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GMAP2 "Action and Investment to defeat Malaria (AIM)" Regional Consultation Report PAHO-Panama 3-4 April 2014

Prepared for

Roll Back Malaria Partnership

Submitted by:

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Prelude: A call to action from the Civil Society group

“Nothing is constructed overnight. Everything involves a process with its stages, its bottlenecks, its ups and downs. They say all roads lead to Rome, but all do not get to Rome. The weak give up too soon. And among those that get there, some will have forgotten the purpose of the journey
Examples of success, without exception, include elements of faith in the value of the undertaking and persistence. From the first vaccine to the eradication of smallpox there were countless cases of persistence. Persist, persist, persist! If you really want to achieve something, the key that opens every door has a name: Persistence
To persist for what we love, want or need, always convenes the "Law of Attraction". And this is that if we plant papaya, we should harvest papayas, if we exercise, we gain muscles, if we eat less we lose weight and would have better health.
To be clear, elimination of malaria is an undertaking of value. The goal is to keep the world free from malaria. The way is to do this sustainably is only possible with the key, “persistence“.
Well there are no magic formulas, no money for “silver bullets." Except persistence! Great athletes spend hours and hours of daily training. The magician performed his trick a thousand times before daring to the public. Scientists endure a lifetime before their hypothesis can be proved. Great writers read before, during and after writing.
The great loves, worthwhile, are characterized by a long persistence for the loved one.
Anyway, we all must “persist” to achieve our dreams and goals.
As for malaria, do we want to fool ourselves for a few weeks or months? The indicators of mortality and morbidity will shoot their truth if we don´t they persist on each of the fronts of this noble battle: research, anti-vector measures, epidemiology, drugs, an effective vaccine, social participation, in short, antimalarial integration efforts within our health systems.
Quitting is not an option in the fight against malaria. Persisting is an ethical imperative.
Zero excuses, just results! And now, now!

1. Introduction

1.1 Consultation Overview

A total of 52 participants took part in both days of the PAHO Regional Consultation held in Panama City, Panama. On day 2 there were 67 participants as some of those who had attended the P.vivax meeting which ran in parallel on the first day joined the second generation global malaria action plan "Action and Investment to defeat Malaria (AIM)" consultation. Participants came from 22 countries in the region (Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Guyana, Guyana Francesa, Haiti, Honduras, Jamaica, Nicaragua, Mexico, Panama, Peru, Paraguay, Peru, Trinidad and Tobago). The meeting was facilitated by Dr. J. Luis Segura, Ms. Molly Loomis, Dr. Helen Prytherch, Dr. Nicador Olbadia III, with assistance from Dr. David Brandling-Bennett, Dr. Eric Mouzin, Mr. Oscar Mesones Lapouble, Ms. Lisa Goldman and Dr. Vanessa Racloz. The conference agenda and participant list are included as Appendices to this document.

1.2 Consultation Objectives

There were three main objectives for the consultation:

- To increase participants' awareness of AIM purpose, process, and relationship with Global Technical Strategy
- To validate feedback on the current Global Malaria Action Plan (GMAP) and desires for AIM
- To gather participants' input on the four key topics of AIM

The four key topics of the consultation aligned with the main sections of the AIM draft outline and include:

- 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 AIM 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 Roll Back Malaria and its role, the Global Technical Strategy , the current GMAP and how AIM can build on it and the complementarity between the Strategy and AIM. 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.

There were three breakout group sessions to address three of the key topics: Developing a business case for malaria reduction and elimination; Mobilizing people and resources; Accelerating action on the pathways to elimination. The fourth key topic on the importance of aligning AIM with other global and regional processes was handled in the plenary. Participants worked in constituency groups: Government; Private sector; Civil Society; Development Partners; and Research/Academia. There were two Government groups, one working in Spanish and the other in English and French; and there were two Development Partner groups, one working in Spanish and the other in English. Each group had an initial discussion of a topic, and presented their results, which they later reviewed based on other groups' results.

2. Results and Actions

The results of the group work are presented in a condensed form in Annex 1. In each case the main discussion points from the three breakout sessions are presented, followed by the Priority Action points.

3. Summary of Key Themes and Implications

Below is a summary of key themes that emerged in the working groups and plenary discussions. These themes have implications for future data collection (to better explore and refine the themes) and for inclusion in the AIM document.

Alignment and divergence in investments: There were important similarities and differences in how the constituencies reported to be investing in malaria. Essential concepts put forward included:

Governments need to invest more in facilitating multisectoral and inter-institutional activities, and in building political alliances, and exercise their unique roles in providing leadership, and setting and enforcing policies.

Development Partners must enhance their ability to work coherently across sectors, to advocate for the strategic advantage of the Civil Society and the Private Sector, to bring together stakeholders, and to support Governments in facilitating an effective multisectoral response. They should use their leveraging capacity to foster multi-country/regional action, identify best practices and engage in high level political advocacy for malaria.

Development Partners and Civil Society Organizations (CSOs) need to align their efforts to stimulate community demand. It was pointed out that these were the only constituencies specifically investing in providing services to the most vulnerable populations, because e.g. focusing on the poorest or working in humanitarian relief.

The Civil Society group came to recognise that it is uniquely placed to reach remote areas and communities affected by armed conflict.

- ***Implications:*** There is a need for all involved to see the "bigger picture" of their combined anti-malaria efforts to facilitate the identification of gaps, duplications or scope for improved alignment. This "bigger picture" needs to reflect investments in both the Strategy and AIM to ensure it is fully complete. AIM needs to provide pointers as to what the "bigger picture" may comprise, to areas of common neglect or overlap, as well as examples of how countries have succeeded in refocusing their response to address them.

Motivations for investing in the fight against malaria: The motivations for investing varied considerably across the constituencies. Some of the reasons reported were a cause of surprise to the others e.g. that part of the reason that CSOs invest is to ensure their place at the "decision-making table", and that a major motivation for Research & Academia is to see research findings incorporated into national policies. The need to ensure that communities continue to invest in malaria-safe behaviour even as the number of cases drop was also highlighted.

Each constituency lacked enough clarity about why the others invested in malaria. This was closely associated with unrealistic expectations as to the role that each constituency could play in a multisectoral response. Resource & Academia flagged how they are often expected to produce results in unfeasible timeframes. The Private Sector considered there is an insufficient comprehension of its strategic advantages and of what would motivate it to invest more– e.g. not in deciding which LLINs to buy, but in offering their supply and distribution mechanisms to get them to the points of need, or to make new technologies or commodities available. The group reported often being approached with long and unrealistic requests for funding.

