Roll Back Malaria Case Management Working Group
6th Meeting

Meeting Report

11th – 13th June 2012
4th Floor, UNAIDS Building, WHO
Geneva

Contents

Acronyms

ACT	Artemisinin Combination Therapies
AL	Artemether Lumefantrine
AMFm	Affordable Medicines Facility - Malaria
ANC	Antenatal Clinic
AS + AQ	Artesunate-Amodiaquine
BCC	Behaviour Change Communication
CCM	Community Case Management
CHW	Community Health Worker
CMWG	Case Management Working Group
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GMAP	Global Malaria Action Plan
GMP	Global Malaria Programme
HWG	Harmonization Working Group
ICCM	Integrated Community Case Management
IEC	Information, Education, Communication
IMAI	Integrated Management of Adolescent and Adult Illness
IMCI	Integrated Management of Childhood Illness
IPTp	Intermittent Preventive Treatment in pregnancy
IRS	Indoor Residual Spraying
ITNs	Insecticide Treated Nets
LLINs	Long Lasting Insecticide treated Nets
MDG	Millennium Development Goals
MERG	Monitoring and Evaluation Reference Group
MoH	Ministry of Health
MiP	Malaria in Pregnancy
MPAC	Malaria Policy Advisory Committee
NGOs	Non-Governmental Organisations
NMCP	National Malaria Control Programme
PSM	Procurement and Supply Management
PSMWG	Procurement and Supply Chain Management Working Group
RBM	Roll Back Malaria
RDT	Rapid Diagnostic Test
SAF	Supplementary Activity Framework
SP	Sulfadoxine-Pyrimethamine
SRN	Sub-Regional Network
TRP	Technical Review Panel
TEG	Technical Expert Group
TFM	Transitional Funding Mechanism (Global Fund)
WHO	World Health Organization

1. Summary

The RBM Case Management Working Group (CMWG) held its 6th annual meeting in Geneva, Switzerland, from the 11th – 13th June 2012, and brought together more than forty participants representing endemic country National Malaria Control Programmes from Africa (Malawi, Nigeria, and the Democratic Republic of Congo) and Asia (Cambodia), Non-Governmental Organisations, research institutions and academia, multi- and bilateral development partners, and the private sector.

The meeting was structured around the three work stream of the working group: a) Diagnostics; b) Expanding Access to Treatment and c) Drug Resistance; and focussed on reviewing progress against the CMWG work plan for 2012, refining activities for the latter half of the year and identifying potential priorities for 2013 in line with Global Malaria Action Plan (GMAP) objectives. Partners working on specific themes and key developments in the area of malaria case management were invited to give short presentations to stimulate discussion and highlight potential challenges and opportunities for the working group to consider when planning its activities for next year. The specific themes discussed were as follows:

- The use of diagnostics in the private sector
- WHO Global Malaria Programme's T3: Test.Treat.Track. Initiative
- Integrated Community Case Management of Childhood Illness (iCCM)
- Information session in Seasonal Malaria Chemoprevention (SMC) and its implications for case management
- Severe Malaria and the revised Severe Malaria guidelines
- The global landscape for malaria control: opportunities and challenges for malaria case management
- Decreased funding and the position of the Case Management Working Group
- Pharmacovigilance
- Indicators for Case Management

The purpose and mandate of the Case Management Working Group was emphasised. It is important for the working group to maximise its added value - in bringing together a diverse group of partners, building consensus and facilitating co-ordination and communication – in order to most effectively complement the global policy and standards setting role of the WHO.

It was noted that working groups should regularly review their membership to ensure they reflect changing priorities and agenda, and that strengthening links between the Case Management Working Group and other Roll Back Malaria mechanisms is a key priority in the coming year. The next steps agreed on by the working group to further develop the 2012/2013 planning are given below.

1. Work streams will submit to CMWG Co chairs & secretariat activities with budget to be completed by latter half of 2012.
2. CMWG co-chair will contact WS focal points to discuss funding availability for 2012 by mid-July.
3. Work streams will submit work plans including priority activities and indicative budgets to CMWG co-chairs and secretariat for 2013 by **31st August 2012.**
4. CMWG co-chairs will follow up with the Procurement and Supply Management Working Group co-chairs and work stream focal points to agree way forward with the Pharmacovigilance work stream.
5. With Franco Pagnoni stepping down from the co-chair role of the CMWG, RBM secretariat will take forward the election process for a new co-chair.
6. The next annual meeting of the Case Management Working Group will be held earlier in the year, in February 2013, to better align with RBM board and mechanism meetings.

Day One

2. Welcome and introductions

Dr Franco Pagnoni and Dr Patrick Kachur, RBM Case Management Working Group Co-chairs

Dr Pagnoni and Dr Kachur opened the meeting with introductions and an overview of the meeting objectives. The meeting brought together over forty participants representing all constituencies of the Roll Back Malaria Partnership.

3. Objectives and expected outputs of the 6th meeting

3.1 Objectives:

1. Update members on Case Management Working Group progress and key developments
2. Identify key issues and priorities in case management post 2011
3. Reach consensus on priorities for CMWG for 2012 and 2013
4. Review work stream 2012 work plans in light of revised GMAP targets
5. Develop work plans for 2013
6. Review the collaboration efforts between the CMWG and other RBM mechanisms and decide how these can be further improved to ensure a cost effective and coordinated RBM response to key issues, particularly the likely reduction in overall funding for malaria programmes

3.2 Expected outputs:

- Shared understanding of current issues relating to case management
- Identification of priorities and development of CMWG roadmap for 2012-2013
- Updated CMWG work plans for 2012-13 that address GMAP objectives
- Improved and effective coordination between the CMWG and other RBM mechanisms

4. Introduction to the Roll Back Malaria (RBM) Objectives and Targets till 2015

Dr. Thomas Teuscher, RBM Executive Director a.i.

