世界衛生組織執行委員會 決議
قرار المجلس التنفيذي لمنظمة الصحة العالمية
RESOLUTION OF THE EXECUTIVE BOARD OF THE WHO
RÉSOLUTION DU CONSEIL EXÉCUTIF DE L'OMS
РЕЗОЛЮЦИЯ ИСПОЛНИТЕЛЬНОГО КОМИТЕТА ВОЗ
RESOLUCION DEL CONSEJO EJECUTIVO DE LA OMS

103rd Session **EB103.R9**

Agenda item 3 **29 January 1999**

Roll Back Malaria

The Executive Board,

Reaffirming the impact of malaria in constraining human development, and appreciating the innovative concepts and operational mechanisms in the Director-General's report on Roll Back Malaria,[1]

RECOMMENDS to the Fifty-second World Health Assembly the adoption of the following resolution:

The Fifty-second World Health Assembly,

Having considered the report of the Director-General on Roll Back Malaria;

Concerned that the global burden of malaria is a challenge to human development and a significant cause of poverty and human suffering, particularly in the poorest nations of the world;

Mindful of the efficacious tools currently available to reduce this burden, and the potential for their more effective use within malaria-affected communities;

Welcoming the decision by the Director-General to establish a Cabinet project to support rolling back malaria which works across the Organization;

Noting that Roll Back Malaria represents a new approach promoted by WHO, in which all concerned parties are encouraged to work in a coordinated partnership, united by common goals, consistent strategies and agreed methods of working, and that Roll Back Malaria is serving as a pathfinder in bringing these concepts into operation in relation to other international health issues;

Commending the key features of the new approach, namely, increased focus on the needs of people at risk, better response to those needs with evidence-based action, greater use of existing tools, their full integration into the health sector as a horizontal programme, and innovative public-private partnerships to develop cost-effective products and tools in view of the emergence of drug and insecticide resistance;

Appreciating the strong commitment to Roll Back Malaria from several heads of State, the Administrator of UNDP, the President of the World Bank, the Executive Director of UNICEF, and

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[1] Document EB103/6.

directors of other development banks, foundations and bilateral assistance agencies, expressed when the global partnership was established in December 1998,

1. ENCOURAGES Member States to reduce malaria-related suffering and promote national development in a sustained way, by rolling back malaria and preventing its resurgence or reintroduction, by:

(1) engaging a wide range of personnel and institutions involved in health systems, disease control, and research, with representatives of civil society, the private sector, development agencies and other sectors;

and, where relevant, by:

(2) ensuring that sufficient resources are available to meet the challenge of rolling back malaria;

(3) establishing and sustaining country-level partnerships to roll back malaria within the context of health sector and human development;

(4) utilizing relevant technical expertise that exists within countries and regions in an effective manner;

2. REQUESTS the Director-General to draw on the whole Organization in supporting Member States by:

(1) promoting harmonized strategies and encouraging consistent technical guidance for efforts to roll back malaria;

(2) working with them as they establish criteria for success in rolling back malaria, and monitoring progress of country and global efforts within the context of health sector and human development;

(3) promoting international investment in cost-effective new approaches and products through focused support for research and for strategic public and private initiatives;

(4) brokering the technical and financial assistance that is required for success;

3. REQUESTS the Director-General:

(1) to report regularly on progress of the global Roll Back Malaria partnership to the Executive Board and the Health Assembly, stressing the contribution that Roll Back Malaria makes to the reduction of poverty, and reviewing the extent to which the partnership serves as a pathfinder for effective joint action on other international health issues;

(2) to promote the aims and outcomes of the Roll Back Malaria partnership in relevant intergovernmental bodies, organizations of the United Nations system, and - when appropriate - other bodies committed to equitable human development.

Ninth meeting, 29 January 1999
EB103/SR/9

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ROLL BACK MALARIA

BRIEFING DOCUMENT

INTRODUCTION

1. Governments and civil society in malaria affected countries will take the lead in rolling back malaria as a means to reduce poverty and mortality, and promote human development. Partners, in considering health sector issues, will agree to work together, at country level, towards common goals using agreed strategies and procedures. The national authorities of countries will direct the partnership.

2. WHO has established a **Cabinet Project** to help country Roll Back Malaria partnerships become fully effective. The project is implemented with the support of WHO`s Clusters and Offices at Headquarters, Regions and Country, and other partners. It is spearheaded in Africa. It promotes effective investment in new medicines and other tools to reduce the burden of malaria through WHO/TDR, MIM and the public-private MMV (Medicines for Malaria Venture).

3. The project helps increase the level of international financial investment in the efforts of countries to Roll Back Malaria through international **advocacy** emphasising the current and potential investment outcomes and ensuring updated information on the global malaria situation.

4. To provide countries with the specialised technical support required to address the challenges of malaria, the project will establish a number of Resource Support Networks, comprising experts in appropriate fields, particularly from relevant regions; thus making implementation plans to reflect an evidence-based response to local needs and realities.

MISSION

5. The Roll Back Malaria Cabinet Project will address a priority health issue through contributions to strengthen national systems, provide effective and strategic interventions through partnerships with groups within and outside WHO, and act as a pathfinder in offering a new approach to the sustainable control of infectious diseases.

GOAL

6. The Roll Back Malaria project will significantly reduce the global burden of disease associated with malaria through interventions adapted to local needs and reinforcement of the health sector.

MAIN AREAS OF WORK

1. Strategy Development, Communication & Advocacy
2. Activating Progress at Country Level
3. Building and Sustaining the Global Partnership
4. Promoting Consistent Technical Guidance
5. Strategy Support for Research and Development
6. Monitoring Progress & Outcomes

BUILDING & SUSTAINING GLOBAL PARTNERSHIP

11. A partnership representing Member States, organisations of the United Nations system, development banks, bilateral development agencies, the private sector, the media and civil society will be established at the global level to support country level action. Partners will agree on the terms of their participation, approaches to international advocacy, means for mobilisation and flow of resources, the basis for monitoring progress, and an appropriate institutional framework to sustain the partnership; thus contributing to more effective action on their part at country level.

PROMOTING CONSISTENT TECHNICAL GUIDANCE

12. Technical support networks will be established to provide expertise that is required for the implementation of RBM by countries. These networks will:

- comprise experts (and institutions) in various disciplines with practical experience available in countries within the region
- provide direct support to control operations
- address specific technical issues that are critical for control policy
- address specific issues that can be more effectively dealt with in an inter-country and/or regional setting
- function in a "demand-responsive" manner with respect to the RBM needs of countries
- encourage collaboration between countries
- be the link with international expertise between research and academic institutions, and disease control operations in endemic countries
- be financed by various partners
- be a potent mechanism through which to build country and regional capacity

STRATEGIC SUPPORT FOR RESEARCH & DEVELOPMENT

13. International Research and Product Development activities that address key constraints to rolling back malaria will be incorporated into the global Roll Back Malaria partnership. This will result in intensified collaboration with the private sector to develop new and more cost effective tools for malaria control. The major institution for this component is the cosponsored Tropical Diseases Research Programme, managed by WHO. Another is the Medicines for Malaria Venture (MMV) which will operate as a commercial enterprise, using public funds to accelerate the development of effective new anti-malarial treatments and vaccines. A third is the Multilateral Initiative on Malaria, an independent consortium of research groups seeking scientific responses to the challenge of malaria in Africa. Roll Back Malaria will help these vital initiatives to agreed priorities to accelerate global efforts to reduce the malaria burden.

MONITORING PROGRESS & OUTCOMES

14. Support to monitoring and evaluation will be provided by RBM, and standardised methods and criteria for monitoring and evaluation of interventions at the district level will be developed. Further, a monitoring and evaluation system will be established within WHO to track the global progress of Roll Back Malaria implementation and its impact on the health sector.

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Distribution: Restricted

Partnerz

ESTABLISHING A GLOBAL PARTNERSHIP TO ROLL BACK MALARIA

FIRST PARTNERS' MEETING

Geneva
8 and 9 December 1998
at the
World Health Organisation
Executive Board Room

DRAFT REPORT
19th January 1999

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The meeting was planned and managed by Dr Pene Key, Short Term Consultant to the Roll Back malaria Project, together with the rest of the RBM team, under the supervision of Dr Tore Godal, Acting Project Manager. This report was prepared by Jenny Hill of the Malaria Consortium, in conjunction with David Nabarro, the current Project Manager (who takes responsibility for its contents).

1. PRELIMINARY PLAN FOR THE GLOBAL PARTNERSHIP TO *ROLL BACK MALARIA*: MEETING CONCLUSIONS

1.1 A global partnership was formally established on 9 December 1998 to intensify the international effort to reduce the malaria burden – to ***Roll Back Malaria***.

1.2 Participants at this first **Partners' Meeting** represented national governments, UN systems agencies, development banks, non-governmental organisations, private sector and bilateral donors.

1.3 Within the limits of their authority, they committed themselves and their organisations to the establishment of country-level partnerships to Roll Back Malaria. Where possible they would work within the context of these partnerships

1.4 The principles of a country ***Roll Back Malaria*** partnership are that:

i. National governments determine the goals, strategy, organisation and operating procedures for Rolling Back Malaria;
ii. A country partnership to Roll Back Malaria is usually set up at the invitation of a country's Head of State;
iii. It involves a situation assessment and strategy development process led by the National Authorities and involving potential partners;
iv. Partners' support for Rolling Back Malaria is provided, where possible, within the context of the *sector-wide approach to health development*;
v. Partners work to common objectives, using agreed strategies, in a transparent manner;
vi. Within the context of these principles, attempts are made to ensure that partners have sufficient flexibility and autonomy to make the fullest possible contribution to Rolling Back Malaria.

1.5 At the country level, WHO will help to ensure that the partnership is a success through providing a range of focussed inputs. These are offered through the WHO Roll Back Malaria (RBM) *Cabinet Project*. This involves personnel within WHO headquarters (from all nine clusters), WHO regional offices, and WHO country offices.

1.6 The WHO RBM project will contribute to country partnerships by offering help in several areas, including:

i. possible agreements and means of working
ii. materials for advocacy
iii. help with developing a consensus on strategy– ensuring that options considered are based on best available evidence
iv. capacity building
v. lesson learning from other countries and from other programmes
vi. support for monitoring progress, and
vii. brokering resources [looking for new channels as well as existing ones].

1.7 WHO regions are key elements of the RBM project, contributing to country partnerships. They may offer other support for national and local-level action within countries.

1.8 At global level, WHO will set up a small 'partners' group' to help the Global RBM Partnership evolve, and to provide guidance to the WHO Roll Back Malaria Project, which supports the partnership. The project will develop strong linkages between partners through the use of advanced communication technology.

1.9 To reduce malaria suffering and death rates substantially, funding mechanisms are needed:

- to enable countries to implement new malaria and health sector development activities
- to ensure that key components of RBM – such as the Medicines for Malaria Venture, the Tropical Disease Research Programme, and the Multilateral Research Initiative on Malaria deliver the desired products
- to build WHO's ability to support partnerships – through in-country action, technical resource networks, international monitoring and global advocacy

1.10 WHO's role is to support the partnership and make it effective, ensuring that it has the greatest likelihood of mobilising cash,

information and other vital resources within the context of what is needed. Current plans for the partnership do not envisage a long-term dedicated financing mechanism unless this is demanded by all. Funding is urgently required for short term needs.

1.11 The RBM partnership will need to mobilise substantial additional resources – approximately $200 million per annum for country level action, together with resources for the WHO Roll Back Malaria Project.

1.12 Political support for partnerships will need to be sustained via:

- information and technical agreements
- reviews of work, with quick reports of results
- high level advocacy
- continued championing and marketing of the idea

In summing up, Dr Brundtland, WHO Director General:

1.13 Expressed her gratitude for the groundswell of support for the basic concept, objectives and approaches to be taken, in Rolling Back Malaria.

1.14 Emphasized the importance of capitalising on the current momentum to get Roll Back Malaria implemented on the ground.

1.15 Underlined the importance of Roll Back Malaria as a pathfinder in identifying new ways for partners in International Health to work together effectively.

1.16 Stressed that Roll Back Malaria - as a pathfinder within the organization, and as a cabinet project - is expected to develop new ways of working between WHO clusters, regions and country activities.

