Report from the Director

Malaria Policy Advisory Committee meeting
13 March, 2013

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Director, Global Malaria Programme
On behalf of WHO Global Malaria Team
World Malaria Report 2012

- Released on 17 December 2012 by H.E. President Sirleaf of Liberia
- Annual reference on the status of global malaria control & elimination; data to 2011 and 2012
- Principal data source is national programs in 104 endemic countries with particular support from: WHO Regional offices, ALMA, CDC, Global Fund, IHME, ISGlobal, MAP (Oxford), UNICEF, USAID
- Summarizes key malaria targets & goals
- Documents trends in financing, intervention coverage and malaria cases and deaths
- Profiles for 99 countries and areas with ongoing transmission
- Country level malaria burden estimates for 2010
International funding for malaria control rose from <US$ 100 million (2000) to US$ 1.66 billion (2011) and US$ 1.84 billion in 2012. Total funds for malaria control in 2011 estimated at US$ 2.3 billion; short of US$ 5.1 billion required to achieve universal coverage of malaria interventions. Projections indicate that total funding will remain at <US$ 2.7 billion between 2013 and 2015.
150 million ITNs needed annually to achieve universal access; number delivered to countries in Saharan Africa was 66 million (2012), down from 145 million (2010)

Without substantial scale-up of vector control in 2013, can expect major resurgences of malaria
Estimated trends in households owning ≥1 ITN and population sleeping under an ITN in sub-Saharan Africa

Percentage of households in sub-Saharan Africa owning ≥1 ITN rose from 3% (2000) to 53% (2011); remained at 53% in 2012.

Proportion of population sleeping under ITN also increased from 2% (2000) to 33% (2011); remained at 33% in 2012.

*Figure 4.2 Estimated trend in proportion of households with at least one ITN and proportion of the population sleeping under an ITN in sub-Saharan Africa, 2000–2012.*

Source: ITN coverage model from the Institute for Health Metrics and Evaluation, which takes into account ITNs supplied by manufacturers, ITNs delivered by NMCPs and household survey results (1). Includes Djibouti, Somalia and Sudan which are in the WHO Eastern Mediterranean Region.
Figure 4.5 Proportion of population at malaria risk protected by IRS by WHO Region, 2000–2011

Source: NMCP reports
Proportion of suspected malaria cases attending public health facilities that receive a diagnostic test

Number of patients tested by microscopy rose to 171 million in 2011, with India accounting for over 108 million blood slide examinations.

Number of RDTs supplied by manufacturers increased from 88 million in 2010 to 155 million in 2011.

Proportion of suspected malaria cases receiving a diagnostic test in the public sector increased from 20% in 2005 to 47% in 2011 in the African Region and from 68% to 77% globally.

Note: Trends are based on reports to WHO which may disproportionately reflect countries with better reporting systems and diagnostic testing rates.
ACT delivery 2005–2011

ACT treatment courses delivered to public and private sectors increased from 11 million (2005) to 76 million (2006), and reached 278 million in 2011.

Increases in ACT procurement in 2011 largely due to AMFm. Although AMFm accounts for a substantial portion of public sector sales, total number of ACTs procured for public sector decreased between 2010 and 2011.
WHO recommends oral artemisinin-based monotherapies (oAMT) be withdrawn from market and replaced with ACTs; endorsed by World Health Assembly in 2007

Number of countries marketing oAMTs decreased from 55 (2008) to 16 (2012); 9 are in African Region

Number of pharmaceutical companies marketing oAMTs dropped from 38 in 2010 to 28 in 2011
An estimated 219 million cases of malaria occurred in 2010, with a wide uncertainty interval. Approximately 80%, or 174 million cases, were in the African Region, with the South-East Asian Region accounting for another 15%.