Link to presentation: <RBM Objectives and Targets until 2015>

Dr. Teuscher presented the updated Global Malaria Action Plan (GMAP) objectives, which have been translated into seven corresponding targets with six milestones. The targets most relevant to the Case Management Working Group were highlighted as well as possible priority actions to underpin the 2013 work plan, which have arisen during discussions of the RBM board.

Updated GMAP objectives and targets relevant for working group:

Objective 1: Reduce global malaria deaths to near zero by end 2015

Target 1.1 Achieve universal access to case management in the public sector: By end 2013, 100% of suspected cases receive a malaria diagnostic test and 100% of confirmed cases receive treatment with appropriate and effective antimalarial drugs.

Target 1.2 Achieve universal access to case management, or appropriate referral, in the private sector: By 2015, 100% of suspected cases receive a malaria diagnostic test and 100% of confirmed cases receive treatment with appropriate and effective antimalarial drugs.

Target 1.3 Achieve universal access to community case management (CCM) of malaria: By 2015, in countries where CCM of malaria is an appropriate strategy, 100% of fever (suspected) cases receive a malaria diagnostic test and 100% of confirmed uncomplicated cases receive treatment with appropriate and effective antimalarial drugs, and 100% of suspected and confirmed severe cases receive appropriate referral.

Possible priority actions underpinning the 2013 work plan:

1. Support the roll-out of surveillance guidelines for the public sector

2. Support the development of a comprehensive private provider strategy based on:
   - Initial landscaping by Ian Boulton
   - Work by Affordable Medicines Facility – malaria (AMFm) Task Force: Evaluate impact of commodity subsidies at global or national scale
   - Tiered pricing approach in the private sector

3. Evaluate health systems and determine the circumstances where Integrated Community Case Management (iCCM) is an appropriate case management delivery strategy

4. Mainstreaming good malaria control in all health services (Integrated Management of Childhood Illness (IMCI), Integrated Management of Adolescent and Adult Illness (IMAI)) by engaging senior managers in Ministries of Health (Director of Health, Permanent Secretary) to ensure motivated well performing health workers

Challenges in community provision and the private sector were proposed as key areas of focus for the CMWG in the coming year. Whilst the way forward with the private sector is unclear, there is need for a broader multi-dimensional strategy that does not rely on one intervention i.e. the AMFm. It was highlighted that many partners are already grappling with the challenges in the private sector but that answers may not be immediately available.

The difference in role between WHO and CMWG was emphasized. Whilst WHO is responsible for setting and promoting standards, global policies and guidelines, the working group should focus on how to scale up these policies and apply the guidance in practice. Co-ordination is essential in order to avoid duplication or fragmentation of effort.

With changing priorities and agenda, all working groups should regularly review their membership to ensure they bring together the right people to address the challenges ahead. There remain those who question the relevance of working groups and so the CMWG needs to be clear about its added value and how it contributes to achieving the GMAP targets.

Link to the updated GMAP Objectives, Targets, Milestones and Priorities agreed by RBM board on 12 June 2011 <http://www.rbm.who.int/gmap/gmap2011update.pdf>

5. Work stream Progress Reports

Work stream focal points presented the progress of work streams against the planned activities of the 2011/2012 work plan. The three work streams are as follows:

1. Diagnostics
2. Expanding Access to Treatment
3. Drug Resistance

5.1 Progress Reports: Diagnostics

Presented by: Dr Lawrence Barat, USAID/PMI, Diagnostics work stream focal point

Link to presentation: <Progress report diagnostics work stream>

A summary of progress of the diagnostics work stream against activities detailed in the 2011/2012 work plan is detailed below.

WG Sub-Activities	Status
Activities on-going from 2011 work plan	
1. Assist the Procurement and Supply Chain Management Working Group in the forecasting of country requirements for RDTs	Manual pilot tested and finalized. Final document is being formatted for publication
2. Support provided to the development of a malaria diagnostics tool kit	Tools have been collected. Only remaining activity is to post to a web site with short descriptions of each tool. Funding is available and the ToR developed. Consultant still to be identified.
Activities from 2012 work plan	
1. Assist PSM Working Group to develop global forecast of RDT requirements	On hold. Awaiting action by PSM WG
2. Disseminate new and existing tools on diagnostic testing for malaria	Tools disseminated electronically via WHO and PMI networks. It was proposed to send work stream representatives to key meetings to present the tools but this has not been possible due to funding constraints.
3. Document (in 2 countries) and disseminate best practices for scaling up diagnostic testing for malaria	Funding provided insufficient to carry out field studies. An alternative approach is being discussed.
4. Develop guidance for scaling up diagnostics in the private sector	No funding identified and there is limited field experience to date. Other groups (e.g. CDDEP) pursuing this line of work. There is also a new UNITAID funded project with PSI, MC, WHO, and FIND to create private sector market for RDTs in five malaria-endemic countries.

Discussion:

- **Non malarial febrile illness:** There is a WHO technical consultation to consider the research agenda and programmatic challenges for managing cases that test negative for malaria. GMP is taking the lead in this exercise but there is need to collaborate with other areas in the WHO, technical partners and groups (including the CMWG).