- ***Implications:*** The foundations for an effective multisectoral response can be more easily laid if all involved are familiar with the core mandate and interests of the other, as well as being aware of their motivation for investing in malaria. This knowledge will enable the malaria community to develop a convincing business case that others will buy into. AIM needs to provide guidance on how this knowledge can be generated as a useful complement to the Multisectoral Action Framework.

Strengthening multisectoral action for progress towards elimination goals: It was discussed that despite the frequent calls for a multisectoral response, the results of what joint action can achieve are not show-cased enough. Participants cited important examples of how countries in the region have made progress in tackling malaria at the intersection of health and agriculture, and are addressing malaria in migrant populations. The groups identified as facilitators of a multisectoral response factors such as: leadership by example; clear communication; the elaboration of a commonly held multisectoral agenda backed by a corresponding funding; the creation of coalitions and umbrella groups to facilitate the participation of all the constituencies; making realistic demands of others that align with their main mandate; a willingness to share information and decision-making; and recognition of achievements. The need to integrate malaria into broader issues that will define the coming decade,

like human rights and climate change, was further highlighted as an important way to reach a wider range of actors from different sectors.

Despite the encouraging examples shared, the challenges to multisectoral action were seen to be considerable, the transaction costs high and the incentives for stronger collaboration weak. It was highlighted that for the final push a more coercive approach may be needed with sanctions for failure to achieve public health or elimination goals. The example of the successful eradication of the screw worm fly was cited whereby the World Trade Organizations effectively forced countries to participate in order to be able to sell their meat and leather on the global market.

- ***Implications:*** AIM needs to address the challenges that frequently beset multisectoral action and provide suggestions and case studies on how they can be overcome at all levels. AIM could usefully describe possible ways to incentivize the multisectoral engagement of different constituencies, and how their input to joint results could be suitably recognised. An important example is the Malaria Champions of the Americas which has identified and documented 15 best practices of multisectoral malaria action in at least 9 countries. A short section may be included on the current evidence on performance-based incentives, their potential to enhance the value of malaria work and their possible pitfalls

Influencing political decision-making: There was scepticism on the part of some of the Government representatives regarding the use of the term "investing", the economic connotations of the term "business case" and doubts as to whether it could really facilitate the mobilization of more resources in their working context. It was underlined that health is generally perceived to be a cost and not an investment, that Ministries of Health and National Malaria Control Programs (NMCPs) are not politically powerful and that the budgets that are requested are routinely undersupplied. Questions were raised about how budgetary allocation processes that appear to be neither open nor transparent can be influenced. Interestingly, other Government representatives provided a contrasting view, describing how they could leverage the importance of the tourism industry to ensure continued investment in malaria. Outbreaks result in the creation of a travel advisory and a drop of visitors and revenue. The Private Sector group highlighted how there could even be scope for a global campaign with partners like TripAdvisor to give tourist sites a "malaria free" designation to attract international visitors.

- ***Implications:*** AIM needs to provide illustrative case studies and examples on how constituencies or countries have succeeded to influence political decision-making, for example the Suriname Malaria Board http://www.youtube.com/watch?v=7SfvwoqZSLM. However, AIM must also engage with the reality that influencing decision-making processes is never easy and often not transparent to avoid reinforcing a sense of powerlessness or creating disillusionment.

Economic data to support the need to invest in elimination: The data to make a strong current and future economic case for investing in elimination is not yet sufficiently available. This is in contrast to malaria control, for which there exists a solid body of evidence that major donors like USAID/PMI and DFID have used to convince their parliamentarians that investing in malaria control brings unprecedented returns in maternal and child health and in reducing poverty and inequities. When it comes to elimination, despite the important "public good" that this represents, data is in shorter supply, whilst the case becomes harder to make in the face of other priorities as the number of cases drop.

- ***Implications*:** AIM can mitigate this gap by framing investment in elimination as a way of protecting the investments made in controlling malaria to date, and of shrinking the map of potential drug and insecticide resistance. There are also other important justifications including that even in *P.vivax* areas malaria is a significant contributor to low birth weight and poor child health – investing in which are known to bring considerable returns.

Updating the "Malaria Control" focus of national programs for progress towards elimination: On several occasions, the need to update the current "Malaria Control" focus of programs to fit the future-looking needs of (pre)-elimination and the prevention of re-introduction was raised. In this context the need to balance the continued need for vertical programs with integration was also flagged. For the push for elimination dedicated programs continue to be needed at national level, with there being scope for some integration at sub-national level. Other elements stressed were the need to continue strengthening capacities, particularly in the areas of leadership, management, networking and supervision; and to strengthen systems to mitigate the loss of institutional memory due to high

staff turn-over. The importance of rewarding hands-on management and problem-solving at sub-national and village level, for mediating conflicting priorities, planning to avoid bottlenecks, and keeping the focus on surveillance and response was further underlined. Working to arrange joint staff training, activities and data sharing with national research institutes was further flagged as having the potential to improve the latter's responsiveness to program's needs and program staffs readiness to put research findings into practice.

- ***Implications:*** AIM needs to provide a roadmap on the future role of national programs as more and more countries and sub-regions move towards elimination, particularly amidst ongoing health sector decentralization and program integration processes. Moreover, guidance is needed on how all the constituencies can support national programs and Governments in general to garner stronger domestic and international political and financial support for sustainable efforts against malaria and the ultimate achievement of elimination goals.

Exploiting the full potential of a regional approach: The important role that regional collaboration play in polio and onchocerciasis eradication programs was raised. Many areas were identified where efficiencies could be gained from stronger regional collaboration in the fight against malaria, such as containing resistance, strengthening cross-border surveillance, for the joint procurement of drugs and supplies, for research and for advocacy. In the Americas there is a well-established and functional Amazon network for the Surveillance of Antimalarial Drug Resistance (RAVREDA). It was highlighted how resources including technical assistance, access to experts and reference laboratories could be arranged regionally. There are also many economic and political bodies like ALADI and CORICOM that could be leveraged to increase the visibility of, and investment in malaria. It was also noted that Development Partners are starting to take a more regional approach. PAHO has a regional mandate and a strong regional network. The Clinton Health Access Initiative (CHAI) advises the Council of Health Ministers from Central America and the Dominican Republic (COMISCA), and the Global Fund is financing the Elimination of Malaria in Meso-America and the Island of Hispaniola (EMMIE) Initiative.

- ***Implications:*** The Americas have many regional bodies with well-established histories and there is an important long-lived tradition of working regionally, with experiences that could form the basis of case studies in AIM. In addition, the progress of EMMIE needs to be monitored as this is a potential future elimination funding model.

