

A photograph of a woman with short dark hair, wearing a light blue patterned dress, holding a young child. The child is wearing a blue dress with red and yellow floral patterns and a white lace collar. They are standing in front of a thatched hut. In the background, several other people are sitting on the ground.

# Highlights of the year

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Malaria Consortium 2014–15

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**malaria  
consortium**  
disease control, better health

## **Thank you**

Our progress and achievements over the past year have been made possible thanks to the unwavering support of our partners and collaborators, including the national governments in all the countries where we work.

We are grateful to our many donors,  
in particular:

Bill & Melinda Gates Foundation

Comic Relief

UK Department for International Development

Deutsche Gesellschaft für Internationale Zusammenarbeit

Global Fund to Fight AIDS, Tuberculosis and Malaria

IS Global

James Percy Foundation

Planet Wheeler Foundation

UNICEF

UNITAID

United Nations Development Programme

United Nations Office for Project Services

US Centers for Disease Control and Prevention

USAID/President's Malaria Initiative

World Health Organization

# Foreword



**Dr Julian Lob-Levyt – Chair**

It has been a positive year for Malaria Consortium. We have continued to grow to meet our objectives. Our management team has worked closely with the Board of Trustees to develop and put in place a new and forward thinking strategic plan to guide us for the next five years. As we move forward, we will have in place the necessary tools and indicators to measure both our success and our organisational effectiveness. My thanks to my fellow trustees and to senior management for all the time and effort put in over the past year. In particular, I would like to thank those trustees who have moved on this year as their terms came to an end. At the same time, let me take the opportunity to welcome a number of new trustees appointed this

past year. They bring further diversity and a set of terrific skills and experience to Malaria Consortium.

In 2015, the world took stock of our collective progress against the eight Millennium Development Goals (MDGs). The MDGs successfully galvanised commitment from around the world to address the most pressing development concerns. Centred around lifting people from extreme poverty and improving the lives of those most disadvantaged, good progress was made in most, if not all, of the goals or in all geographical areas. Three of the development goals directly concerned health.

Goal six, which includes the target to ‘have halted by 2015 and begun to reverse the incidence of malaria’ has been one of the more successful goals, and in which Malaria Consortium has undoubtedly played a part. According to the World Health Organization, in the space of only 15 years, between 2000 and 2015, the rate of new malaria infections has dropped by approximately 37 percent, with the global malaria death rate falling by a dramatic 60 percent during the same period. This means over six million deaths have been prevented since 2000. Much of this success is attributable to the use of treated mosquito

nets, an intervention in which Malaria Consortium has been a major player.

The successor to the MDGs has also been a hot topic of conversation. Unsurprisingly, the success of a small number of focussed MDGs ending in 2015 has led to a significant broadening of goals for the future, built around a theme of sustainability. This year, the thinking became more concrete, resulting in 17 ambitious Sustainable Development Goals (SDGs) and 169 targets, which will be adopted on 1 January 2016. The most significant change for us is that there is no longer a dedicated malaria-related goal. Instead, there is an overarching health goal, with numerous sub-goals under which malaria and other diseases fall. There are also a number of positive synergies between advances in malaria, and health more broadly, and progress towards the achievement of the other SDGs.

While this will be challenging for malaria stakeholders, we should nonetheless welcome a broader set of linked Sustainable Development Goals. Development is broad and complex. There are no magic bullets. But this does mean that as we move forward, Malaria Consortium will need to find innovative ways in which our focus on the control and elimination of malaria and other

specific diseases, as well child and maternal health, can contribute to the achievement of the SDGs. As we broaden our approach into these new areas, our programmes will continue to drive forward sustainable, evidence-based solutions to effective health delivery, providing the entry points by which broader health and development goals can be realised.

As we transition to this new global approach for the next 15 years of international development, Malaria Consortium will look forward to continuing to share the achievements of our dedicated staff, partners and our donors, building upon the impressive accounting of the learning and successes of the past year.

Finally, as my term comes to an end, 2016 will be my last year as Chair of the Board. We have excellent staff, a strong Board and associated governance structures and a solid strategic plan to guide us into the future. It has been nothing but an exciting and positive experience and I thank everyone who has contributed to that.

Dr Julian Lob-Levyt  
Chair



### **Charles Nelson – Chief Executive**

As Julian noted in his foreword, this has been a positive year for Malaria Consortium in delivering against our refreshed mission to improve lives in Africa and Asia through sustainable, evidence-based programmes that combat targeted diseases and promote child and maternal health.

There is significant reason to be encouraged in the fight against malaria. Major progress has been made in reducing malaria deaths and incidence over the period of the Millennium Development Goals (MDGs). While many parts of Africa will not approach malaria elimination for several years, there are other parts of Africa, and several countries in Asia, which are now setting their sights on elimination within the next 15 years, and Malaria Consortium is actively participating in that agenda.

Malaria doesn't just 'go away'. To quote an eminent US Army malariologist towards the end of the Second World War, "malaria is beaten by a combination of hard work, diligent compliance, and a consistent supply of commodities". The nature of the work changes somewhat with the level of remaining transmission, but the need for effort, diligence and consistency of supply of



appropriate preventive mechanisms, tests and treatments remain.

To that end, we continue to work across all the levels of transmission, helping local governments to tailor, innovate, adopt and apply interventions best suited to their real and immediate needs, both through public and private delivery models, with the ultimate aim of building resilience and sustainability into their overall health systems. In higher residual transmission areas, we provide preventive treatments, vector control and case management expertise and services, in many cases focusing on the gaps in provision and barriers to effective intervention. In lower transmission environments, we help develop and implement high quality surveillance and response models to accelerate elimination in the face of growing drug and insecticide resistance, focusing mainly on the mobile, migrant and ethnic populations at most risk from the disease.

Despite significant success, the work is not finished. At the outset of the MDGs, we had to declare that one child dies every 30 seconds. This has now halved. This is real and honest progress. But if we began again today with the fact that ‘one child dies every minute’ from a completely preventable disease, it is our hope that the global community would and will still step up until the burden and risk is reduced, such that malaria elimination can become a reality. This is the message of the recently released Global Technical Strategy of the World Health Organization and Roll Back Malaria’s framework, Action and Investment to Defeat Malaria 2016–2030.

But our work is not just about malaria. Over the years we have driven integration of activity around the febrile child, and deliver integrated community case management

programmes, that deal with the other two main causes of fever in children, pneumonia and diarrhoea. In addition, we have piloted the inclusion of malnutrition with links to nutrition programmes.

We have also focused on the wider needs of pregnant women and newborns who, though particularly susceptible to malarial infection, need other antenatal and postnatal support. We have extended our engagement with overcoming death and disability caused by dengue and other neglected tropical diseases, often encountered by the same communities affected by malaria. Our work on health system effectiveness and efficiency at a more holistic level is growing and we are developing our capacity accordingly.

In this Annual Review, we highlight some examples of our work, though we could never cover all that we would like to have told you about. We hope you find them interesting and encouraging, balanced with realism that there is still much to be done.

We are thankful to all our partners who have shared and are sharing this journey with us and, although there is much uncertainty about how things will develop in the coming years of the Sustainable Development Goals, we look forward to forging future partnerships that help us gain ground in the fight to rid the world of preventable disease.

Charles Nelson  
Chief Executive

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# Mission and approach

Malaria Consortium works with partners, including all levels of government, to improve the lives of all, especially the poorest and marginalised, in Africa and Asia. We target key health burdens, including malaria, pneumonia, diarrhoea, dengue and neglected tropical diseases, along with other factors that affect child and maternal health. We achieve this by:

- designing and conducting cutting edge implementation research, surveillance and monitoring and evaluation
- selectively scaling up and delivering sustainable, evidence-based health programmes
- providing technical assistance and consulting services that shape and strengthen national and international health policies, strategies and systems and build local capacity, and
- seeking to ensure our experience, thought leadership, practical findings and research results are effectively communicated and contribute to the coordinated improvement of access to and quality of healthcare

# Key moments in 2014–15

**Malaria Consortium has been at the centre of innovation, research, debate and discussion around malaria and other diseases over the past year. Here are some of the highlights.**

## April 2014

We are invited to join the World Health Organization's Global Malaria Programme's Technical Expert Group on Surveillance, Monitoring and Evaluation.

