World Health Organization

Regional Office for South-East Asia

Malaria 2025: Accelerate to Eliminate

The Global Technical Strategy for Malaria: 2016-2025

Report on Regional Consultation in South East Asia

New Delhi, India

28 – 29 April 2014

1. Background

In response to the request from Member States in May 2013 during the World Health Assembly, the World Health Organization (WHO) is coordinating the development of the Global Technical Strategy (GTS) for Malaria, 2016-2025. The GTS will articulate the vision and goals for malaria over the next decade and bring together current policy recommendations in a comprehensive, evidence-based strategy for Member States to use. The strategy will define the global direction of malaria control and elimination over the next decade. The GTS will also provide the technical foundation for the Roll Back Malaria Partnership Global Malaria Action Plan 2 (GMAP2), which will be a call to action for all RBM partners to support countries in implementing the GTS.

In order to ensure that the GTS will meet the needs of Member States, the GTS has been developed through an inclusive process that includes consultations in all WHO regions with the participation of the representatives of Member States and the key stakeholders involved in malaria control and elimination. Moreover, countries in the WHO South-East Asia Region has some epidemiological features that are different from those in Sub-Saharan Africa where over 80% of malaria cases and deaths occur. In SEA Region, the major population at risk is adults, *P. falciparum* and *P vivax* co-exist with slight predominance of the former except in Nepal and Sri Lanka where *P. vivax* is the predominant species. In the Democratic People's Republic of Korea, *P. vivax* is the only species present. In these contexts, WHO/SEARO in collaboration with WHO/Global Malaria Programme organized a Regional Consultation from 28 to 29 April 2014 in New Delhi, India.

2. Objectives and expected outcomes

The objective of the consultation is to share information, experience and lessons learnt from Member States of WHO South East Asia (SEA) Region as well as the partner agencies and provide technical inputs to the draft of the Global Technical Strategy for Malaria (GTS): 2016-2025.

The expected outcomes are the following:

- Information, experience and lessons learnt shared to inform national malaria control (elimination) strategies in WHO SEA Region.
- Technical inputs, suggestions, and comments to the GTS 2016-2025 are consolidated and report developed.
- Next steps, actions, future plans to accelerate programme implementation discussed. To provide inputs for developing the Global Technical Strategy 2016 – 2025 to accelerate malaria control towards elimination.

3. Participants

A total of 71 participants joined the consultation. They included national malaria programme managers and other senior staff from all Member States (except Timor Leste), the Chair and members of the Regional Malaria Technical Advisory Group, Directors and researchers from WHO Collaborating Centers on malaria and vector borne diseases, NGOs, development partners, Roll Back Malaria Partnership Secretariat and WHO (GMP, Regional Office, Country Offices and ERAR Hub) (Annex 1).

4. Opening Session

Dr Rajesh Bhatia, Director, Communicable Diseases Department, SEARO, welcomed the participants on behalf of Dr Poonam Khetrapal Singh, Regional Director, WHO Regional Office for South East and delivered her message. The Regional Director's message highlighted the global and regional progress in malaria control as well as the challenges to sustain progress towards elimination the disease. However, progress is fragile; more innovative tools and methods need to be done to reach the goal of elimination. The importance of multi-sectoral collaboration in reaching the hard-to reach populations, environment control rather than relying on technology, health system strengthening, and developing flexible, adaptable, changeable strategies were emphasized. Moreover, the need to mobilized resources to attain universal coverage of key interventions and for operational research to improve the programme was highlighted. Since malaria is multi-dimensional, its control and elimination should be part of socio-economic development.

Dr Leonard Ortega, Regional Adviser (Malaria) briefly explained the rationale, objectives and expected outcomes of the meeting, provided overview of the agenda and introduced the participants.