Aligning accountability for common malaria elimination goals: The discussions around accountability were closely linked to the issue of clarifying roles and expectations, as well as monitoring and evaluation (M&E). Governments were seen to have a key role to play in clarifying a common M&E framework that all stakeholders could buy into. Whilst Development Partners and Donors like the Global Fund were seen to have a strong influence on the definition of such framework, the involvement of CSOs, Research & Academia and the Private Sector was seen to need strengthening. Indeed, in the Americas it was considered that the alignment of goals and strategies across countries and the region as well as optimal use of common malaria M&E frameworks across the Region have been key to current strong progress. The challenge of non-alignment of accountability was broadly recognised, although in the discussions it was realised that even where formal lines of accountability did not exist, influence could be brought to bear. The accountability to communities was also discussed. Although Governments are accountable to their citizens, it remains a sad reality that those most affected by malaria carry the least political weight. A two pronged approach of continuing high level political advocacy, whilst working to strengthen platforms for community participation and stimulate bottom-up demand for new products and quality services was seen to be needed.

- ***Implications:*** Lines of accountability are often narrowly construed in the first instance. However, by leveraging the motivation that each constituency has to invest in malaria, defining a common M&E framework, and clearly agreeing roles and responsibilities, the lines of accountability can be redrawn. The AIM document needs to provide examples of possible leverage points and show how mutual accountability for investment, action, preparedness and the (non) achievement of regional or national elimination goals can be strengthened.

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 Panama. Paper versions of the survey were

> "*Malaria needs to be seen in a regional, multinational perspective and the discussions today encouraged me that here in the Americas we are on the right track"*
>
> Regional Consultation participant's feedback

circulated on day two of the Regional Consultation. Thirty one participants (60% of those attending both days) 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 (93%) either strongly agreed or agreed that the objectives of the Regional Consultation were clearly communicated and met. In addition, 90% agreed that the Regional Consultation was well organized. All of the respondents agreed that the sessions provided ample opportunities to participate, however there were concerns that the groups did not talk to one another enough, that the health sector was overrepresented, that the Civil Society and in particular Private Sector groups lacked participants that really belonged to these constituencies, and that too much time was spent in groups. In particular, the third breakout session on day two and the questions about accountability caused difficulties.

> *"I love that a big picture, multisectoral and regional approach is being taken for AIM…..It is commendable that we looked at topics like the business case, advocacy and social movement. However, in actually discussing what that looks like we realize just how difficult it is to do…"*
>
> Regional Consultation participant's feedback

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

- AIM must underline the essentiality of addressing malaria in vulnerable populations particularly migrants who are often at high risk. Only by ensuring malaria prevention, diagnosis and quality treatment reach these groups can elimination goals be achieved.
- Information management and data: AIM needs to address several aspects including how information is managed in a multisectoral response, and how information is managed in the drive for elimination where investigations are needed down to the household level. Guidance is needed on the use of data between constituencies and, the sharing of data between the information management systems of different countries in the elimination phase.
- There are already well developed tools and approaches on how to strengthen work across sectors, for example the ecosystem approach. AIM could contain a short reference section.
- There isn't a one-size fits all solution. Guidance on dynamic problem-solving needs to be provided. If it proves not to be possible to cover all levels and contexts then any limitations in scope should be highlighted at the outset of the AIM document.

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 Panama will translate to other consultations. However, several were thought to be relevant and were acted upon.

- ***Refine the structure of the working groups.*** There was concern that the groups did not spend enough time talking to one another and spent too much time discussing as a constituency. It was therefore decided to only use the constituency groups for the first group session. For the second and third breakout sessions multisectoral groups will be built and participants asked to "defend" their identity which should liven up the exchanges.
- ***Further refine presentation content to clarify key concepts like business case and return on investment.*** The consultation showed that this was not primarily a question of language but one of "culture" and that there were concerns about its applicability in the context of the Americas. The Development Partner groups also flagged that the focus on the business case should not cause us to lose sight of other reasons for investing in malaria – human rights, poverty reduction and to improve health and reduce suffering.
- ***Refocus breakout two to ensure the issue of resource mobilization receives more attention.*** In both Brazzaville and Panama the issue of raising additional funds was eclipsed by the discussion on how to engage stakeholders and work multisectorally. To address this, the questions and requested action points were reweighted to increase the focus on how to mobilize resources and the challenges and experiences of so doing.

- ***Provide more feedback on how the current GMAP has been used.*** Beyond the survey results more concrete evidence was asked for eg. citations etc. An effort will be made to find this information.

- ***Use of group work facilitators and the Gallery Walk.*** The introduction of group work facilitators worked well and has been adopted. A guidance sheet for the facilitators was prepared. The Gallery Walk was not fully exploited to highlight differences between the constituencies and focus discussion upon why those differences exist. Steps will be taken to address this from now on.

- ***Allow countries more scope to share experiences or possible case studies.*** In Panama a large number of countries were all in one Spanish-speaking Government working group. The participants did not feel that they had sufficient forum to share examples from their countries. It was decided to introduce an "idea collector" where participants could share lessons learned or potential case studies re. creating an effective multisectoral approach, strengthening accountability, engaging new stakeholders or mobilizing additional resources and provide a contact for follow up by the AIM Consultant Team.

- ***Ensuring that a critical mass of participants follow both the Global Technical Strategy and the AIM discussions.*** It was highlighted that as both documents are under development and many topics will be addressed by both there is a need for a critical mass of participants to follow both discussions to ensure alignment and optimize synergies.

Annex 1:

1. Results of Breakout Session I: Creating a business case for malaria reduction and elimination

1.1 What each constituency is investing in malaria

Governments invest in malaria financially by providing a budget for programs, staff (salaries, benefits), for infrastructure, laboratories, drugs, commodities (bed nets, insecticides etc.), for malaria-related activities including vector control, canal draining, epidemiological surveillance and wider health information and planning systems. Governments also provide health care to their populations, including health promotion, malaria prevention and treatment services. Furthermore, they invest in facilitating multisectoral and inter-institutional activities, and in political alliances ranging from the Global Fund to the Peace Corps. It was flagged that in the last instance the budget allocation to health is decided by the Ministry of Finance and that the actual allocation often falls far below the sum that is required and requested.