- **Adherence to test results:** Participants suggested greater efforts are needed to reinforce key messages on adherence to test results and address how cases with negative results are managed.

- **Quantification:** Programme reviews from last year brought forward issues with RDT quantification, and the WHO formulae were found to be complex. Whilst the manual describes the step by step process in detail, greater consideration should perhaps be given to how the manual is rolled out. The work stream could look into how best it could support the PSMWG and HWG in this exercise.

- **Antibiotics usage:** There was a question regarding availability of evidence on antibiotic usage and if there is a trend towards over-prescription resulting from negative malaria test results. There is concern that if non malarial fevers are routinely treated with antibiotics this may spread resistance. It was noted that in certain countries antibiotics are still not widely available and so there is on-going advocacy to increase the supply of these drugs at health facilities.

5.2 Progress Reports: Expanding Access to Treatment

Presented by: Shannon Downey, CORE Group, Expanding Access work stream co-focal point;
Link to presentation: <Progress report expanding access to treatment work stream>

A summary of progress of the Expanding Access to Treatment work stream against activities detailed in the 2011/2012 work plan is detailed below.

WG Sub-Activities	Status
Activities on-going from 2011 work plan	
1. Develop a framework on the core elements of malaria case management for evaluating success factors and barriers for rapid scale up of prompt and effective diagnosis and treatment, using information already available	This piece of work has been undertaken by the CDC malaria branch. No funding was allocated to allow a dedicated consultant to be employed. A draft is now available and will be shared with the work stream for further discussion.
Activities from 2012 work plan	
1. Assess policy environment for CCM of malaria/iCCM in the 10 priority countries, diffuse lessons learned and actively advocate for positive policy changes in at least 3 target countries	There is currently no funding identified for this activity. A UNICEF document "CCM of Diarrhoea, Malaria and Pneumonia of Sick Children for Sub-Sahara Africa in 2010: Data Report of a Desk Based Survey of UNICEF Country Offices" provides some useful data as a starting point. The work stream will discuss in a later session how best to take this activity forward.
2. In line with WHO policy recommendation/update on the management of severe malaria – develop related/addendum community-focused IEC/BCC guidelines/resources	There is currently no funding identified for this activity.
3. Write position paper directed towards the RBM Board and Partnership advocating for the rapid implementation of the updated WHO policy for management of severe malaria	There was a question about the relevance of writing a position paper to the RBM board and if it might be more productive to channel efforts at country level. Instead the group could focus on advocating for coordination and support (e.g. through opportunities arising from the 'Committing to Child Survival: A Promise Renewed' call to action held in Washington on 14-15th June 2012.)

Discussion:

- **Advocacy and Funding:** Malaria specific funds are often used to deliver iCCM programming. There may be a role for the work stream in advocating for more integrated funding. iCCM should be promoted as a key implementation method as part of the call to action on child survival held in Washington on 14-15th June, which may prompt the establishment of new finance mechanisms. The joint WHO/UNICEF statement on iCCM to be released in June 2012 may also support advocacy efforts.

- **Referral system:** Concerns were raised about the identification of and referral process for severe cases (not only of malaria) at community level. There is a key question about how to deal with referral when facilities at the referral centre are no better than what is available in the community.

- **iCCM and where it fits in the health system:** There was a discussion about some of the barriers to implementation and the difficulties introducing iCCM at different administrative levels within the MoH (i.e. national, provincial, district) and across different departments/sections.

- **Policy environment:** The challenges and complexity of assessing the policy environment were considered. The global CCM taskforce has established the CCM central website with the aim of providing a web based platform with reliable and updated information.

5.3 Progress Reports: Drug Resistance

Presented by: Dr Sylvia Meek, Malaria Consortium, CMWG drug resistance work stream co-focal point;
Link to presentation: <Progress report drug resistance work stream>

A summary of progress of the Drug Resistance work stream against activities detailed in the 2011/2012 work plan is detailed below.

WG Sub-Activities	Status
Activities on-going from 2011 work plan	
1. Review of management & containment efforts of past drug resistance	In final draft.
2. Review of efficacy monitoring networks	Completed. Being prepared for dissemination.
Activities from 2012 work plan	
1. Develop consensus statement for RBM Board advising GFATM TRP to require funded countries to track TES every 2 yrs. as an indicator of performance	There was a question about the relevance of taking this activity forward now, as a number of actions elsewhere have already been taken to this end.
2. Collate existing sources of data on whole range of AM drugs registered/ available in a limited number of countries	There is limited availability of funding to carry out this activity.
3. Develop consensus statement for RBM Board to reemphasize implementation of AMT ban	This activity is no longer considered the best approach. Most countries already either have a ban in place or have indicated their intent to ban. The main challenge is how to ensure these policies are implemented.
4. Develop consensus statement for RBM Board to recommend drug quality assurance as a key component of minimizing resistance	A consensus statement has been drafted. It can be reviewed and finalised if still considered relevant.

Discussion:

- **Joint Assessment on Artemisinin resistance response:** It was proposed the work stream might frame its new round of planning around the key areas outlined in the conclusions of the joint assessment of artemisinin resistance response, which were as follows:

    - Intensify current field operations and manage them for results
    - Secure adequate financial resources
    - Clarify and implement policy decisions on diagnosis and treatment
    - Build political support
    - Strengthen coordination and oversight mechanisms
    - Maintain, expand and improve drug efficacy surveillance networks
    - Accelerate priority research
    - Target high risk populations and behaviours and engage with relevant employment sectors
    - Prioritise Myanmar (while maintaining momentum elsewhere)
    - Engage with the pharmaceutical and other sectors

- **Linking with Malaria Policy Advisory Committee (MPAC) and Technical Expert Group (TEG):** Members of the CMWG also sit on the MPAC and the TEG on drug resistance, which will strengthen the links between these groups.