1.17 Pointed out that Roll Back Malaria presented a broad institutional challenge, going far beyond those concerned with malaria at HQ, regional, and country offices.

2. INTRODUCTION

The meeting of partners to 'Roll Back Malaria' (RBM) was opened by Dr David Heymann, Executive Director of the Communicable Diseases cluster, on behalf of the Director General. Dr Heymann described the positioning of the Roll Back Malaria project, initiated by the Director General to facilitate intensified efforts and look at new ways of controlling malaria, within WHO. RBM is a project of Cabinet, has a house in the Communicable Diseases programme, and draws on expertise in other WHO clusters such as Emergency and Humanitarian Action, Health Systems Development and Health Technology and Pharmaceuticals.

Ambassador Store described WHO's renewal process, a result of the Director General's pledge to reform the organisation following her election at the WHA in May 1998. Led by a senior management team, regrouping of programmes and activities began on 21st July 1998, the day the Director General took office: 50 programmes have been regrouped into 9 clusters, then reduced to 35 departments, and the organisation is in the process of appointing new directors. Other fundamental changes are the introduction of staff mobility and rotation, so that Headquarters is more inspired by countries and the organisation becomes 'one WHO'; transparency of budgets at all levels of the organisation; and bringing management support closer to technical programmes and actions to improve efficiency and consistency. As a Cabinet project, RBM is defined as a pathfinder, teaching WHO how to work across programmes, across the house, and how to develop co-ownership among partner agencies and among countries.

Dr David Heymann nominated the Chair - David Nabarro, Head of Health and Population Division, UK Department for International Development; the Vice Chair - Dr Z Maiga, Secretary General of the Ministry of Health, Mali; and the Rapporteur - Dr Madeleine Leloup, Ministry of Foreign Affairs, France.

The meeting was attended by 41 representatives of national and government agencies, 19 representatives of regional and international organisations, 8 representatives of WHO regional offices and 8 members of the RBM Secretariat (see list of participants in Annex 2).

3. ESTABLISHING A GLOBAL PARTNERSHIP

3.1 Reasons for the Partnership

The Malaria Burden: problems and issues - Dr Fred Binka

Malaria affects 100 countries world wide, causing 300-500 million clinical cases per year, over 80% of which are in Africa, and one million deaths per year, over 95% of which are in children under five years in Africa. Severe forms of the disease result in neurological sequelae and disability, the extent of which is probably underestimated but which no doubt has a significant impact on cognitive learning especially among children. The malaria situation is worsening: malaria has been reintroduced to areas where eradication was achieved in the 1950s and 60s; malaria is now found in areas previously free of the disease; and the number of epidemics in Africa, Southeast Asia and South America are increasing.

Perhaps the major threat to the control of malaria is the development of drug resistance - to sulphadoxine-primethamine and mefloquine in South East Asia and to chloroquine and, more recently, to sulphadoxine-pyrimethamine in Africa. Other major problems in the control of malaria are poor access to health care and issues associated with delivery, including: under utilisation of public health facilities and high use of the formal and non-formal private sector, poor availability of antimalarials in public health facilities and high costs.

Contributions to help countries tackle the malaria burden, from external sources, totalled US$287.5 million in 1997[1]. Sources included Development Banks (US$172 million), Bilateral agencies (US$32 million), Multilateral agencies (US$15 million), research institutions (US$4 million), NGOs (US$16 million) and the private sector (US$6 million).

Background to RBM and Preparatory Phase - Dr Tore Godal and David Nabarro

Political and financial commitments to malaria have seen a significant increase in recent years, and particularly in the last two years, as illustrated by the number of new malaria initiatives. These include the Africa Initiative on Malaria (AIM), the Multilateral Initiative on Malaria, the Director General's special fund for accelerated action in Africa and new co-operation with the private sector, such as the Medicines for Malaria Venture. There have been a number of significant political statements by political bodies including the G8 countries, four UN agencies, the OAU and most recently by WHO's newly elected Director General.

The basic concept of RBM is to address a priority problem within the context of health sector development, intersectoral collaboration and community action. WHO will

[1] Martinez J, Hill J and Meek S (1998) Global Coordination of Malaria Control Efforts - issues and options for supporting country strategies. A study commissioned by WHO/CTD

provide strategic direction to a global partnership to make the best use of available resources through the RBM project.

Objectives of the RBM partnership are to:

- Significantly reduce the global malaria burden through improving people's access to interventions adapted to local needs
- Achieve results through effective support to health sector development
- National goals to be set by countries based on situation analysis and feasibility assessment
- Global targets will be set from aggregated national goals at the end of the RBM preparatory phase (end 1999)

Expected results at the end of the RBM project period are:

- Significant reductions in poor people's burdens due to malaria: ideally halving of malaria mortality by 2010
- Improvements in people's access to effective anti-malaria interventions adapted to local needs and contexts
- National health sectors, and other sectors associated with human development, respond better to requirements of poor people in relation to malaria
- The RBM approach contributes to the effectiveness of actions by other groups within and outside WHO

Intermediate objectives for 2001 for:

1) country level action,
2) the Global RBM Partnership,
3) synergy within WHO and associated bodies,
4) monitoring, review and reporting,
5) development and deployment of new tools,
6) advocacy, resource mobilisation and the provision of assistance for RBM.

The RBM approach will be to build on current efforts, with the Africa Initiative on Malaria as the spearhead, and the Global Malaria Control Strategy, based on regional, epidemiological and health systems needs and focus on community and district level action. The first priority will be areas of high transmission in Africa, followed by countries experiencing epidemic malaria and malaria endemic countries in other regions. Investment will also be made in research and development of new tools that can help short term gains.

3.2 Existing Partnerships

Analysis of country-level partnerships for health

Country level experiences of coordinating international assistance for better health were presented for Uganda (Dr P Byaruhanga), Zambia (Dr JJ Banda), India (Dr Shiv Lal), Vietnam (Prof Pham Manh Hung), the Democratic Republic of Congo (Dr Mathey Boo) and Mali (Dr Maiga).

Uganda is attempting to consolidate their health services after years of political turmoil in the 1970s and early 1980s. A resource flow map for inputs to the health sector in Uganda highlights the problem which results with multiple inputs of several different donors, each with different objectives, leading to uncoordinated, duplicated efforts realising limited impact. Steps are now being taken to improve and simplify resource co-ordination through a single clearing house in the Ministry of Finance, from where earmarked beneficiaries can access resources, i.e. through Sector Wide Approaches (SWAps). However, there are many challenges that have yet to be addressed to advance this approach.

Zambia has introduced a partnership of cosponsors for district health services, where funds from central donor accounts are managed by a Central Board of Health (CBOH) district account. Districts then receive funds from the CBOH account as well as from central MOH on a quarterly basis. Cooperating partners also adhere to joint planning and monitoring missions and operate according to jointly agreed standards of financial and administrative management systems. The system is well planned and locally driven, allowing districts a large degree of freedom. Funding delays are however a problem.

India spends more than one third of the government health budget on malaria. Initial experiences following the revision of the national malaria control strategy in line with the Global Malaria Control Strategy have been encouraging - the disease is largely contained. However, more than 70% of malaria cases go to the private sector for treatment of variable quality and there is need to educate the community combined with effective multisectoral coordination at the community level and continuing updating of private medical practitioners.

In Vietnam, in the period between 1991 and 1997, the number of malaria deaths has been reduced by 97%, the number of malaria outbreaks by 92%, and the number of malaria cases by 59%. The success of the National Malaria Control Programme is due to strong leadership and organisation of the programme by government, realistic objectives and appropriate technical measures. The National Health Programme is directed and implemented by MOH with the coordination of the Ministry of Planning, Investment and Finance. Administration and management of resources are decentralised to local levels. International donors undergo a process of acceptance and then work with the Steering Committee of the Malaria Control Programme to undertake needs assessments, strategy development and planning of malaria activities. Differences in the fiscal years and financial management regulations between the

government and its partners causes delays in addition to which there is limited management capacity of MOH staff.

DRC has undergone a number of much needed changes with regard to donor coordination. Currently health sector inputs are coordinated by an interagency committee, with subcommittees for malaria and other programmes. The committee is currently changing its method of working.

Analysis of global and regional Partnerships for Health - Dr Penelope Key

An analysis of existing global and regional partnerships which have had varying degrees of success was undertaken in order to identify key characteristics of successful programmes of relevance to establishing the RBM partnership mechanism. Some of these have a public health mandate (polio eradication, UNAIDS) while others address other sectors such as agriculture or the environment. There is a wide spectrum of existing partnership structures and governance, ranging from the tightly governed, legally binding group at one end to the loose stakeholder coalitions at the other end. In the middle sit a large group with a degree of governance and structure, but having a flexible operating modality. The degree of ownership by, or involvement of, countries as equal partners varies from virtual exclusion to full, such as the Intergovernmental Forum on Chemical Safety.

Partnerships whose prime purpose or mandate is for raising and managing financial resources, usually centrally operated, tend to be tightly governed, with strict membership rules, legal agreements, management staff and tight criteria for allocation of funds. Partnerships whose primary mandate is co-ordination of strategies and activities, with action taking place at country level, tend (though not always) to be looser, informal coalitions of stakeholders, where secretariat functions are undertaken by programme staff. Partnerships with secretariats that are autonomous or independent of programme management tend to demonstrate better ownership by the partners, but they have sustainability problems.

Where resource mobilisation and management functions are integral to programmes, as in WHO TDR and HRP and WHO GPVI, this has a real cost in terms of staff time and detracts from programme achievements. It appears that there is value in out-placing this function to an independent Partnership Structure; Resource mobilisation must be planned and continuous. Involvement of private (commercial) sector agencies as full members of partnerships may dictate the partnership structure. WHO, for instance, has regulations which exclude their full (voting) membership of certain official committees.

A high-profile Civil Society Champion is invaluable for continued advocacy and resource mobilisation. The roles of each Partner organisation should be defined clearly from the start. Building the partnerships requires time and effort. Continued, consistent information and updating of partners about programme progress is essential. Personal rapport is needed between partners at a high level. Political commitment in endemic countries must be maintained. Inter-sectoral support in countries is vital to public health programmes and requires involvement of the Head of State to succeed.

Regional Partnerships have shown considerable success. The West Africa OCP is the outstanding example. This is firmly sited in the tight governance group. One longstanding collaboration in Asia (SEMEO-TROPMED) is institution-based but has proved its worth, the second (ACTMalaria) has started well but long term funding is a problem. Regional partnerships will be challenged by agencies' differing regional definitions. In the case of malaria, boundaries based on epidemiological types are more logical. Cross-regional representation is invaluable.

Proposals are made for possible structure of the RBM partnerships based on past experiences and lessons learned.

4. ISSUES IN ESTABLISHING THE RBM PARTNERSHIP: Summary of Discussions

The presentations summarised above provoked active discussion among participants concerning the important issues in establishing the RBM partnership mechanism. There was excellent participation by all participants and particularly by country representatives - ministers, malaria programme managers and representatives of non-government agencies - who were alert in responding to what the donors were saying. This lively interaction was one of the highlights of the meeting. This section attempts to summarise the issues raised during this discussion.

The RBM project of WHO has been initiated for a five year period in order to establish and consolidate WHO structure, leadership and partnerships to 'roll back malaria'. During the lifespan of the WHO project, the RBM partnership must become highly effective to ensure continuity of intensified efforts at the end of the WHO project. The success of the RBM partnership in terms of its impact on malaria will be dependent on its ability to sustain intensified action in Malaria Endemic Countries over a 20 to 30 year period. Within WHO, the RBM project will become integrated into ongouing activity within five years.

RBM will address malaria in the context of health sector development. The RBM partnership must therefore find ways to address the different status of health sector development and reform in different countries. It must also ensure that Health Sector Development and malaria technical issues are brought together, for example, to ensure that pharmaceutical policy, and drug resistance issues, are properly handled within the health sector context , and that malaria related action takes account of the low salaries of health workers. Partners will therefore have to become immersed in significant health sector issues. Results of the RBM partnership will be assessed in terms of health sector development-related outcomes as well as malaria outcomes.

