World Health Organization

Friday, 15 March 2013

Time	Session	Purpose of session, target outcomes and questions for MPAC	Type
	Session 9		open
09:00	Elimination Scenario Planning Tool **(M Lynch)**	For information and discussion on next steps	
09:30	Global Technical Strategy (2016 – 2025) **(R Newman)**	For discussion and input	
11:00	**Coffee/tea break**		
11:30	Formulation of MPAC recommendations	MPAC to finalize wording on any recommendations	closed
13:00	**Lunch**		
14:15	Formulation of MPAC recommendations – cont.	MPAC to finalize wording on any recommendations	closed
15.30	**Coffee/tea break**		
15:45	Formulation of MPAC recommendations – cont.	MPAC to finalize wording on any recommendations	closed
16.30	Summary of next steps + agenda for September 2013		
17:00	**Close of meeting**		

Malaria Elimination Scenario Planning: progress and future plans

During the last decade, substantial progress has been made in controlling malaria worldwide. The magnitude of that progress has led some malaria endemic countries to consider the possibility of malaria elimination. Existing program guidance for elimination activities provided by WHO includes a only a limited discussion of its technical and operational feasibility. WHO and partners in global malaria control recognized that countries considering elimination would benefit from a more detailed elimination planning toolkit, one which would cover the technical, operational and financial aspects of malaria elimination and which could provide realistic timelines for programmes moving from the control to the elimination phase of malaria program operations. Consequently, WHO has worked with partners from the Clinton Health Access Initiative, Imperial College, Johns Hopkins, University of Southhampton, and the Global Health Group to develop such a tool. The Elimination Scenario Planning (ESP) toolkit includes a manual which reviews elimination concepts and guides users through the technical, operational, and financial feasibility of elimination. The manual is linked to malaria transmission model software, focused on *Plasmodium falciparum* in Africa, which allows users to explore the effect of a range of intervention packages to achieve elimination.

The malaria ESP toolkit was field tested at a meeting of malaria stakeholders from The Gambia and Senegal held in Banjul, The Gambia during 2012. Workshop participants used the tool to explore the effect of various combinations and coverage levels of interventions on malaria transmission in their respective countries. Participants were also asked to evaluate the utility of the ESP toolkit for country-level strategic planning, with elimination in mind. Discussion points and feedback from the country participants were gathered and have informed further refinement of the toolkit. The ESP toolkit manual is currently being finalized for release within the next few months.

During the development of the toolkit, WHO and partners recognized that a similar approach, linking concepts in implementation of interventions to an accessible transmission model which presented possible outcomes of intervention combinations, could be used for malaria program planning in other settings. GMP would appreciate input from the MPAC on what other directions we could take in the development of this tool.

We envision at least three new directions for the ESP tool:

1) Should the ESP toolkit be modified to function as a general program planning tool?

As originally conceived, the toolkit is focused on planning for elimination scenarios, where the goal is reducing transmission to zero. Many of the concepts covered in the manual regarding technical and operational aspects of implementing interventions are applicable to countries who have near- term goals short of elimination. Similarly, the transmission software is not designed exclusively for elimination outcomes. With a steadily growing list of intervention tools, one aspect of the software that countries in control program phase may find useful is the ability to explore combinations of

interventions. Modeling partners are working on adding cost component to the interventions so that an projected cost for different intervention combinations could be derived.

2) Should the ESP toolkit be extended to address scenarios of low transmission *P. falciparum* outside of Africa?

The ESP toolkit manual and transmission software are focused on *P. falciparum* endemic countries in Africa, where most countries have moderate to high baseline malaria transmission. Extending the toolkit to address settings with low transmission of *P. falciparum* outside Africa would involve further development of the transmission model software, for instance incorporating factors relevant to different vectors, and modification of the manual to highlight technical and operational aspects of interventions relevant to low transmission settings, such as case management and surveillance strategies.