Prof Pratap Singhavivanon, Associate Professor, Faculty of Tropical Medicine, Mahidol University and chairperson of the Malaria Regional Technical Advisory Group (RTAG) and Dr A. C. Dhariwal, Director, National Bureau of Vector Borne Diseases, Ministry of Health and Family Welfare, India, were elected as the chair and co-chair of the consultation. Dr Mushfiqur Rahman, Epidemiologist, M & E Officer, National Malaria Control Programme, Bangladesh and Dr Risintha Premaratne, Acting Director, Anti-malaria Campaign, Sri Lanka, were designated as the rapporteurs.

5. Presentations and group work

Setting the Scene and Introduction

The opening presentation described the process to develop the content of the Global Technical Strategy and explained the purpose and target audience of the document. The importance of the Regional Consultations and regional inputs was stressed as a critical component of the development process to ensure it meets the needs of Member State malaria programmes. The presentation also described the alignment between the Global Technical Strategy and the Global Malaria Action Plan2. Finally, the GTS website was highlighted and participants learned that the next version of the document will be posted for public comment in July prior to the final review by the Malaria Policy Advisory Committee before submission to the Executive Board to the World Health Assembly.

Global and regional progress since 2000: opportunities and challenges

This presentation described the progress in malaria control and reductions in mortality rates and cases both globally and in the South-East Asia Region from 2000 to 2012 to set the context for the Global Technical Strategy. Impressive reductions have been achieved and the trajectory of the declines is in line with the 75% reduction goals.

In SEA Region, around 96% of reported malaria cases and deaths are reported from India, Indonesia and Myanmar. Between 2000 and 2012, reported cases decreased from 2.9 to 2 million and reported malaria deaths decreased from 6500 to 1200. WHO estimated that there were 27 million cases and 42,000 deaths in 2012 in the region where around 1.4 billion people are at risk of malaria. Five countries already achieved >75% decrease in case incidence and 2 countries are projected to achieve >75% decrease by 2015. All countries are aiming for malaria elimination. Sri Lanka is the most advanced; in 2000 there were around 210,000 cases and there is no indigenous case detected since November 2012. Malaria endemicity is generally low, focal and limited to rural areas except in some cities in India where urban transmission occur. However, there are pockets where endemicity is high such as in forest and forest fringes, border areas and development project sites. Multiple vectors are present. Except in DPR Korea where only *P vivax* is present, *P. falciparum* and *P vivax* co-exist and their distributions vary from country to country. Some key challenges are artemisinin resistance, insecticide resistance, outdoor transmission, forest-related malaria, malaria among workers in development projects, and relapses due to vivax malaria. These should be taken into account in the Global Technical Strategy.

Strategic Directions: Accelerating Malaria Control Towards Elimination in South East Asia Region, 2014 – 2020

To help ensure alignment of GTS to the regional needs, the 6 strategic objectives to accelerate malaria control towards elimination were presented. The strategic directions are the outcomes of consultations with Malaria Technical Advisory Group, programme managers and other partners in the region. The epidemiological situation and socio-economic determinants of malaria in the region were taken into account in formulating the strategic directions.

1) Generate strategic information for policy and strategy development, operational planning and decision-making.

2) Scale-up key interventions in countries and areas with high burden of malaria, particularly in foothills, forested and border areas, at development project sites and among indigenous communities.
3) Reorient national malaria control programmes towards pre-elimination/elimination in countries with very low burden of malaria.
4) Prevent emergence of artemisinin resistance, and eliminate it in areas where it has already emerged.
5) Strengthen managerial and technical capacities for malaria control and elimination.
6) Strengthen partnerships, multi-sectoral participation and international collaboration in malaria control and elimination.

Core Concepts

The document includes concepts that are core to the strategy for the next decade including challenges, core values, the vision and goals and the pathway to elimination. Key challenges to the acceleration of malaria programmes for the next decade include drug and insecticide resistance; the infectious reservoir contributing to transmission; difficulties in diagnosing and treating *P. vivax* malaria; outdoor biting and resting vectors; increasing appropriate diagnosis, treatment and reporting of cases from the private healthcare sector; health systems and human capacity and sufficient financial resources. The core values underlying the strategy are country and community leadership, gathering and using data for programmatic decisions, acceleration of programmes, sustained success, and equity.