There were an estimated 660 000 malaria deaths in 2010, of which 90% were in the African Region. Approximately 86% of global malaria deaths were of children under 5 years of age.
Comparison of WHO and IHME estimates 2010

Figure Box 8.2 Estimates of number of malaria deaths in 2010, by age group and geographical region (1,2)

Source: IHME and WHO estimates
### Proportion of cases detected by surveillance systems

<table>
<thead>
<tr>
<th>Region</th>
<th>Estimated number of cases 2010</th>
<th>Reported number of cases 2010</th>
<th>Reported/estimated</th>
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<td>Africa</td>
<td>174,000</td>
<td>18,000</td>
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<td>Americas</td>
<td>1,100</td>
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<td>Europe</td>
<td>0.2</td>
<td>0.2</td>
<td>87%</td>
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<tr>
<td>South-East Asia</td>
<td>32,000</td>
<td>2,400</td>
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</tr>
<tr>
<td>Western Pacific</td>
<td>1,700</td>
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<tr>
<td>World</td>
<td>219,000</td>
<td>22,500</td>
<td>10%</td>
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</tbody>
</table>

*Malaria surveillance systems detect only 10% of cases estimated to occur annually*
Bottlenecks in case detection

- Malaria cases
- Seeking treatment
- At a government health facility
- Covered by surveillance system
- Tested
- Reported

Graph showing the number of malaria cases, with a significant number seeking treatment at a government health facility, followed by those covered by the surveillance system, and the remaining cases being tested and reported.
Bottlenecks in case detection by WHO region

Figure 7.5 Bottlenecks in case detection, by WHO Region
Public sector includes cases in the private sector that are reported through the public sector

Proportion of malaria cases

Source: NMCP reports, WHO estimates
Assessing trends in malaria through surveillance systems

Case detection rates are lowest in countries with the highest number of malaria cases.

A reliable assessment of trends can be made in 58 countries out of 99 with ongoing transmission using data submitted to WHO.

These countries account for only 34 million or 15% of total estimated cases in 2010.

Figure 7.6 Proportion of malaria cases captured by surveillance systems, in relation to total estimated number of cases and whether trends over time can be assessed

Source: NMCP reports, WHO estimates
Progress towards 2015 target of 75% reduction in malaria case incidence

50 countries are on track to reduce malaria case incidence by 75% by 2015: these account for only 3% of total estimated cases.
Progress in reducing cases and in relation to initial burden

For the 58 countries in which it is possible to assess trends, greater reductions in cases have been seen in countries with smaller reported case loads.

Figure 8.3 Percentage change in reported case incidence versus reported cases in 2000

Countries reporting a smaller number of cases in 2000 achieved larger rates of decrease in malaria incidence. There are a few outliers from this general pattern, in particular 3 countries in the Region of the Americas which have recorded an increase in malaria case incidence since 2000.

Source: NMCP reports
17 countries account for 80% of estimated cases and 14 countries account for 80% of estimated deaths in 2010.
Progress faster in smaller countries; greater number of cases and deaths averted in highest burden countries

If malaria case incidence and mortality rates witnessed in 2000 had continued there would have been 274 million more malaria cases and 1.1 million more malaria deaths between 2001-2010.

The majority of cases averted (52%) and lives saved (58%) are in the 10 countries with the highest estimated malaria burdens i.e. malaria programmes are having their greatest impact where the burden is highest.
Of 104 endemic countries in 2012, 79 countries classified as being in control phase, 10 in pre-elimination, 10 in elimination, and 5 in prevention of introduction phase. Elimination of malaria in the European Region appears attainable by 2015.