However, action through the health system is only a part of controlling malaria. The RBM partnership needs to find viable entry points for malaria control especially to engage households and to mobilise whole societies. As a first step, the partnership must involve the poor and the rest of civil society in dialogue about Rolling Back Malaria by involving those NGOs which articulate demands and interests of civil society. The challenge is to ensure effective communications between all groups interested in Rolling Back malaria: several of these do not communicate effectively with each other at present. The partnership needs to combine focused thinking with a sophisticated, response - which goes beyond health care systems. This response must also engage the private sector at all levels - from multinational entities to local shopkeepers.

In addition to a broad response to tackling malaria, RBM needs to take account of other issues besides malaria. Malaria is only part of the burden carried by poor people, particularly by women. The RBM partnership needs a proper understanding of the causal relationship between poverty and malaria and of other social and economic issues

which affect the poor. This will require the development of appropriate gender and poverty strategies for RBM.

Financial contributions to national malaria control activities have often been poorly aligned to the burden posed by malaria, and the related needs of poor people. The RBM partnership must develop a rational approach to ensure that resource flows within countries, and through partners, are aligned with the burden of malaria. Funding contributions as well as strategies need to be based on regional, epidemiological and health systems needs. Focus must be on community and district level action; and this will require simplified, timely and transparent funding channels which allow districts the freedom to manage their own funds. The challenge for the partnership will be how to intensify action for malaria through a common pot/basket to avoid the complex situation found in Uganda and other countries. It is however recognised that not all partners will be able to channel funds through SWAps, and flexibility of funding mechanisms will be needed. The RBM partnership will also have to find effective means to garner untapped resources in both the public sector and the private sector.

Clarity of roles within the partnership is essential from the outset. Countries should be central to the partnerships at all levels and especially at country level; this will be government or indeed other recognised institutions responsible for States or parts of States. Co-ordination at country level will be critical to the success of RBM: the organisational issues on malaria work at country level within MOH and between MOH and other service providers need to be clearly understood and addressed by the partnership. Partnerships need to be sensitive to local conditions and draw on existing country experiences.

While WHO has a core role to play in the partnership at global level, other partners may have comparative advantages at country and regional levels and this needs further discussion. The partnership will need to learn lessons from other programmes both within and beyond the sector, and from region to region. The role of the WHO project - at Headquarters, Regions and Country level - to support the Global RBM partnership is therefore likely to be different depending on context. A partner will be a partner at every level: once a partner at global level, this applies at country and regional level, and partners must speak with one voice at every level. The ways in which partnerships operate at different levels will differ, and they must not be too complicated, rigid or time consuming. The objectives of the partnerships at each level need to be realistic. Criteria for success in the short, as well as the long, term are required so that the partnership can demonstrate progress.

Advocacy for RBM must go beyond malaria and address other causes of mortality, inequity and poverty. Furthermore, justification for support must always combine human rights with hard economics. This broad approach will be central to the partnership's advocacy role. Advocacy at community level is also needed in order to mobilise the people affected by malaria, who have become refractory to the disease. There needs to be a clear link between local and international advocacy, with messages originating at the grassroots. A northern champion for the RBM partnership in needed.

Once political will is mobilised, challenges for the RBM partnership are how to translate political will, both of the international community and from malaria endemic countries, into precise and concrete action and how to garner regional and country perspectives on how the RBM partnership should work.

5 ROUND UP SESSION

5.1 During the round-up session with Dr Brundtland, very strong and broad support was expressed for the Roll Back Malaria initiative, and the underlying approach, including;

- the strong linkage to health sector development
- the need to engage various partners, NGO's, Civil Society and various types of health providers at the local level
- adding value and investment to research efforts for the development of new and better tools through MMV, MIM and TDR

5.2 There was strong support for the leadership role of WHO in taking the global RBM partnership forward.

5.3 WHO was requested to take a leadership role on Roll Back Malaria and to take the partnership forward in a flexible way, building on current structures, rather than building new ones.

5.4 Partners were satisfied with the way Roll Back Malaria had been taken forward during 1998, and noted the commitment already expressed by Governments in affected countries, Civil Society Institutions, Donor countries, the private sector, the UN system's Agencies and Development Banks.

5.5 Some partners proposed a follow-up meeting of the full group towards the end of 1999.

Annex 1

Planned outcomes of the meeting (prepared November 1998)

1. Agreement on purpose, operation and possible structure of the partnership

2. Frameworks for country-level agreement on:

    - synchronising partners' strategies
    - resource mobilisation, flow and provision in a transparent and coherent manner
    - Monitoring and review of partnership action, financial accounting, communications and maintenance of partnerships

3. Agreement on approaches to international advocacy, public relations and political action in relation to RBM

4. An understanding or the roles and responsibilities of different partners, and an examination of the need for governance and/or legal instruments

5. A shared understanding of the role of the WHO-RBM project in relation to the global partnership

6. Plans for taking forward the partnership

Annex 2

List of Participants

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Annex 3

Agenda

Tuesday, 8 December

0830 – 0900 Registration

0900 - 0915 Opening and Introductions
- Dr David L. Heymann, Executive Director, Communicable Diseases

0915 – 1000 WHO Renewal: progress and challenges
- Ambassador J.G. Støre, EXD, DGO

Appointment of Chair / Rapporteur
Meeting Objectives

1000 - 1045 The Malaria Challenge

1. The malaria burden world-wide; problems and issues
   Present Contributions to Malaria Control
   - Dr F. Binka, WHO/RBM Team

2. Roll Back Malaria: The preparatory phase
   - Dr Tore Godal, Acting Project Manager, WHO/RBM

- Discussion

1045 - 1100 Coffee Break

1100 - 1300 Global Partnerships for national and local action

3. Existing mechanisms for coordinating international assistance for better health

- Country perspectives; experiences and lessons learned

  Zambia Dr J.J. Banda
  Uganda Dr Philip Byaruhanga, Minister of State for Health
  UNDP, India, Mali & Vietnam as discussants

- Existing Global and Regional Partnerships

- Dr P.J. Key, WHO/RBM Team and
  Dr Ok Pannenborg, The World Bank

- Discussion

1300 – 1430 Lunch Break

1300 Poster Session commences in Foyer:

Represented Agency's Work Plans for support to RBM / Malaria Control for 1998/99 and beyond
Technical posters

1430 - 1600 Establishing the RBM partnership

4. The purpose, operation and possible structure of the partnership
   - Dr P. J. Key, WHO/RBM Team

   Possible organization for the RBM-African Initiative for Malaria
   - Dr A. Kaboré, Director of Communicable Diseases, WHO/AFRO

5. An understanding of the roles and responsibilities of different partners
   - Mrs M.-H. Mathey-Boo, WHO/AFRO

6. How the bi-lateral agencies can best participate
   - Dr Dennis Carroll, USAID

7. The Role of Local Government and Civil Society
   - Ms F. Issaka, Ghana

- Discussion

1600 – 1615 Tea Break

1615 – 1745 continue discussion

1800 – 2000 Reception in French Restaurant

Wednesday, 9 December

0900 – 0945 Advocacy and Public Relations

8. Approaches to international advocacy, public relations and political action in relation to RBM - Dr David Alnwick, UNICEF

- Discussion

0945 – 1030 RBM Funding

9. Funding and financial arrangements for long term support for RBM Country programmes - Dr Ok Pannenborg, The World Bank

1030 – 1100 Coffee Break

1100 – 1230 Potential for Frameworks at country, regional and global levels:

- synchronising partners' strategies and plans
- resource mobilisation, flow and provision in a transparent and coherent manner
- monitoring and review of partnership action, financial accounting, communications and maintenance of partnerships

1230 – 1400 Lunch Break

1400 – 1530 Plans for taking forward the partnership

10. Institutional Structure

- An RBM partnership secretariat
- A standing committee
- Governance and/or legal instruments
- Global/regional/block/National stakeholder meetings

1530 – 1545 Tea Break

1545 – 1700

- Conclusions and Recommendations

1700 Closure

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WHO Roll Back Malaria (RBM)
Emergency and Humanitarian Action (EHA)

OUTLINE STRATEGY FOR MALARIA CONTROL IN COMPLEX EMERGENCIES

Dr S. Meek, Malaria Consortium
Dr M. Rowland, HealthNet International/Malaria Consortium
Dr M. Connolly, WHO

TABLE OF CONTENTS

1. Rationale

Malaria is a major communicable disease of the tropics and subtropics, killing more than one million people each year. Roll Back Malaria (RBM) is a new global partnership that will address this priority health issue at the country and local level. The objective of RBM is to significantly reduce the global malaria burden through interventions adapted to local needs and by reinforcement of the health sector. RBM was launched in October 1998 by WHO, World Bank, UNICEF and UNDP. WHO will provide strategic leadership to the global partnership which is drawn from malaria affected countries, UN organisations, bilateral development agencies, non-governmental organisations and the private sector. RBM will build on all current malaria efforts to achieve targeted levels of coverage in the affected population.

Malaria is a disease of the poor, especially of those in remote areas with no easy access to health services. Malaria is also associated with conflict or the aftermath of conflict, as it is a disease that flourishes in conditions of crisis and population displacement. Complex emergencies have been defined as "situations affecting large civilian populations, involving war or civil strife, food shortages and population displacement, resulting in excess mortality and morbidity". In complex emergencies, the factors that contribute to the malaria burden include:

- breakdown of health services and of malaria control programmes
- movements of non-immune people or concentration of people in high risk areas for malaria
- weakened nutritional state of the displaced population
- environmental deterioration that encourages vector breeding
- problems of supply of food and medicine and difficulty of access

Conflict results in instability and lack of governance. UN organisations and NGOs (international and local) often take responsibility for providing health services in collaboration with the host country. The insecurity makes long-term planning impossible and the breakdown in systems can cause major difficulties for health care delivery. RBM has identified malaria control in complex emergencies as an important initiative to reduce the global burden of malaria. It also recognises that the problem of malaria in such situations deserve special attention, and that strategies used in stable situations must be adapted for complex emergencies.

An important component of RBM is the establishment of networks composed of experts who can provide technical support to interventions in endemic countries. One of these networks will be on Malaria Control in Complex Emergencies. This RBM Network represents a opportunity to bring together malaria experts that specialise in providing health services in complex emergencies, to share and learn from their experiences and from that to develop and assist implement a strategy for effective malaria control in complex emergencies. The challenge is to implement malaria control programmes that are scientifically optimal and operationally feasible for each situation. The strategy will guide coordinating and implementing agencies – UN, NGOs and national authorities - on how to plan malaria control in complex emergencies, on how to select the most appropriate interventions, on case management, on surveillance and response, prevention and personal protection, resource and training needs, coordination, and what should be monitored and evaluated. Gaps in knowledge needing further research will be identified.

Roll Back Malaria

Objective
The malaria burden in participating countries is significantly reduced through
- interventions adapted to local needs
- reinforcement of the health sector with first priority being given to high transmission areas of Africa

RBM project helps through
- creating a global partnership for advocacy, financial support, co-ordination, monitoring
- creating country level partnerships to ensure harmonised strategies
- providing consistent technical guidance through technical support networks
- endorsing technical content of strategies based on WHO strategies/international best practices
- ensuring that partners adopt appropriate strategies and implement in a harmonised manner

2. Definitions

Complex emergencies evolve from the acute to the post-emergency phase. The acute phase may be defined as the period where the crude mortality rate is above one death per 10,000 per day. The acute phase is characterised by a number of events: population displacement internally (internally displaced persons - IDP) or cross border (refugee) but may affect a static population or an ethnic group, a change in authority at local or national level, a breakdown in infrastructure (health, logistics), impaired access to food, and higher mortality. The acute phase may last only a few months.

The post-emergency phase begins when mortality rates return to the level of the surrounding population and basic needs are met. During the post-emergency phase there is reasonable confidence in security, the health situation is under control, longer term approaches can be initiated, and more input can be made into capacity building and reconstruction. However, the post-emergency phase can transit rapidly backwards if the conflict resumes or slowly forwards if stability is maintained.

In chronic emergency countries, usually characterised by political deadlock of some kind, some areas of the country may stay in an acute phase while others move towards the post-emergency phase.

Different levels of health service are achievable in the acute and post-emergency phases, and different operational strategies or approaches may be required. Some operational agencies specialise in helping in the acute phase, others in the post-emergency phase. The malaria control strategy outlined in this paper summarizes what can be attempted at the different phases of the emergency.

