

Highlights from the Trustees' report and financial statements 2015-16



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This document contains extracts from the Malaria Consortium Trustees' Report and Financial Statements For the Year to 31 March 2016. A full set of accounts including the full trustees' report is available at:

www.malariaconsortium.org/resources/publications/861/

Highlights from the Trustees' report and financial statements 2015-16



The year 2015-16 has seen us again make progress in delivering our mission to improve lives in Africa and Asia through sustainable, evidence-based programmes that combat targeted diseases and promote child and maternal health.

There remains significant reason to be encouraged in the fight against malaria with further confirmation that progress is being made in reducing malaria deaths and incidence. It is important to note, however, that the context within which the world sees infectious disease control and elimination is changing. Two examples perhaps will suffice.

Firstly, there are the new Sustainable Development Goals (SDGs), which replace the Millennium Development Goals of 2000-15, now adopted by the UN General Assembly. While delighted that malaria and neglected tropical diseases both feature as indicators within an objective on 'Good Health and Wellbeing' (No.3), the 17 objectives and 230 indicators of the SDGs now target a much wider range of complex issues aimed at improving lives and equity and reducing the negative impact of humankind on the planet. Work is therefore ongoing to keep the infectious disease control and elimination agenda high in the priorities of national governments and the international community, so as not to lose the momentum gained over the last 15 years.

Secondly, there are new health challenges. These challenges are both acute, as in the response to the outbreak of Ebola in several countries of West Africa, with its accompanying risk of transmission globally, and chronic, with the arrival of non-communicable diseases of older age and lifestyle change where infectious disease

management and improved maternity and neonatal interventions have been the priorities. As epidemiology changes, and diseases are gradually contained, a broader strengthening of the health system must occur, with greater degrees of integration of all interventions where it is cost-effective to do so.

With this backdrop, it is important to remind ourselves that Malaria doesn't just 'go away' – it has to be worked away; that more children under the age of five die from malaria in one week than the total number of those who have lost their lives to Ebola since its identification in the 1970s; that many millions continue to suffer the debilitating effects of repeated exposure to infection from neglected diseases; and that malnutrition remains a reality for a large part of the world.

As such, we still have a major job to do to respond to these ongoing realities and our 2015-19 strategy reflects this. We continue to work across all the levels of transmission, helping national 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.

Where malaria transmission risk exists, 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 this reporting period we have had the privilege of leading an initiative to reach over 3.2m children (less than 5 years old) with a prophylactic intervention, called 'Seasonal Malaria Chemoprevention',

in seven countries across the Sahel region of sub-Saharan Africa. This is a once-a-month, drug-based intervention, approved by the World Health Organization, appropriate where the rainy season happens over a four month period of the year and brings with it an upsurge of the mosquito population and malaria. This is demonstrating a significant (more than 60 percent) reduction in all cause presentation of fever for the age group. This intervention is highly cost effective and we have been able to demonstrate it can be taken to scale in some of the most remote regions. While the available drugs remain effective we see this as a major contributor to reducing malaria-related deaths and morbidity. In low transmission environments, we continue to 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.

In last year's message we spoke of our work in integrating activity around the febrile child, particularly through integrated community case management programmes, dealing with the other main causes of fever in children, pneumonia and diarrhoea and tracking and responding to malnutrition. Differential diagnosis is critical and new diagnostic approaches continue to arrive. We have been working to test various options for supporting the diagnosis of pneumonia, testing many devices, in multiple countries, for suitability for use by community health workers and their supervisors.

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. This has become all the more important

as we see the growth in mosquito-borne viruses such as Zika and Dengue. It is worth noting that these viruses are transmitted by a different mosquito (*Aedes aegypti*) than transmits malaria (*Anopheles*), and though in some cases co-endemic, the interventions used for malaria are not always applicable due to different biting habits (day rather than night). While needing different interventions, these viruses have reopened the debate on the need for entomological tracking and intervention, not just epidemiological tracking and intervention, and both are core to Malaria Consortium's mandate and expertise.