| Region                  | Pre-elimination         | Elimination       | Prevention of re-introduction | Recently certified as malaria free |
|-------------------------|-------------------------|-------------------|                              |-------------------------------------|
| African                 | Cape Verde              | Algeria           |                               |                                     |
| Region of the Americas  | Argentina               |                   |                               |                                     |
|                         | Costa Rica              |                   |                               |                                     |
|                         | Ecuador                 |                   |                               |                                     |
|                         | El Salvador             |                   |                               |                                     |
|                         | Mexico                  |                   |                               |                                     |
|                         | Paraguay                |                   |                               |                                     |
| Eastern Mediterranean   |                         | Iran (Islamic Republic of) |                           |                                     |
|                         |                         | Saudi Arabia      |                               |                                     |
|                         |                         |                   | Egypt                         |                                     |
|                         |                         |                   | Iraq                           |                                     |
|                         |                         |                   | Oman                           |                                     |
|                         |                         |                   | Syrian Arab Republic          |                                     |
| European                |                         | Azerbaijan        | Georgia                        | Armenia - 2011                       |
|                         |                         | Kyrgyzstan        |                               |                                     |
|                         |                         | Tajikistan        |                               |                                     |
|                         |                         | Turkey            |                               |                                     |
|                         |                         | Uzbekistan        |                               |                                     |
| South-East Asia         | Bhutan                  | Sri Lanka          |                               |                                     |
|                         | Democratic People’s    |                   |                               |                                     |
|                         | Republic of Korea       |                   |                               |                                     |
| Western Pacific         | Malaysia                | Republic of Korea  |                               |                                     |

Source: NMCP reports
Regional Updates
AFRO Update 1 – Scale up, SME/OR

Background

- Parasitological diagnosis of malaria still low in most countries including high burden countries (Angola, Burkina Faso, Côte d’Ivoire, DRC, Malawi, Mozambique, Nigeria, Tanzania, Uganda)
- Compliance of health workers to RDTs vs. microscopy
- Scaling up RDTs and development of implementation manuals for QA/QC.
- Strengthening capacity for laboratory diagnosis as part of larger effort of strengthening surveillance for accelerated malaria control and pre-elimination.

Discussion

- Robust plan for continuous supply of RDT and microscopy reagents in high burden counties
- BCC/IEC to improve adherence of health workers to diagnostic test result and clear direction on management of non-malaria fevers
- QA/QC of malaria diagnosis (Microscopy & RDT)
- Strengthening pharmacovigilance system at country/Regional level with collaborating centers and networks of experts

Action or Next Steps

- Support countries in planning for supply of laboratory reagents and QC/QA system
- Operational research
AFRO Update 2 – Scale up, SME/OR

Background

- Botswana, Eritrea, Namibia, South Africa, Swaziland and United Republic of Tanzania-Zanzibar moving towards pre-elimination phase.
- Cross-Border/Island pre-elimination initiatives (moving to phase: Mauritania, Senegal, The Gambia, Cape Verde, Bioko, Madagascar, Comoros, Sierra Leone).
- WHO East & Southern Africa Intercountry Support Team developed handbook on vector control to help countries to address current challenges of moving from very strong VC programmes to next phase towards elimination;

Discussion

- Inadequate surveillance data to guiding phase-out of some activities
- Community engagement to better target VC interventions
- Global and Regional support to cross-border initiatives

Action or Next Steps

- Alignment of vector control interventions with surveillance in control & elimination
- Community awareness and engagement
- Regional cooperation and cross-border vector control activities
- Support to countries for implementation of GPIRM: ANVR, Collaborating Centers
EMRO Update 1 - Malaria diagnosis

Background

• In 2011, only 37% of reported malaria cases confirmed with parasitological testing

Discussion

• Defects in recording and reporting systems – example: not all cases confirmed by RDTs are captured (e.g., s- Sudan)
• No national resources secured for RDTs - all from donor funding
• Lack of confidence in RDT results in some areas and microscopy in other areas (both clients & health workers)

Action or Next Steps

• Advocate for mobilizing financial resources at national and international levels to scale up quality diagnostic testing and ensure sustainability
• Need for position statement on use of RDTs (where and when) for malaria free countries including for routine diagnostic testing and screening
• More advocacy for standardization of RDT format
• Develop roster of experts and standard tools for diagnostic system assessment including QC/QA
EMRO Update 2 - Prevention of re-establishment of malaria transmission

Background

- 14 EMR countries free of malaria, of which 2 are certified, 3 (Egypt, Syria, Iraq) reported no cases >3 years, but did not request certification. Oman had local outbreaks in past years after importation.
- Risk of local malaria transmission is increasing: high vulnerability and receptivity (huge population movement, new water projects).