3. Strategy

3.1 Development of a plan

In order to implement appropriate and effective malaria control, it is essential to develop a plan. The elements of a good plan are:

1. Situation analysis
2. Define objectives for malaria control based on the severity of the problem, human/material resources available, level of control in the host country and the expected future movements of refugees
3. Select strategies - the following sections give details of these strategies
4. Decide on activities
5. Develop a workplan with responsible officer, objectives and targets
6. Agree with all interested parties on organisational framework
7. Develop indicators for monitoring and evaluation, and plan how they will be measured
8. Plan operational research, if gaps in necessary information are identified
9. Develop a budget

3.2 Situation analysis and assessment

An initial assessment of the situation is essential in order to plan the appropriate response, to decide upon the most effective interventions, and to avoid costly or life-threatening mistakes. An assessment team of experienced and qualified people with a mix of complementary skills in disease control and operations should be mobilized to assess the underlying causes and establish objectives and priorities. It is also important to assess the displaced community itself, to determine human resources available and methods to ensure their involvement in interventions. Information should be collected on:

- *Environment*
  - *geographical factors, water, agriculture*
  - *seasonal variation in rainfall and temperature*
  - *site selection*
- *Population*
  - *density, age & sex*
  - *ethnic structure*
  - *displaced & host, settlement patterns*
- *Epidemiology*
  - *disease endemicity*
  - *vectors and breeding sites*
  - *identifying at risk communities or areas*
- *Security*
  - *military & other authorities*
  - *access to vulnerables*
- *Available resources and logistics*
  - *human*
  - *health facilities*
  - *drugs, etc*
  - *funds*
  - *logistics, import practices*
  - *legal, registration policy*

Assessment guidelines exist already and should be used, but specific malaria information must be added such as local drug resistance, government health policy, and pre-emergency national malaria control guidelines. Team members should be drawn from local health professionals, operational NGOs and from other agencies that can provide skills in epidemiology, vector control, medicine and organisation. Presence of a donor representative may ensure project funding.

The situation may have to re-assessed when the acute phase is over since different strategies will be needed.

3.3 Site Planning

If camps are unavoidable, good site selection may reduce or prevent malaria. It is vital that the assessment is made as early as possible to lobby against potentially malarious sites that might support vector breeding.

3.4 Disease management

3.4.1 Diagnosis

Diagnosis is essential. Microscopic diagnosis may not be possible in the acute phase of an emergency or where there is a very weak health system. Where no microscopy is possible diagnosis must depend on clinical symptoms and knowledge of the risk of malaria, recognising that this is not very accurate. In much of Africa, even under stable political and economic conditions, clinical diagnosis is used in areas of high transmission, as presence of parasitaemia does not correlate well with disease. Slide confirmation is particularly important in areas where drug resistance necessitates use of expensive drugs or where treatment failure due to resistance can progress rapidly to severe malaria. It is also important in limiting unnecessary use of drugs.

The recently developed rapid diagnostic tests are very useful for screening large numbers of patients, but are currently too expensive for individual diagnosis in most places, and also remain positive after treatment and do not accurately measure parasite density. In Cambodia where antimalarial treatment is becoming extremely expensive, there is consideration of use of rapid tests for routine diagnosis.

3.4.2 Treatment

The treatment provided should be based on knowledge of drug resistance patterns in the area. This is particularly important as displaced populations are especially vulnerable due to low immunity (from malnutrition or lack of previous exposure to malaria) and to risk of being unable to seek retreatment if treatment fails.

Local up to date information on drug resistance is essential for developing appropriate treatment policy. Local health authorities who may have the information already and operational agencies should collaborate on obtaining the information. Other causes of treatment failure, such as non-compliance, vomiting and poor quality drugs should always be monitored. Drug efficacy monitoring should follow standard procedures as developed by WHO. As drug resistance is rapidly developing it is also important to evaluate second line or future treatments prospectively.

Combinations of artemisinin derivatives and various other antimalarials are currently being used in South East Asia due to the spread of drug resistance. These combinations are under evaluation in Africa at present, and information on safety and efficacy is expected in 1999. Depending on the results there may be a change in approach to chemotherapy in Africa aimed at protecting the few remaining effective antimalarials from rapid development of resistance of *Plasmodium falciparum* whilst providing the patient with an acceptable treatment. There is a major concern about what to do when sulfadoxine-pyrimethamine resistance becomes more widespread, as it already has in Southeast Asia.

Management of severe malaria should be according to the national treatment protocols/ WHO recommendations and guidelines. Training manuals will be developed by WHO.

Treatment of *Plasmodium falciparum* gametocytes with primaquine is not recommended, as evidence of its effectiveness is inadequate, and it can be dangerous in glucose 6 phosphate dehydrogenase (G6PD) deficient individuals. Artemisinin derivatives have been shown to have a gametocytocidal effect, and combinations including them may lead to a reduction in transmission in some areas.

WHO will maintain a database of national treatment protocols of emergency affected countries where these protocols exist. If protocols need to be adapted in the event of a complex emergency, this should be developed and endorsed by WHO. The database should also include information on drug sensitivity, simple protocols for sensitivity testing and mapping of malaria and malaria risk (epidemiological, climatic, land use, etc) in complex emergency countries. The WHO/HINAP project will hold malaria data on complex emergency countries on its website.

3.4.3 Chemoprophylaxis and preventive treatment

In complex emergencies, chemoprophylaxis for malaria should be limited to pregnant women, expatriate staff, and special groups such as the army. The drugs available for chemoprophylaxis in these situations are chloroquine, proguanil, pyremethanine/dapsone, mefloquine and doxycycline.

In highly endemic *P.falciparum* areas, where malaria in pregnancy is associated with high maternal and infant morbidity and mortality, semi-immune primi- and secundigravidae should receive intermittent preventive treatment with an effective, preferably one-dose antimalarial drug delivered in the context of antenatal care. Such intermittent treatment should be started from the second trimester onwards and not be given at intervals less than one month apart. Studies indicate that HIV-positive pregnant women may need such intermittent treatment on a monthly basis during all pregnancies.

The ratio of low birth weight (LBW) in primigravidae versus multigravidae in a population in a malaria endemic area may be used to identify the endemic areas where malaria control in pregnancy is inadequate and where intermittent treatment should be beneficial to pregnant women.

Non-immune pregnant women exposed to falciparum malaria transmission are at high risk of severe disease, death, and high rates of pregnancy failure. They should have access to prompt and adequate medical care. In addition, in exceptional circumstance it

may be suitable to offer weekly chemoprophylaxis, if compliance with an effective and safe antimalarial drug can be assured. Where weekly chemoprophylaxis is not possible, non-immune pregnant women exposed to malaria transmission should at least be offered directly-observed intermittent treatment.

Recent studies from Thailand show LBW associated with maternal vivax malaria infection during pregnancy. This may be an indication for weekly chloroquine prophylaxis in some situations where compliance can be assured.

3.4.4 Service delivery

A clear, understandable, implementable treatment regimen should be established and communicated to all involved in health service delivery.
First line treatment may need to be changed if drug resistance studies show that the national policy is ineffective.
On-site training of health workers is needed to improve case management: the cost of drugs, the consequence of non-compliance and potential side effects should be clearly spelled out to avoid confusion.
Accessibility of the population to the health structures is important, and may determine the most appropriate type of health systems, including mobile clinics and community health workers where indicated.
Ongoing rigorous evaluation of the case management strategy is essential to identify needs to improve it.
Quality control of the laboratory should be given high priority.

In the acute phase, cash incentives may be needed to carry out control interventions, but food-for-work is an option. Delivery of services should be integrated with primary health structures or networks (e.g. using local NGOs or community based organisations) as soon as possible. Delivery systems should be diversified and community participation encouraged to reduce costs and to improve efficiency and coverage. In the post-emergency phase the commercial sector may provide sustainable supply of nets and insecticide (sachets or tablets for home-treatment).

3.5 Prevention

3.5.1 Acute phase

The choice of intervention for disease prevention in the acute phase is not prescriptive and will vary according to effectiveness, feasibility, cost and speed of supply. The key local factors influencing choice are:

1. Type of shelter available
- permanent housing, tents, plastic sheeting
2. Human behavior
- culture, sleeping practices, mobility
3. Vector behavior
- biting cycle, indoor or outdoor resting

Some promising new methods of prevention (insecticide treated tents, clothing) have been implemented to good effect in emergencies in Asia and Africa. These are still under development and are not necessarily transferable to other regions owing to differences in culture, dress, malaria endemicity or vector habits.

- Insecticide treated mosquito nets (ITN) are suitable if nets were previously used by the population, and if living in structures that allow mosquito nets to be supported or hung. ITN may be appropriate for those who regularly travel cross-border to insecure areas. Not precluded in other situations but
  - if people are new to nets, they may be less likely to use the nets appropriately (good IEC essential)
  - consider human or environmental factors that may lead to loss or damage of nets, or hasten insecticide decay
  - procurement of nets means higher initial costs than for other methods (see cost analysis estimates below).
- Permethrin sprayed blankets and other materials are a promising initial option for those under temporary shelters made of standard UNHCR plastic sheeting or where correct use of ITNs is in doubt
  - treated bedding has not been tested outside Asia or in highly endemic conditions
- Permethrin treated outer clothing worn in the evening or in bed is effective in south Asia but needs testing in highly endemic African conditions Insecticide sprayed tents for "transit" buildings, temporary treatment facilities, and family shelters
  - not tested outside Asia
  - use of plastic sheeting more common in complex emergencies in Africa and conventional sheeting is not suitable for insecticide treatment
- Indoor spraying of residual insecticide ("house spraying") has been the method of control most often used in chronic refugee situations. It is suitable for refugee populations who have built or are occupying mud huts or houses. To be effective the local mosquito vector must be indoor resting (seek expert advice) and the programme must treat all the houses.
  - effective in West and South Asia when sprayed at the beginning of the transmission season but less effective in SE Asia
  - limited effectiveness in highly endemic parts of Africa
  - has to be repeated annually in Asia and at 3-6 month intervals in stable endemic areas; repeated application becomes expensive in chronic emergencies
- Environmental control may be difficult during the acute phase except on a local scale, and impact is often limited. To reduce the number of vector breeding sites:
  - drain clean water around water tap stands & rain water drains
  – larvicide vector breeding sites if these are limited in number (seek expert advice)
  – drain ponds, but may not be acceptable if used for washing

Local epidemics justify additional resources for spraying operations. In areas where malaria is seasonal, by the time these become fully operational epidemic conditions may have declined.

Relative efficacy and cost effectiveness
The alpha-cyano pyrethroids, such as deltamethrin and lambdacyhalothrin, are the most effective insecticides for indoor spraying or treatment of nets. Permethrin is preferred for topsheets or blankets since it has a very low human toxicity.

Among Afghan refugees in Pakistan, insecticide treated nets, tents, and housing appear to be equally effective against malaria (giving about 60% protection against falciparum malaria). Treated bedding and clothing are 10-20% less effective than treated nets. In endemic Africa, treated bednets are the most effective intervention (reducing malaria

death by 42% and morbidity by 45% in the Gambian trials).

Treated bedding and clothing are cheaper than nets in camps since only insecticide has to be provided. House spraying is cheaper than nets if done only once or twice. If people are willing to pay for nets, nets become more cost-effective than house spraying (see below: post-emergency phase).

Cost analysis is a useful substitute for cost-effectiveness analysis when local effectiveness is not known. When the effects of the interventions being compared are broadly similar (see above), then cost analysis on its own may be sufficient to make a choice.

In West Asia (Afghanistan/Pakistan), the cost per person protected* per year is:

Treated nets	$1.5 (in first year, $0.25 thereafter)
Treated blankets	$0.25 (cost of blankets/sheets excluded)
House spraying	$0.5
Tent spraying	$0.25

* Includes cost of insecticide and nets but not of operations. Assumes that house is occupied by 10 people and a net by 3-4 people.