- **Field operations:** The need to maintain coverage was highlighted as a concern, as there is a risk of losing momentum (e.g. Cambodia is taking steps to return to high net coverage as a way of tackling resistance). Supporting the development of adequate surveillance systems, case detection and prompt response will enable efforts to be focussed in areas where greatest resistance is found.

Day Two

Key partners working on specific themes were invited to give short presentations to stimulate a discussion. The objective was to give participants the opportunity to express their views on the theme and reach a consensus within the CMWG.

6. Theme 1: The Use of Diagnostics in the Private Sector

Elizabeth Streat, Malaria Consortium. Link to Presentation: *<1. E.Streat-Diagnostics>*
Nora Petty, Clinton Health Access Initiative. Link to Presentation: *<2. Available shortly>*

Discussion:

- **Aspirational targets:** Caution should be exercised in trying to achieve the aspirational GMAP targets and rapidly driving forward work in the private sector without due care and consideration. There is need for pragmatism and recognition that implementation needs to move forward before all policies are necessarily in place in order to make progress.

- **Pricing and Incentives for consumer and provider:** The importance of incentives for the consumer as well as the provider was noted. RDT price has to be low enough that consumers are willing to pay but also give a sufficient margin for suppliers. The pricing of RDTs should also be looked at in relation to the cost and margin for ACTs, with the aim of providing diagnosis and treatment as a package for which the cost is not prohibitive to the end user. A pricing strategy should take into consideration a range of factors as reducing the price alone does not necessarily equate to consumer buying (e.g. an MC rapid survey in Uganda showed a common perception that the AMFm drugs were not genuine because they were so inexpensive)

- **Diversity of private sector:** The private sector comprises a diversity of actors and its make-up varies from country to country. Breaking down and understanding the component parts of the sector might allow specific issues to be teased out. Rather than 'one size fits all', there is call for a country by country approach, which takes into consideration other major factors (e.g. epidemiology, treatment seeking behaviours and access to other types of treatment).
- **Regulatory environment:** Lack of regulation is a serious impediment in the private sector. Even when policies are in place, enforcement is difficult. Regulations prohibiting private sector providers from testing will result in the volume of RDTs remaining low in the sector and interventions continuing as small pilot schemes.
- Improving regulatory function is a significant challenge and with the limited resources of the CMWG, there is a need to be **realistic about what can be achieved** in this area. It was proposed the CWMG could consider developing an activity aimed at improving understanding of the regulatory environment and how the private sector is organised.
- **Wholesalers** in country do not have information on how to select the right product and RDT suppliers do not have a presence in country. A question was asked about how this information could be more effectively communicated.

7. Theme 2: WHO Global Malaria Programme's T3: Test.Treat.Track. Initiative

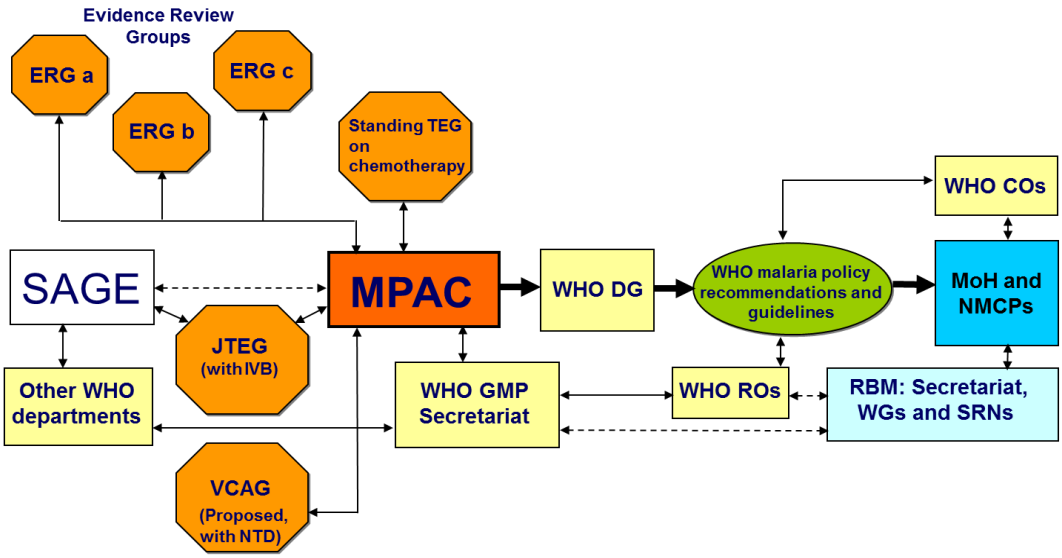
Robert Newman, WHO Global Malaria Programme Director.

Link to presentation: *<3. R.Newman-T3>*

Dr Newman presented details of the WHO GMP new T3: Test.Treat.Track. initiative launched on World Malaria Day 2012. The new initiative urges malaria-endemic countries and donors to move towards universal access to diagnostic testing and antimalarial treatment, and to build stronger malaria surveillance systems. The **potential areas of activity for the CMWG in the T3 initiative** were outlined:

- Mapping of in-country partners capable of supporting National Malaria Control Programmes to scale-up T3 (Diagnostic testing; Treatment; Surveillance)
- Harmonizing the work of in-country partners in support of T3
- Ensuring dissemination of global guidance documents
- Assisting with national adaptation of global norms
- Creating consensus among partners with regard to implementing T3
- Identifying south-south capacity building opportunities

- **Malaria Policy Advisory Committee (MPAC):** The background to establishing the Malaria Policy Advisory Committee, its role and highlights of its history to date were described. The following organogram shows how MPAC fits within the WHO, GMP and RBM mechanisms.