Development Partners provide funding for broader poverty reduction or sustainable development. Investments are also being made in Health System Strengthening as countries move towards Universal Health Coverage, or via funding allocated specifically to malaria programmes. It was noted that funding is declining as technical cooperation is considered more appropriate in the LAC region. This covers knowledge, know-how, expert time, capacity building, transfer of technologies, it may involve investing in scientific or implementation research, and depending upon country presence might also include infrastructure, equipment, or logistics. It was further noted that Development Partners invest in advocacy, and that their reputation often makes them well placed to convene actors, open spaces for discussion, identify best practices and to facilitate multi-country coordination and South-South learning. Development Partners also invest in the private sector via Product Development Partnerships to stimulate further investment and markets.

Civil Society invests time and technical support in the implementation of malaria-related activities mainly in terms of health education, malaria prevention and strengthening of community health workers to diagnose and treat those affected. Civil Society also works hard to engage communities to demand better health services, including for malaria. This is often done on a voluntary basis. More formally, Civil Society invests in playing their role on municipal health committees. The work of Civil Society is essential to reach those in remote areas or communities affected by armed conflict.

The **Private Sector** invests in workers' health, in commodities (Long-lasting Insecticide Treated Nets (LLINs), Rapid Diagnostic Tests (RDTs), logistics (vehicles), infrastructure and partnerships e.g. Public Private Partnerships with Ministries of Health, the Global Fund to Fight AIDS, TB and Malaria (GFATM). It also invests in innovative product development. More generally, the private sector works to strengthen economic development which may amount to an important indirect investment in the tourist sector or health systems.

Research & Academia invests time and the funding they receive for malaria research, some research institutions generate their own funds that they may re-invest. They also invest infrastructure, equipment and work with partners to build local capacity.

1.2 Expectations of return on these investments

Governments invest in malaria to improve the health of their populations and by so doing to gain political mileage and positively influence public opinion. In addition, sectoral line ministries are motivated to invest for technical reasons and to have data to track progress. The Caribbean countries stressed that Governments invest to protect their tourism industry as any outbreak results in the creation of a travel advisory.

Development Partners expect their investment to lead to a decrease in poverty, progress in achieving the MDGs, improved productivity in agriculture and education, improvements in quality of life, stronger county leadership, better quality health care, greater equity, sustainability of projects/programs, strengthened national capacities, a furthering of the national interests of the cooperating country and a reduction of dependency on international cooperation.

Civil Society expects a return in terms of recognition for the time that community volunteers invest and for bringing services to those in greatest need. Moreover, Civil Society acts in the expectation that it will participate fully in the work processes aimed at controlling and eliminating malaria.

The **Private Sector** invests to create healthy, satisfied and productive workforces. It also invests for the sake of its public image, for reasons of corporate social responsibility and to enhance community relations. In Guyana, for example, the mining industry was blamed for increased malaria and keen to mitigate this. Other expectations include fiscal benefits like tax breaks/removal of barriers and red tape.

Research & Academia expects the translation of findings into policy and practice, acknowledgement, publications, data exchange and feedback, facilitated collaboration with Ministries of Health, recognition at local, national and global level. Further expectations that were discussed included the transfer of technology and knowledge, the development of new tools and strengthening of partners' capacity.

1.3 Measuring the investment

In some countries it was reported that **Governments** collect and report costs and outputs for budget implementation control, rather than to assess the return on investment. Others reported having Monitoring and Evaluation officers, some of whom had been introduced in the context of GFATM programs. Yet others have undertaken cost/effectiveness assessments. In national programs very specific malaria indicators are used including the number of parasites, cases, exported/imported, geographical trends in outbreaks, elimination status. This data has to be provided so Ministries of Health can see the program is meeting its target and deserving of the funding they request. Other data that is collected and considered include tourism statistics/travel advisories, health care costs (national insurance, social services) and out of pocket expenditure.

The **Development Partners** reported that if the funding or support is for national programmes then the targets and means of measurement are generally quite clear cut. However, the notorious difficulties of measuring the impact of technical cooperation and capacity building (attribution gap) were also raised especially in "low malaria incidence" and "at risk of malaria" contexts.

The **Civil Society** Group reported that at community level little measurement is done, although studies could perhaps be commissioned. Larger Civil Society Organizations (CSOs) are called upon to measure and report their investment in their funders. The Private Sector measures the return on its investment in terms of productivity, profitability, product development, economic growth, community development, household incomes and increased tourism.

The **Research & Academia** Group reported measuring its return in terms of the number of grants received, publications in journals and their impact factor, the development of new tools and strategy, as well as through the extensiveness of their networks and alumni associations and more indirectly through the impact that research findings have on policy choices and indicators, although there is scope to improve the methods available to assess this objectively.

1.4 Investment Gaps

The **Government** groups highlighted gaps in the areas of monitoring and evaluation, capacity building, health promotion and facilitating multisectoral and intersectoral collaboration. Funding gaps for scientific research into high impact issues (e.g. how climate change will impact on malaria and progress to elimination in the region) was also underlined. Impartial technical advice was also found to be lacking (e.g. on which brands of RDTs to bulk purchase). The groups then reprioritized their investments to focus upon: strategic alliances; trans-border activities; inter-sectorial coordination; including at the intersections of health/agriculture (e.g. certain crop strains reduce vector load) and of housing/urban planning etc.; ensuring policies are in place so they can be legislated for and enforced.

The **Development Partners** identified a gap in building political commitment for malaria and related issues (eg. public good nature of elimination) through global advocacy and reflected that this constituency has a particular responsibility to increase its investments here. They also observed a funding gap for research in the areas of diagnostics, vaccine development and other innovations to get to elimination, and saw the need to invest more in coordination to bring Ministries of Health and the Private Sector around the table. Efficient service delivery was also highlighted as an area where there is not enough investment. The Development Partners appreciated that the Government groups also drew attention to the need for domestic funding for malaria which, although challenging is something that funding mechanisms, including GFATM are now increasingly calling for.

To ensure continued investment in malaria for the long term timeframe that is still required the Development Partners discussed the importance of framing this in terms of protecting the investment that has already been made. Continued investment to reach elimination can also be framed in terms of

the contribution it will make to shrinking the potential resistance map and containing global resistance. For the Bill and Melinda Gates Foundation (BMGF) – the best protection of investment in malaria control is to get to elimination. Control cannot be invested in for ever. People will get tired of it. History shows us – and quite specifically the history of the America in the 1980s and 1990s - that if investments in malaria control stop too early then it will resurge.

The **Civil Society** group realized that there was an important investment gap regarding impartial outreach to migrant or dispersed populations and refocused their investments and actions to reflect this. In addition, the group came to recognize the important role the other constituencies consider Civil Society plays in global advocacy.