3.5.2 Post-emergency phase

Agencies need to carry out regular strategic reviews of the control programme and re-evaluate interventions as:

- emergency needs change and mortality is brought under control
- beneficiary involvement and skills improve
- displaced people living in plastic shelter or tents construct local style huts; this will allow increased use of mosquito nets or indoor spraying
- this phase allows a longer term approach and provides opportunities for establishing wider use of self protection methods

As malaria is a focal and controllable disease it may be necessary to redeploy resources to where they are more needed.

- Treated materials and nets
  Some cost recovery should be introduced for new nets as people's livelihoods improve
  Retreatment process needs to be established on a cost recovery basis
  Free or reduced cost distribution is essential for some vulnerables (widows with young children, orphans etc.)
- Environmental control may be possible during rehabilitation of irrigation and water supply sources; collaboration needed with agencies responsible for agricultural and rural development.
- House spraying should become increasingly focal; prioritization of camps for spraying should be based on sound indicators such as malaria incidence rates to ensure cost-effectiveness.
- Funds saved from house spraying might be allocated for nets and more sustainable interventions instead.

Net treatment process

- Ideally recipients should impregnate the materials themselves as this reinforces awareness of the insecticide, its importance in protection, and encourages proper net care. However, in the acute phase, this might cause additional delay to initial implementation, so pre-treatment is acceptable in this phase.
- Re-treatment should always be done by recipients, with training in safety.

3.5.3 Inappropriate interventions at any stage of the emergency

- Aerial spraying; too dangerous in acute phase, too expensive in post-emergency phase.
- Scrub clearance (there is no evidence that this reduces man-vector contact).
- Outdoor spraying with residual insecticide; expensive, environmentally contaminating, usually fails to reach the targeted vector, limited impact.

3.6 Malaria Surveillance

3.6.1 Surveillance indicators

Malaria surveillance is essential to assess the impact of the disease on the displaced population in a complex emergency. It is also necessary to plan and implement an appropriate control programme and to monitor progress. Malaria surveillance should be done in the context of integrated disease surveillance.

The information sources or indicators available will depend on whether the region cannot, could, or does support malaria transmission. Historical epidemiological information and recent climatic records (seasonal rainfall and temperature patterns) may provide evidence of a potential malaria problem. These data may be held by health authorities or meteorological services. Mapping of malaria and malaria risk is presently an active area of research in Africa, and this might be extended to complex emergency countries as part of the preparation for dealing with any future epidemic. In addition to key climatic variables, indicators reflecting population movement and breakdown of health services may predict outbreaks or epidemics. Demographic changes to watch out for, known to trigger epidemics in complex emergencies, are:

- migration of non-immune groups into areas with current malaria transmission
- migration of infected groups into malaria-free areas which are capable of supporting renewed transmission
- movement of infected groups into an area with established malaria transmission but of a different strain

These may be exacerbated by environmental changes that favour vector breeding or increased man-vector contact.

Despite its limitation, a clinically defined case definition must suffice during the acute phase of an emergency since microscopic confirmation is unlikely to be available particularly in high transmission areas. In unstable endemic areas, even the best clinical algorithms may wrongly classify a disease episode as being malaria and may also fail to identify many true cases of malaria; microscopy diagnosis should be provided as soon as possible to improve case management and surveillance. In stable endemic areas, microscopy may not be so useful for defining cases; anaemia in children and pregnant women, low birth weight, and high rates of splenomegaly, may serve as supporting indicators.

Epidemiological information systems are essential in all malaria control programmes to assess the country's malaria situation, allow the forecasting of epidemics, define risk groups, and monitor programme progress. Although data collection is difficult in the acute phase of an emergency, minimal information is required in order to assess the impact of malaria and to prepare a response:

- Species of *Plasmodium*
  which species are present, in what ratio, and in which seasons?
- Mortality
  what evidence is there for excess mortality or for malaria being the cause?
- Morbidity
  what is the incidence of fever and incidence of malaria?
  what is the evidence for an increase in incidence of malaria?
  which age groups are affected (<5, 5-14, >14y)?
  pregnancy outcomes (low birthweight, stillbirth, prematurity)

These indices are only meaningful in relation to population as the denominator. During an emergency population size may be difficult to estimate.

- Slide positivity rate as a measure of parasite prevalence is a very useful malariometric index in unstable malaria areas, since it is independent of population size and may show a sudden increase during an epidemic. Its interpretation depends, however, on the criteria used for taking slides. In such areas *Plasmodium* parasitaemia is equivalent to a malaria episode. In areas with stable malaria, asymptomatic malaria is common, slide positivity may not reflect disease so accurately, and rates must be interpreted cautiously.

- Entomological inoculation rate may be discounted during the acute phase since the components of this index (human biting rates and sporozoite rates of vectors) are difficult to obtain and the index has little immediate value for programme management. During the post-emergency phase, if expertise is present to interpret the data, such information collected over the course of a year may aid evaluation and re-planning.

3.6.2 Surveillance and epidemic investigation

Where malaria is potentially a problem, the resources and expertise needed to investigate any outbreak should be prepared in advance. Epidemic preparedness measures for malaria should taken jointly with other disease of epidemic potential in the area e.g. identification of laboratory for sensitivity testing, stockpiles of drugs/equipment. In the event of a suspected outbreak, the investigation should ideally be conducted by epidemiologists or others skilled in outbreak investigation with local health workers so that knowledge and skills developed can be used again in future outbreaks.

To ensure that data are of the required quality, an excess of information should not be requested from the health care system. But to respond appropriately to the outbreak, the following minimal information is required:

Population
Who is affected?
Where are they from?
How are they living?
Disease
Number with acute febrile illness
Number with confirmed uncomplicated malaria

Number with microscopically confirmed severe malaria
Number of malaria deaths
Number of maternal deaths due to malaria
Proportion of children with anaemia
Proportion of pregnant women with anaemia
Drug resistance; the proportion of treatment failures

Management

Number of health facilities
Available staff and expertise
Access of population to the health facilities
Availability of drugs and supplies
Malaria policy and treatment guidelines

Exceptional circumstances justify an exceptional response, and in an epidemic there may be a need to deviate from national treatment protocols. WHO should have an advisory role in such instances.

3.7 Epidemic response

Deciding on the intervention to adopt will depend upon available resources, state of the health system, and other health priorities. The main aim of the response must be to reduce mortality and disease burden. Three strategies for intervention might be feasible according to the situation:

1. Mass treatment of fever cases
2. Case detection by outreach services
3. Passive case detection

In a severe outbreak the majority of fever cases may be due to malaria. Even if microscopy was available there may not be time to confirm the diagnosis of every suspected case. Mass treatment of febrile cases is then justified. If, exceptionally, an expensive treatment is required because the malaria is multi-drug resistant, use of microscopy or the more expensive rapid diagnostic kits might be justified. Microscopy is, however, very useful for monitoring epidemic trends through the monitoring of slide positivity rates (i.e. malaria as a proportion of all febrile illness) in samples of slides taken from fever cases at regular intervals.

Health services should reach as deeply into the community as possible and make full use of community health workers if available. Active case detection is fully justified during an outbreak when there is mortality due to malaria and referral systems are unavailable.

Ideally, treatments should be short and simple (preferably one-day) to avoid the necessity for follow up or the chances of severe malaria developing.

Passive case detection is not a sufficient response in the acute phase if excess mortality is documented and the population is dispersed. It is more suited for chronic refugee situations when mortality is under control. Then, laboratory services with quality control are essential not just for routine case management but also for surveillance of disease trends. Such data may be used to justify implementing vector control or personal

protection. Consolidated microscopy data trends are also useful for assessing the impact of control interventions. When refugees are settled in numerous camps, consolidated microscopy data and population data from each camp may be used to estimate malaria incidence rates which may be used in turn as an indicator to prioritize camps for targeting of prevention. The monitoring of field laboratories from a central reference laboratory and imposition of quality control forms the basis for a health information system.

3.8 Disease awareness education

Simple messages are needed that:

- improve understanding of disease
- encourage appropriate treatment-seeking behavior
- make the connection between protection against mosquitoes and prevention of disease
- improve mosquito net retention and correct use
- emphasise who needs protection most (usually children and pregnant women)

Health messages may be delivered through community health workers (CHWs), posters, leaflets, and the mass media.

3.9 Training

Who to train?

- Policy makers
- Health co-ordinators: National/local/expatriate NGO staff
- Clinical workers

Content

The epidemiology of malaria and appropriate control measures may differ greatly between Asia and Africa, so region-specific material may be needed. Control measures may differ between the acute and post-emergency phase. There should be information on how to organise malaria control, basic features of malaria control, diagnosis and treatment using WHO training manuals and methods of prevention and surveillance. Active supervision of health staff and regular updating of materials are important.

Issues

- The RBM technical support network has an important role to play.
- With the high turnover of NGOs there is an ongoing need for training.
- Evaluation and follow-up are important looking at change in practice.
- Malaria control should not be taught in isolation but as part of a broader training.
- A training programme should be planned to lead to the greatest possible degree of self-sufficiency of displaced health workers, so that they can continue to work when the emergency is over.
- In chronic refugee situations the training needs will change and in some cases may need to take into consideration the refugees' repatriation.

3.10 Coordination

3.10.1 Organisational framework among agencies

Coordination and information sharing may

- reduce security risk
- improve efficiency
- prevent duplication of activities
- provide common logistic systems
- mediate or improve agency negotiating power with authorities or factions

Coordination might be provided under a UN umbrella agency or by a special coordination body which agencies subscribe to. Within such fora it is possible to establish sector committees to address specific health issues.

3.10.2 Division of responsibility

During a complex emergency, a health agency may take responsibility for a specific geographical area and run general health care services within it, or may specialise and take responsibility for a particular health service role (e.g. CHW training, laboratory quality control, EPI) over a wider area. Either way coordination is essential; in the former case, to ensure standardised protocols, in the latter case, so that general health agencies can benefit from specialised services. Malaria is a specialist activity that should be implemented through the general health services. That is as true for a complex emergency as it is for stable conditions. General health agencies (MOH, UN or NGOs) might, for example, coordinate with an agency specialising in laboratory training services who has taken on the responsibility for ensuring the quality of diagnosis and treatment in NGO clinics. Another agency specialising in disease control might take responsibility for malaria prevention, and provide technical advice, commodities, or training to agencies that want to implement personal protection or vector control in their specific area of operation.

3.10.3 External expertise

Several agencies can provide specialist assistance on malaria:
RBM resource networks
WHO
CDC
Tropical Medicine Institutes
Malaria Consortium
Specialist NGOs
National Malaria Control Programmes and ministries of health

There is no single formula for enlisting assistance, and this will depend on coordination arrangements within each complex emergency.

3.11 Monitoring and evaluation

Management and disease indicators should be set from the outset and monitored throughout to ensure programme quality, progress, coverage, and to guide strategic direction.

The number of indicators needs to be rationalized. The disease indicators selected will depend on the state of development of the surveillance system (see section 3.5) while the operational indicators will depend on intervention selected.

New indicators (e.g. stocks and accounting) need to be established in the post-acute phase if cost-recovery or revolving funds are introduced.

Periodic, systematic evaluation of the programme (needs, plans, implementation, and impact) provides evidence of progress or need for change.

Evaluation of epidemiological impact may be impossible during the acute phase but should be considered during the post-acute phase when the population settles and laboratory diagnosis becomes available. Confirmation of disease control will justify continued implementation and helps secure further financial support. Suitable evaluation methods include cross sectional prevalence surveys (i.e. mass blood surveys) and simple case control studies at clinics (e.g. comparison of slide positivity rates between personal protection users and non-users). Technical advice on design should be sought.

3.12 Operational research

The following is a list of areas where further operational research is needed.

3.12.1 Protection from malaria in pregnancy

Strategies to protect pregnant women are available but more research needed in complex emergencies. Research on various interventions would be valuable.

3.12.2 Insecticide treated materials

Treated blankets and outer clothing: Preliminary research in Asia indicates these could be useful in the acute phase as they get around some of the constraints inherent with bednets, namely the need for appropriate behaviour, logistics and supply problems, expense). Further work is needed on:

- suitability of alpha-cyano pyrethroids over permethrin (especially irritancy and other side-effects)
- suitability of different materials and treatment methods (spraying, immersion)
- efficacy under highly endemic conditions or by other cultures (especially in Africa)

Insecticide treated mosquito nets: Use and impact in acute phase. There is scepticism that ITN would be used appropriately or have an impact. To define policy, need further case studies and evaluation making use of rapid immuno-diagnostics and case-control methods. Washing practices, and use of low-dose treatments to accommodate frequent washings.