Our five-year Pioneer project in Uganda ends, with key results showing increased coverage of long-lasting insecticide treated nets (LLINs), strengthened health-seeking behaviour and improved malaria diagnosis (p.19).



## May 2014

Malaria Consortium and partners are awarded a grant to oversee the largest yet global programme to increase seasonal malaria chemoprevention across the Sahel region of Africa.

We are elected vice chair of the UK Coalition against Neglected Tropical Diseases and participate at a coalition's event on neglected tropical diseases control and elimination during the World Health Assembly.

## June 2014

We convene a meeting in Geneva bringing together global health experts to discuss the initial recommendations from stage 1 of our pneumonia diagnostics project.



## August 2014

Our 16-month universal LLIN campaign with the Ugandan government is completed, distributing 21 million nets across the country.

We help to form a partnership between a global manufacturer and a partner in Nigeria for the local production of WHO Pesticide Evaluation Scheme recommended LLINs.

## September 2014

Our two-year project supporting community health workers rural Mozambique ends, delivering an improved training curriculum for the Ministry of Health's national malaria programme.

## October 2014

A new Malaria Consortium office opens in Burkina Faso and we begin a new partnership with an NGO in Chad to support our seasonal malaria chemoprevention project, ACCESS-SMC.





At the Third Global Symposium on Health Systems Research in Cape Town, we present evidence on varied issues including on pneumonia, preventive treatment for pregnant women and integrated community health management.



## November 2014

On World Pneumonia Day, we lead a global campaign with partners to raise awareness of pneumonia. A call to action for universal access to pneumonia prevention and care by Malaria Consortium and partners is also published by the Lancet.

We contribute to regional plans for malaria elimination in the Greater Mekong Subregion by 2030.

Malaria Consortium submits evidence to the UK's International Development Committee's health system strengthening inquiry.

We give over 15 presentations at the 63rd annual American Society of Tropical Medicine and Hygiene meeting in New Orleans.

## December 2014

We are co-authors on six papers in a major publication on the progress of integrated community case management.

We present our various interventions to prevent and control malaria and other diseases in Asia at the Joint International Tropical Medicine meeting in Bangkok.



Our Cambodia project – which looked at screening households with a malaria case – ends, having successfully reinforced the use of mobile phones in alerting health authorities to respond to new malaria cases.

## December 2014 – January 2015

We convene a roundtable event with donors and experts on the issue of drug resistant malaria. A special report, Malaria: the last mile, is published in partnership with the UK's New Statesman magazine as a result of this.



## January 2015

We support the renovation of a clinic in rural Uganda for Comic Relief's Red Nose Day 2015 campaign.

## February 2015

At the World Congress on Public Health in Delhi, we present evidence on the uptake of malaria rapid diagnostic tests through an advocacy and behaviour change communication approach.



## March 2015

Our Stop Malaria Project in Uganda comes to an end after six years of implementing malaria control activities.

# Sharing learning and raising awareness



Malaria Consortium believes that the best results come from activities that are based on solid evidence, which is why research, monitoring and evaluation are core elements in all our work. We commit to capturing and applying what we learn as we go, ensuring positive and lasting results are achieved, scaled up and sustainable.

We are also committed to sharing our experience and learning with partners, practitioners, donors and others in the development sector to help influence and advance policy and practice. This year we have achieved this via a range of platforms and outputs. We highlight some of these in the pages that follow.





“

Malaria is a problem that affects everyone here and so we are happy to accept SMC [medicine] and protect our children”

mother of child receiving SMC

Children line up to receive seasonal malaria chemoprevention (SMC) during a distribution in Nigeria in 2015.

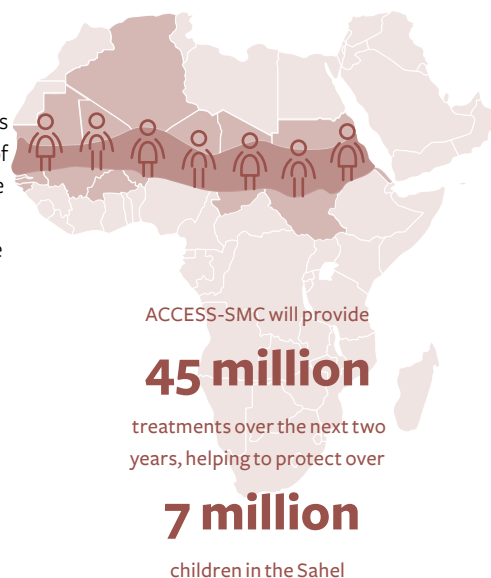
# Scaling up our efforts in malaria prevention

Over the past decade, malaria incidence and mortality have seen significant declines thanks to global prevention and control efforts. Yet millions of people remain at risk. Preventive drugs still do not reach many children under five or pregnant women and millions of households do not own any or enough mosquito nets.

Malaria Consortium has stayed committed to addressing these gaps, applying the appropriate mix of interventions as well as developing a clear understanding of the drivers of change to inform and influence malaria prevention strategies. Over the past year, we have seen impressive progress as we continue to increase our reach to the most vulnerable and marginalised populations.

♦ One of the most significant advances has been the expansion of our work providing preventive malaria treatment to millions of children across the Sahel. Following encouraging results from our pilot seasonal malaria chemoprevention (SMC) activities in northern **Nigeria**, we were awarded a UNITAID grant to oversee the largest-yet global programme to scale up SMC across seven countries: **Burkina Faso, Chad, Guinea Conakry, Mali, Niger, Nigeria** and **The Gambia**. A consortium of partners led by Malaria

Consortium is now running the ACCESS-SMC project (Achieving Catalytic Expansion of Seasonal Malaria Chemoprevention in the Sahel), providing 45 million treatments over the next two years, helping to protect over 7 million children in the region.



♦ Malaria Consortium continues to play an important role in distributing and promoting the use of long lasting insecticidal nets

(LLINs). We are providing leadership in both global and national contexts, designing systems for continuous LLIN distribution and for assessing coverage.

Over the past year, we have been involved in delivering LLINs through a number of mass distribution campaigns. In Uganda, with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria, US Agency for International Development and US President's Malaria Initiative (USAID/PMI) and the UK Department for International Development (DFID), we partnered with the government to distribute 21.3 million nets across the country – achieving universal coverage, a major milestone in the country's efforts towards malaria control.

In **Nigeria**, we distributed 10.2 million nets in campaigns in three states funded by DFID, and we further supported the distribution of 3.8 million nets through a project funded by USAID/PMI. These efforts combined reached a target population of 28 million.

With funding from Comic Relief and DFID, we have also been exploring methods for sustaining high LLIN coverage levels through alternative distribution channels and initiatives for net care and repair in both **Nigeria** and **Uganda**.



We supported a one of a kind campaign to distribute over

**21 million**

nets in Uganda resulting in

**95%**

net coverage in the country for the first time



### Research



A qualitative study to assess consumer preferences and barriers to use of long lasting insecticidal nets in Myanmar <http://bit.ly/1Yv9tOb>

Impact of a behaviour change communication programme on net durability in eastern Uganda <http://bit.ly/1Ab9JrG>

Challenges to recording and reporting of uptake of intermittent preventive treatment in pregnancy at facility level in Uganda <http://bit.ly/1MEz7fD>

### Online Q&A

Prevention or cure, what's the best approach in malaria control? <http://bit.ly/1rT8slk>

### Presentations

Addressing vector control challenges in the Greater Mekong Subregion <http://bit.ly/1FXGG9k>

Positive deviance: An innovative approach to improve malaria outcomes <http://bit.ly/1QTszZb>

Malaria in pregnancy in Southeast Asia: A neglected disease? <http://bit.ly/1gGpBdl>

◆ We are continuing to conduct research and collect evidence to increase understanding of and improve our response to the disease.