8. Theme 3: Integrated Community Case Management (iCCM) of Childhood Illness

Cathy Wolfheim, WHO Maternal, Newborn, Child and Adolescent Health; *<4. C. Wolfheim-iCCM>*
Rory Neft, UNICEF ESARO Regional Malaria and iCCM Advisor; Link to presentation: *<5. R.Neft-UNICEF>*
Yves Cyaka, Population Services International; Link to presentation: *<6. Y.Cyaka-PSI>*

Discussion:

- **Referral systems:** There is an urgent need to strengthen referral systems and consider what steps can be taken when the referral centre has fewer facilities than those available at community level. It was noted that whilst making treatment available at community level is saving lives, health system strengthening is essential to allow for adequate referral.

- **Resources for integrated programmes:** Current strategies for community case management (CCM) of malaria highlight the rationale for an integrated approach (e.g. the introduction of RDTs leads to the question of how to manage cases with negative test results). Assessing and assigning resources for integrated programmes can be difficult, particularly when resources are directed to individual diseases.

- **Entry point for iCCM:** Although guidelines and policies are starting to align, there is still a long way to go before full integration is achieved, particularly in terms of funding. Countries that implemented community case management had a solid basis upon which to build an integrated approach. In many countries there is a diversity of both funders and implementers, which makes implementing iCCM a greater challenge.

- **Communicating the Boundaries of iCCM**: One of the strengths of the iCCM approach is that it has not been prescriptive in its application. Instead it has been developed on the basis of what a country has determined is needed at community level. However, this has led to some confusion with regard to the core components of iCCM.

- **iCCM Delivery:** A concern was raised about the potential overloading of community based delivery mechanisms. It was highlighted that some countries already implementing a package of interventions are putting in place cadres of extension workers to address the capacity issue. The difference between extending health systems into communities through paid extension workers and having volunteer systems was also noted.

9. Theme 4: Information session on Seasonal Malaria Chemoprevention (SMC) and its implications for case management

Peter Olumese, WHO Global Malaria Programme
Link to presentation: *<7. P.Olumese-WHO>*

Antimalarial treatment policies:

- The choice of Sulfadoxine + Amodiaquine (SP+AQ) (a non-artemisinin based combination) allows artemisinin based combinations to be reserved for treating symptomatic cases without increasing selection pressure for resistance.
- Treatment of breakthrough malaria infections during the period of SMC should not include either Amodiaquine or Sulfadoxine or combination drugs containing either of these medicines, such as Artesunate + Amodiaquine (AS+AQ).

Deployment strategies

- Presently there is insufficient evidence to recommend a standard deployment strategy and individual approaches best suited to local conditions should be used. If possible, delivery should be integrated into existing programmes (e.g. Community Case Management, Community Health Workers (CHWs)).

In areas where SMC is deployed:

- Drug resistance monitoring and system evaluation should be supported or instituted. Deployment of AQ + SP may lead to increased resistance and have potential implications for Artemisinin Combination Therapies (ACTs) containing AQ or SP.
- The health system needs to monitor AQ+SP doses administered to evaluate the programme impact. Existing systems to document severe malaria, malaria deaths, and record confirmed malaria cases should be strengthened.
- Pharmacovigilance should be strengthened or if not existing, instituted.

Discussion:

- **Pharamacovigilance:** There was a discussion about the possible interaction of anti-malarial drugs with ARVs and other drugs such as those to treat NTDs, for which mass drug administration occurs. This is being taken up with the relevant HIV/NTD contacts. Countries are being encouraged to integrate rather than establish parallel pharmacovigilance systems.

- **Drugs and packaging**: Tolerance and acceptability were discussed. A large scale study undertaken in Senegal that considered these issues found they were not of major concern. An AQ + SP co-blister is the preferred packaging as it maintains the integrity of the tablets and helps with adherence.

- **Delivery mechanism:** Concerns were raised about the potential overloading of community health workers and the sustainability of such a programme in the current financial climate. Community based delivery is considered the best mechanism to ensure the necessary high coverage. It was noted that only certain regions in particular countries (e.g. northern Nigeria) met the qualification criteria for SMC however this raised questions about how it would be practically delivered in these areas alone.

- **Integrating with current treatment protocols:** The feasibility of integrating SMC (i.e. that AQ + SP should not be used to treat breakthrough infections) into treatment protocols, particularly in countries that have adopted AS + AQ as first line treatment, was questioned.

10. Theme 5: Severe Malaria

Peter Olumese, WHO Global Malaria Programme; Link to presentation: *<8. P.Olumese-WHO>*
Penny Grewal, Medicines for Malaria Venture (MMV); Link to presentation: *<9. P.Grewal-MMV>*
Martin De Smet, Médecins Sans Frontières (MSF) ; Link to presentation *<10. M.DeSmet-MSF>*

Discussion:

- **Injectable Artesunate policy and revised Severe Malaria guidelines:** Over 20 countries have already adopted the new recommendations or are in the process of updating their national guidelines on severe malaria. The final draft of the revised treatment guidelines is available and feedback is being sought from the TEG and other external reviewers. It will be finalised and printed in the 3rd quarter of 2012. Treatment for all non-falciparum malaria is included in the revised guidelines. Greater effort is needed to understand the challenges in **implementing rectal artesunate**. A key blockage is the **lack of pre-qualified drugs**, which makes scaling up difficult.