In this Annual Review, we highlight, in more detail, some examples of the progress against our strategic objectives, but 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 ongoing journey with us. I cannot end without a short tribute to our Global Technical Director, Dr Sylvia Meek. Sylvia died earlier in the year after living with cancer for 18 months. A superb scientist, she was the driving force behind the technical excellence of Malaria Consortium's evidence-based approach. Even more, she was admired and loved by those she came in contact with around the world for her humanity, courage and gentleness of spirit. She will be deeply missed. She dedicated her life to saving the lives of others and those of us who have had the privilege of knowing and working with her, will build on her legacy and demonstrate the reality of the strength-in-depth she has left behind. If you would like to know more, please visit our website.

Charles Nelson
Chief Executive

Our mission is to improve lives in Africa and Asia through sustainable, evidence-based programmes that combat targeted diseases and promote child and maternal health.

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 their 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

Objectives

This reporting period, reflects the first operating year of a new five year strategy 2015-2019, with four key business areas and five new strategic objectives. This strategy has been developed in light of the transition at a global level from the Millennium Development Goals (MDGs) to the new Sustainable Development Goals (SDGs) agreed at the United Nations General Assembly in 2015.

The four key business areas are:

Preventive Treatment

Looking at intervention through prophylaxis, mass drug administration and existing and emerging vaccines.

Vector Control

Looking both at interventions to reduce the number of vectors present in the community and keeping beneficiaries apart from the vector.

Case management

Covering both diagnosis and treatment, improving both access to and the quality of services available should an individual present with symptoms.

Health Service Effectiveness and Efficiency

Recognising that there are many diverse elements to health system strengthening, we focus on the key interventions that deliver the functionality and data necessary for effective decision making and response to health needs.

We recognise that these business areas are not always found in isolation and the five strategic objectives aim to reflect this. Our first objective covers our overarching work to put in place the policies, mechanisms and resources necessary, at a national and international level, to ensure the right interventions are not hindered by lack of support at a political level. The remaining four objectives are directly linked to each of the business areas. We will measure the progress of our strategy against these objectives. The objectives are:

1. To guide international and national policies and strategies to enhance control and accelerate elimination of targeted diseases and malnutrition.
2. To reach at least 10 million people (in the strategy period) with preventive treatment, supporting the appropriate uptake of emerging vaccines and drug-based prevention approaches.
3. To engage in at-scale delivery of effective vector control interventions and develop, investigate, promote and implement novel, vector-focused approaches that reduce disease transmission.
4. To improve access to, and the quality of services for, the diagnosis and treatment of diseases and/or those that enhance child and maternal health.
5. To improve health system effectiveness and efficiency, through enhanced surveillance, outbreak response, referral, reporting, and capacity and market development.

Our achievements

At an operational level, Malaria Consortium has continued to expand our programmes to improve access to effective prevention and treatment of malaria, pneumonia and neglected tropical diseases to some of the poorest populations in Africa and Asia.

We have launched in Burkina Faso, Chad and Sierra Leone and funded a pilot study in the Chittagong Hill Tract in Bangladesh.

A selection of key achievements and challenges for the year, linked to our objectives, is presented below:

To guide international and national policies and strategies to enhance control and accelerate elimination of targeted diseases and malnutrition

Malaria Consortium, both at international and national level, has maintained presence in key partnerships and working groups linked to policy and advocacy – Internationally at the WHO's Malaria Policy Advisory Committee (MPAC) and Vector Control Working Group and have been actively engaged in the reformation of the Roll Back Malaria Partnership. In the UK, we work with the All Party Parliamentary Group for Malaria and Neglected Tropical Diseases. We partner with Ministries of Health in each country, and also work with local advocacy partners in endemic areas, aiming to change policy and practice so as to end malaria and neglected tropical diseases. For example, 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 +. Where appropriate we work to broker deals with the private sector to establish sustainable channels for delivery of public health and ensure clear, regulated, contributions. We also work with the commercial sector internationally especially to assess new public health products which may provide the next generation of interventions that need to be built into policy. We continue to serve on the WHO Drug Resistance Containment Technical Expert Group which is guiding global strategies on tackling the threat of artemisinin resistance.