Over the past year, we have been focusing on addressing outdoor malaria transmission, particularly in the Greater Mekong Subregion where many forest workers are exposed to malaria while working outdoors at night. Results from a study funded by USAID/PMI and DFID suggest high acceptability and good adherence to distributed insecticide-treated clothing in rubber plantations in Myanmar. Malaria Consortium will be reassessing the acceptability of the clothing during the rainy season when mosquito activity peaks. These findings will inform the scale-up of the project and distribution of insecticide-treated materials to the populations at risk.

In Uganda, we have been analysing data from a research study funded by DFID that will help to determine the effect of insecticide use for malaria vector control and agriculture on insecticide resistance and malaria prevalence in the country.

We are gaining a better understanding of pyrethroid resistance patterns in malaria vectors through our major long-term research project, Beyond Garki, which is now completing an analysis of our baseline survey in four sites in Ethiopia and Uganda [see p.24].

In Asia, we also expanded our vector control activities this year to include dengue [see p.16].

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## Protecting pregnant women

**Pregnant women are particularly vulnerable to malaria because of their reduced immunity to the disease.**

**We have remained focused on ensuring preventive interventions are integrated into maternal and child healthcare services. In Uganda, research from our COMDIS-HSD programme, funded by DFID, suggested that health workers' poor knowledge of intermittent preventive treatment in pregnancy (IPTp) guidelines had resulted in missed opportunities to provide the treatment to pregnant women attending antenatal care. This led to a pilot intervention designed to complement the government's training programme on malaria in pregnancy by sending text messages to health workers to help increase their knowledge of IPTp.**

**Our work on developing strategies for the effective prevention and treatment of malaria in pregnancy not only helps protect this at-risk group, but also reinforces ongoing malaria elimination efforts, particularly in Southeast Asia, as pregnant women may transmit infection if not diagnosed and treated.**

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# In focus: integrated approach to disease control in Nigeria



**Nigeria hosts one of Malaria Consortium's highly effective and successful portfolios of programmes and projects. We present here some highlights from our projects to demonstrate the impact of our work across the country.**

Around a quarter of all malaria cases and deaths in the world – and the highest number of malaria related deaths – occur in Nigeria. Our presence in the country started from our £89 million eight-year project funded by DFID to manage the Support to National Malaria Programme (SuNMaP). We have since strengthened our profile with a range of projects that focus on unique approaches to reducing the overwhelming burden of malaria and supporting national and state malaria control programmes. Our role also extends to the control of NTDs, and integrating our work with other common childhood diseases.

- ◆ As it enters its eighth and final year, our SuNMaP programme has been bringing technical expertise and experience to fight malaria in 10 states. The number of households owning at least one LLIN increased from seven percent in 2008 to 49.5 percent in 2013 in the programme states. Access to quality case management of malaria at all levels of healthcare has

increased, as has demand for preventive and case management services. Furthermore, activities in malaria control are now better harmonised across partners.

[www.malariaconsortium.org/sunmap/](http://www.malariaconsortium.org/sunmap/)

- ◆ We have been building sustainable LLIN systems that bridge advocacy, policy, distribution, monitoring and communications in malaria-endemic countries through our USAID-funded NetWorks project which successfully ended this year. Our work designing sustainable distribution models through schools, community and community drugs distributors has fed into a national guideline for LLIN distribution. Nationwide roll-out of the guidelines has led to increased demand for LLINs.

- ◆ We are supporting programme management, prevention and treatment of malaria, as well as creating demand for commodities and services. Through our MAPS project, funded by USAID, we are extending our reach from the federal to community level. This work is contributing to an increase in access to malaria rapid diagnostic tests and correct diagnosis of malaria in the states supported by the project.

- ◆ More children are being treated for malaria through the rollout of integrated community case management in Niger state through our Rapid Access Expansion project, funded through the World Health Organization (WHO) by the Foreign Affairs, Trade and Development Canada. Close to 36,000 malaria episodes in young children have been treated with appropriate antimalarials. Over 17,000 diarrhoeal cases were treated and 4,000 pneumonia cases have been treated with amoxicillin.

- ◆ We are continuing to make malaria treatments available to children under five in the most remote areas. Our pioneering seasonal malaria chemoprevention work in Katsina, Nigeria exceeded our target of reaching 240,574 children to reach 277,091 children in 2014. This work has since been extended in Northern Nigeria this year through our ACCESS-SMC project funded by UNITAID. [www.access-smc.org](http://www.access-smc.org)

- ◆ We are improving severe malaria outcomes to reduce mortality from severe malaria through the adoption of injectable artesunate (Inj-AS). This work, funded by UNITAID, will guarantee access to high-quality Inj-AS for the treatment of severe malaria and lead to



its increased use. The proportion of severe malaria treated with Inj-AS compared to quinine and artemether in sampled facilities is now 85 percent compared to zero at baseline.

♦ We are continuing to recognise the importance of working with the private sector. Through a project, funded by UNITAID, we are creating an enabling environment for the widespread availability of rapid diagnostic tests in the private sector. This work was piloted in 350 outlets consisting of private patent medicine vendors, pharmacies and stand-alone private laboratories. It is now being scaled up to 3,500 outlets in three states.

### Publications

Harmonisation of malaria control in Nigeria <http://bit.ly/1QtiqlD>

Developing a long-lasting insecticidal net retail market in Nigeria  
<http://bit.ly/1OExxes>



## Nigeria in numbers



### Long lasting insecticidal nets:

**13 million** direct distribution through campaigns, continuous and commercial sector channels

Over **90 million** supported distribution through nationwide stand-alone campaigns



### Drugs procured and distributed through public health facilities and the commercial sector:

**5.5 million** doses of sulfadoxine-pyrimethamine

**8 million** doses of artemisinin-based combination therapies

**3.5 million** malaria rapid diagnostic tests

**2 million** chemoprevention treatments



### Trained health personnel:

**30,000** in malaria case management

**4,000** on malaria programme management

**4,000** on the use of mRDTs for malaria

**3,500** on malaria in pregnancy

**350** laboratory technicians on malaria microscopy

## Strategic advice and policy influence

Malaria Consortium has supported the development of several national and state control strategies in Nigeria over recent years, including:

- National Malaria Strategic Plans (2009–2013 and –2020)
- Malaria annual operational plans for National Malaria Elimination Programme, state malaria elimination programmes and activity plan for local government areas
- National strategy, methodology and plan to distribute over 90 million LLINs through campaigns

Malaria Consortium continues to be prominent in influencing policy on malaria in Nigeria. For example, through SuNMaP we have supported a comprehensive Malaria Programme Review that provided the evidence to shape the country's strategic direction for malaria control. The recommendations from this review have largely guided the thematic areas covered by the National Malaria Strategic Plan 2014–2020.

Additionally, in 2015, the federal Ministry of Health's national integrated community case management (iCCM) task force adapted as a national document our decision tree tool previously developed with the Niger state Ministry of Health to guide iCCM implementation at the sub-national level.

# Combatting neglected tropical diseases

Neglected tropical diseases (NTDs) affect over a billion people and result in 500,000 deaths per year. As interest grows in preventing death and disability caused by NTDs, Malaria Consortium has been using the lessons learnt from malaria control to help meet the challenge of these diseases.

♦ The success of our innovative interventions using positive deviance for malaria prevention and control in Cambodia, Thailand and Myanmar has paved the way for the application of the approach in more challenging settings.

In Myanmar, through a study funded by DFID, we are collaborating with government to evaluate positive deviance on dengue prevention and control. In Cambodia, we have piloted a positive deviance approach for dengue prevention and control and are now identifying existing local solutions for dengue prevention.

♦ While prevention remains the best method of reducing the number of dengue cases, prevention strategies can be costly. In Cambodia, where we are continuing to assist the national dengue programme, we are evaluating low-cost, effective alternative methods of vector control to reduce

the burden of dengue through support from DFID and Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ).