The **Private Sector** identified investment gaps in orchestrating communication and coordination between public and private sectors and the constituencies, in resource mobilization and the creation of incentives for Governments to achieve public health goals (bonuses, credits, performance based prizes etc.), as well as a lack of political alliances in the Americas that are specifically focused on malaria (ALMA, APLMA).

Having viewed the investments being made by the other constituencies, **Research & Academia** refocused their investments to providing knowledge on social/cultural aspects of communities for sustainability of interventions, developing an evidence base to demonstrate the economic advantage of elimination and to developing new tools/strategies for elimination (MalERA). They would seek to invest more in interacting with national programs and communities when defining the malaria research agenda.

1.5 Priority Actions from Breakout Session I:

The Government Groups prioritised:

1. Stronger advocacy at highest level
2. Strengthening technical capacity and build capacity for operating in terms of a business case approach
3. Collection and analysis of information
4. Requesting technical assistance or researchers as needed to interpret/generate data needed to make a convincing business case
5. Ensuring greater domestic funding for malaria

The Development Partners Groups prioritised:

1. Defining the control/elimination/avoid re-introduction scenario for which the case should be made
2. Pulling the needed data together – also from other sectors like agriculture, education – case studies (eg. Bahamas and Jamaica make a huge investment to stop/reverse reintroduction), and ensure it is used for evidence-based decision making and priority setting
3. Identifying best practice
4. Facilitating alignment between Global and country level guidelines
5. Demonstrating what happens if we stop investing – may involve commissioning research.
6. Working to enhance cooperation between constituencies and countries, align interests towards the business case
7. Ensuring continuity of investment to ensure sustainability (don't drop the ball too early) e.g. institutionalization of an innovative approach or tool takes more and longer support.

The Civil Society Group prioritised:

1. Researching the impact of community volunteers efforts to improve malaria prevention, early care-seeking, correct diagnosis and quality treatment
2. Investing in communication for behavior change
3. Strengthening leadership to sensitize decision-makers about the strategic advantage of working with CSOs
4. Promoting the creation of organizations and networks of civil society organizations working on the issue of malaria.

The Private Sector Group prioritised:

1. Documentation of best practices in Americas region
2. Assessing/communicating the cost of malaria to business and cost-savings from malaria control
3. Providing incentives for business to invest in health/malaria
4. Spreading information/tool box to get businesses involved eg. WEF/UAM/Malaria Safe Guidelines http://www.k4health.org/toolkits/united-against-malaria/guidelines-employer-based-malaria-control-programmes

The Research & Academia Group prioritised:

1. Creating evidence of the economic benefit of elimination
2. Developing new drugs and commodities
3. Working to overcome the English language bias in publishing so that examples from the Americas can reach a global audience
4. Involving communities more closely in the development of implementation to ensure socio-cultural acceptability.

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

2.1 Expectations that the constituencies have of one another

The **Government** Groups thought that all the other constituencies generally expected the ultimate responsibility for malaria to lie with them, specifically with the Ministry of Health. It was felt to be a reasonable expectation that Government provide leadership in convening actors from across sectors or ensuring that information is shared. Moreover, it was discussed that it is the role of Government to provide plans that other stakeholder can buy into, but that Government itself must be reasonable in the expectations that it makes of the other constituencies regarding implementation.

The **Development Partners** Groups reported being expected to provide money, expertise and leadership and to engage in advocacy. They considered that Governments expect them to create more visibility for malaria, as well as to fund/support getting the evidence in place on what should be done. The Private Sector and Civil Society expect Development Partners to carry out a coordinating role, especially when there is distrust of Governments. Civil Society looks to Development Partners for promotion of their role as valid interlocutors, for their inclusion and participation in decision-making processes as well as for funding, whilst Research and Academia look to them for funding and recognition.

It was further discussed that Development Partners are expected to work in accordance with the Paris Declaration, to ensure ownership is with countries, to coordinate, harmonize and follow country strategies and M&E systems. The One-UN initiative was also mentioned. Although overall, it was admitted that there is often room for improvement in this regard. It was held that the funding demands made of Development Partners are often unrealistic. Development Partners also have to raise resources – and in times of economic crisis it is important to show that investing in malaria is good value for money because international funding gaps raises credibility issues.

The **Private Sector** considered there was often little understanding of what would motivate them to invest or where their strategic advantage lies – eg. not in deciding which LLINs to buy, but in offering their supply and distribution mechanisms to get them to the points of need, or to make new technologies or commodities available. They reported that the Private Sector is often approached with long and unrealistic requests for funding.

The **Civil Society** Group discussed that the other constituencies expect them to be powerful, strong at advocacy, able to bring visibility to malaria, able to integrate in, and work to reach, communities at need. They also felt that they are expected to be more organized. These were considered realistic and reasonable expectations.

Resource & Academia discussed that the other constituencies expect them to stay free of bias, to maintain their integrity and provide evidence-based impartial advice. They are also expected to respond to the research agenda and produce timely, relevant information, tools and innovations. These were considered largely realistic expectations; except that the timelines required to develop new technologies and products are usually substantially underestimated.

2.2 Challenges to multisectoral action for malaria

The main challenge mentioned by the **Government** Groups was that malaria is generally perceived as a health issue and there is little political will for multisectoral action. Very few countries have a mechanism in place for a multi-ministry response. Still fewer have produced binding multisectoral plans and succeeded to mobilize funding to implement them. Funding is almost never multisectoral. It was further noted that as other sectors come on board then data has to be shared and some control has to be relinquished regarding decision-making and resource allocation. The concern was raised that by asking others to join the response it can look as if the Ministry of Health has failed to do its job. More generally, it was identified to be a challenge that the Ministry of Health often has people with technical skills, but that they may lack the skills needed to forge and sustain partnership and relationships.

The **Development Partner** Groups reflected that leadership and multisectoral mechanisms were often lacking, as was continuity of Government priorities. An integral overview was felt to be missing, with most actors having a sector-based, rather fragmented, partial perspective. There is still a tendency to favour vertical programs, scope for greater integration in the health system, insufficient, representation of civil society and research & academia in decision-making processes and challenges to effectively address malaria in vulnerable populations. It was further discussed that there can be some political cost to working with the Private Sector which also present a challenge, for example; opposition parties

may accuse the businesses involved of paying for political campaigns. The groups further reflected that their own inability to work across sectors is also a barrier and that there is a need for great organisational coherence if an agency supports different sectors in a country.