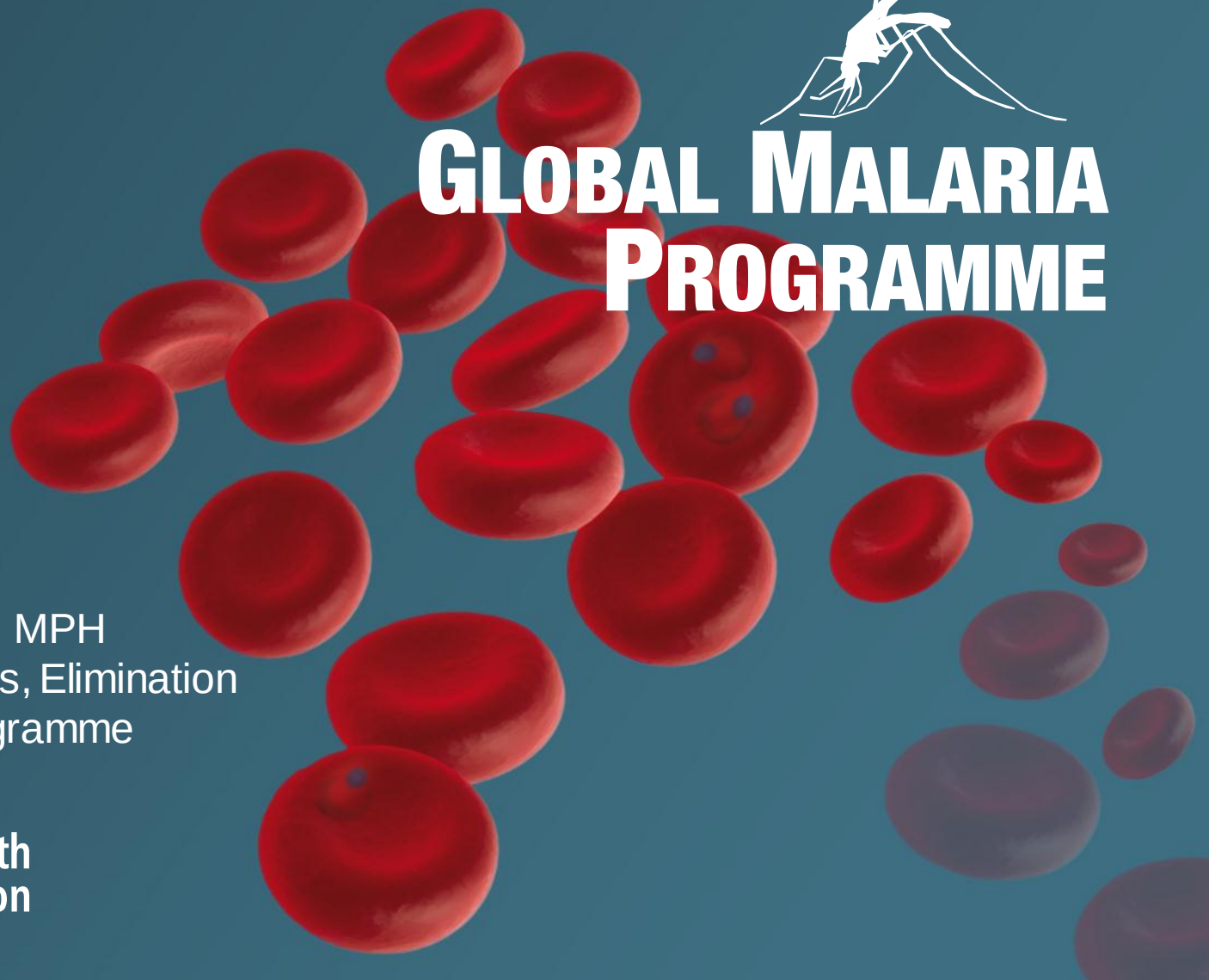
3) Should the ESP toolkit be extended to cover settings where *P. vivax* is predominant?

Extending the toolkit to address settings where *P. vivax* is predominant would also require further development of transmission model software and modification of the manual. A scenario planning toolkit for *P. vivax* settings would be in line with current work of GMP in the development of a P. vivax strategy. .