♦ We are building on the lessons learnt and our experience in malaria control to provide support to governments. In Nigeria, we developed a decision tree tool combining the control of malaria and NTDs. This tool will guide policy makers and implementers in carrying out an integrated package of interventions.

In South Sudan, the government selected Malaria Consortium to lead a situation analysis report which will inform the revision of the NTD strategy for the next five years. We will continue to extend our support in the development and implementation of this strategy.

We are also using our long lasting insecticidal nets distribution experience to improve mass drug administration to support the prevention of NTDs. This year, with funding from DFID, we provided over 100,000 school children in the Southern Nations, Nationalities and People's Region in Ethiopia with preventive treatment for a range of NTDs, with 150,000 targeted for the next year. In mid-western Uganda, we are assessing the situation of NTDs in 19 districts

and have supported health workers in supplying drugs to children during mass drug administration.

Finally, we have been assessing how community dialogues – an approach we use to change behaviours around malaria and other childhood diseases – can be effective for the prevention and control of schistosomiasis. In Nampula province in Mozambique, through our COMDIS-HSD programme, we found that there was very low knowledge of the disease within the community. In response, 170 community volunteers were trained to facilitate discussions on how the disease affects the community and to find local solutions.




## Infographic

Schistosomiasis: Knowledge, attitudes and practices in Nampula province, Mozambique <http://bit.ly/1P3LzFk>

## Presentation

Knowledge, attitudes and practices related to dengue prevention in Cambodia <http://bit.ly/1L26h6H>





We are using the lessons  
learnt from malaria control  
to help meet the challenge  
of NTDs

Mothers with their children gather for  
a community dialogues session to learn  
about schistosomiasis, a neglected  
tropical disease that is highly endemic in  
Mozambique.



# Improving diagnosis and treatment of malaria and other infections

Early diagnosis and treatment for malaria, pneumonia and diarrhoea are key to limiting morbidity and preventing mortality from these diseases. However, equitable access to diagnosis and appropriate treatment is a huge challenge, especially in many rural areas where quality healthcare is hardest to access.

◆ Malaria Consortium is responding to this challenge by developing and implementing interventions that focus on accurate diagnosis, especially in areas where resources are limited. Most notably, we have been testing a selection of new field diagnostic tools for pneumonia for community health workers' use, with funding from the Bill & Melinda Gates Foundation. This year, testing is progressing in **Cambodia, South Sudan, Uganda and Ethiopia**, where a high proportion of deaths in children under five years caused by pneumonia occur.

[www.malariaconsortium.org/projects/pneumonia-diagnostics](http://www.malariaconsortium.org/projects/pneumonia-diagnostics)

◆ We continue to see good results from our work training community health workers to diagnose and treat common childhood conditions through integrated community case management (iCCM). Our work in this area has benefitted many people in remote

communities this year. Over 140,000 children in **Uganda** were diagnosed and treated through our iCCM programme funded by DFID. In **Mozambique**, over 380,000 cases of childhood illness were treated with funding from the Foreign Affairs, Trade and Development Canada through the WHO.

In the Northern Bahr el Ghazal state in **South Sudan**, our research supported by DFID has found a lack of knowledge of the danger signs and criteria for referral of malnourished children within iCCM and nutrition programmes. These findings will inform future efforts to improve health and nutrition referrals to healthcare centres and nutrition workers.



Over

**140,000**

children in Uganda and over

**380,000**

cases of childhood illness in  
Mozambique diagnosed and treated  
through our iCCM programmes



## Research

Pneumonia diagnostics: searching for new tools for frontline health workers in resource-poor settings  
<http://bit.ly/1KuDK63>

Rational use of antibiotics by community health workers and caregivers in Zambia  
<http://bit.ly/1FaRUfX>

Effectiveness and treatment adherence to artemether-lumefantrine colour coded unit dosed blister-packs versus standard blister-packs in the treatment of uncomplicated malaria in Ugandan children <http://bit.ly/1QtgmtM>

Blended e-learning course: An innovative approach to train private providers on diagnosis and treatment of febrile illnesses  
<http://bit.ly/1it3WXa>

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## Holistic systems strengthening in Uganda

The past year has seen the end of our five-year Pioneer project funded by Comic Relief. The intention was to reduce malaria related morbidity and mortality in five districts in mid-western Uganda through a range of interventions, including mass net distribution, improved diagnostics at facility level and, at the community level, strengthened communication to encourage a better understanding of the disease and corresponding health-seeking behaviour.

The results of the project were very satisfying. Our research activities suggested that mass LLIN distribution, combined with other malaria control interventions, contributed to the reduction of malaria transmission. Introducing malaria rapid diagnostic tests (mRDTs) at low level health facilities resulted in increased number of patients receiving correct malaria diagnosis and appropriate treatment. Together with training on proper supply chain management, this led to antimalarial stockouts being remarkably reduced.

### Pioneer milestones

- Over **600,000** LLINs distributed to 234,591 households covering over one million people to achieve universal coverage in four districts
- **2,848** community dialogues conducted by village health teams to teach malaria control and other good health behaviours such as the use of proper latrines, cleaning the compounds, eating healthier and caring better for children
- **1,668,547** people accessed free, good quality, confirmatory diagnostic tests for malaria through these health centres
- **342,052** children had access to life-saving treatments

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### Publications

Malaria Consortium's Pioneer project 2009-2014: A holistic systems control in mid-western Uganda  
<http://bit.ly/hFaXOO7>

Community dialogues for child health: Results from a process evaluation in three countries  
<http://bit.ly/hilRVxR>



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## Malnutrition

**As well as malaria, malnutrition claims millions of lives, especially of children under five in Africa. Malaria Consortium has introduced innovative approaches in fragile states such as South Sudan to deliver care for malnourished children in the community linked to established iCCM programmes.**

**This year, we have contributed to a major report, *Linking nutrition and integrated community case management: A review of operational experiences*, published by an inter-agency group of organisations tackling iCCM and nutrition, of which Malaria Consortium is a member. We are also now a member of a subgroup of the iCCM Task Force, which is taking forward the policies and practices on improving nutritional interventions.**

**We are also exploring whether our SMC delivery platform can be used effectively for nutrition interventions in Nigeria, where there are high levels of severe acute malnutrition. If found to be suitable, we will train community health workers delivering SMC to screen children for acute malnutrition and properly refer children to existing facilities for treatment. We are also looking to pilot associated nutrition interventions within SMC to improve the intervention and increase the cost effectiveness of SMC.**

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# Making an impact at community level

Malaria Consortium has many years of experience implementing iCCM projects to control malaria and other conditions, particularly in hard-to-reach areas. This year, for example, we used our knowledge to provide technical guidance for a Global Fund proposal that led to funding to scale up iCCM in 33 more districts in Uganda.

◆ We are building on our experience to pilot interventions to improve the management of childhood illnesses such as malaria, pneumonia and diarrhoea. In Uganda and Mozambique, with funding from the Bill & Melinda Gates Foundation and through our Innovations at Scale for Community Access and Lasting Effects (inSCALE) project supported by DFID, we have been working to identify, test and scale up the use of mobile phones by community health workers (CHWs) as a tool for managing cases of illness. This work has resulted in a significant improvement in the appropriate treatment and retention of CHWs in Uganda.  
[www.malariaconsortium.org/inscale/](http://www.malariaconsortium.org/inscale/)

◆ In Uganda, we are also reaching more people through our inSCALE village health clubs – community-led meetings where CHWs work with community members to

identify key health challenges and solutions. This year, we reached over 500 communities, spreading positive health-seeking behaviours and knowledge of health issues.

◆ We make continuous efforts to find ways in which iCCM programmes can be adopted and maintained by national health systems to ensure sustainability. With funding from the Foreign Affairs, Trade and Development Canada through the WHO, we have continued our iCCM work in Mozambique and have begun iCCM support in Niger state in Nigeria.