The UKaid SuNMaP programme in Nigeria concluded after 7.5 years working directly alongside the National Malaria Elimination Programme. Dissemination events were held in all supported states and at a national level and highlighted the significant contribution of the programme to the progress of the fight against malaria in Nigeria, and the harmonisation of policy and the key stakeholders.

To reach at least 10 million people (in the strategy period) with preventive treatment, supporting the appropriate uptake of emerging vaccines and drug-based prevention approaches

The primary intervention that has contributed to this objective has been seasonal malaria chemoprevention for children of 3-59 months in the Sahel Region of Sub-Saharan Africa. This intervention is approved by WHO for this age-group for regions where malaria transmission is at a peak during a period of no more than four months, and where the available drugs (Sulphadoxine Pyrimethamine & Amodiaquine (SPAQ)) are still effective. The total eligible group for this intervention is about 25 million children. Funded by UNITAID, Malaria Consortium is leading a partnership of Catholic Relief Services (CRS), London School of Hygiene & Tropical Medicine (LSHTM), Medicines for Malaria Venture (MMV), Management Sciences for Health (MSH) and Speak Up Africa to develop the market for child friendly dispersible products across seven countries (Nigeria, Chad, Burkina Faso, Mali, Niger, Guinea and The Gambia). In the 2015 rainy season, we reached over 3.2 million children with the requisite four monthly doses and saw presentation of fever at clinics drop by a dramatic 65+%. This is the first programme of its type, going to scale in this way across seven countries and, although we did not reach of the initial target (twice the achieved level) this was due to non-availability of appropriately qualified product – an issue which has been resolved for the 2016 season, it represented a significant step forward and has resulted in strong domestic uptake and the interest of other major international donors.

Malaria Consortium has continued to seek funding opportunities to expand mass drug administration for various neglected tropical diseases, but limited additional funding has been realised. However, work funded through our Programme Partnership agreement has allowed us to push ahead with research work on the effect of community dialogues on the uptake of available treatment for schistosomiasis in Mozambique and the roll-out of treatment for worm infections in nearly 170 thousand

children in Central Equatoria, South Sudan. Also, in Ethiopia we have worked in four districts, to pilot an integrated malaria, schistosomiasis and soil-transmitted helminth approach in schools.

Malaria Consortium is experienced in conducting field trials of vaccines and has been exploring the chance to run scaled-up trials for the recently registered RTSS vaccine for Malaria from GlaxoSmithKline. This has been recommended as an additional tool in high transmission areas but programmes have not yet been finalised. A dengue vaccine is also awaited.

To engage in at-scale delivery of effective vector control interventions and develop, investigate, promote and implement novel, vector-focused approaches that reduce disease transmission

Malaria Consortium has continued to be involved in large scale distribution of long-lasting insecticide-treated nets (LLINs), which remain one of the key, high-value interventions against malaria. In Nigeria, with both UKaid and USAID funding, we were engaged in campaigns to deliver 5.5 million nets in three states reaching a target population of 11 million people, and 0.65 million nets delivered through continuous distribution channels such as schools and antenatal care. Though getting significant interest from the private sector, it has proved a challenge to get consistent uptake of nets through commercial channels, as leakage of free nets and price diminution distort the market. In northern Mozambique, supported by Global Fund, Malaria Consortium delivered 1.4 million nets in Niassa and Nampula provinces to a target population of 2.6 million. The total value of gifts in kind was lower than the previous years both because the sum of the nets needed for campaigns was less than the prior year, and where nets were utilised in Nigeria, they did not meet the necessary criteria to be categorised as gifts in kind (e.g. Malaria Consortium was not required to take ownership of the nets at any point).

Results from some Malaria Consortium research, in partnership with London School of Hygiene & Tropical Medicine, showed that, although resistance is growing in mosquitos to the pyrethroid used as the insecticide, there was still a significant effect on the ability of the parasite to develop in the mosquito before transmission. While new insecticides are being developed, and even as the efficacy of the net reduces to control the mosquito population, this research suggests that ongoing use of currently available LLINs is highly valuable as transmission rates will continue to be reduced.