The **Civil Society** group identified lack of leadership, lack of recognition from Governments, differing focus and interests of the different constituencies and organizations involved and challenges to measure progress in a way that takes socio-cultural determinants of health into account. They highlighted for example that in remote areas of Haiti the population do not like the malaria program and lack basic malaria knowledge. The lack of involvement of social scientists and anthropologists in the design of interventions and the lack of involvement of Civil Society organizations to overcome cultural barriers were further identified as challenges.

The group itself raised some of the challenges to working with the **Private Sector**. In particular, it was noted that if the Private Sector moves beyond the "campaign mentality" and starts to provide malaria or broader health services, then there is a risk that if profits fall these services will be withdrawn.

However, positive examples were also given. For example, clinics run by Mining companies on Suriname strive to provide miner-friendly services located in places the miners already frequent such as grocery stores and bars. They also operate at nights and weekends, provide services in many languages to cater for the migrant background of many workers and make sure not to ask for any ID papers – many of them not having a formal work permit.

Overall, the essentiality of a multisectoral approach to reach out to migrants was stressed. There is trafficking of illegal migrants to the region from countries including Senegal, Ethiopia, China and Ghana. The malaria outbreaks in PAHO in 2003-2008 show parasites are from Africa. In addition, the region has undergone a major transition from an agricultural to a service-based economy. This means that there is newly emerged Private Sector that has been little tapped into for health issues. Nowhere is this more true that in tourism. Ways need to be found to get hotel owners and businesses to care about the region having a malaria-free designation. There could be scope for a global campaign with partners like TripAdvisor to give sites "malaria free" badges, and create an incentive for tourists to report malaria cases and to prefer malaria-free destinations.

An idea was generated by the group to look for ways to link malaria elimination to World Trade Agreements and Banking / Investment grades. This could use the Carbon Credit model and eliminating Countries would get "points" and preferred credits for achieving health indicators – or better loan conditions from World Bank – higher ranking of Investment Grade. Competition could be created between regional countries so that those in power will ask why their neighbours are getting better investment grades.

The **Research & Academia** Group noted that funding for research is generally sector-specific. They highlighted the need for better dialogue between national programs and local research institutions to foster greater two way understanding. This would facilitate greater use of research findings in health policy and the identification of a research agenda that is relevant to local needs. The importance of involving affected communities in implementation research and R&D was also flagged, as was the time it takes to build relationships and build trust. R&A can also help establish the cost/value of interventions, including multisectoral action.

Generally the facilitating factors across all groups had similar basic elements that included the need for leadership by example, the creation of a commonly held multisectoral agenda and a clarification of the role of each actor. Good examples that were mentioned included interministerial working groups, the work of the RBM harmonization group and UNDAF's track record of bringing Governments and the Private Sector together, as well as the creation of umbrella groups to ease the participation of Private Sector and Civil Society actors in country planning processes.

The importance of multisectoral action could also be stressed when it comes to global advocacy eg. by showing that countries that have made good progress, for example, in tackling malaria in migrant populations and used a multisectoral approach to get there. Moreover, strategic advantage could be taken of overarching issues like human rights or climate change to bring actors from different sectors together and have them realize their common interests. The potential to leverage forums with political power like CECOMISCA to mobilize resources was also underlined.

2.3 Social Movement

From across the groups it was discussed that the people most affected by malaria are amongst the most disenfranchised. Ways need to be found to raise malaria to a priority issue at community level. All too often malaria is simply accepted as a fact of life in highly affected communities. However, by showing that something can be done about malaria and disseminating such messages via the media,

Public Service Announcements, Community Boards etc. and by working with community champions, volunteers and teachers, to change expectations, generate demand for services and that this will eventually translate into BCC. Other actions to push this could also be introduced – for example, in Jamaica there is a social services program that provides government subsidies to poor families. To remain in the program the families have to undertake some actions which currently include bringing their children for vaccination and could be readily extended to include malaria prevention.

The need for continued high level advocacy, involving senior government officials, the involvement of executives of companies, and UN malaria special envoys was identified as key for maintaining political visibility for malaria in the long term.

In addition, there was general agreement across all the groups that they could work more closely with communities. The Civil Society group in particular called for us all to stand up and insist that we defeat malaria as outlined in the prelude to this report.

2.4 Priority Actions from Breakout Session II:

The Government Groups prioritised:

1. Undertaking a stakeholder mapping exercise and exploring relationships and connections
2. Formation of multisectoral task force for malaria, institutionalization of spaces to convene different government sectors and to form alliances with Private sector / Research & Academia and Civil Society
3. Facilitating sharing of information, statistics, problem, possible solutions
4. Development of a multisectoral malaria elimination plan with a realistic budget
5. Lobbying that all ministries need to allocate a certain percentage of their budget to malaria and have malaria as a standing point on their agendas. For example, the Ministry of Labour could mandate that people coming from endemic areas be advised to test for the presence of parasites, testing of workers, women attending ANC etc.

The Development Partner Groups prioritised:

1. Identifying and defining integrating themes and mechanisms
2. Proposing activities that allow for participation of agents from different sectors, each participating by exercising their natural or normal role/scope rather than imposing a role that they cannot fulfil ie. Ensuring the business plan is tailored to each stakeholder perspective and not only to that of the health sector
3. Promoting and favouring programs and projects that incorporate multisectoral and participatory elements
4. Supporting the establishment of national coordination mechanisms, and/or strengthen them
5. Facilitating adoption of integrative approaches such as the ecosystem model

The Civil Society Group prioritised:

1. Agreeing on the leadership and modalities for organizing and recognising the multisectoral response
2. Civil Society actors must operate as a network with each other and with other actors
3. Capacity strengthening
4. Resource Management
5. Establishment of permanent forums for joint decision-making, including about resources

The Private Sector Group prioritised:

1. The need for strong coordination and action
2. Greater involvement of the Private Sector
3. Clarifying where the Private Sector can make a difference

The Research & Academia Group prioritised:

1. Strengthening interaction between the Ministry of Health and Research institutions by having joint staff training, projects and data sharing. This could form the start of a research to policy movement which would also bring more recognition for Research & Academia
2. Working to see scientific research translated into national, regional and global policy documents, through data sharing and conferences that are targeted at practitioners and not only at academics
3. Working more closely with affected communities.

3. Results of Breakout Session III: Overcoming bottlenecks to regional and country level action

3.1 Benefits of a regional response to malaria

The **Government** groups identified the importance of regional agreements for increasing political commitment, for the exchange of technical assistance, training, reference laboratories, quality control of procedures, for the joint procurement of drugs and supplies, to strengthen cross-border malaria surveillance, share best practices and generally to pool resources.