In South Sudan, through work funded by DFID, we are continuing to work as part of a consortium, strengthening links between iCCM and nutrition.

Meanwhile, the past year has also seen us planning the expansion of our iCCM work to Myanmar, which currently faces the highest malaria burden in the Greater Mekong Subregion.



## Research

Impact of an integrated community case management programme on uptake of appropriate diarrhoea and pneumonia treatments in Uganda  
<http://bit.ly/hNZImWp>

## Film

Making community health workers part of the public health solution  
<http://bit.ly/hMpIRrb>

## Online Q&A

Community healthcare: Can public and private providers work together?  
<http://bit.ly/huQiCOu>





“

Sometimes when I return from my home visits, I find mothers waiting for me. Mothers from other communities without a community health worker also bring their children to me”

Caterina, Mozambique

Caterina is a community health worker trained to diagnose and treat malaria, diarrhoea and pneumonia in children. Every month, she travels 18km on sandy roads to collect her medicines and supplies.



# Strengthening the health system

Sustained progress against malaria and other diseases requires strong and resilient health systems. However, in many malaria endemic countries, unequal geographic distribution of resources and health workforces is a recurring challenge.

Health systems effectiveness and efficiency, therefore, has been a core principle for Malaria Consortium from its beginning. Some of our most significant implementations focus on effectiveness and efficiency, capacity from the state level to the local level by developing training materials for SMC distribution, severe malaria case management and iCCM implementation. A major achievement this year was the completion of programme management course guides which we developed for the WHO to provide health professionals with a comprehensive and practical training on planning and managing a national malaria programme.

◆ The past year has also seen progress in several areas: In **Uganda**, we completed a project in Mbale funded by Comic Relief which provided useful insights on strengthening health systems. This work enabled us to work closely with district health authorities on referral, management

of severely ill children, supply chain management and linking community service delivery with the health facility system.

Also in **Uganda**, with support from DFID, we trained village health teams to use central Health Management Information System tools and promote health-seeking behaviours. In **Ethiopia**, nearly 500 health workers and teachers received training on the quantification, dispensing and monitoring the safety of de-worming drugs. In **South Sudan**, 20 government surveillance officers received capacity development support for monitoring and evaluation.

◆ The private sector continues to have a crucial role in delivering health services. In **Nigeria** and **Uganda**, our work with the commercial sector, funded by UNITAID, focused on increasing demand for mRDTs and improving the quality of care for febrile illnesses. This year, more than 500 private sector providers have been trained on diagnosing and treating febrile illnesses through a specially developed blended e-learning course as well as on using a mobile application to track sales of mRDTs and enable remote supervision, the validation of procedures and adherence to national treatment guidelines.

Together with partners, we are also aiming to create a market for injectable artesunate to treat severe malaria, through a project funded by UNITAID. In **Ethiopia**, **Nigeria** and **Uganda**, Malaria Consortium is training health workers on the delivery of injectable artesunate as well as undertaking research on rectal artesunate, for the successful uptake of these treatments.



### Publication

Integrating malaria rapid diagnostic tests into the health system in Uganda: Preparing health workers for routine use of mRDTs <http://bit.ly/iMIEeLI>

Making Connections: The Mbale malaria control project strengthens links between communities and health systems to reduce child deaths <http://bit.ly/ijsPAvM>

### Research

Improving uptake of malaria rapid diagnostic tests in Uganda through a multi-pronged communication approach <http://bit.ly/iNLWdQ2>

### Peer reviewed article

Integrated community case management of malaria, pneumonia and diarrhoea across three African countries: A qualitative study exploring lessons learnt and implications for further scale up <http://bit.ly/iKADKkX>

### Online Q&A

Making health systems work in poor countries <http://bit.ly/iNWReCf>

## Mhealth

We are continuing to strengthen our work on mobile health (mHealth), which has emerged as an important tool for improving health systems especially in remote locations. mHealth allows users to access and transmit data, stay in touch with supervisors, be informed of supply stockouts, and use applications that guide health workers through the diagnosis and referral process.

In Asia, mobile phones have been instrumental in tracking cases of drug resistant malaria and linking them to a central database, which can then be used to help facilitate responses to outbreaks and plan interventions more effectively. In Cambodia, through support from the US Centers for Disease Control and Prevention and US President's Malaria Initiative (CDC/PMI) as well as the Bill & Melinda Gates Foundation, we provided training to village malaria workers, health facility staff and private sector pharmacists to send SMS reports to a central information unit for each case of confirmed malaria.

In Mozambique and Uganda, through our inSCALE project, we are implementing innovative approaches using mHealth technology to improve case management of children with pneumonia, diarrhoea and malaria, in addition to improved supervision and data flow.

In Mozambique, we developed the inSCALE CommCare smart phone application, which provides step-by-step guidance for community health workers who diagnose illness in children. A reduction in the number of illness episodes were seen owing to the use of this application. With government interest in this approach, we are now looking to extend its scope by adding a pregnancy registration and tracking module, a supply chain management tool and linking the application to the central data management system.



### Research

Development and piloting of a unified technology solution for malaria rapid diagnostic tests <http://bit.ly/iWidSBK>

### Publication

Mobile health approaches to improve motivation and performance of community health workers in Mozambique <http://bit.ly/iPsIGwL>

### Films

inSCALE mobile technology in Mozambique: Enhancing community health <http://bit.ly/i1z12cMD>

# Making progress with data

Good quality and timely data on malaria are crucial for effective and responsible decision making. However, having this type of data available is a big challenge in many malaria-endemic countries. Malaria Consortium continues to help fill data gaps through surveys, monitoring and evaluation activities, and support to governments to improve centralised data management systems.

- ◆ Our work in this area is increasingly significant, especially in Southeast Asia, where drug resistant malaria has emerged. Tracking cases and collecting data on levels of endemicity in the region are critical to targeting interventions more effectively.
- ◆ Over the past year, Malaria Consortium was appointed as the technical lead organisation to conduct Myanmar's first nationwide Malaria Indicator Survey in partnership with the government. This important work will contribute towards prioritising malaria services to areas of greatest malaria burden.

◆ The best results are achieved when existing datasets are combined to evaluate the impact of malaria interventions. In light of this, we have begun a data mining initiative in Uganda and Nigeria, with funding from DFID, evaluating data from our projects and from national health surveys.

We are also continuing an analysis of Demographic and Health Survey and Malaria Indicator Survey data gathered from several countries across Africa over three decades to provide evidence and recommendations for effective malaria interventions.

- ◆ Our technical findings continue to contribute to the global malaria evidence base and receive interest from across the sector. This year, our work on the evaluation of large scale iCCM programmes in three sub-Saharan African countries was published in a special iCCM issue of the Journal of Global Health, following its presentation at the iCCM Evidence Review Symposium in Accra, Ghana in March 2014.

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## Understanding the changing landscape of malaria

**The changing epidemiology of malaria requires better knowledge of risk factors to drive forward effective control and elimination strategies. In 2012, we launched our flagship project, Beyond Garki, funded by DFID to address a gap in understanding the current dynamics of the epidemiology and control of malaria.**

**Between 2012 and 2014, the project conducted four surveys in selected sites in Uganda and Ethiopia, to monitor malaria epidemiology within the context of various interventions. Our findings indicate that malaria epidemiology seems to be changing compared to earlier published data. Low to moderate malaria prevalence was observed in the selected sites including in previously highly endemic areas.**

**Read the detailed analyses of the baseline and subsequent surveys at:**  
[www.malariaconsortium.org/beyondgarki](http://www.malariaconsortium.org/beyondgarki)

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Good quality and timely data on malaria are crucial for effective and responsible decision making

A family gets tested for malaria in Myanmar, where the country's first nationwide Malaria Indicator Survey launches this year.



# Moving towards malaria elimination

As the burden of malaria around the world continues to reduce, many endemic countries are adopting strategies to eliminate the disease entirely.