- **Costing of Severe Malaria:** The approach is shifting to one of costing against a country's strategic plan. An area that requires some guidance is on costing for Severe Malaria, for which there is little information readily available. There are a number of different costing tools available (e.g. Medicines for Malaria Venture (MMV) has been working on 'funding calculator'). There may be a role for the CMWG in harmonising these tools and working on an agreed method that can be used when discussing with countries and donors.

- **Global Fund Transitional Funding Mechanism (TFM):** For the TFM proposals case management is considered an integrated package (diagnosis, treatment of uncomplicated and severe malaria) and so the change from quinine to artesunate or the inclusion of injectable artesunate in TFM proposals is not considered a new intervention and is following the updated WHO recommendations. For the GF, there is also an issue regarding how countries calculate their counterpart financing. It would be helpful if a proposed method came from a consensus group such as the CMWG.

- **Other Funding Mechanisms:** In addition to the Global Fund, there are other sources of funding available. It was noted that it is not only the cost of the drug involved in making the shift. The Resource Mobilization Group has been providing support to countries on how to raise awareness and funds from other sources.

- **New method for requesting drug donation from the Chinese government:** The new application method is via written requests directly to Chinese embassies in-country. There is no standard format. The request should include information about amount and drug preferences. Training materials are also provided free of charge. IV artesunate is available. The CMWG should consider how it could support countries in writing their applications to the embassy.

11. Theme 6: The global landscape for malaria control: opportunities and challenges for case management

Seven participants were invited to join a panel and share their views on the opportunities and challenges for malaria case management including:

- Challenges of implementing and scaling up an effective case management programme in the current financial climate and decreased Global Fund resources;
- How can malaria programmes be made more cost effective including broad areas for prioritisation;
- How to expand community and private sector delivery in face of reducing funds;
- AMFm in the context of the global landscape for malaria control

Andrea Bosman, WHO Global Malaria Programme

- **Strengthening supply system:** There has been strong debate surrounding the AMFm and community based delivery, however we need to move away from polarised perspectives and consider what might be the most appropriate strategy in a given context.
- Broad membership, networking, communication reach and sharing experience on good practices are the main ways in which **working groups can add value**. The group should make the most of these advantages and consider how best to contribute to the **T3 initiative**. The use of rectal artesunate is an example where the lack of experience in delivering the intervention resulted in a lack of scale up.
- **Diagnostics** may become the key programme focus over the next 5 years. For diagnostics in the private sector there is call for more experience on how this can be delivered and a need for greater knowledge on how to implement the new policy recommendations.

Josephine Namboze, WHO AFRO

- With a reduction in funding for activities, we see more **dedicated to commodities rather than service delivery**, which affects quality of care (e.g. supervision is often a neglected component).
- **Parasitological diagnosis:** There needs to be greater emphasis on parasitological diagnosis as this will minimise the use of ACTs.
- **Packaging of commodities and wastage**: Packaging should reflect the current epidemiological transition in malaria (e.g. selling packs of 25 RDTs to health facilities that do not see that number of cases within the expiry period). Wastage is also an issue, for example, many countries are ordering ACTs that are not used within the expiry period. Inter-country redistribution is a challenge.
- **Funding**: Despite significant advocacy on funding for these products, domestic funding remains low. Different groups need to explore way to increase domestic funding from governments.
- **Many partners are piloting new approaches:** there is need to ensure a package of recommended interventions are rolled out and implemented at optimal level before introducing something new.
- **AMFm:** The possibility of extending the AMFm programme into countries not included in the first phase could be explored. If the package under AMFm is agreed, other partners may be interested in supporting this approach.

Oluwatoyin Jolayemi, The Global Fund: Update on the Affordable Medicine Facility – malaria (AMFm)

- Hosted and managed by the Global Fund, the AMFm is a 2 year pilot that started in 2010 and is expected to end in 2012.
- The AMFm has four objectives: i) increase accessibility; ii) increase affordability; iii) increase market share and iv) increase usage of ACTs for malaria treatment.
- A baseline was carried out by the London School of Hygiene and Tropical Medicine in 2010 and an end line evaluation was undertaken in December 2011. There is a consultative forum taking place on the 27 – 28 June 2012, in which countries are coming together to validate the findings. The final report is expected to be available in August 2012.
- The committee responsible for looking at scenarios post 2012 carried out country consultations and commissioned studies to look at the impact of AMFm on the global dynamics of ACTs. A new working group is considering post 2012 scenarios.
- For more information about the AMFm please check: http://www.theglobalfund.org/en/amfm/

John Sande, National Malaria Control Programme, Malawi

- **Challenges in quantification** are affecting the availability of products. Malawi needs support in this area, which would also save costs in terms of procurement.
- Greater support is needed from partners for **procuring supplies** (e.g. only 10% of resources for RDT procurement were provided by the Global Fund) There is high demand for RDTs at community level, as the guidelines are clear i.e. that any suspected case must be tested. The demand for RDTs is presently outstripping the supply.
- **Wastage is a key concern**. Health workers rejected AS + AM, but procurement had already been made for this second line treatment (so 5% were procured not consumed). The attitude of health workers is important, so there is need to do a situation analysis to understand their concerns.
- **Treatment at community level:** There have been efforts to expand ACTs to community level, particularly through the private sector, through a partnership with Novartis and PSI. There are challenges in monitoring though, so we are unaware of consumption levels and this compounds issues with quantification.
- **Drug resistance issues:** The last drug efficacy study in Malawi was in 2010 and there are plans for a follow up.
- **Injectable Artesunate:** The Severe Malaria policy was changed last year and we are now working with partners to develop an implementation plan.