Discussion

- Imported cases from Pakistan are increasing.
- Loss of expert technicians and workers of MCP without adequate replacement.
- Collapse of the malaria programme in some countries (Syria and Libya).
- Malaria and VBDs are not considered a priority health problem in many countries.

Actions or next steps

- Develop briefs for high level political and economic fora to sustain appropriate programme funding for eliminating and malaria free countries.
- Advocacy document for national parliaments and equivalent, as the Arab League summit and the Organization of Islamic Countries, support programme review and strategy update.
- Sustain regional stock of ACT and support capacity building.
EURO Update 2 - Priority issues 2013

- **Malaria Elimination** (WHO/Europe, GMP/HQ, Global Fund, B&MGF and countries)
- Prevention of malaria re-introduction and certification of malaria elimination (WHO/Europe, GMP/HQ, Global Fund, B&MGF, ECDC, MSF and countries)
- **Capacity building on malaria elimination** (WHO/Europe, GMP/HQ, the Russian Federation, Global Fund and countries)
- Cross-border collaboration on malaria elimination (WHO/Europe, EMRO/WHO, GMP/HQ, Global Fund, B&MGF and countries)
- Promotion of integrated vector management approach (WHO/Europe, NTD/HQ, Global Fund, UNEP, GEF, Green Cross International, MKI and countries)
Approx. 23 million people live in areas at high or moderate risk for malaria

489,610 confirmed cases; 113 malaria deaths (2011)

59% reduction cases; 70% decline deaths since 2000

69% *P. vivax*; 30% *P. falciparum*; <1% *P. malariae* (reported Brazil, Colombia, F. Guiana, Guyana, Peru, Suriname, Venezuela)

Reduced Incidence in 18 of 21 endemic countries (2000 and 2010 - achievement Roll Back Malaria goal 50% reduction). Non-achievement: Dominican Republic, Haiti and Venezuela

Increased cases Guyana (2011): now four countries compared with 2000; but downward trend in Dominican Republic since 2005

Non-endemic countries: average 2,000 malaria cases (imported or introduced) per year

WHO-GMP criteria, six in pre-elimination phase (Argentina, Costa Rica, Ecuador, El Salvador, Mexico and Paraguay); elimination also considered feasible in Hispaniola
PAHO Update 2 - Targets and Challenges

- Continue efforts to reduce incidence and prevent malaria related deaths vis a vis increased mining, population movement, accessibility to health providers, availability and adherence to appropriate treatment

- Elimination of *P. falciparum* (susceptibility to CQ – Mexico, Central America, Hispaniola)
- Elimination of *P. vivax* (Argentina, Paraguay)
- Request certification elimination - Argentina

- Suspected emergence reduced efficacy – Artemisinin (SUR, GUY); Amazon efficacy monitoring
- Global Program Artemisinin Resistance Containment

- Elimination of *P. vivax* (*greater challenge*) ~ 70% cases in Region
- Global Strategy and Plan - Control and Elimination of *P. vivax*

- Global Program Insecticide Resistance Management

- AMI/RAVREDA – *new additional* network focus on elimination? – lessons other Regions

- Prevent re-establishment of transmission where interrupted - Bahamas and Jamaica: outbreaks 2006. Lessons for other non-endemic countries. Surveillance and Quality Diagnosis

- Recent announcement Global Fund financing - Elimination malaria from Mesoamerica and Hispaniola – program reorientation
SEARO Update 1 - Control of malaria among high risk groups

Background
• High risk groups include migrant workers, ethnic communities, settlers in forest fringes
• Pockets of high endemicity in remote hard to reach areas, including international borders, populated by ethnic communities

Discussion
• Delivery mechanisms to reach the hard to reach high risk groups
• Additional tools needed to control outdoor transmission

Action or Next Steps
• Situation analyses – forest related malaria, malaria along international borders, malaria among tribal communities
• Operational research (including MDA in isolated/remote villages? – Bangladesh is proposing)
• Research to develop tools to control of outdoor transmission
SEARO Update 2 - Prevention of resurgence