Treated (layered) plastic sheeting: Treated tents have been shown to work but plastic sheeting is favoured increasingly by relief agencies. Sheeting cannot be treated using conventional methods. Treatment of laminated polyethylene sheeting, analogous to the 'olyset' slow release treated nets, may substitute.

3.12.3 Vector control

Impact and acceptability of ULV aerosoling of camps and buildings: Aerosoling is normally only done under special circumstances:

- during an acute epidemic
- newly established camp or mobile population
- when no other method will work
- to control fly borne disease (e.g. shigella) or dengue

Because evaluation is difficult in the acute phase, effectiveness would be better demonstrated in post-acute conditions in paired intervention/control camps (even though the camps selected would not normally be aerosoled except in an epidemic).

3.12.4 ITN operational strategies

Mosquito net distribution strategy effectiveness in acute and post acute phases: the range of delivery strategies possible (e.g. clinics, CHWs, mobile teams, private sector) needs to be further developed and evaluated with respect to costs and cost-effectiveness; uptake, coverage and equity achievable; best IEC methods for stimulating demand creation and appropriate use; "essential protection kits", single dose sachets. And how to achieve a transition from free provision in the acute phase to cost recovery in the post-emergency phase

3.12.5 Case management

The Private Sector: In the post-emergency phase aid declines but the government may not be able to fully resume a provider role. The private sector may take over this function but with little sense of accountability or responsibility. Accreditation or certification systems, with monitoring of quality control, regulated by government or WHO, may stimulate improved prescribing practices, improve case management, and reduce user costs.

Better understanding of different communities' beliefs and treatment-seeking behaviors is essential for developing appropriate treatment policy.

Monitoring drug efficacy and assessing the efficacy and practicality of newer treatment regimes continues to be necessary

3.12.6 Service delivery

Comparison of different health delivery systems for malaria control in complex emergencies may provide useful information for future emergencies.

Press Release

United Nations Development Programme • United Nations Children's Fund • World Bank • World Health Organization

EMBARGO:
1000 a.m., New York time, Friday, 30 Oct 1998

Press Release WHO/77
30 October 1998

FOUR INTERNATIONAL ORGANIZATIONS UNITE TO ROLL BACK MALARIA

The United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the World Bank and the World Health Organization (WHO) have joined forces to launch a new campaign to fight malaria, which kills more than one million people a year.

The programme, "Roll Back Malaria", seeks to reduce substantially the human suffering and economic losses due one of to the worlds most costly diseases. Malaria causes an estimated 300 to 500 million acute cases per year, with most deaths occurring among children in Africa -- nearly 3,000 die each day. It has been estimated that malaria accounts for about 10% of the disease burden in Africa.

"Malaria is the number one health priority of people and leaders in affected communities and countries, but their voices have not been heard," says Dr Gro Harlem Brundtland, WHO Director General. Roll Back Malaria was initiated when Dr Brundtland was elected WHO Director-General in May. "The human suffering is unacceptable and so is the economic burden and impediment to progress. Africa and other regions with malaria are responding and we must answer their call," she says.

Roll Back Malaria (RBM) is different from previous efforts to fight malaria. RBM will work not only through new tools for controlling malaria but also by strengthening the health services to affected populations. RBM will implement its activities through partnerships with international organizations, governments in endemic and non-endemic countries, academic institutions, the private sector and nongovernmental organizations. Above all, it will be a united effort by the four international agencies concerned with malaria and its effects on health and economic development.

Malaria is, above all, a disease of the young and of the poor, many of them children who live in remote areas with no easy access to health services. But the use of simple prevention and control methods has shown startling results: in trials conducted in The Gambia, Burkina Faso, Kenya and Ghana, the use of bednets -- which are treated with biodegradable pyrethyroid insecticide was shown to effectively protect sleeping children from malarial mosquitoes, resulting in dramatic reductions in deaths among children under five years of age. Deaths were reduced by average of one fourth in these mega trials.

Roll Back Malaria will seek to:

- strengthen health systems to ensure better delivery of health care, especially at district and community levels;
- ensure the proper and expanded use of insecticide-treated mosquito nets;
- ensure adequate access to basic healthcare and training of healthcare workers;
- encourage the development of simpler and more effective means of administering medicines; such as training of village health workers, mothers and drug peddlers on early and appropriate treatment of malaria, especially for children;
- encourage the development of more effective and new anti-malaria drugs and vaccines.

"While strengthening the health sector is essential to Roll Back Malaria," says UNICEF Executive Director Carol Bellamy, "the new strategy will be most effective when families, communities, local leaders and other groups, such as shopkeepers and schoolteachers, become fully committed and involved in the effort. In all of the countries seriously affected by malaria, communities have already demonstrated that rapid improvements in child health are possible when they are given the right kind of support and encouragement. We are confident that this new initiative will be able to provide this."

Unlike most other major diseases in the world, malaria is spreading. As roads are built, forests cut down, new mining areas opened up, habitats which favour the breeding of mosquitoes expand, and what starts out as economic development often unintentionally leads to an underperforming and sick workforce.

"The poor suffer the most from malaria," says James Gustave Speth, Administrator of the UNDP. "The international community must firmly commit itself to this new partnership and to developing integrated actions that take aim at both malaria and at its greatest breeding ground which is poverty. UNDP looks forward to working with its UN and other partners in this worldwide campaign against malaria."

"Making significant, sustained inroads in the battle against malaria urgently requires a coordinated, focused initiative. Governments, international organizations, the research community and the pharmaceutical industry must all play a major role. The World Bank is committed to playing its part in the mobilization of resources needed to spur such a coordinated response," says James D Wolfensohn, President of the World Bank Group.

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Malaria and economic development

Roll Back Malaria is being launched at a time of growing scientific interest and investment in malaria, which still remains grossly underfunded.

"We and other groups of economist researchers are trying to determine the consequences of malaria on economic development," says Jeffrey Sachs, Professor at Harvard. "Our findings are striking. They point to Malaria as a major impediment to economic development."

Poor health via disability from diseases such as malaria reduces incomes by as much as 12 percent in some studies, a particularly important factor in developing countries where a significant proportion of the workforce is involved in agriculture and other forms of manual labour.

The evidence also suggests that the effects of improved health are likely greatest for the most vulnerable -- the poorest and those with the least amount of education.

New tools

Bednets: Large-scale field trials have conclusively demonstrated that the use of bednets treated with biodegradable pyrethroid insecticide can protect children from dying from malaria. Do-it-yourself approaches to insecticide treatment of nets are now available.

Mapping: Based on satellite mapping and climatic information, the distribution of malaria can now be determined at the community level.

For countries participating in RBM, national malaria information will be integrated with regional information to produce a comprehensive national malaria control map, as part of the international mapping of the disease.

The information will allow a better estimation of the burden of malaria and the population at risk, and hence a better assessment for RBM. It will also provide more reliable and area-specific information for national and international advocacy for malaria control. Where RBM operations have started, information on the availability and quality of health services and the results of monitoring and evaluation will be added to the data base.

Bringing treatments to the people: In Africa, the RBM will create a network of teams to go into villages and analyze treatment and prevention practices at the household and community level, the availability and quality of health care by the public and private sector, and potential local partners. The RBM will provide technical and financial support for each analysis through this network at the district level.

Treatment at home can be greatly facilitated by simple packaging of drugs; fast-acting rectal caps can rescue life-threatening disease in children.

Most victims of malaria die simply because they do not have access to health care, or their cases are not diagnosed as malaria. In addition, life saving drugs are often not available.

"These tools will greatly help in bringing the attack where it matters, says Dr. David Nabarro, newly appointed leader of the central team for Roll Back Malaria, headquartered at WHO in Geneva.

Research breakthroughs

Researchers are investigating a wide range of activities in malaria are severely underfunded, but investment is increasing thanks to a new Multilateral Initiative for Malaria research (MIM). The new techniques being investigated include ways of preventing the mosquito parasite from infecting the mosquito.

"A number of scientists are trying to make the mosquito resistant to the parasite," says Fotis Kafatos, Director-General of the European Molecular Biology Laboratories in Heidelberg, Germany. "Using the most sophisticated techniques in molecular genetics we are discovering an array of novel possibilities."

Several vaccine candidates using the latest breakthroughs in vaccine technology are undergoing field testing in Asia and Africa and in US volunteers, while the whole genome (a complete set of hereditary factors) of the malaria parasite is being sequenced.

"This will create completely new opportunities," says Dr. Harold Varmus, Director of United States National Institutes of Health (NIH), which is one of the leading drivers in the MIM. "Malaria is a global concern. We are gearing up our support for research both here and abroad."

New discoveries have led to many different approaches to a malaria vaccine, with many of the possibilities already undergoing human trials. However, scientists estimate that it will take 7-15 years before an effective malaria vaccine is ready.

Vaccines taking advantage of DNA research may provide one of the best hopes. One possibility is being developed by the US. Naval Medical Research Institute, the US Agency for International Development and partners in Ghana, Australia, France and the US private sector.

"Our work in relationship to WHO objectives is focused on producing multi-gene DNA vaccines designed to reduce morbidity and mortality of malaria in young children in sub-Saharan Africa," says Dr. Stephen Hoffman, of the Naval Medical Research Institute. The major project is entitled MuStDO 15.1 (multi-Stage DNA vaccine operation), which is a 15-gene malaria DNA vaccine.

Researchers hope to initiate clinical trials of this new vaccine within 18 months. Dr. Hoffman has just published the first proof of the principle that DNA vaccines are immunogenic in normal, healthy humans.

Another promising vaccine candidate has just begun field trials in the African nation of the Gambia. This new recombinant protein vaccine, RTS,S, developed by SmithKline Biologicals, would prevent the malaria parasite infectious stage from entering or developing within liver cells of human beings. Such vaccines would prevent the severe and life-threatening consequences of malaria in non-immune individuals.

Another approach is to develop a vaccine that prevents transmission of the malaria parasite from one infected person to another person. This type of vaccine would block the development of the parasite in the mosquito, thus preventing the parasite from infecting someone else. This transmission blocking vaccine is under development by scientists at the US NIH, in collaboration with WHO/TDR. The NIH has recently initiated a major Malaria Vaccine Development Programme aimed at ensuring the production of clinical grade materials for use in clinical trials.

A different asexual blood stage vaccine type is based on a cocktail of antigens. One such synthetic peptide vaccine, SPf66, developed by Manuel Pattaroyo working at the Instituto de Inmunología in Bogota, Colombia, has been tested in field trials in South America, Africa and Southeast Asia. It has only been partially effective to date. Dr. Pattaroyo is using sophisticated biochemical methods to improve its potency.

The leading scientific journal Nature published this week research from Kenya, Thailand and Malawi which shows that pregnant women living in malarious areas develop a unique immunity which protects them from malarial infection. Professor Bernard Brabin of the Liverpool School of Tropical medicine, who is a co-author of the paper, and has worked for 20 years on the subject of malaria in pregnancy, says that it is the most exciting scientific development in this field for decades and could open the way for developing a vaccine to protect pregnant women from malaria.

Public private sector collaboration

Because malaria is largely found among poor people in poor countries, the private sector can not engage fully in research and development. A public-private sector initiative is being set up to circumvent the problem. The New Medicines for Malaria Venture will be financed by public sector and philanthropic bodies. The private sector will primarily provide facilities and staff. Industry is committed to making this work, says Harvey Bale, Executive Director of the International Federation of Pharmaceutical Manufacturers Associations.

The four UN-System organizations contribute unique expertise

UNDP has committed to the following actions.
At country level, **UNDP** will:

1. Create capacity for integration of malaria-related action into national poverty eradication policies, strategies and programs.
2. Strengthen, through Sustainable Human Development activities, the balance of action among state, private sector, civil society and communities themselves, to ensure that people have access to basic social services and productive assets.
3. Work through the UN Resident Coordinator system to encourage collaborative programming in support of intersectoral action and resource mobilization.