Ly Po, National Malaria Control Programme, Cambodia

- Cambodia has a plan for malaria elimination with a target of pre-elimination by 2016 – 2020 and elimination by 2021 – 2025.
- The programme is expanding early diagnosis and treatment at community level by increasing the number of Village level Malaria Workers.
- Cambodia has successfully undertaken diagnosis using RDTs at community level for several years.
- Behaviour Change Communication/Information, Education, Communication (BCC/IEC) efforts are increasing the number of people with an understanding about malaria.
- Malaria control in migrant workers in a key challenge, along with increasing artemisinin resistance.
- Without the Global Fund or other support the government will not be able to achieve its goal of malaria elimination by 2025.

Benjamin Matindii Atua, National Malaria Control Programme, DRC

- **Public sector**: Measures have been taken to ensure no charges are applied for drugs or insecticides entering the country, however the challenge for health care delivery is with access. The national plan has actions to reinforce the sector but no budget support is allocated. Case management at community level has been introduced.
- **Private sector:** There are concerns with quality of products as the Ministry has less control of the supply chain in this sector. There are private subsectors that do not adhere to national guidelines and regulations. This issue is being addressed by setting up public-private partnerships, initially with ACTs but now with RDTs too, in order to bring them in-line with national directives. Other measures are also been adopted (e.g. giving tax exemptions) to improve quality.
- **Promotion of traditional medicine:** Certain plant based traditional medicines have been found to have a degree of efficacy but there is no WHO guidance on the use of traditional medicines, which if efficacious will need to be protected. An increase in faith healing has also been noted, which keeps patients from accessin g appropriate treatment. A number of measures are being considered to address this issue but it is a matter that demands sensitivity.

Godwin Ntadom, National Malaria Control Programme, Nigeria

- **SM policy:** The SM policy and guidelines have been updated to reflect the use of injectable artesunate for SM.
- **Implementation RDTs:** The first phase has just been completed and levels of awareness are growing. State governments have been sensitized and are willing to use their own funds.
- **AMFm:** There has been a significant amount of initial promotion around the AMFm but now less so and the private sector actors are concerned about the future of the programme.
- **ACT and RDT supply:** It has not been possible to scale up RDTs in all states (21 of 37 states so far). Even in states where RDTs are deployed, coverage may not include the entire state. Some health facility workers still need training. There is still insufficient supply of ACTs in the country.

12. Decreased funds and the position of the CMWG

Dr. Jan van Erps, RBM Secretariat

- **Work plan and KPIs:** The group needs to consider how it is going to report against the relevant Key Performance Indicators (KPIs) for 2012 (see Appendix):

    1. **Proportion of country plans assessed to align with GMAP:** The baseline is 17 countries and the target for end 2012 is 30 countries.
    2. **Number of countries implementing drug resistance containment plans:** The baseline is 0 and the target for 2012 is the Greater Mekong Region.

- **Planning and budget:** The inconsistent history of funding for Working Groups has led to changing expectations in terms of member contribution and group outputs. When RBM was in its infancy WGs did not receive any funding. Over the last few years greater levels of funding were allocated but we are once again entering a period of resource scarcity. The CMWG can at least identify priorities and provide direction even when activities are not funded. It is also important to look at what partners are already doing, identify potential synergies and consider how the CMWG could add value.

- **Case Management Working Group and the Roll Back Malaria board:** There was a discussion about the increasing level of guidance and direction from the RBM board on priorities for the attention of the working group. Assurance was given with regard to the receptiveness of the RBM board to other gaps and priorities that may be put forward by the Case Management Working Group.

- **Raising Funds:** Working Groups are encouraged to mobilise their own funds (e.g. through other donors) and also check with partners that may be willing to contribute to certain activities. It was, however, noted this approach can result in activities taken forward for which the group can mobilise funds (i.e. those of interest to partners) rather than focussing on agreed priorities or gaps. In addition, the planning cycle of RBM mechanisms does not correspond to that of partners, most of which have already committed resources for the coming 18 months to 2 years.

13. Theme 7: Pharmacovigilance

Shanthi Pal, Pharmacovigilance work stream co-chair, PSM Working Group

Link to presentation *<11. S.Pal-WHO>*

- **Position of the PV work stream:** There was a discussion last year with regard to which working group hosted the Pharmacovigilance work stream, which presently resides with the Procurement and Supply Management Working Group (PSMWG). It was suggested the group may be better placed as part of the CMWG.

- **Activities undertaken and progress of the work stream** in 2010/2011 were presented. This includes a toolkit that provides the necessary resources for a country to carry out pharmacovigilance for anti-malarial drugs in a resource poor setting (link below). Dr Pal also outlined the main areas of work for 2012 and beyond.
  <http://www.pvtoolkit.org/index.php?option=com_content&view=article&id=43&Itemid=50>

- There was a discussion regarding the rationale for transferring the work stream into the case management working group. A question was raised about whether or not the CMWG has additional expertise to add to the work stream and if CMWG members have the relevant contacts at country level to take this area of work forward. The importance of co-ordinating PV issues across the other CMWG work streams was also noted.