The **Development Partner** and **Private Sector** groups confirmed the view that sub-regional approaches are essential for efficiency, to contain resistance and to ensure successful elimination in the region. There are many economic and political bodies that could be leveraged. PAHO has a regional mandate with regional, sub-regional and country levels points of presence and a strong network. USAID supports RAVREDA through the Amazon Malaria Initiative since 2002. The Clinton Health Access Initiative CHAI advises COMISCA the regional alliance of Ministries of Health and finds it highly efficient as 10 countries can be reached via a single contact. The Global Fund is funding the Meso-American Elimination Initiative launched with the Costa Rica declaration signed by Ministries of Health in 2013.

It was discussed that Development Partners could usefully work to strengthen the capacity of such regional bodies so they can support the countries concerned, identify best practice and encourage South-South learning and exchange. Previous elimination efforts tended to downplay the importance of research. This lesson has now been learned and there are important regional research networks in Mesoamerica, and operating under the Amazon Malaria Initiative umbrella.

The **Civil Society** and **Research & Academia** groups shared similar views regarding the advantages of regional networks to exchange knowledge, share resources, create a critical mass for political visibility and to reach out to vulnerable groups in cross-border contexts.

The **Private Sector** shared a Regional Collaboration Success Story regarding the Screw Worm Fly. Cattle ranchers in Texas decided to eradicate this fly by releasing irradiated/sterilized male flies. They created an independent international commission – purchased the planes and had soon sterilized the flies in Mexico on down through Central America. In less than 10 years the worm was totally eradicated. Countries were coerced into participating by the World Trade Organization in order to have access to sell meat and leather into world markets. A similarly coercive approach is needed to finally defeat malaria.

3.2 Bottlenecks to action

At regional level, politics was raised as a key bottleneck across all the groups. For example, Bolivia and Venezuela have pulled out of AMI as the funding comes partially from USAID. It is hoped that neighbouring countries like Brazil will bring regional influence to bear to reverse the poor malaria situation particularly in Venezuela. Certainly this is what happens in the area of child immunization as if one country stops then the other countries notice the adverse effects quickly. It was also noted that the mere existence of regional declarations for elimination are not enough, they need political visibility, “commitment” and to be backed by resources.

Other frequently mentioned bottlenecks included bureaucracy, that malaria is not seen to be a priority, the lack of malaria focal persons at other ministries, poor communication and networking skills, high staff turnover, loss of experienced staff, the creation of new and parallel, non-harmonized mechanisms by international cooperation agencies

3.3 Accountability

Governments are accountable to their citizens, their parliament, to national audit authorities, the media, donors and the international community. Government has an important coordinating role when it comes to clarifying a common framework for M&E.

Development Partners are accountable to the Government that funds them and the Partnership Government, with whom joint goals are agreed. The Development Partner group highlighted that some of the key control donors (USAID, DFID) have gone to great lengths to convince their parliamentarians about the benefits of investing in control, particularly by improving the health of women and children. A compelling advocacy case for elimination is still to be created.

Research & Academia is accountable to its funders and its peers, although it was recognized that accountability is also needed to national elimination goals and affected communities. **Civil Society**/CSOs are accountable to their funders, their members and those that they represent. The **Private Sector** is essentially accountable to its shareholders and for its bottom line. However there is a move for change eg. the extractive industries transparency movement which encourages oil, gas and mining companies to publish what they pay to Governments rich in natural resources.

3.4 Mechanisms for strengthening mutual accountability for the (non)achievement of malaria elimination goals

The **Government** groups outlined how accountability in public administration can be strengthened through the introduction of performance based budgets (Mexico has malaria related indicators), standardizing information systems for enhanced comparability, encouraging participation from civil society, and by providing policies, supervision and monitoring to ensure compliance with regulatory frameworks. The latter would facilitate holding the Private Sector accountable for addressing the occupational risk of malaria amongst its workers and to mitigate any environment impact to their activities.

To make Research & Academia more accountable for regional and national research priorities Governments could organise a Research Day, with a conference and publications. In Haiti an external panel reviews whether research protocols are in line with national goals and follows up to ensure findings are incorporated in policy. The **Development Partners** groups also saw themselves as having a facilitating role in the creation of a mutually agreed research agenda, although they recognized the challenge to align this with the position of funding bodies. They can also play a role in ensuring that research findings are translated into policy, and to build the local capacity of NMCPs.

The **Development Partners** groups flagged how RBM has the M&E Working Group - which is a mechanism for presenting technical documents to civil society and other constituencies. Development Partners can play a key role in helping Governments to see that Civil Society is often well placed to achieve impact and delivery of services and commodities. Development Partners are also well placed to get the Private Sector involved in terms of policy regulation eg. establish regional equivalents of the ACT consortium in Africa which looks at the role the private sector plays in providing access to quality treatment for malaria, and to open a dialogue about Private Sector accountability. The Global Fund could also set some conditions there.

The **Private Sector** group highlighted that it could be more consistently called upon to participate in CCMs. It described how the Private Sector often does not have access to information from National programs and other constituencies. The Private Sector did not consider that it could hold Development Partners accountable, apart than through individual tax payments, but thought it could still bring some influence to bear.

The **Research & Academia** group argued that it could influence accountability by evaluating publications/ research for ability to impact public health, holding national programs and others accountable for using research, increasing recognition of good implementation research, working to reduce the tendency to only publish in English and by undertaking advocacy for the research agenda with Development Partners. It called for stronger national programs and civil society activism to push the researchers to answer the open questions for making elimination a reality.

The **Civil Society** group stressed how their role is fundamental to holding all the other constituencies to account. For this to be possible, all the constituencies need to reach out to Civil Society and ensure its meaningful and truly representative participation in joint planning, decision-making, implementation and monitoring & evaluation of malaria activities.

3.5 Priority Actions from Breakout Session III:

The Government Groups prioritised:

1. Putting agreements between countries in place. Ensuring their institutionalisation so they will not be subject to transitory changes between administrations
2. Agreeing common goals, guidelines and indicators
3. Advocacy in country to increase and sustain the budget in malaria
4. Joint mass procurement of commodities and drugs to lower the price
5. Strengthening capabilities of Government staff
6. Rewarding staff performance including hands-on management
7. Thinking outside the box – an idea would be to tie investing in malaria to our ability to access loans!
8. Finding ways to sidestep Government bureaucracy eg. have an emergency malaria plan as in emergency situations the formal steps can be by-passed.
9. Addressing the lack of coordination. E.g. bed net distribution campaign - in highly endemic areas there might be 8 staff if we are lucky, but they cannot distribute 8000 LLINs, so there is a need to leverage volunteers from other groups. If we are aware such a situation is arising then we can mobilize networks in advance.