At regional/sub-regional levels, **UNDP** will:

1. Support links between Sub-regional Resource Facilities (SURFs), providing technical referral services to country offices and the Roll Back Malaria resource support networks.
2. Collaborate with WHO Regional Offices to strengthen capacity of relevant regional inter-governmental organizations (ISO) in support of Roll Back Malaria.

At global level, **UNDP** is providing continuing support for the UNDP/World Bank/WHO Special Programme for Research & Training in Tropical Diseases (TDR), which has as a

major focus the development of drugs and tools for malaria control and adapting research in local settings.

UNICEF will:

1. Provide support to intensified malaria control efforts via its country programs.
2. Work with Government & NGO partners to:
   - give special attention to reducing the terrible toll of malaria on young children and pregnant women;
   - further strengthen support for community-based and local action to improve health and nutrition;
   - focus on making insecticide treated mosquito nets available to all families that need them and on ensuring that every child with malaria has access to early and effective treatment;
   - mobilize leaders (community, district and national) to make effective malaria control a priority.
3. At international level, raise additional funds for country activities, and focus support on 10 of the most severely affected countries in the next two years.
4. Take lead responsibility for developing an impregnated bednet resource network.

The World Bank Group strongly supports the Roll Back Malaria global partnership. Malaria has a major impact on social and economic development. Consequently, the Bank has committed to:

1. Increase World Bank investments in malaria control and research;
2. Facilitate resource mobilization to support RBM;
3. Enhance a more effective involvement of Departments of Finance, Economics, Infrastructure, Agriculture and others to become full partners in reducing malaria as an economic factor;
4. Explore innovative finance mechanisms to deliver support;
5. Support research on the economic aspects of malaria;
6. Help establish private-public partnerships with industry on new malaria products.

Together with Roll Back Malaria partners, the Bank will actively pursue these activities through its country programs and research agendas. Malaria must be reduced as a negative factor on macro-economic growth.

WHO will be coordinating the Roll Back Malaria project. Project Countries and affected populations have identified malaria as a priority health issue. Activities will cut across WHO programs & regions to:

1. Support governments & partners:
   - strengthen the health sector to better tackle malaria;
   - monitor the geographic spread of malaria;
   - measure results and outcomes of action;
2. Improve technical efficiency & capacity:
   - build & support technical support networks, regional and local;
   - invest in the development of new methods, tools and capacity strengthening through research networks and programs;
3. To improve resource allocation, utilization and mobilization:
   - local/national: promote concerted action by stakeholders
   - regional: establish resource networks;

- global: supporting partners for common action and sharing information on malaria, programs and resources.

Global Malaria Rates*

REGION	CLINICAL CASES
AFRICA (South of the Sahara)	270-480 million estimated**
AMERICAS	
(Including Brazil)	2.2-5.6 million estimated
(Brazil alone)	1.1-2.8 million reported
MIDDLE SOUTH ASIA	
(Including India)	2.6 million reported
(India alone)	2.1 million reported
ASIA WEST OF INDIA	
(Including Afghanistan)	0.5 million reported
(Afghanistan alone)	0.3 million reported
EASTERN ASIA & OCEANIA	
(Including Thailand, Vietnam and The Solomon Islands)	1.0 million reported
(Thailand, Vietnam and The Solomon Islands alone)	0.5 million reported
EUROPE	
(Including Turkey and the former USSR)	12 000 reported

* Estimates of global malaria mortality are 1 million deaths a year, and occur primarily in African children under five years of age.

** Included in this total, there are 140-280 million estimated cases of malaria in children under the age of five.

Source: WHO, 1998

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Roll Back Malaria

A Global Partnership

March 15th 1999

Presentation Structure

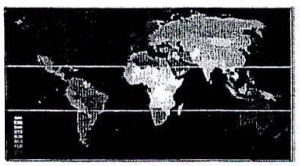
- Global Malaria Burden
- Background to Roll Back Malaria
- RBM Partnership Principles
- RBM Partnership Strategy
- Process for Rolling Back Malaria
- Criteria for success of the RBM partnership
- Proposed Values for RBM
- Challenges
- Plans, Progress and Issues to be addressed

Global Malaria Burden

- Disease Burden
  - 300-500 million clinical cases per year
    - A global problem
    - 80% of cases in Africa
  - 1 million deaths per year
    - confirmed by recent analysis
    - > 95% of deaths among under-fives in Africa
  - Disability from severe form of the disease
  - Health sectors find it hard to cope

Malaria affects poor people the most

GNP
per capita
(1995)



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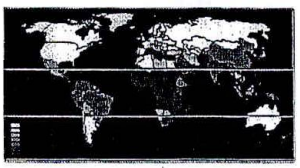

Background to Roll Back Malaria

- Despite partial success of eradication efforts in the 1960s, malaria causes increased levels of suffering particularly among children
- New initiative proposed by Organisation for African Unity and World Health Assembly since 1994
- Accelerated efforts in Africa 1995 - present
- WHO Africa Region proposed Africa Malaria Initiative in 1997
- Global effort to Roll Back Malaria proposed by Dr Brundtland when standing as DG a year ago

Background: the RBM concept

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- Preparatory work from February 1998;
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- Inception July 1998;
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  - (significant cause of poverty and suffering)
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- Primary focus of response must be with people at risk
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- If people know more they are in a better position to make beneficial choices
- Choices influenced by knowledge, understanding, resources and services, opportunities to act, supportive environment

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RBM Principles: where are we now?

- People focus
- Partnerships at the country level
- Prioritising malaria - appropriately - within health sector development
- Packaging the response to malaria - agreed strategy, clear deliverables
- Project in WHO, supporting global partnership
- Private sector involvement
- Professional "technical support networks"
- Pathfinder for work on communicable disease

8

Strategy: informed response to a complex disease

- Malaria situations vary: need to assess and respond to the pattern in each case
- Existing efforts could yield so much more
  - Early detection
  - Rapid assistance
  - Multiple prevention
  - Well-coordinated strategies
  - Dynamic coalition of stakeholders
  - incorporated fully into *Health Sector*

9

Strategy: Determined search for new tools

- However, in some situations, significant gains will depend on cost-effective new products and tools
  - a vaccine is needed, and there are promising candidates
  - new drugs - such as rectal artesunate - are vital to reduce mortality and combat drug resistance

10

Strategy: Clear communications

Clear explanations of
what is involved
in
Rolling Back Malaria
adjusted to the interests of
the recipient
For example . . . .

11

Roll Back Malaria

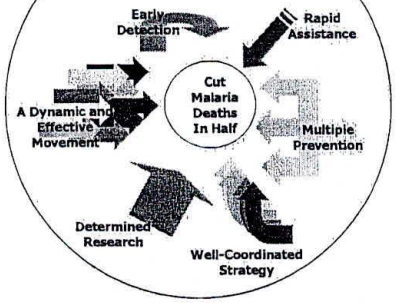
Multiple strategies
targeted to local needs

Roll Back Malaria is a co-ordinated and intensified response to local malaria control needs. It mobilizes effective and appropriate action based on a careful assessment of the unique local situation.

A global movement
focused on local initiatives

Roll Back Malaria seeks to increase the political commitment of influential institutions to control the disease. It channels this commitment in support of local partnerships and national initiatives working toward common goals.

Six Elements of Roll Back Malaria



1. EARLY DETECTION

Community Awareness
Grassroots education and training programmes can prepare families and community members to identify malaria symptoms more quickly

Surveillance and climate studies to detect areas and populations most at risk.

Resistance Alert By carefully following the spread of drug resistance, prescriptions can be changed to ensure patients are treated with effective drugs.

2. RAPID ASSISTANCE

Home is the First Hospital
A simple packet of fast-acting drugs made widely available for use by parents can rescue children before it is too late.

Bringing Treatment to the People
People with fever often seek help from friends or local healers. Communities will become knowledgeable in recognising new malaria cases and treat them quickly.

Providing care for the very sick:
Accessible health services and quality treatments are important for curing people with severe malaria illness

3. MULTIPLE PREVENTION

Bednets treated with insecticides – in Africa, Asia and the Pacific region – have reduced childhood malaria deaths by an average of 25%

Personal protection in the home, with insecticides and other deterrents, can further reduce the likelihood of being bitten

Community action, when well planned, & **Environmental Management**, done properly, limit mosquito breeding

4. WELL-COORDINATED STRATEGY

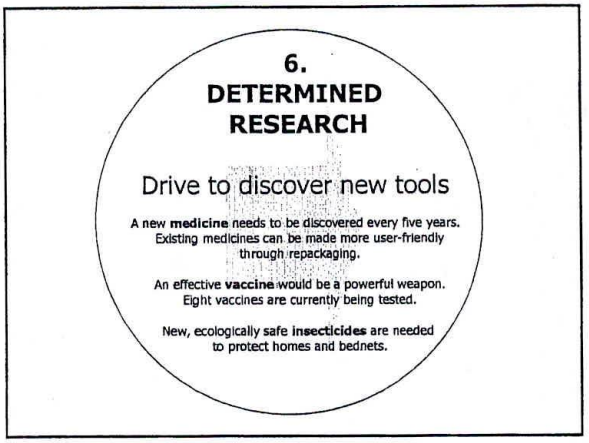
Social Mobilisation: enabling households to respond better to the malaria threat

Better Health Care: ensuring that health services, private practitioners and local healers can respond to problems posed by malaria

Involvement of many sectors:
schools, community groups, local business and government departments all have a part to play

5. DYNAMIC AND EFFECTIVE MOVEMENT

A Coalition of Stakeholders
The private sector, foundations and trusts
NGOs, civil society, associations and the media
Research and academic institutions
UNDP, World Bank, UNICEF and development agencies
Community participation
Partnership fostered and sustained by national government
Backed by who-sponsored technical networks



Process for Rolling Back Malaria (RBM)

- Objective
  - The malaria burden in participating countries is halved through
    - interventions adapted to local needs
    - reinforcement of the health sector
- Approach
  - Global response tailored to local situation with spearhead in Africa
  - Countries in the lead
  - Emphasis on partnerships which lead to effective action: avoid missed opportunities
  - Drawing on the full range of interests in WHO

Components of the RBM process

1 Intensified National Action, through Country-level Partnerships to Roll Back Malaria

2 Political and Institutional backing through the Global partnership

3 Harmonised strategies and consistent technical guidance through promotion (and sponsorship) of technical support networks

4 Strategic investments in better tools through focused support for research and public-private initiatives

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1a: Intensified National Action through country-level partnerships

- National Authorities
  - committed to RBM
  - seek a wide range of partners
    - (including civil society, private sector, donors, media)
  - encourage partners to **agree to work together** in a flexible manner
    - towards common goals
    - using agreed strategies and procedures
    - within context of Health Sector Development
- Institutionalise partnership procedures as soon as possible

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1b: WHO support to country-level partnerships

- WHO Roll Back Malaria project helps through
  - Brokering technical/financial assistance for situation analysis and strategy implementation
  - Endorsing technical content of strategies based on WHO standards / international best practices
  - Encouraging partners to stick to agreement
  - Monitoring progress within context of health sector development
- Project includes headquarters and regional resources

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2: Political and institutional backing through global RBM partnership

- An opportunity for all partners to
  - focus on the needs of Country Partnerships
  - ensure sustained commitment by partners at headquarters and regional levels
  - monitor effectiveness of efforts to Roll Back Malaria within context of health sector development; report on progress to partners
  - link with other global partnerships for development
- Support from WHO project
  - a *slimline* secretariat for the partnership

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3a: Harmonised strategies; consistent technical guidance

- WHO-RBM project will seek ways
  - to sustain a common approach to Rolling Back Malaria throughout the organisation and beyond
  - to ensure that partners adopt appropriate strategies and implement in a harmonised manner
  - to help countries access consistent technical guidance
  - to encourage operational research in country to develop the best strategies
- through sponsoring
  - work to develop common concepts and strategies
  - structured "technical support networks"

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3b: RBM Project draws on capacity throughout WHO to

- advocate the new concept
- set standards, promote best practices, endorse proposed actions
- establish links with national authorities, help them sustain partnerships
- support development and implementation of strategies
- broker financial and technical assistance
- track progress
- sponsor research and development

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3c: RBM project promotes Consistent Technical Support: Issues and Networks

- 9 critical issues for effective RBM identified
- Networks offer access to Experts, mainly from within the region
- Review and inform on State of the Art
- Provide technical support to countries upon request

Networks

- Needs assessment
- Implementation of bednets
- Home-management
- Sector-wide approaches
- Drug resistance
- Access/quality of drugs
- Mapping malaria/health care
- Prevention of epidemics
- Complex emergencies

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4: Strategic investments in better tools through the Global Partnership

- Advocacy of focused research to identify new approaches for prevention and treatment
  - TDR, Multilateral Initiative on Malaria
- Support for public-private efforts to discover new products (medicines, vaccines, insecticides)
  - Medicines for Malaria Venture Capital Fund
  - Malaria Vaccine Initiative?
- Partnership with commercial entities to support development and marketing of products to make them accessible to those who need them

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Criteria for overall RBM Partnership Success

- Country Partnerships
  - Are they being developed? Are they owned by national authorities, with inclusive membership?
  - Are strategies harmonised? Are good opportunities being taken? Are outcomes being monitored?
  - Is technical guidance consistent and useful?
- Global partnership
  - Is there evidence of political commitment? Are partners contributing? Is there a multidisciplinary approach?
  - Is there transparency on objectives, resources, strategies?
  - Are global strategies harmonised - within the health sector context? Does WHO have a consistent approach?