Background
• Several countries are eliminating malaria

Discussion
• Receptivity and vulnerability is high; resurgence of transmission is always a threat
• Several areas need to be strengthened (e.g., surveillance and response, staff capacity, SOPs, delimitation of risk areas, etc)

Action or Next Steps
• Training (e.g., malaria elimination; surveillance)
• Stratification and mapping of risk areas
• Practical guide for malaria elimination and prevention of resurgence
• Advocacy (to sustain financing; multi-sectoral support)
WPRO Update 1- Reaching Targets

Background
• WHA 58.2: 75% reduction in malaria morbidity and mortality by 2015 (2000 baseline).
• Regional Action Plan (RAP) for Malaria Control and Elimination in the Western Pacific (2010-2015), endorsed by WP RCM 2009: 50% reduction in malaria morbidity and mortality (2007 baseline)
• Sydney Malaria 2012 Saving Lives in Asia-Pacific Consensus supports and expands WHA 58.2 targets
• 2012 ASEAN and East Asia Summit strongly commit to malaria

Discussion
• Progress towards WHA 58.2 targets made, to varying degrees
• Progress towards Regional Action Plan targets not encouraging
• Sustainability of efforts needs to be considered
• Resurgence of malaria in some countries

Action or Next Steps
• Country malaria program reviews, followed by review of national strategic plans
• Gap analysis by country and the entire region
• Intensive resource mobilization
• Intensify WHO TA in some countries
• Follow up and capitalize on political commitment (e.g. APLMA, task forces)
WPRO Update 2 - Drug Resistance

Background

- Four/six Greater Mekong Subregion (GMS) countries affected by artemisinin resistance, containment operations ongoing
- Resistance to partner drugs emerging (mefloquine, piperaquine, lumefantrine)
- $16M (BMFG/AusAID) to coordinate GMS response, but insufficient funding in countries
- Commitment of development partners and ASEAN increased

Discussion

- WHO has technical leadership for artemisinin resistance containment and response, high expectations
- Emergency Response Plan based on the joint assessment development partners
- Regional Hub to be established in Cambodia with close collaboration the 3 levels of WHO
- "not business as usual approach" is needed

Action or Next Steps

- Launch ERAR Plan on April 25, 2013 in Cambodia with WPR RD and Director GMP; ERAR is on agenda of high-level meeting in August, for further political commitment.
- Finalize staff recruitment, new *modus operandi* approved by RDs, develop workplan
- Intensify TA to countries for NSPs with ERAR activities and gap analysis
- Resource mobilization, including $100M for regional AR initiative from GF
- Intensify antimalarial drug efficacy monitoring
- Expand approach to address antimicrobial resistance more broadly.
GMP Updates
Global Strategic Plan for *P. vivax* control & elimination

- Because *P. vivax* not perceived to be a major killer compared to *P. falciparum*, often features as an “add-on” to strategies
- 2.6 billion people at risk
- More formidable technical challenge
- In September 2012, MPAC endorsed urgent need to develop a global plan for *P. vivax*
- Although will be included in Global Technical Strategy for Malaria Control and Elimination (2016-2025), recommended that vivax plan be developed first
Structure for developing *P. vivax* plan

Steering Committee oversight

- WMR Data
- Country Landscape Briefs
- Thematic Reviews
- Writing comm.
- Strategy formulation
- Writing comm.
- MPAC review

Secretariat support (WHO-GMP and WHO Regions)

Global report (journal supplement)

Draft global *P. vivax* strategic plan

- Updated policy recommendations
- Priority research areas
Global Strategic Plan for *P. vivax* control & elimination

- Initial Steering Committee meeting in November 2012 at ASTMH
- Writing Committee (includes most of Steering Committee) to be convened in early 2013
- Regional and country stakeholders to be convened in 2013
- Presentation to MPAC in 2014
- Support provided by MMV
Global Strategic Plan for *P. vivax* control & elimination

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<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
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Compiling the Evidence Base