While many parts of Africa will not be ready to tackle the elimination agenda for several years, some African countries and several countries in Asia are setting their sights on elimination within the next 15 years. Malaria Consortium has been at the forefront of this agenda, taking the lessons learnt from countries that have been successful in eliminating malaria and applying them to high-transmission countries in Africa and in particular, to elimination strategies within the Greater Mekong Subregion in Asia.

Over the past year our work with governments and tailoring elimination approaches to national, regional or sub-regional contexts has seen good progress.

♦ In **Cambodia**, our IMMERSE project, supported by CDC/PMI has undertaken a range of activities to track artemisinin resistance and to improve health systems performance as well as motivation of health workers. For example, in Pailin province, Malaria Consortium supported village malaria workers in 68 out of 114 villages, covering over

70,600 individuals and providing them with monthly training, transportation allowance and follow up support.

Also in **Cambodia**, we are aiming to understand the feasibility and potential impact of screening for asymptomatic malaria in households where a febrile case of malaria has been reported. With support from the Bill & Melinda Gates Foundation through the Malaria Elimination Scientific Alliance, we have completed research that suggests that reactive case detection and treatment may not be appropriate for very low transmission settings where exposure to malaria occurs away from the community such as in forested areas.

♦ Increasingly, our work in malaria surveillance, monitoring and evaluation in the Asia region is being recognised. This year, in addition to being appointed to undertake the first National Malaria Indicator Survey in **Myanmar**, we have supported the National Malaria Centre to disseminate the results from the fourth large-scale malaria survey in **Cambodia**. The survey, which Malaria Consortium designed, aims to inform the development of future malaria interventions in the country.

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## Strategic advice and policy influence

Malaria Consortium is a member of the WHO Drug Resistance Containment Technical Expert Group, which is guiding global strategies on tackling the threat of artemisinin resistance. We have worked on a feasibility assessment for *Plasmodium falciparum* elimination for the whole Greater Mekong Subregion, which concluded that elimination is feasible, if adequate financing is made available. We are also a member of the WHO Surveillance, Monitoring and Evaluation Technical Expert Group, where we have contributed to developing malaria elimination indicators for a new field manual.

Malaria Consortium has also been actively contributing to the WHO's Emergency Response of Artemisinin Resistance (ERAR) Framework cross-border meetings and technical working groups. This year, we completed a series of surveillance assessments in the six Greater Mekong Subregion countries to support the ERAR Framework.

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# Tackling the spread of drug resistance

Eliminating malaria carries heightened urgency in Southeast Asia, where the rise and spread of drug resistant malaria threatens to undermine global control efforts to control the disease. In some areas along the Cambodia-Thailand border, *P. falciparum* malaria has become resistant to most effective antimalarial medicines. If drug resistant malaria reaches Africa, where the burden of disease is highest, the impact could be devastating, leading to a huge resurgence in cases and the deaths of young children in particular.

This is why much of Malaria Consortium's work in Asia is focused on supporting strategies for the rapid elimination of malaria in areas where there are high levels of artemisinin resistance. We highlight here some of our work with national, regional and international partners to eliminate malaria from the Greater Mekong Subregion by 2030.

- We are contributing to the fight against drug resistant malaria in **Cambodia** through our project on the implementation of a regional artemisinin initiative, funded by the Global Fund. This work is helping to assure universal coverage of LLINs, extending access to quality diagnosis, prevention and treatment, halting the sale of oral artemisinin monotherapies in the private sector, and establishing rigorous surveillance systems.
- In **Thailand** and **Cambodia**, we are supporting the government in developing malaria elimination strategies. We are also partnering with the Asia Pacific Malaria Elimination Network to support member countries in developing successful strategies to eliminate malaria by 2030. We have assisted national surveillance systems and strategies, with a focus on monitoring and evaluation, as well as vector control.
- In **Thailand**, we have contributed to the Partnership for Containment of Artemisinin Resistance project with support from the Bill & Melinda Gates Foundation through the WHO. Malaria Consortium is collaborating with partners on the implementation and use of a web-based, real-time malaria information system for the early detection and effective treatment and follow-up of all malaria cases. With support from CDC/PMI, we are also providing technical support for the development of a behaviour change communications strategy for **Thailand** and the cross border areas with **Cambodia** and **Myanmar**.
- Malaria Consortium has successfully applied a positive deviance approach on malaria in order to improve preventive behaviour among mobile and migrant populations in **Cambodia**, **Thailand** and **Myanmar**. With support from DFID, the Bill & Melinda Gates Foundation and the Global Fund, we provided technical support to national malaria control programmes towards the design, implementation and evaluation of this approach on malaria prevention, control and elimination in the region.

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## Cross border surveillance of malaria

As part of our elimination efforts, we continue to explore how cross-border surveillance can be adapted and better targeted to the most difficult to reach populations and whether it should be continued and scaled up further in Southeast Asia.

This year, Malaria Consortium is consolidating discussions with the Cambodia National Malaria Control Programme and stakeholders to establish a regional cross-border surveillance platform in the Greater Mekong Subregion building from our cross-border findings.

We further solidified our position as a leading organisation addressing artemisinin resistance along country borders in the Greater Mekong Subregion. We started four new research projects this year, winning support from Global Fund to scale up diagnostic testing in the Cambodia-Laos border.

The Thai-Cambodia-Laos border region is of central importance to efforts to stop the spread of drug resistant malaria and eliminate the disease in the region. Highly mobile migrant communities living in this region who are vulnerable to drug resistant malaria cross the borders regularly for work and, therefore, play a key role in its spread.

Early research results have identified important locations on the Cambodia-Laos border, where prevalence of asymptomatic infections in cross-border travellers indicates the high potential value of providing malaria protection packages to these travellers, thus linking surveillance to timely response.

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### Films and animation

Malaria elimination in Cambodia and Myanmar <http://bit.ly/iTCyaVt>

Active case detection and treatment in Cambodia and Thailand  
<http://bit.ly/iJv57jW>

The threat of drug resistant malaria  
<http://bit.ly/iDNqfNF>

### Research

Understanding malaria prevention and treatment strategies among migrants in Thailand's Cambodia and Myanmar border areas <http://bit.ly/iEfHA1g>

### Presentation

Cambodia malaria surveillance system  
<http://bit.ly/iLP4nK>



“

Although we do not know much about malaria, we know that if we get sick, there is one village malaria worker nearby who we can seek for advice. We also received these mosquito nets from the village malaria worker”

Khem Bou, Cambodia

Among those being reached by trained village malaria workers in Pailin, Cambodia is Khem Bou, a mother of two who had relocated her family to Pailin to find work at a cassava farm.