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Criteria for overall Partnership Success (2)

- Health Sector Development (public+private)
  - Is good quality care provided for those with malaria?
  - Do they access - and benefit from - this care?
  - Does health sector development result in greater benefits for more people?
- Strategic Investments
  - New products discovered?
  - Distribution approaches reach poorer people?
- Prevention and treatment of malaria
  - Are more people (children and pregnant women) receiving timely and appropriate treatment?
  - Are more people protected with Insecticide-Treated Nets?

30

Criteria for overall Partnership Success (3)

- Malaria burden
  - Is there a decline in malaria-related mortality and morbidity in areas of continuous infection?
  - Is there a reduction in malaria suffering (incidence and severity) due to epidemics?
  - Are poor people better able to attend school, earn a living, find new opportunities, have children safely and become better off?
  - Are there more opportunities for sustained economic and human development in the locality?

31

10 Values for Roll Back Malaria (1)

- RBM is a social movement supported by many partners
- RBM is owned by all the partners
- Decisions are made by consensus
- Country priorities drive Roll Back Malaria
- Partners function independently, but in concert
- Partners contribute where they have a comparative advantage - or interest

32

10 Values for Roll Back Malaria (2)

- Action plans are clear, evidence-based, prioritised and adapted to local realities
- RBM *is* about broadening and strengthening the capacity of health sectors to fight all diseases
- RBM *is not* a new agency or funding institution
- The ultimate objective is to reduce poverty and promote development

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Challenges for Rolling Back Malaria: 1999

- **A consistent WHO-wide approach for Rolling Back Malaria: maintain involvement of all clusters**
- **Ensure that National Authorities are in the lead in country partnerships**
- **Encourage partners to respond to local situations in ways that yield maximum benefit from existing control tools *and* strengthen the health sector**
- **Mobilise additional resources to help countries Roll Back Malaria without encouraging inter-disease competition or vertical programmes**

Challenges for Rolling Back Malaria: 1999

- **Encourage conduct of, and investment in, good quality strategic research and product discovery [MIM]**
- **Promote interest in development of new tools and investment in selected public-private partnerships [MMV]**

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Plans and Progress: Developing the RBM approach in WHO

1 Develop the concept, make sure it is widely known, get key groups to join in

2 Build the global partnership, keep it going

3 Activate country-level progress through
   Supporting critical actions
   Backing strategy development and country partnerships

4 Promote consistency of technical guidance

5 Strategic support for research and development

6 Monitor progress

36

Issues - the concept

- Is the proposed concept and approach feasible?
- Can it be put into practice given the resources available to national governments?
- Does WHO's capacity to support RBM depend on additional capacity in Ministries of Health or in WRs' offices?

37

Issues - implementation

- How - at country level - to take account of
  - ongoing or planned action against malaria?
  - Ongoing plans and progress with Health Sector Development?
- How to ensure the most effective action to Roll Back malaria within this context?

38

Issues - partnerships

- How to ensure that the WHO RBM project
  - has access to up-to-date information on what is happening,
  - is plugged in to partnerships even when these are being taken forward by others,
  - offers flexible support in a responsive manner,
  - takes full account of Health Sector, decentralisation, and other development initiatives,

39

Issues - funding

- How to establish effective procedures for ensuring that countries have access to additional funds to enable them to Roll Back malaria, while
- Supporting the existing sector-wide approach to health, and
- Ensuring that the WHO has sufficient resources - at the country level - to add value to ways in which these funds are used?

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The Prize

Much reduced malaria burden

Human development

Poverty reduction

41

Summary

- Malaria: Health Sector responds to Human Development issue
- New approach builds on previous experience
- People focus, strategic synergy, partnership
- Yet disease is complex and needs sophisticated response
- RBM: Ambitious goal, process approach, health sector context
- Global and country partnerships led by national authorities
- Partners work together in flexible but disciplined manner
- WHO supports partnerships: brokering, endorsing, monitoring
- WHO encourages harmonised strategies, consistent guidance
- Focused research and public/private efforts for new tools
- Evaluation: Clear criteria for partnership success
- Challenges: technical consistency, countries in lead, resources

The Roll Back Malaria Movement: Progress Report

David Nabarro: WHO Roll Back Malaria Cabinet Project
Geneva: April 1999

1

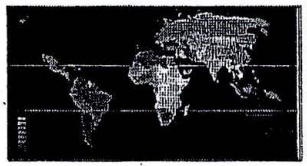
Global Malaria Burden

- Disease Burden
  - 300-500 million clinical cases per year
    - A global problem
    - 80% of cases in Africa
  - 1 million deaths per year
    - confirmed by recent analysis
    - > 95% of deaths in Africa
  - Disability from severe form of the disease
  - Health sectors find it hard to cope

2

Malaria affects poor people the most

GNP per capita (1995)



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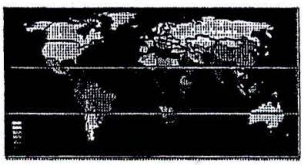

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Roll Back Malaria: progress 1999

- **High level political backing**
- **Robust International Partnerships**
- **Strong advocacy for community level action**
- **Critical contribution from WHO**
- **Intense action at country level**
- **Long-term investment in better tools**

6

High level political backing

→ Economic and social impact of illness recognised

→ 29 Heads of State committed to Rolling Back Malaria

→ Malaria a national development priority in many nations - beyond the Ministries of Health

→ Full support from G8 leaders

7

Robust International Partnerships

→ International development organisations committed to working together

→ Global partnership established with strong regional alliances

→ Joint working to an agreed plan

→ Private sector, NGOs, research community and foundations all engaged

8

Strong advocacy for community-level action

→ Global movement supporting local initiatives

→ Co-ordinated approach to strengthen public and private health care

→ Multiple strategies focused on local malaria needs

→ Diverse partnership acting in concert

→ Clear messages why, what, how and when

9

Critical contribution from WHO

→ Goals articulated

→ New and effective strategies identified
→ personal protection, home-based treatment, prediction and response to epidemics, evidence-based responses

→ Promoting the movement, Sustaining partnerships, Brokering resources

→ Unified WHO response: HQ, Regions, Countries

Country-level process underway

→ in-country consultations
→ sub-regional consensus meetings
→ building momentum at country level
→ developing RBM partnerships, fostering the movement
→ using technical instruments (situation analysis and strategy development)
→ accessing technical support networks
→ agreeing national plans for RBM
→ mobilising additional resources

11

New and better products

- Help ensure that existing tools are used wisely
- Identify new diagnostic tools, and standardised case definition
- Develop new treatments, introduce them with care to preserve their utility
- A vaccine - in 10 years?
- Useful instruments for economic and behavioural analysis

12

Promising progress

- **Ethiopia**
- **Guinea**
- **Cote d'Ivoire**
- **Mozambique**
- **Complex Emergencies**
- **Mekong delta**
- **Mali**
- **Phillipines**
- **Armenia**

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The Challenge

- **Build and strengthen country level partnerships**
- **Establish Technical Support Networks**
- **Sustain the partnership**
- **Mobilise a further $10 m in 1999, $60m in 2000**

14

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World Bank

RBM/World Bank

The World Bank Group strongly supports the *Roll Back Malaria* global partnership. Malaria has a major impact on social and economic development. Consequently, the Bank has committed to:

- Increase World Bank investments in malaria control and research
- Facilitate resource mobilization to support RBM
- Enhance a more effective involvement of Departments of Finance, Economics, Infrastructure, Agriculture and others to become full partners in reducing malaria as an economic factor
- Explore innovative finance mechanisms to deliver support
- Support research on the economic aspects of malaria
- Help establish private-public partnerships with industry on new malaria products.

Together with *Roll Back Malaria* partners, the Bank will actively pursue these activities through its country programmes and research agendas. Malaria must be reduced as a negative factor on macro-economic growth.

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WHO

RBM/WHO Project

Countries and affected populations have identified malaria as a priority health issue. Activities will cut across WHO programmes and regions to:

1. Support governments & partners

- Strengthen the health sector to better tackle malaria
- Monitor the geographic spread of malaria
- Measure results and outcomes of action

2. Improve technical efficiency & capacity

- Build & support technical networks in affected countries
- Invest in the development of new methods, tools and capacity strengthening through research networks and programmes.

3. Collaborate and coordinate in order to improve resource allocation and utilization

- Local/national: promote concerted action by stakeholders
- Regional: establish resource networks
- Global: support partners for common action
- Share information on malaria, programmes and resources.

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Roll Back Malaria

GLOBAL INITIATIVE

A worldwide partnership to fight malaria, one of the world's most devastating diseases

Roll Back Malaria

A network of national governments, international organizations, private sector and others, contributing their skills and resources to maximize the impact against malaria

Roll Back Malaria

Dr Gro Harlem Brundtland's initiative to

- Rally forces to fight malaria, a serious threat to health and sustainable development
- Build on all existing efforts through local, national, regional and global partnerships
- Maximize the impact of contributions from major stakeholders - including affected countries, G8 nations, World Bank, UNDP, UNICEF, WHO and the private sector

Roll Back Malaria

Roll Back Malaria

- ▶ Bringing reliable, sustainable prevention and early treatment to affected populations
- ▶ Investing in research and development of effective, affordable tools
- ▶ Evaluating achievements against clearly defined goals
- ▶ Building human and institutional resources

UNDP

RBM/UNDP

Malaria has important implications for health and poverty. Effective responses will require broad-based support across sectors and the involvement of a range of development partners.
UNDP has committed to the following actions:

At country level

1. Create capacity for integration of malaria-related action into national poverty eradication policies, strategies and programmes.
2. Strengthen, through Sustainable Human Development activities, the balance of action among state, private sector, civil society and communities themselves, to ensure that people have access to basic social services and productive assets.
3. Work through the UN Resident Coordinator system to encourage collaborative programming in support of intersectoral action and resource mobilization.

At regional/sub-regional levels

1. Support links between Sub-regional Resource Facilities (SURFs), providing technical referral services to country offices and the *Roll Back Malaria* resource support networks.
2. Collaborate with WHO Regional Offices to strengthen capacity of relevant regional inter-governmental organisations (ISO) in support of *Roll Back Malaria*.

At global level

UNDP is providing continuing support for the UNDP/World Bank/WHO Special Programme for Research & Training in Tropical Diseases (TDR), which has as a major focus the development of drugs and tools for malaria control and adapting research in local settings.

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UNICEF

RBM/UNICEF

UNICEF will:

1. Provide support to intensified malaria control efforts via its country programmes.

2. Work with Government & NGO partners to:
- ▶ Give special attention to reducing the terrible toll of malaria on young children and pregnant women
- ▶ Further strengthen support for community-based and local action to improve health and nutrition
- ▶ Focus on making insecticide treated mosquito nets available to all families that need them and on ensuring that every child with malaria has access to early and effective treatment
- ▶ Mobilize leaders (community, district and national) to make effective malaria control a priority.

3. At international level, raise additional funds for country activities, and focus support on 10 of the most severely affected countries in the next two years.

4. Take lead responsibility for developing an impregnated bednet resource network.

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