1. **World Malaria Report**
   - Data collection
   - Data analysis

2. **Country landscapes/background papers**
   - India: 2 states
   - Brazil
   - PNG
   - Other countries

3. **Thematic reviews**
   - *P. vivax* epidemiology
   - *P. vivax* biology
   - Vector control considerations for *P. vivax*
   - Diagnosis & treatment (inc G6PD deficiency, resistance)
   - Surveillance and elimination
   - Health systems responses (policies, financing, IEC etc)
   - Cost-effectiveness of interventions and optimal mix
   - Research priorities

Analysis and Formulation of Strategy

- Regional overviews
- Developing strategy
- Developing global report on *P. vivax*
- Finalize database of references
- Finalize Strategy & Report
Malaria Situation Room - Objectives

- Track financial flow, commodities, intervention coverage and impact, and to proactively identify bottlenecks
- Work with countries to develop solutions for action
- Initially, the Situation Room will track these data in the 10 highest burden countries in Africa (Nigeria, DRC, Tanzania, Uganda, Mozambique, Ghana, Côte d'Ivoire, Burkina Faso, Niger, Cameroon) that account for over 70% of regional and 56% of global malaria burden
Malaria Situation Room - Progress

- WHO secured funding from Bill & Melinda Gates Foundation to cover start-up and three years of operations

- Staffing plan:
  - GMP - one professional and one GS
  - WHO - PSM expert on loan
  - RBM - two professionals
  - ALMA - one professional (seconded)
  - IFRC - one professional (seconded)
  - Consultant-operation manager (recruitment in progress)
  - AFRO - one staff (P3) to assist MSR and RSIS/SHOC will be recruited

- Dedicated space recently created; will be equipped with display and communication facilities

- Steering committee (GMP, RBM, UN-SEO, ALMA) - Teleconference every other week

- Malaria Situation Room team - teleconferences every other week
Situation Room Update – Next Steps

- Informing the 10 member states:
  - RD/AFRO to send letter MoHs
- Launch event (WHA, date and venue TBD):
  - to engage the MoH of the 10 countries and key partners to ensure high level commitment and support
- Populate data (national, subnational, etc)
- Finalize web-based data entry and display tool (14 Apr)
RAcE 2015 – Key elements

Support iCCM in 5 African countries as an integral part of government health services

• 5 year project: April 2012 to 2017
• CAD $74.5M

Objectives:

• Increase access to correct diagnosis, treatment and referrals for malaria, pneumonia and diarrhea at the community level
• Stimulate policy review and regulatory update on disease case management in countries, including adaptation of supply management and surveillance systems
RAcE 2015 – Progress

- 5 countries jointly selected by GMP, MCA and AFRO: Malawi, Mozambique, DRC, Niger, Nigeria

- Implementing partners selected in 4 countries, after guidance workshops, co-facilitated by WHO and MoH's
  - Malawi and Mozambique: Save the Children
  - DRC: International Rescue Committee
  - Niger: World Vision

  **Implementation expected to start April-May 2013**

- Nigeria: two states (Niger and Abia) selected in collaboration with FMoH

  **Implementation expected to start July 2013**
Malawi: 4 districts, 160,000 children 2-59 months

Niger: 3 districts, 184,000 children 2-59 months

Mozambique: 4 provinces, 308,000 children 2-59 months

DRC: 2 provinces, 150,000 children 2-59 months
GMP website restructuring

- Website content review and restructuring process began three months ago – almost finished;
- All GMP content has been updated, each technical section expanded, new ones added;
- Content architecture revised to ensure all current priorities are appropriately covered/linked, with improved navigation and search function;
- 200+ documents have been reviewed for validity (almost half will be labeled 'archived');
- Most changes have been done, but not yet visible to public. New website to go live in April;
- New website will serve as foundation for strengthened knowledge management work, incl. regular digital outreach to partners.
SMC: policy and implementation status

- WHO Policy formulation – (March 2012)
- Development and publication of an Implementation Manual – (November 2012)
- Orientation and training workshop for 10 countries (December 2012)
Artemisinin Resistance in Greater Mekong Subregion (GMS) - Updates