Elimination Scenario Planning Tool

MPAC

March 13-15, 2013



GLOBAL MALARIA PROGRAMME

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Strategy, Economics, Elimination
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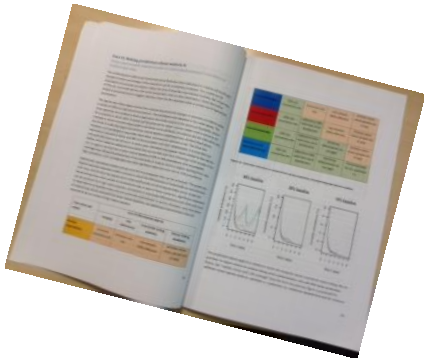
Need for malaria elimination planning tool

- Progress in fighting malaria worldwide
- Magnitude of progress in some countries has raised question of malaria elimination, even in historically high burden countries
- Countries considering elimination would benefit from tool to provide rigor for program planning
- WHO and partners (Clinton Health Access Initiative, Imperial College, Global Health Group, Johns Hopkins, University of Southhampton), supported by BMGF, have been developing Elimination Scenario Planning (ESP) tool

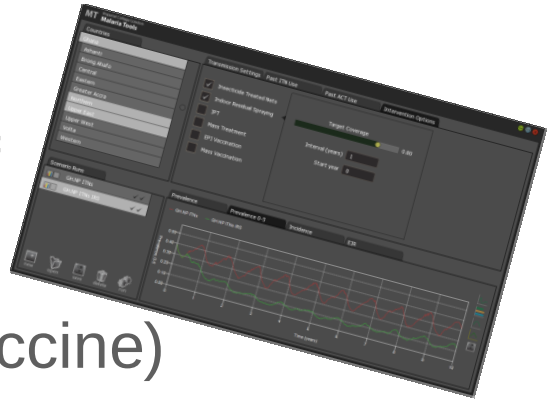
ESP tool components

- **ESP Manual**
  - Reviews key concepts in elimination planning
  - Technical, Operational, Financial feasibility of elimination