The long-term vision is eradication: a world free of malaria and the vision for this Strategy is to accelerate progress to a world free of malaria. The three goals for 2016-2025 are proposed as:

- To reduce malaria mortality rates globally by 75% compared to 2015
- To reduce malaria case incidence globally by 75% compared to 2015
- To eliminate malaria from 20 countries that had ongoing transmission of malaria in 2015.

Finally, the pathway to elimination was revised to three stages including reduce, eliminate and sustain.

Strategic Directions

Each of the five strategic directions (Surveillance and response, Preventing cases and reducing transmission, T3: Test.Treat.Track, Innovations and implementation research, and Development and health systems strengthening) was presented in plenary for clarifications and brief comments before the participants broke into three working groups to provide detailed inputs on the strategic directions.

6. Conclusions and Recommendations

Challenges

1) Additional challenges that should be considered are:
    - The need for appropriate strategies to control urban malaria
    - Cross border issues
    - Migrant and mobile populations/refugees
    - Inaccessible and hard-to-reach populations, including ethnic communities
    - Forest related malaria, malaria in development project sites and outdoor transmission

Core Values

1) Clarify ownership of the programme by the country and community empowerment including good governance and stewardship in the country and community leadership value
2) Consider adding the following core values:
    - Evidence based policy and implementation
    - Universal access
    - Malaria should be regarded as a social and economic problem, not just a public health problem
    - Multi-sectoral collaboration in the context of "health in all policies"

Vision and Goals

The vision and goals are relevant to Member Countries and are ambitious enough. SEARO countries have articulated the following elimination targets:

- Bangladesh – 2020
- Bhutan – 2016
- DPR Korea- in process setting target of elimination
- India – no target year yet, but aims to put the whole country in pre-elimination phase by 2017
- Indonesia – 2030
- Myanmar – 2030
- Nepal – 2026
- Sri Lanka – WHO certification by end 2015
- Timor Leste - in process setting target of elimination
- Thailand (90% districts) – 2020

Pathway to Elimination

1) Most attendees thought "control" should be retained while some thought a new pathway with new terms such as "reduce" would be motivating. All programme managers and the Malaria RTAG support retention of "control".
2) Harmonize the Pathway with the terminology in existing WHO documents such as "Disease surveillance for Elimination of malaria - an operational manual" and "Malaria Elimination Manual".
3) The benefits of changing terminology do not outweigh the risks / efforts associated with the implications

Surveillance and Response

1) Add definitions to the document, in line with other WHO documents (high transmission, low transmission, elimination)
2) Include screening for high risk groups (irregular migrants, travelers from high-endemic areas, migrant workers, peace keeping forces to and from malaria endemic countries etc.)
3) Emphasize the importance of having malaria as a notifiable disease and of having sentinel surveillance like Early Warning and Response System
4) Highlight the importance of sharing data
5) Address issues on quality of data and feedback systems, coverage of routinely collected data, private sector reporting and cross border data sharing
6) Add a list of references at the end
7) Make M&E more visible by having brief but clear paragraph on its importance in moving towards elimination.
8) Additional edits to the section itself were suggested and can be found in the attached draft

Vector Control to prevent cases and reduce transmission

1) Guidance is needed on vector control for different transmission levels and the transition from endemic to elimination phase including Integrated Vector Management.
2) Optimizing vector control tools and strategies in different settings should be described including urban, forest and mobile populations
3) Community participation in vector control should be reinforced through intensive awareness campaigns using local resources and leadership. In particular, IEC and BCC are needed for community mobilization for use of LLINs and IRS
4) Vector control in the context of environmental and ecological changes, impact of climate change resulting in vector composition, densities and bionomics need to be addressed.
5) Guidance is needed on the capacity building of entomologists for vector surveillance, control and insecticide resistance monitoring and management. GTS should encourage professional career development of entomologists.
6) Guidance is needed on: the role of IRS vs. LLINs during elimination, safe disposal of LLINs, approaches for outdoor transmission and on the adoption of evidence based and appropriate technology.