- Scope of problem unchanged since last MPAC meeting
- Activities in Myanmar being scaled up under MARC project
- Emergency Response to Artemisinin Resistance in GMS developed
  - Endorsed by countries in late February 2013
  - Launch planned for World Malaria Day in
- Resources for coordinating the response received from Bill & Melinda Gates Foundation, and expected from AusAid
- WHO Regional Hub being opened in Cambodia
- Global Fund included Regional Proposal for responding to artemisinin resistance in GMS in Early Applicants for New Funding Model: $100 million over 3 years
- Main factor limiting success remains resources
  - Need to do more of what is working
Scope of AR containment activities

- Tier I (inactive)
- Tier II (inactive)
- Myanmar
- Thailand
- Viet Nam
- Cambodia
SHWEKYIN TOWNSHIP, Bago State, Myanmar
Treated malaria cases by type of service provider (2001 - 2012)

By BHS  By Volunteer  At Screening point

<table>
<thead>
<tr>
<th>Year</th>
<th>By BHS</th>
<th>By Volunteer</th>
<th>At Screening point</th>
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<tbody>
<tr>
<td>2001</td>
<td>1945</td>
<td>1943</td>
<td>976</td>
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<td>1439</td>
<td>1399</td>
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Malaria inpatients & CFR (Shwe Kyin Township) (2001 - 2012)
Cerebral malaria cases (Shwe Kyin Township) (2005 - 2012)
Structure of Emergency Response to Artemisinin Resistance (ERAR)
Management of Severe Malaria

• Third edition of the Practical Handbook for the *Management of Severe Malaria* published in November 2012
  • Incorporates the current updates and knowledge in the practical management of severe malaria
  • Support (financial and human) received from RBM Case Management Working Group and MMV
Elimination case studies

- 10 case studies being produced jointly with Global Health Group
- Four launched in October 2012: Cape Verde, Sri Lanka, Turkmenistan, Mauritius
- Six to be launched this year: Turkey, Philippines, Malaysia, La Reunion, Tunisia, Bhutan
- Detailed description of epidemiology, control strategies applied over time, successes and failures and lessons learnt.
- To help NMCPs and other partners contemplating elimination have a better understanding of process involved
2013 World Health Assembly process

- In January 2013, WHO Executive Board considered progress report on resolution WHA 64.17 on malaria
- US delegation, supported by other delegations, called for report to be elevated to a stand-alone technical item at 66th WHA and an update on the response to emerging artemisinin resistance
- WHO has prepared 2400-word report on malaria reviewing recent progress and key challenges; listing latest guidance; and discussing role of MPAC and need for the global technical strategy 2016-2025
- Currently considering ways to build on political momentum at WHA on malaria. Launch of Situation Room is one option
- During WHA, cluster will organize technical briefing on Global Fund new funding model (all three diseases)
The New Funding Model

Key features and implementation
## Key features

### Predictable funding
- Applicants are given an indicative funding range over a 3-year period
- The Secretariat will hold indicative amounts for applicants until they apply

### Timing of requests
- Applicants apply for funding when they want
- Applicants can submit different disease or HCSS requests at different times
- Applicants can use in-country planning cycles

### Length of grants
- Three years

### Early feedback
- Applicants submit a funding request through a “Concept Note”
- Early feedback from the Secretariat and the TRP = higher success rate

### Incentive funding
- Competitive funding in addition to indicative range
- Rewards high impact, well-performing programs
- Encourages full expression of demand

### Grant-making
- Upfront risk and capacity assessments
- Differentiated processes to ensure disbursement-ready grants
- Funding requests negotiated before Board approval

The new funding model changes the way applicants apply for funding, get approval of their proposals and then manage their grants.
How does the new model differ from the previous model?