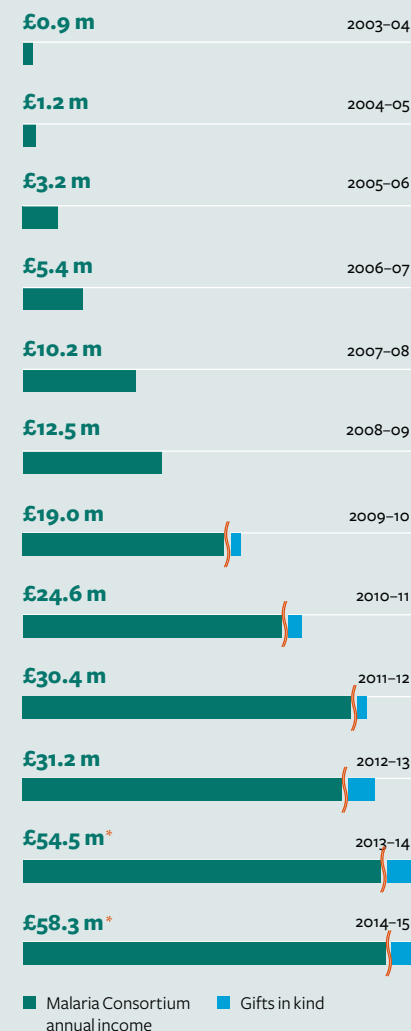
# Account summary

## Statement of financial activities (incorporating an income and expenditure account) for the year ended 31 March 2015

	2015			2014
	Unrestricted funds £000s	Restricted funds £000s	Total funds £000s	Total funds £000s
<b>Incoming resources</b>				
Incoming resources from generated funds				
Voluntary Income				
Donations for Core Operations	2	-	2	15
Gifts in kind	65	20,926	20,991	22,860
Investment income				
Interest received	7	-	7	17
Other income	159	-	159	41
Incoming resources from charitable activities				
Grants, contracts & consultancy income	7,439	29,700	37,139	31,602
<b>Total incoming resources</b>	<b>7,672</b>	<b>50,626</b>	<b>58,298</b>	<b>54,535</b>
<b>Resources expended</b>				
Cost of generating funds	652	-	652	671
Charitable activities	5,154	50,626	55,780	54,156
Governance costs	377	-	377	276
<b>Total resources expended</b>	<b>6,183</b>	<b>50,626</b>	<b>56,809</b>	<b>55,103</b>
<b>Net incoming / (outgoing) resources before transfer</b>	<b>1,489</b>	<b>-</b>	<b>1,489</b>	<b>(568)</b>
Gross transfer between funds	35	(35)	-	-
<b>Net income / (expenditure) for the period</b>	<b>1,524</b>	<b>(35)</b>	<b>1,489</b>	<b>(568)</b>
<b>Fund balances at start of year</b>	<b>4,958</b>	<b>35</b>	<b>4,993</b>	<b>5,561</b>
<b>Fund balances at end of year</b>	<b>6,482</b>	<b>-</b>	<b>6,482</b>	<b>4,993</b>

The Statement of Financial Activities includes all recognised gains and losses in the current and preceding year.  
All operations are continuing.

## Malaria Consortium income



\* Figure include gifts in kind for Uganda net distribution:  
£20.5 m (2014-15)  
£22.4 m (2013-14)

## Balance sheet as at 31 March 2015

	2015		2014	
	£000s	£000s	£000s	£000s
<b>Fixed assets</b>				
Intangible assets		21		33
Tangible assets		600		602
<b>Current assets</b>				
Debtors	8,048		3,425	
Cash at bank and in hand	12,766		11,424	
<b>Total</b>	<b>20,814</b>		<b>14,849</b>	
<b>Creditors</b>				
Amounts falling due within one year	(14,526)		(10,355)	
		6,288		4,494
<b>Total assets less current liabilities</b>		6,909		5,129
Provision for liabilities		(427)		(136)
<b>Net assets</b>		<b>6,482</b>		<b>4,993</b>
<b>Represented by:</b>				
Unrestricted funds		6,482		4,958
Restricted funds		-		35
<b>Total</b>		<b>6,482</b>		<b>4,993</b>



## The Trustees

The Trustees, who are also Directors under company law, who served during the year and up to the date of this report were as follows:

Chair	Dr Julian Lob-Levyt
Treasurer	Richard Page (resigned 23 June 2015)
Acting	
Treasurer	Peter Potter-Lesage
	Robert Seabrook
	Tim Armstrong (resigned 5 March 2015)
	Professor Fred Binka
	Ian Boulton
	Professor Sir Brian Greenwood
	The Rt. Hon. Baroness Hayman
	Professor Melissa Leach
	Dr Joanna Schellenberg
	Dr Nermeen Varawalla
	Kate Wallace (resigned 30 July 2015)
	Roger Wilson (resigned 13 June 2015)
	Dr Neil Squires (app 27 April 2015)
	Canisius Anthony (app 17 July 2015)

## Structure, governance and management

### *Trustees and organisational structure*

Malaria Consortium was established under a Memorandum of Association which established the objects and powers of the charitable company, and is governed under its Articles of Association. The charity is governed by a Board of Trustees, of whom there shall never be less than three, and the maximum number shall be eighteen. The Trustees meet quarterly for the Board of Trustees meeting, and for the Annual General Meeting, at which the audited accounts for the year are formally approved. At the AGM one third of the Trustees retire, and are eligible for re-election as long as they have not served for a continuous period exceeding six years. After six years Trustees must retire.

New trustees are recruited for their skills in areas relevant to the governance, aims or the changing nature of strategy and activities of Malaria Consortium. The trustees may at any time select a suitable person as a trustee, either to fill a vacancy or by way of addition to their number, who should be appointed in consultation with all existing trustees on the Board and preferably with unanimous support for the appointment.

Trustees are sought in a variety of ways involving exploration of the field of potential candidates, including by recommendation from those working for or with Malaria Consortium, or from existing trustees. Potential trustees are scrutinised by the Officers of the Board of Trustees and by the Board as a whole. All new trustees receive an induction to the organisation by the Chief Executive and may be invited to attend a Board Meeting prior to election. During the year, four Board Meetings took place, including the AGM and a retreat held in November 2014. An average of 10 trustees attended each meeting.

There are three sub-committees of the Board, the Governance Committee, the Finance, Audit and Risk Committee and the Compensation Committee. The purpose of the Governance Committee is to review and make recommendations regarding Board effectiveness, provide direction regarding on-going Board development and lead the process of Board renewal. Currently, the Committee comprises five members including the Chief Executive who is a non-voting member of the Committee. During the year there were four meetings of the Governance Committee; four trustees were at three meetings and two trustees at one meeting.

The purpose of the Finance, Audit and Risk Committee is to provide assurance to the Board that an effective internal control and risk management system is maintained and that Malaria Consortium's financial performance is being effectively managed. Currently, the Committee comprises six members, including two non-trustee members, and the Chief Executive and Chief Finance Officer as non-voting members. During the year there were four meetings of the committee and an average of three trustees attended each meeting.

The purpose of the Compensation Committee is to review and make recommendations on the Chief Executive's remuneration, the framework for the Global Management Group's remuneration and the organisation's human resources strategy and policies. Currently, the Committee comprises four trustee members, including the Chair of the Board of Trustees. The committee met once during the year at which four trustees were in attendance.

The Board of Trustees approves the major strategic decisions for the organisation. Each year, a number of trustees are invited to make field visits to be fully informed about Malaria Consortium's activities, thus enabling them to effectively support these strategic decisions. The Board of Trustees delegates day-to-day operational decision-making to the Chief Executive, who, with the Global Management Group, runs the organisation. The GMG is supported by Senior Management Teams at regional and country level responsible for technical, management and finance, as well as projects and programmes.

Malaria Consortium's head office is in London, United Kingdom. The regional offices for Africa, based in Kampala, Uganda and for Asia, based in Bangkok, Thailand coordinate and supervise programmes and projects at country level in the two regions. The Country Director of Nigeria reports directly to the Chief Executive. Global activities and any work in other parts of the world are directed through the head office in the UK. During this reporting period, country offices in Africa were operating in Kampala, Uganda; Juba, South Sudan; Addis Ababa, Ethiopia; Maputo, Mozambique; Ouagadougou, Burkina Faso; and Abuja, Nigeria. Additional provincial or sub-national offices were operational in Mbale, Hoima and Soroti in Uganda, Aweil in South Sudan, Inhambane and Nampula provinces in Mozambique, Hawassa in Ethiopia and in Kano, Lagos, Anambra, Katsina, Niger, Ogun, Enugu, Jigawa and Kaduna states in Nigeria. Staff in Nigeria also support Yobe state from Jigawa, and have presence implementing programmes in 9 other states. The Uganda Malaria Research Centre continues its activities in Kampala. In Asia offices were operational in Bangkok and Chiang Mai in Thailand and Phnom Penh, Ratnakiri and Pailin in Cambodia as well as in Yangon, Myanmar.

During this year Malaria Consortium's partners who have supported our work at the global and regional level include the Department for International Development/United Kingdom Aid, United States Agency for International Development and US President's Malaria Initiative, Bill & Melinda Gates Foundation, Comic Relief, Global Malaria Programme of the World Health Organization, the Global Fund to Fight AIDS,



Tuberculosis and Malaria, Centers of Disease Control and Prevention, USA, UNICEF, UNITAID, the World Food Program and the James Percy Foundation.