Medicines to prevent cases and reduce transmission

1) Regionally appropriate alternatives to IPTp, IPTi, and SMC should be suggested (e.g. LLIN to every pregnant woman).
2) Standby treatment should be considered for special high risk groups (e.g. forest goers)
3) Strategies for chemoprevention for internal travelers and migrants referencing existing guidance should be included.
4) Strategies for identifying "asymptomatic" cases should be addressed.
5) The Strategy should include routine screening of target groups – Army, travelers, migrant workers.
6) The role of mass drug administration should be clearly defined.

T3: Test.Treat.Track

1) "Track" should be a component under surveillance and include tracking adherence of *P. vivax* patients and tracking migrant/mobile population
2) Improved pharmacovigilance should be included– especially recording of adverse effects of primaquine
3) The role of microscopy in malaria diagnosis and surveillance should be defined (e.g. percentage of RDT positive cases that should be confirmed by microscopy, gametocyte detection in elimination settings)
4) Increase the emphasis on chloroquine for treating *P. vivax* and chloroquine resistance
5) The Strategy should include management of malaria negative febrile cases
6) Guidance on stratification and foci management should be included
7) Encourage directly observed therapy (DOT) in elimination areas
8) Emphasize the importance of early treatment within 24 hours

Innovation and implementation research:

1) Diagnostic tests: priority tools include diagnosis of other species, asymptomatic cases in the field, non-invasive tests and point of care diagnosis of G6PD deficiency
2) Antimalarials: priority tools include drugs for Chemoprevention (IPTi, IST, IPTp), prophylactic drugs for <8 yrs and pilot testing mass screen and treat, focal screen and treat and mass drug administration in low endemic settings
3) Vector Control: Innovative and cost effective technologies are being explored: Protective clothing/impregnated dress, new active ingredients for IRS, LLINs with longer residual life, combination nets, new biological control agent i.e. Fungi, ivermectin administration, herbal repellant for outdoor transmission etc. Implementation research priorities include: RS/GIS for vector surveillance in remote areas, pilot studies on the impact of IVM, impact of combining IRS and LLINs vs. alone and vectorial competency of mosquitoes for different Plasmodium species
4) The collaboration between national malaria programmes and research institutes needs to be strengthened at country level.
5) Vaccines: Emphasize the need for vaccines targeting at risk adult populations outside Africa.
6) Countries need to be prepared to introduce new tools through fast track registration mechanism

Development and health systems strengthening:

1) The community and social networks should be empowered to improve early reporting of suspected malaria cases to health facilities
2) Adequate numbers of trained staff are required at all levels and transmission levels; basic health working capacity should be strengthened
3) Procurement and supply management should be added, including – surveillance, forecasting, timely procurement and supply
4) Advocacy Communication & Social Mobilization (ACSM) should be emphasized.
5) Critical challenges include political commitment, sufficient resources, using an incentivized approach, the limited career path for entomologists, inter-country linkages for insecticide resistance and vector control

General comments:

1) Cross border collaboration issues are a major challenge and must be included in the GTS.
2) Strategies to target hard to reach at-risk populations including adult forest workers, ethnic minorities, mobile and migrant workers both legal and illegal, refugees, military, and urban areas must be added.
3) The need for integrated approach to vector borne diseases
4) The need for a different regional approach for vivax malaria (i.e. 50% of cases in the region)
5) Involvement of civil society (NGOs, FBOs, CSOs) and other sectors such as mining, construction and plantation should be included and mapped to improve engagement
6) Ensuring the quality of services and commodities should be addressed.
7) BCC, community mobilization and advocacy should be included
8) The integration of the malaria programme with the health system is occurring in many countries; the GTS should mention benefits and risks of integrating too early.
9) Approaches to maintaining resources and political commitment in the elimination and prevention of reintroduction phases should be emphasized.

