Belayneh	Bayer ES	General manager
40	Ambrose Anguka	Bayer ES	Business Manager

41	Harki Sahim	Vestergaard	AM
42	Ahanhan Zoceaire	RBM	Consultant
43	Prosper Chaki	IHI/RBM	Consultant

11. Agenda for the Consultation

Time	Session	
08.30-09.00	Official Welcome and Introductions	
09.00-09.15	Orientation to GMAP2/AIM including: • Overview of the Development Process (Task Force, regional consultations, key-informant interviews, document review, 1st wave of country and community consultations) • Link to the Global Malaria Technical Strategy • Outline/Summary of the draft AIM document • Purpose of Country Wave 2 Consultations	Dr. Nick Lorenz
09.15-10.00	Split into groups. Start to review the Call to Action, Chapter 1, Chapter 2 and Chapter 3.	Group work
10.00-10.30	Refreshment break and group photo	
10:30-11:30	Complete the review up to the end of Chapter 3.	Group work
11.30-12.30	Feedback on the call to action, and chapters 1-3.	Plenary
12.30-13.30	Lunch	
13.30-14.00	Brief introduction to the afternoon session and how AIM progress can be monitored	
14.00-16.00	Form 6 groups and review in detail one priority area of Chapter 4 (refreshment break is integrated in this session)	Group work
16.00-17.00	Feedback session (high level impressions – rather than details)	Moderated by Dr. Nick Lorenz
17.00-17.30	Personal feedback form	
17.30	Wrap up, next steps and official close	