The Development Partner Groups prioritised:

1. Empowering Governments and Ministries
2. Making sure Development Partners work together
3. Providing technical and financial support to sub-regional efforts, rather than individual countries.
4. Facilitating South-South cooperation especially to identify evidence of best practice
5. Designing innovative financing mechanisms to overcome common implementation challenges.

The Private Sector Group prioritised:

1. Leveraging political influence at the highest levels
2. Creation of a Regional Tourism Task Force (key economic driver)
3. Involving Chamber of Commerce
4. Tapping into Junior Chamber International, Rotary and other business organizations

The Civil Society Group prioritised:

1. Giving a political voice to the most disadvantaged
2. Strengthening demands for accountability
3. Engaging in creation of joint M&E systems
4. Building regional and national networks of CSOs
5. Involvement of local communities in all aspects of the fight against malaria

The Research & Academia Group prioritised:

1. Building capacity for research
2. Stimulating regional research networks (South-South)
3. Establishing a clear research agenda focused upon elimination with country programs
4. Involving those most affected by the disease

Appendix 1: PAHO Agenda for the Consultation on the second generation Global Malaria Action Plan "Action and Investment to defeat Malaria (AIM)"

April 3 (Thursday) – Global Malaria Action Plan 2 Stakeholder Consultations

09.00-09.20	Welcome and Introduction by Roll Back Malaria Partnership	Dr. Eric Mouzin Progress and Impact Unit
09.20-09.45	Purpose of AIM by RBM	AIM Task Force Chair Dr. David Brandling-Bennett Bill and Melinda Gates Foundation
09.45-10.00	Objectives, methodology, focus areas for the consultation	Dr. J. Luis Segura AIM Consultant Team
10.00-10.30	Feedback on review of GMAP (findings from pre-consultation questionnaire)	Dr. Helen Prytherch AIM Consultant Team
10.30-11.00	Coffee break	
11.00-12:30	Breakout Session I: Developing a business case for malaria reduction and elimination	Ms. Molly Loomis AIM Consultant Team
12.30-13:30	Lunch & Gallery Walk	
13.30-15.00	Breakout Session I:Gallery Walk, Analysis, and Report back	Ms. Molly Loomis AIM Consultant Team
15.00-15.15	Introduction to RBM/UNDP Multisectoral Action Framework	Dr. Oscar Mesones Lapouble Pan American Health Organization
15.15-16.15	Breakout Session II: Mobilizing people and resources	Dr. Helen Prytherch AIM Consultant Team
16.15-16.30	Coffee break	AIM Consultant Team
16.30-17.45	Breakout Session II: Gallery Walk, Analysis and Report back	Dr. Helen Prytherch
17.45-18.00	Wrap up	Dr. Nicanor Obaldia III

April 4 (Friday) – AIM Stakeholder Consultations

09.00-09.15	Welcome and Short Introduction from Roll Back Malaria Partnership (for *P.vivax meeting* participants)	Dr. Eric Mouzin Progress and Impact Unit, RBM
09.15-09.30	Recap on the purpose of AIM (for *P.vivax* meeting participants)	AIM Task Force Chair Dr. David Brandling-Bennett Bill and Melinda Gates Foundation
09.30-10.00	Summary of the outcomes of day 1 and Gallery Walk	Dr. Nicanor Obaldia III
10.00-11.00	Breakout Session III: Accelerating regional and country level action on the pathways to elimination	Dr. J. Luis Segura AIM Consultant Team
11.00-11.30	Coffee break	
11.30-13.00	Breakout Session III: Gallery Walk, Analysis and Report back	Dr. J. Luis Segura AIM Consultant Team
13.00-14.00	Lunch	
14.00-14.30	Making AIM work at global and regional level	Dr. Helen Prytherch AIM Consultant Team
14.30-14.45	Evaluation of consultation	Dr. Nicanor Obaldia III
14.45-15.00	Wrap up and next steps	Ms. Molly Loomis AIM Consultant Team
15.00-15.15	Official Close	Dr Rainier Escalada PAHO and AIM Task Force Chair Dr. David Brandling-Bennett

Appendix 2: Overview of working group members

Civil Society - Oscar Mesones Lapouble

Izanelda Batista Magalhães
Olivia Edith Meza Arteaga
Olga Murillo
Prabhjot Singh
María Naxalia Zamora González
(Cynthia Zulamith Viveros de Franchi)
Luis Carlos Ramos Aguilar
Oscar Galan

Development Partners - Helen Prytherch

Antonio Hegar
(Arleta Añez)
(Nicolas Ceron)
Patrice Lawrence-Williams
(Dr. Rainer P. Escalada)
(Richard Cibulskis)
Zsofia Szilagyi
David Brandling-Bennett
Yitades Gebre
(Dra. Maria Jesus Sanchez)

Development Partners - Jaime Chang

(Jose Pablo Escobar)
Hans Salas Maronsky
Romeo Montoya
(Aida Soto)
Monica Guardo
Guillermo Gonzalvez
(Haroldo Bezerra)
Cesar Diaz
Eduardo Ortiz
Humberto Montiel

Government - Molly Loomis

Kim Bautista
(Dra. Paola Marchesini)
Darlie Antoine
Francia Prosper Chen
Ronald Chapman
Felicia Balfour-Greenslade
Reyaud Rahman
Clive Tilluckdharry
Jean Frantz Lemoine

Government - Luis Segura

Lilliana Jiménez Gutiérrez
Carlos Andres Tumbaco
(Hector Olguín Bernal)
Rolando López Ampié
Lourdes García
Yessica Candanedo
(Carlos Victoria)
(Monica Ortiz)
Martín Orlando Clendenes Alvarado
Jaime Aleman
Joel Nain Maldonado
(Mario Zaidemberg)
Ildefonso Cepeda

Private Sector - Lisa Goldman

Monique Perret-Gentil
(Trenton Ruebush)
Elizabeth Ivanovic
Patrick Harding
Eric Mouzin
(Dr. Arnaud Le Menach)
Nicanor Obaldia
Rene Salgado

Research & Academia - Vanessa Racloz

(Dr. John Reeder)
(Dra. Zaida Yadon)
Gabrielle Hunter
(John Macarthur)
(Dr. Socrates Herrera)
(Dr. Andrés (Wily) Lescano)
Larry Slutsker
(Dra. Lise Musset)
Lorenzo Caceres

(Those in brackets attended P.vivax meeting on day 1)