Annexes:

1. Agenda
2. List of Participants

Malaria 2025: Accelerate to Eliminate
The Global Technical Strategy for Malaria: 2016-2025

Regional Consultation in South East Asia
28 – 29 April 2014, Le Meridien Hotel, New Delhi, India

Objective: To provide inputs for developing the Global Technical Strategy 2016 – 2025 to accelerate malaria control towards elimination.

Tentative program

28 April, Monday – Global Technical Strategy Expert Consultation

08:00 – 09:00 Registration

09:00 – 09:30 Opening Session

09:30 – 10:00 Group photograph and coffee break

10:00 – 11:00 Setting the Scene
- Objectives of the consultation, GTS Development Process and Country Input – (*Sandii Lwin)*
- Global and regional progress; opportunities and challenges in malaria since 2000 and
- Strategic Directions: Accelerating Malaria Control Towards Elimination in South East Asia Region, 2014 – 2020 *(L. Ortega)*
  Discussion

11:00 – 12:00 Plenary: Core Concepts *(E. Shutes and W. Satimai)*
- Challenges
- Vision and Goals
- Core values
- Pathway to Elimination
  Discussion

12:00 – 13:00 Lunch

Tentative program (cont.)

13:00 – 14:30 Strategic Directions – Plenary (*Presentation and discussion)*
- Surveillance and Response (*M. Lynch)*
- Preventing cases and reducing transmission (*A. Mnzava)*
- T3: Test. Treat. Track *(D. Gopinath)*
- Innovation and implementation research *(D. Bustos)*
- Development and Health systems strengthening *(L. Ortega)*

14:30 – 15:30 Break-out groups: Four break-out groups each review Strategic Directions *(L. Ortega)*
1. Surveillance and Response
2. Vector Control to prevent cases and reduce transmission
3. Medicines to prevent cases and reduce transmission and T3: Test, Treat, Track

	4. Innovation and implementation research
15:30 – 16:00	Coffee break
16:00 – 18:00	Break-out groups: Continue facilitated discussion with specified outputs
18:30	Cocktail Reception

29 April, Tuesday – Global Technical Strategy Expert Consultation

09:00 – 09:15	Plenary: Recap of Day 1 and direction for continued group work *(Chairperson)*
09:15 – 10:30	Break-out groups: Wrap up Strategic Directions Summary
10:30 – 11:00	Coffee break
11:00 – 12:30	Break-out groups: Cross-cutting themes – feedback on Core Concepts
12:30 – 13:30	Lunch
13:30 – 15:00	Plenary: Four Groups Report Back
15:00 – 15:30	Coffee Break
15:30 – 17:00	Plenary: Discussions, Conclusions and Recommendations
17:00 – 17:15	Closing session
18:00 – 20:00	Joint meeting: SEARO Malaria Technical Advisory Group, Malaria Program Managers and WHO Malaria Staff

List of Participants

COUNTRY PARTICIPANTS

Bangladesh

1. Dr Mohammad Jahirul Karim
   Program Manager, BAN-MAL and
   Deputy Programme Manager (MAL & VBDC)
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2. Dr MD. Mushfiqur Rahman
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Bhutan

3. Mr Rinzin Namgay
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4. Dr Dechen Pemo
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   Vector-borne Disease Control Program
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21. Dr Mihirini P Hewavitarane
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Thailand

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23. Dr Prayuth Sudathip
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26. Ms Sandii Lwin
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    Managing Director
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27. Dr Wichai Satimai
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41. Dr Garima Pathak
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42. Dr Sanne Fournier-Wendes
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45. Dr Neena Valecha
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50. Prof Pratap Singhasivanon
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51. Dr Panduka Wijeratane
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Roll Back Malaria Partnership Secretariat

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