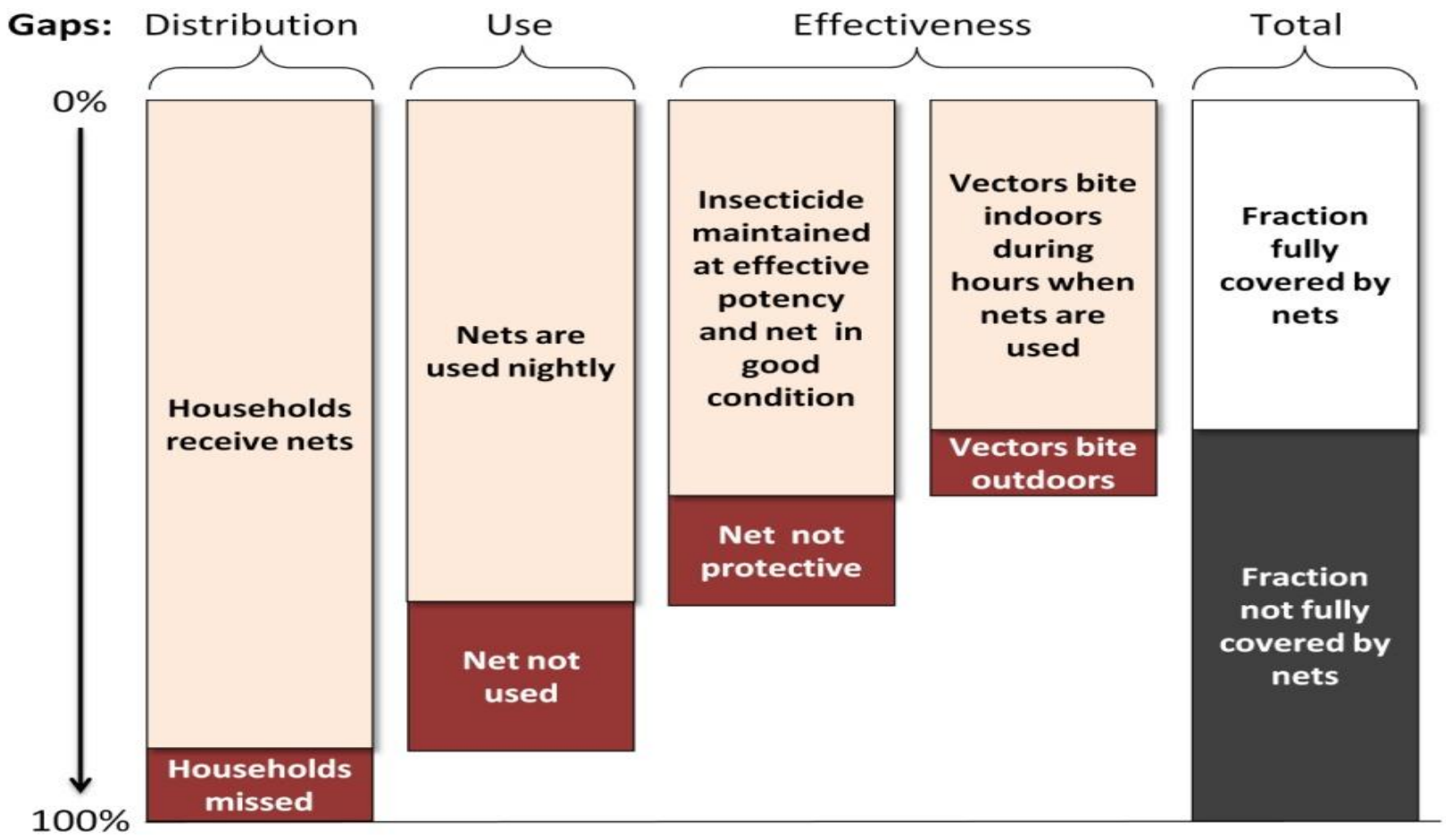


- **Malaria transmission model (*P. falciparum*, Africa)**
  - Establish baseline transmission level
  - Explore effect of different combinations of interventions

    (LLINs, IRS, IPTi, SMC, MDA/MSAT, vaccine)



Concept of effective coverage



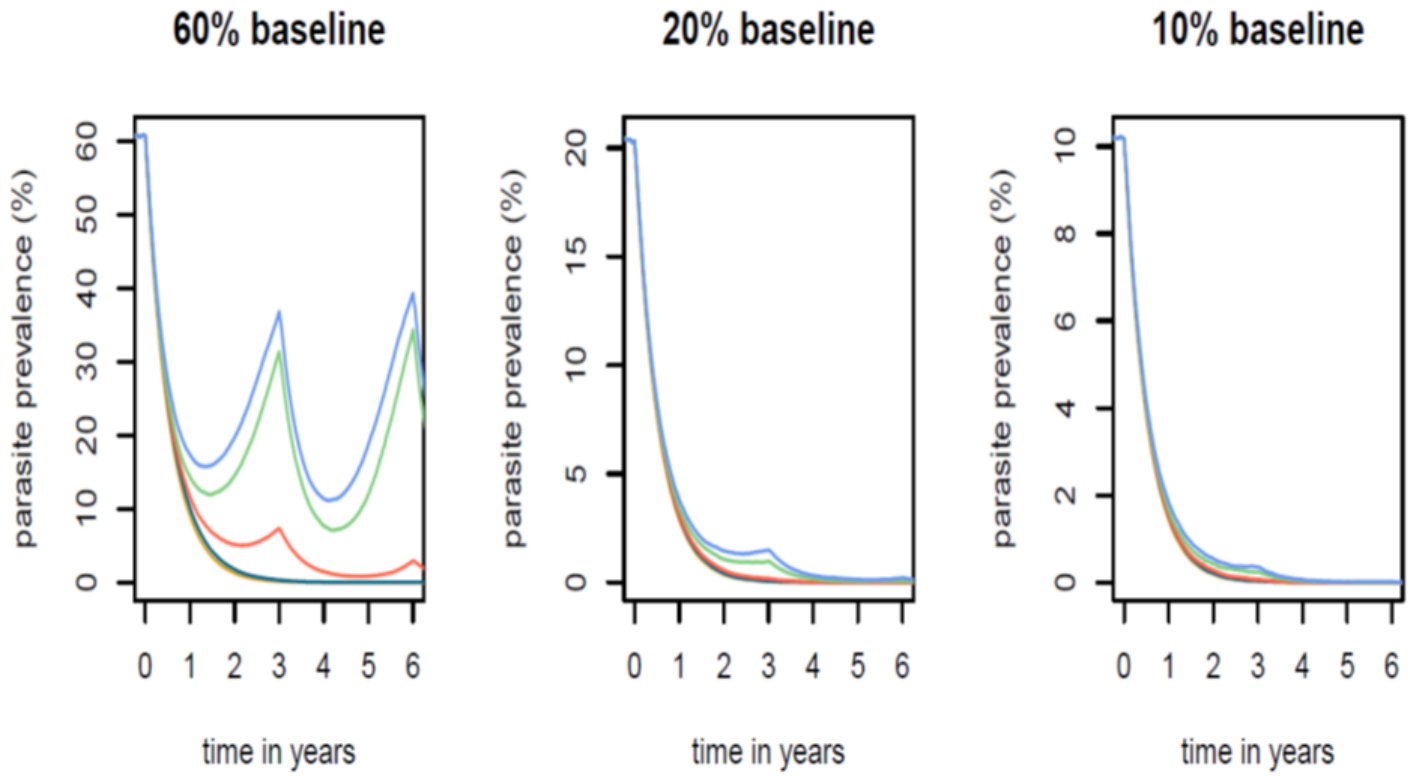
Brief malaria transmission model description

