Global Technical Strategy for Malaria Control and Elimination 2016-2025

1. Learning from the past

The last Global Strategy for malaria was launched in 1993. In 1989 the WHO Executive Board and the World Health Assembly, respectively, adopted resolutions EB83.R16 and WHA 42.30, asserting that malaria control must be a global priority and that it was essential for the achievement of health for all and the objectives of child survival programmes. In January 1990 a proposal was made at the 85th session of the Executive Board that a global conference should be convened at a ministerial level to focus on the worsening situation, to adopt a global strategy for malaria control, and to intensify the commitment to malaria control of political and health leaders, and donor agencies.

The development of the Global Strategy -- which included four main components: disease management through early diagnosis and prompt treatment; planning and application of selective and sustainable preventive measures; early detection or prevention of epidemics and their containment; and capacity building for regular assessment of the malaria situation, including the social and economic determinants of the disease -- was a combined effort involving experts at the national, regional and global levels.

The strategy evolved during three interregional meetings held in Brazzaville, New Delhi and Brasilia in 1991 and 1992 – each averaging 130 participants and a budget of $300,000 (not adjusted for today's value) - and during five meetings of a global consultative group that guided the preparation of the Ministerial Conference. It was finally adopted by the Ministerial Conference in Amsterdam, which included 450 participants from 95 countries, in October 1992. The conference was chaired by the Minister of Health, Congo, and by four vice-chairs – the Ministers of Health from Guatemala, Indonesia, Oman and Vanuatu - from the five malaria-endemic WHO regions. The total cost of this process was approximately $3 million at the time.

How successful the strategy was following its release is unclear as it was not evaluated. However, very few resources were targeted for malaria throughout the 1990s, and there was a steady worsening of the malaria situation globally. It was not until the early to mid-2000's, following the founding of the Roll Back Malaria (RBM) partnership by WHO, Unicef, UNDP, and the World Bank, that the global malaria community began to see a marked increase in resources, which led to the scale-up of available tools, and the start of what has since been a measurable reduction in disease burden.

Links to the Global Strategy for malaria control, and the implementation guide that accompanied its launch, are available online:

a) Title: A Global strategy for malaria control.
Publication info: Geneva : World Health Organization, 1993.
Physical description: 30 p.
Electronic access: http://whqlibdoc.who.int/publications/9241561610.pdf

b) Title: Implementation of the global malaria control strategy: report of a WHO Study Group on the Implementation of the Global Plan of Action for Malaria Control 1993-2000 [meeting held in Geneva from 8 to 12 February 1993]
Publication info: Geneva : World Health Organization, 1993.
Physical description: 57 p.
Electronic access: http://whqlibdoc.who.int/trs/WHO_TRS_839.pdf

In the mid 2000s, GMP began the process of developing an internal global strategy, but the process was never concluded, and no document was ever released.

In 2008, the RBM partnership released the Global Malaria Action Plan (GMAP). This document, while quite technically detailed in nature, was not a new technical strategy. Rather, it was a "call to arms" for the many partners working on malaria control to focus on the same goals and objectives, and follow similar strategies. It was developed through a broad consultative process with individuals across various RBM constituencies, let by a team of consultants. From a technical perspective, new strategies were not proposed. Rather, the document was grounded in WHO recommendations for malaria control and elimination. The aim of the document was to improve advocacy, resource mobilization, and partner harmonization.

2. The need for a new Global Strategy

The last decade has witnessed unprecedented progress in malaria control, especially in Africa, the continent that still bears the greatest malaria burden. A massive increase in resources has led to tremendous scale-up and increased access and coverage of key antimalarial interventions resulting in moderate declines in malaria cases and deaths.

Given this context, at its last meeting in September, the Malaria Policy Advisory Committee (MPAC) supported the idea that WHO-GMP should develop a Global Technical Strategy for Malaria Control and Elimination, 2016–2025, a period which was perceived as a reasonable and feasible time frame. The recommendation was that stratification and district (peripheral) capacity for malaria control should be central to any new strategy. The development of the strategy also offered an opportunity to review a "menu" of options at the country level and consider prioritization, particularly the need for surveillance, monitoring, evaluation, and operational research. MPAC stressed that it was important to have a bottom-up, country driven approach to the development of this document. It suggested that an evidence review group (ERG) be convened to provide the technical input for the intervention mix and epidemiological stratification that would be central to the new strategy.

MPAC also strongly supported the idea of a revised GMAP that had buy-in from a broad range of stakeholders and sectors. Key suggestions included that it should: (a) be based on a foundation of the WHO Global Malaria Technical Strategy for Malaria Control and Elimination, 2016–2025; (b) address financial and operational elements; (c) be a concise document; (d) RBM and WHO should work closely together in its development; and (e) its goals should be realistic and measurable. Since then, the RBM Board, in its December meeting, has endorsed the GMAP being updated, with a time frame for launch in 2015. The details of the process have not yet been elucidated, although there will be an ad hoc task force overseeing it.