At country level, our partners include National Malaria Control Programmes and Ministries of Health; local and regional UN offices; regional organisations in West, East, and Southern Africa, bilateral donors; international foundations; civil society organisations; development projects, private sector and most importantly communities suffering from malaria and other communicable diseases.

Close collaborations are maintained with academic institutions in UK including the Nuffield Centre for International Health and Development at Leeds University, the London School of Hygiene & Tropical Medicine and University College, London; Johns Hopkins University in the USA; Makerere University, Uganda; Kwame Nkrumah University of Science and Technology, Ghana; the University of Nigeria; Eduardo Mondlane University, Mozambique; Mahidol University, Thailand; and Pasteur Institute, Cambodia.

Malaria Consortium is involved with the Roll Back Malaria Partnership globally and at country level. In the UK, we work with the All Party Parliamentary Group for Malaria and Neglected Tropical Diseases, Malaria No More UK and others. We have a considerable amount of local advocacy partners in endemic areas, working to advocate for change and an end to malaria and neglected tropical diseases. In Nigeria, we work with the Christian Health Association of Nigeria, the Federation of Muslim Women's Association of Nigeria, the Health Reform Foundation of Nigeria, the Centre for Communication Programme Nigeria and the Health Policy and Research centre of the University of Nigeria. In Ethiopia, our partners include Coalition against Malaria in Ethiopia and the Carter Centre. In Mozambique, we work in conjunction with NAIMA +.

Malaria Consortium works with the commercial sector internationally especially in assessing public health products, mainly insecticide-treated mosquito nets, and more recently rapid diagnostic tests for malaria.

Malaria Consortium raises its income, which is predominantly restricted, through successful

project contract and grant applications. The organisation currently receives a small amount of funding through fundraising efforts of public and private supporters to whom we are very grateful.

Malaria Consortium, owns 100% of the shareholding of Malaria Enterprise Limited. The directors of Malaria Enterprise Limited are Richard Page, the previous Treasurer, the Chief Executive and the Chief Finance Officer of Malaria Consortium. Malaria Enterprise Limited was dormant during the year.

Malaria Consortium US Inc. was established in 2009 to further the aim and objectives of Malaria Consortium in the United States of America. The directors of Malaria Consortium US Inc. are two ex-trustees of Malaria Consortium and are independent from the UK Board of Trustees. As Malaria Consortium does not control the activities of Malaria Consortium US Inc. Malaria Consortium does not consolidate its results within these accounts.

### Principal risks and uncertainties

The responsibility for overseeing the management of risk has been delegated by the Trustees to the Finance, Audit and Risk Committee that reports to the Board. The Risk Assessment and Risk Management processes are reviewed quarterly by the committee and updated. During the year the Board of Trustees approved the Risk Appetite of the organisation. The major risks, to which the charity is exposed, as identified by the Trustees, are reviewed and processes have been established to manage those risks. The Finance, Audit and Risk Committee review quarterly the Risk Assessment Register (RAR) that shows the impact and probability of the major risks; this is updated and key risks are reported to the Board by the Committee.

### Statement of Trustees' responsibilities in relation to the Account Summary

The Account Summary comprises the Statement of Financial Activities and Balance Sheet, of Malaria Consortium.

The Account Summary presented within the Highlights of the year 2014/15 does not constitute the full financial statements of Malaria Consortium for the financial years ended 31 March 2015 and 31 March 2014 but represents extracts from them. These extracts do not provide as full an understanding of the financial performance and position of Malaria Consortium as the full annual financial statements of Malaria Consortium.

The financial statements for those years have been reported on by Malaria Consortium's independent auditor. The reports of the auditor were:

- unqualified;
- did not include a reference to any matters to which the auditor drew attention by way of emphasis without qualifying their report; and
- did not contain a statement under section 498 (2) or (3) of the Companies Act 2006.

The Trustees have accepted responsibility for preparing the Highlights of the year 2014/15 and for preparing the Account Summary included therein by extracting the Statement of Financial Activities and Balance Sheet included in the Account Summary directly from Malaria Consortium's full annual financial statements.

The Account Summary was approved by the Trustees and signed on their behalf on 15 November 2015.



Peter Potter-Lesage  
Acting Treasurer

### **Independent statement of KPMG LLP to Malaria Consortium**

We have examined the Account Summary of Malaria Consortium (“the charitable company”) for the year ended 31 March 2015 set out on pages 30 to 31 of the Highlights of the year 2014/15.

This statement is made solely to the charitable company on terms that have been agreed with the charitable company. Our work has been undertaken so that we might state to the charitable company those matters we have agreed to state to it in such a statement and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charitable company for our work, for this statement, or for the opinions we have formed.

### **Respective responsibilities of trustees and KPMG LLP**

As explained more fully in the Trustees’ Responsibilities above, the Trustees have accepted responsibility for extracting the Account Summary within the Highlights of the year 2014/15 from the full annual financial statements of the charitable company.

Our responsibility is to report to the charitable company our opinion on the accurate extraction of the Account Summary within the Highlights of the year 2014/15 from the full annual financial statements of the charitable company.

### **Basis of opinion**

Our examination of the Account Summary consists primarily of agreeing the amounts and captions included in the Account Summary to the corresponding items within the full annual financial statements of the charitable company for the year ended 31 March 2015.

We also read the other information contained in the Highlights of the year for 2014/15 and consider the implications for our statement if we become aware of any apparent misstatements or material inconsistencies with the Account Summary.

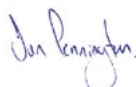
This engagement is separate from the audit of the annual financial statements of the charitable company and the report here relates only to the extraction of the Account Summary from the

annual financial statements and does not extend to the annual financial statements taken as a whole.

As set out in our audit report on those financial statements, that audit report is made solely to the charitable company’s members, as a body, in accordance with Chapter 3 of Part 16 of the Companies Act 2006. The audit work has been undertaken so that we might state to the charitable company’s members those matters we are required to state to them in an auditor’s report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charitable company and the charitable company’s members, as a body, for that audit work, for the audit report, or for the opinions we have formed in respect of that audit.

### **Opinion on Account Summary**

On the basis of the work performed, in our opinion the Account Summary included in the Highlights of the year for 2014/15 has been accurately extracted from the full annual financial statements of the charitable company for the year ended 31 March 2015.



.....  
Ian Pennington (Senior Statutory Auditors)  
For and on behalf of KPMG LLP, Statutory Auditor  
Chartered Accountants  
15 Canada Square  
London  
E14 5GL

## Our resources

### Peer reviewed publications

Malaria Consortium staff have led or provided input into a number of published journal articles this year.

[www.malariaconsortium.org/pages/journal-articles.htm](http://www.malariaconsortium.org/pages/journal-articles.htm)

### Publications database

Our online database contains over 300 resources including technical reports, learning papers and advocacy briefs.

[www.malariaconsortium.org/resources/publications](http://www.malariaconsortium.org/resources/publications)

### Website

Our web pages have a wealth of information in the areas we work in and our projects worldwide.

[www.malariaconsortium.org](http://www.malariaconsortium.org)

### Films

Our experiences in the field are captured in our films.

[www.youtube.com/user/malariaconsortiumuk](http://www.youtube.com/user/malariaconsortiumuk)

## Connect with us

### Follow us

On Twitter: [@FightingMalaria](https://twitter.com/FightingMalaria)

On Facebook: [MalariaConsortium](https://www.facebook.com/MalariaConsortium)

On LinkedIn: [Malaria Consortium](https://www.linkedin.com/company/malaria-consortium)

### eNewsletters

Our eNewsletters showcase our latest activities and outputs.

[www.malariaconsortium.org/newsletter](http://www.malariaconsortium.org/newsletter)







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Malaria Consortium/Tine Frank



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