- Individual-based simulation model
- Fit from parasite prevalence data from 34 African transmission settings
- Allows variation in baseline conditions and effect of different combinations of interventions
- Gives output in several formats—parasite prevalence, incidence, EIR—and shows timeline

Model publicly available
http://www1.imperial.ac.uk/publichealth/departments/ide/research_groups/malaria/malariatools/

Malaria transmission model interface

Estimated reductions in malaria prevalence from various baselines, incorporating operational factors



ESP next steps

- Manual and software evaluated in workshop in Banjul with NMCP staff and partners from The Gambia and Senegal
- Revised manual and software based on workshop feedback; incorporating feedback from further review
- Finalize with WHO and partners, release and dissemination of ESP during 2013
- Considering whether toolkit could be modified or extended for malaria program planning in other settings

Input from MPAC on the way forward for ESP

- **Comments on ESP toolkit**

- **Comment on possible future directions for ESP**
  - **Should ESP toolkit be modified to function as a general program planning tool?**
    - Use existing model; cost component
  - **Should ESP toolkit be extended to address low transmission *P. falciparum* outside Africa?**
    - Updated model; artemisinin resistance containment
  - **Should ESP toolkit be extended to cover settings where *P. vivax* is predominant?**
    - Updated model; in line with strategy development

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?

Developing the Global Technical Strategy for Malaria Control and Elimination 2016-2025

Malaria Policy Advisory Committee
Geneva
15 March 2013

Robert D. Newman, MD, MPH
Director, GMP

World Health Organization

Outline of Discussion

- Introduction
  - Learning from the Past
  - Need for new Global Strategy
- Timing and WHA resolution
- Consultation
- Differentiation
- Stratification
- Goals
- Input from Global Team discussion

Learning from the past

- Last WHO Global Strategy published in 1993
  - Adopted by Ministerial Conference in Amsterdam with 450 participants
  - Developed through three interregional meetings in Brazzaville, New Delhi and Brasilia in 1991 and 1992

- Global Malaria Action Plan – RBM Partnership
  - Developed through broad consultative process led by a team of consultants and launched in 2008
  - Refers to WHO technical strategies with an aim to improve advocacy, resource mobilization and partner harmonization

The need for a new Global Strategy

- The landscape has changed:
  - A decade of significant investment and scale-up of implementation has led to impressive reductions in burden
  - Heterogeneity within countries and regions will require improved surveillance to target the at risk population
  - Resources are likely to remain constrained and increased efficiency will be necessary to sustain progress

- Global Malaria Action Plan II – RBM Partnership
  - Board has developed TORs for an ad hoc task force
  - TORs refer to GMAP II being based on the Global Technical Strategy for Malaria Control and Elimination 2016-2025

Timing and WHA resolution

- 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?
- To what extent should the GTS go through the WHA process? This may 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.
- 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?

Consultation

- How should the consultation process be structured to facilitate ownership, buy in, alignment and harmonization with regions, countries and partners?
- How to optimize consultation while minimizing bottlenecks?
- Should there be an ERG or a Steering Committee or both; and what are the criteria for constitution?

Differentiation

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

Stratification

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

Goals

- Should the GTS establish new impact goals for malaria control and elimination by 2025?

Input from Global Team discussion

- Current technical strategies are fragmented (GPARC, GPIRM), it will be useful to pull these documents together
- Global Technical Strategy should not be too prescriptive or detailed; Regions and Countries will need to adapt principles to their settings
- Gather current knowledge, evidence and goals from Countries and Regions to support existing ambitious goals
- Input from Regions and Countries will be critical; it would be useful to have a draft document to provide feedback on
- ADG experience from other teams: WHA resolution is powerful, but process is heavy and challenging; a two step process may be more efficient and allow more flexibility in timing