We are implementing an integrated vector management programme for dengue control in Cambodia, particularly seeing how well accepted a variety of approaches are to the community, and field testing tools. This will provide significant insight on a number of diseases as the vector, *Aedes aegypti*, is the one responsible for the transmission of the Zika virus and yellow fever. It has been a challenge to solidify donor interest in direct funding.

There has been significant activity looking at insecticide treated clothing in Southeast Asia, as many migrant and mobile populations are night/forest workers and particularly vulnerable to being bitten. The products have been well received in principle, but there are still some issues to resolve on price-point, acceptability of design for younger people, and the willingness of employers to fund such products as 'uniform'.

To improve access to, and the quality of services for the diagnosis and treatment of diseases and/or those that enhance child and maternal health

In the unfortunate event that transmission of any of the diseases or shortage of food requires intervention, this objective is targeted at improving access to and the quality in differential diagnosis and treatment at all levels of the health system.

In diagnosis, major steps continue to be taken in the widespread use of rapid diagnostic tests and acceptance that there should be parasitological diagnosis of malaria prior to diagnosis has been built into most countries' protocols. While this progress has been made, there is more to do to assure that protocol is followed, both in terms of quality supply and consistent clinician behaviour. There was a setback for in plans for expanding private sector use in Nigeria and Uganda when a funding extension was not forthcoming.

There has been significant progress on the field evaluation of different tools for diagnosis of pneumonia. Funded by the Bill & Melinda Gates Foundation, Malaria Consortium has led a piece of work evaluating multiple electronic devices across six countries, comparing to existing norms. There is certainly hope that cost-effective tools can be added to effectively diagnose, and therefore treat pneumonia.

Integrated community case management (iCCM) of malaria, pneumonia and diarrhoea remains a key approach to intervening in the common childhood diseases found in Southeast Asia and sub-Saharan Africa. This is now being linked more regularly to community assessment of

malnutrition and access to therapeutic feeding, directly or indirectly (iCCM+). We now have experience of this in Mozambique, Uganda, Nigeria, South Sudan and Myanmar. In each country the exact role played by the community workers differs and combination funding is required as a very supportive Global Fund can only provide commodities associated with malaria in this context.

We continue to push an agenda for engagement in case, morbidity and disability management for certain neglected tropical diseases (such as lymphatic filariasis) to complement programmes of mass drug administration. It continues to be a challenge in systems where chronic case management of any sort is not a common feature and where funding is constrained.

In this year we were also involved, in partnership with the Comic Relief 'Big Build', in the recreation of a health centre in Iyolwa, Uganda. This has been followed by further funding to ensure that referrals for complex case management operate effectively.