From previous model:

- Passive role by the Secretariat in influencing investments
- Timelines largely defined by the Global Fund
- Hands-off Secretariat role prior to Board approval
- Low predictability: timing of Rounds, success rates and available funds
- Cumbersome undifferentiated process to grant signing with different delays

To new funding model:

- More active portfolio management to optimize impact
- Timelines largely defined by each country
- Ongoing engagement by Secretariat
- High predictability: timing, success rates, indicative funding range
- Disbursement-ready grants with differentiated approach
Overview of the new funding model

1. NSP support
2. NSP allocation formula
3. Country dialogue
4. Concept Note
5. TRP review
6. Grant-making
7. Grant-Approval Committee
8. Determination of split between diseases & HCSS
9. Unfunded quality demand
10. Board approval

Indicative funding
Band allocation
Allocation formula
Incentive funding
Determine/ approve adjusted funding amount
Incentive funding
In new funding model, disease programs will fall into one of three categories

<table>
<thead>
<tr>
<th>How they receive funding</th>
<th>What they do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early applicants</td>
<td>All steps of the new funding model process — country dialogue, submitting a concept note, TRP review, rant making</td>
</tr>
<tr>
<td>New grant: eligible for indicative and incentive funding</td>
<td></td>
</tr>
<tr>
<td>Interim applicants</td>
<td>Country dialogue</td>
</tr>
<tr>
<td>Renewals and extensions of existing grants, and redesigns to access funding in 2013</td>
<td></td>
</tr>
<tr>
<td>Standard applicants</td>
<td>Country dialogue</td>
</tr>
<tr>
<td>Prepare for applications to be submitted in late 2013 or in 2014</td>
<td></td>
</tr>
</tbody>
</table>
GF New funding model: current status & timelines

1. Early
   - Selection of early applicants
   - Application plus real-time learning
   - New grants signed

2. Interim
   - Selection of interim applicants
   - Interim funding through renewals, grant extensions and redesigned programs

3. Standard
   - In-country preparation and national strategy development
   - New grants signed

Application, review and grant-making

NFM: Key features and implementation
Version 8.1 – 28 February 2013
Which are the countries involved? – Malaria

Early applicants

- Myanmar
  - US$ 21 million
  - Single country

- Regional Artemisinin Resistance (malaria)
  - US$ 100 million
  - Regional applicant

- Mesoamerica
  - US$ 10 million
  - Regional applicant

Interim applicants

- 16 Countries
  - US$ 520.8 million
### Countries at risk of interruption of essential services or activities

<table>
<thead>
<tr>
<th>Essential services or activities</th>
<th>For the purposes of the transition to the NFM, is defined using the same approach the Secretariat developed with the Transitional Funding Mechanism (TFM) in 2011 and 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timelines</td>
<td>For the period of 2013 to the end of Q3 2014</td>
</tr>
<tr>
<td>LLIN replacement</td>
<td>For the transition to the NFM, the Global Fund will cover LLIN replacement costs if the last distribution was Global Fund financed, within the limits of funding available and other service interruptions for malaria</td>
</tr>
</tbody>
</table>

“Funding that prevents service-disruption by providing up to two years of funding to continue, at the same scope and scale, essential prevention, treatment and/or care programs currently financed by the Global Fund that face an imminent disruption if the CCM can demonstrate it cannot reprogram existing grants or identify alternative sources of funding (domestic or from other donors).”
Evidence Review Groups

ERG a
ERG b
ERG c

Standing TEG on Malaria Vector Control
Standing TEG on Drug Resistance & Containment
Standing TEG on Chemotherapy

SAGE

JTEG (with IVB)

MPAC

WHO DG

WHO GMP Secretariat

WHO ROs

RBM: Secretariat, WGs and SRNs

WHO COs

MoH and NMCPs

NEW

Reducing malaria transmission: like draining a pond
Malaria Stratification: Lao PDR

[Map of Lao PDR with color-coded incidence rates of malaria.]

Courtesy: D. Gopinath
Why **durable** development matters for the future of malaria control & elimination

Investment ► Control

Dis-investment ► Resurgence
The greatest threat to continued success in malaria control and elimination is financial rather than biological.