There was consensus from MPAC members and observers that what is needed today is different from what was needed when GMAP was first launched. At that time, the focus was on scale-up and GMAP provided a useful umbrella for this. At present, the new focus should address the heterogeneity and changing dynamics of malaria in order to secure continued progress and in particular, guide countries and regions. MPAC concluded that there was a need for WHO to play a stronger role in providing clear technical strategies to countries, who struggle to reconcile divergent technical guidance, particularly with regard to malaria elimination.

Although MPAC saw developing technical strategies as a core function of WHO-GMP, it advised that any "roadmap to eradication", currently also under consideration by the global malaria community, would be so far-reaching in its depth and breadth across many sectors, that it was beyond the capacity of WHO-GMP alone, or any single organization for that matter, to address at this point in time. MPAC advised that any roadmap to eradication be kept separate, but that via its Global Technical Strategy for Malaria Control and Elimination 2016–2025, and through other mechanisms, WHO-GMP should be a critical partner in the process for constructing such a detailed roadmap.

3. Summary of GMP internal discussions since the last MPAC meeting

There are two major factors driving the timing of the Global Technical Strategy (GTS): alignment with post-MDG goals and the recommendation of the joint SAGE-MPAC meeting on the RTS,S malaria vaccine currently scheduled for October 2015, which is very close to the proposed target GTS launch, which should occur before the end of 2015. Although the vaccine itself is unlikely to result in a major paradigm shift, it will need to be included in the GTS and worded with consideration given to the possibility that a policy decision may not be reached at the joint meeting.

In terms of process, there has been much discussion about whether to seek formal World Health Assembly (WHA) endorsement of the GTS. On the one hand, WHA endorsement increases the engagement of Member States, and elevates the political profile of the strategy. On the other hand, the WHA process is lengthy and cumbersome, and may further complicate the timing of developing, finalizing, and launching the GTS. In the meantime, mention of the GTS has been included in the paper on malaria that has been requested by the WHO Executive Board, and that will be presented to the WHA in May. In this way, there will be WHA documentation that the strategy has been requested by MPAC and is under development.

It should also be noted that malaria strategic plans already exist for many WHO Regions, generally endorsed by the relevant Regional Committee, although some of these strategies come to an end in 2015. How will the GTS fit in with regional plans and processes, and subsequently, country plans and processes? This is a discussion item at the Regional Malaria Advisors meeting with GMP on 12 March, and will be summarized for MPAC during its own discussion session on the GTS on 15 March.

The extent of country and regional consultation in developing the GTS remains a major question. On one hand, broad input is critical. However, on the other hand, it is not feasible or efficient in terms of funding, time, and human resources, to replicate the process of developing the last global strategy. GMP can draw on the experiences of developing the *Global Plan for Artemisinin Resistance Containment* and the *Global Plan for Insecticide Resistance Management* as successful models for how to rapidly develop global strategic plans with broad stakeholder engagement at a reasonable cost. Ultimately, we are developing a **technical**, not a **political** strategy, which is why this is being done under the auspices of the MPAC.

In terms of content, there is agreement that the GTS should be a crisp, rigorous document that is primarily useful to Member States and secondarily provides the technical basis for GMAP II to help mobilize resources and implementation of interventions in countries.

There is agreement that universal targets for coverage of at risk populations should be maintained, but the impact indicators should involve a more detailed and bottom-up process based on country analyses and review. GMP has access to detailed annual country data, much of which is too specific to be used for the annual World Malaria Report for which it is collected, but might be helpful in determining what the optimal resources, stratification and cost efficient intervention mixes and their sequence for countries should be. Modeling work around this has already been commissioned by the Gates Foundation and can feed into the strategy.

GMP envisions establishing an internal working group to help lead the process under the advice of MPAC. This working group will develop an initial draft outline of the GTS, prior to engaging a consultant to assist with the process. We will also need to develop a concept note to seek donor funding to support this work. However, several questions about the way forward remain.

4. Questions for MPAC

a) Timing –
   i. Should the fact that a policy recommendation on the RTS,S vaccine will not be made until late 2015 impact the development of the GTS?
   ii. To what extent should the GTS go through the WHA process? This would heavily impact the likelihood of the GTS being ready in time for a 2015 launch, and for its ability to serve as the foundation for the GMAP II.
   iii. Should the timeline be even further accelerated (to have the strategy finalized by late 2014), so that we ensure the GTS does strongly shape the development of the GMAP II?

b) Consultation –
   i. How to best get buy in, alignment and harmonization with regions, countries and partners?
   ii. How to optimize consultation while minimizing bottlenecks?
   iii. Should there be an ERG or a Steering Committee or both; and what are the criteria for constitution?

c) Differentiation --
   i. How do we work collectively to make clear the differences between but also the interconnected nature of the GTS and GMAPII?

d) Stratification –
   i. How detailed should stratification be in the global plan, vs. making the principle of micro-stratification a global approach for developing country-level plans?

e) Goals
   i. Should the GTS establish new impact goals for malaria control and elimination by 2025?