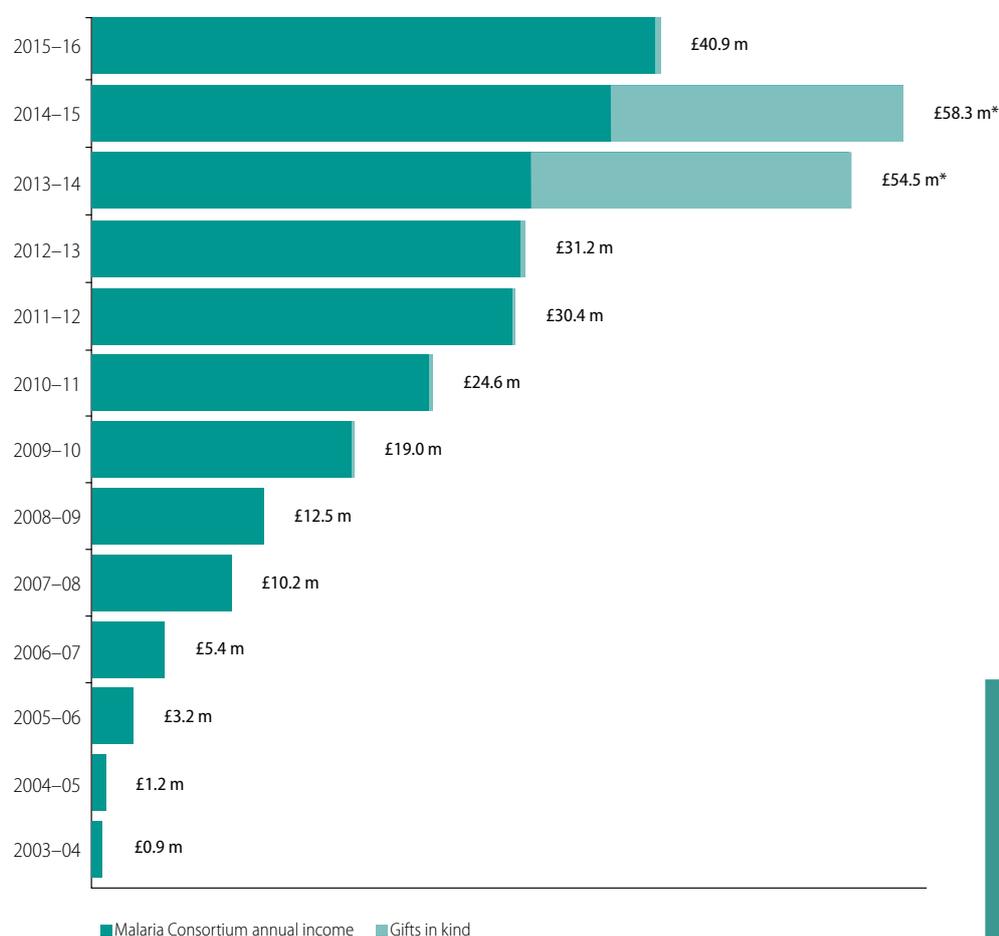
To improve health system effectiveness and efficiency, through enhanced surveillance, outbreak response, referral, reporting, and capacity and market development

Our last objective is focused on health system effectiveness and efficiency. Malaria Consortium has traditionally used malaria as our access point and leveraged off this to support wider aspects of service delivery such as community delivery, clinical capacity building, laboratory services, antenatal care, child and maternal health and data capture and analysis. This has been particularly effective in high malaria transmission areas as we help bring down the burden of both simple and complex cases of disease and allow the system to concentrate on improving differential diagnosis and targeted treatment in remaining cases. It also allows time for the clinical staff to build capacity and balance the supply chain.

As burden decreases and the thinking moves towards elimination, new tools and techniques have to be put in place. Surveillance and rapid response to outbreaks become key and surveillance becomes an intervention in its own right. Technology is increasingly playing a part in data capture and sharing and in the support and supervision of remote and community workers. Linkages are also being made to wider interventions in child and maternal health.

Malaria Consortium has invested through the reporting year to develop new sub-strategies and approaches for surveillance and interventions in the wider health system and have continued to build our portfolio of activities. In Myanmar and Ethiopia we have led the country-wide Malaria indicator surveys. We are working on key elimination strategies in Cambodia and Thailand. In Mozambique and Uganda, we finalised our work on the inSCALE programme, looking at the increased effectiveness of community health workers with the support of technology and, in Mozambique, this is now being expanded to widen the number of functions (e.g. pregnancy registration) and cover a significantly greater geography. In Sierra Leone we are exploring how best to rebuild the health system post-Ebola and instate a new, stronger surveillance approach. In Laos, we completed a review of the dengue surveillance system and are looking to support implementation of recommendations. With our communicable disease health system delivery research (COMDIS-HSD) activity in partnership with Leeds University, we are exploring: the barriers to uptake of intermittent preventive treatment of malaria in pregnancy in Uganda; the effectiveness of a community dialogues' approach in enhancing community participation and improving knowledge and practices for the prevention and control of NTDs; exploring factors which affect the rational use of antibiotics at community level in Zambia; and evaluating integrated community case management in rural and peri-urban settings in Uganda.

Annual income



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

The Trustees' Report and Financial Statements For the Year to 31 March 2016 is available at:

www.malariaconsortium.org/resources/publications/861/

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

Publications database

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

Films

Our experiences in the field are captured in our films.
www.youtube.com/user/malariaconsortiumuk

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