- **Next steps:** CMWG Co-chairs will follow up after the meeting with the PSMWG Co-chairs, PV work stream leaders and those CMWG members who expressed an interest to be involved in discussions about the work stream (ACT consortium, MC, MMV, Accordia, Novartis and Sanofi Aventis) to agree the way forward.

14. Theme 8: Case management indicators

Richard Cibulskis, Monitoring and Evaluation Reference Group (MERG) Co-Chair

Link to presentation *<12. R.Cibulskis-WHO/GMP>*

- **Structure:** Dr Cibulskis presented how the indicators from MERG and WHO relate to the GMAP. It was highlighted that the focus for MERG is to monitor and evaluate progress against the GMAP objectives. There are only four indicators relevant to case management recommended by the WHO.

- The **Health Facility Survey** is considered the most appropriate method to collect the information however this has the disadvantage of only covering the public sector. There was reluctance to further encumber the service provision assessments (SPA). It was proposed a lighter tool and undertaken on an annual basis could be carried out in a large number of countries without dependence on a large team of consultants.

- Eventually the information should come from **functional routine systems** but for certain countries it may be some time before this is feasible. Routine surveillance also primarily collects information from the public sector. There are key challenges around collecting information from the community and the private sector and making links between case reporting and diagnostics.

- It was noted that these are the **core list of indicators** i.e. the minimum for which information has to be collected. The CMWG can put forward additional indicators for specific programme monitoring and evaluation if considered worthwhile.

- **Drawing the line and working with what we have:** There was a discussion regarding the number and scope of the indicators included in the revised set. Certain dimensions are absent, notably quality measures, provider compliance and consumer adherence. There is a need to move towards indicators for fever management in general rather than malaria specific. Some indicators have already been measured over an extensive period of time and so there is reluctance to change the denominators.

Day Three

15. Session Four: Harmonisation with other RBM mechanisms

15.1 Malaria in Pregnancy (MPWG) Working Group

Viviana Mangiaterra, Malaria in Pregnancy Working Group Co-chair

Link to presentation: *<13. V.Mangiaterra-MPWG>*

The MPWG work plan outlines a number of activities relevant to the CMWG:

- Ensuring capacity for appropriate case management of ill women presenting at ANCs
- Country commodity quantification data available; used to inform country/global forecasts
- Roadmap for making new diagnostic technologies available and disseminated.
- Appropriate use of drugs for treatment and prevention through strengthening competencies of ANC providers
- Pharmacovigilance: pilot studies on pregnancy register for drugs safety and assessment of birth defects

Discussion:

- **Bridging reproductive and malaria programmes:** There are key implementation challenges and issues of ownership in bridging reproductive health and malaria programmes and in many countries this partnership is not working very well. Bridging this gap requires the necessary funding and capacity to be handed over to reproductive health programmes. In many countries IPTp is considered a malaria rather than reproductive health programme.

- **Opportunity for intervention at ANCs**: Pregnant women do not attend adult clinics and so the only point of contact the health system has with the main adult risk group for malaria is through antenatal clinics (ANC). Women often only attend an ANC once. A comprehensive package of care should be delivered at ANCs to take advantage of the opportunity to reach this group.

- There are however concerns about **point of delivery**. Interventions provided outside clinic settings (i.e. community based outreach) should be avoided because presently many women are and should be encouraged to attend a health facility to monitor their pregnancy. On the other hand, this approach would exclude those who do not or are unable to attend a clinic.

- **Efficacy of SP for Intermittent Preventive Treatment in pregnancy (IPTp):** A question was raised with regard to the availability of information on the efficacy of SP (sulphadoxine-pyrimethamine) for IPTp. This is a key challenge for IPTp as there are growing concerns over resistance. There is a meeting in July to present results on new trials for prevention and treatment and MiP Consortium is carrying out research in different settings. In the Asian context, studies are on-going and alternatives are being tested (e.g. see the recent review 'Malaria in pregnancy in the Asia-Pacific region' (2011) *The Lancet Infectious Diseases*, 12 (1) 75 - 88).

15.2 Procurement and Supply Management Working Group (PSMWG)

Sophie Logez, PSM Working Group Co-Chair

- **ACT demand forecasting 2012/2013:** The forecasting considers two scenarios: i) the status quo if AMFm continues as it is currently in 8 countries (9 pilots); and ii) transition period depending on the decision on whether or not to continue AMFm. This could involve a greater decrease after 6 months to account for an exit strategy. For the 2013 estimation, a decrease in demand from private sector channels is predicted in countries with the AMFm. A decrease in demand in non AMFm countries is not anticipated.

- A question was raised about the challenge in delivery of goods from manufacturers to programmes. The PSMWG is considering how it can work with countries to improve distribution and procurement plans to reduce wastage and avoid any gaps in supply. It is also looking at the way in which contracts are organised with manufacturers.

- **Artemisinin demand and supply**: Production levels are covering the estimation of the demand for 2012 and for next year the demand should also be covered without any difficulty.

- **LLINs and commodities:** The recently released WHO publication 'Procurement guidelines on public health pesticides' has a heavy focus on vector control for malaria and includes specific recommendations on how to organise country level sampling and testing.

- **PSM bottlenecks:** This work stream engages with countries to identify and find solutions to PSM bottlenecks, and workshops are organized to address specific themes or challenges. This group also has regular updates on AMFm implementation.

- **Diagnostics workstream**: An RDT taskforce is considering the way forward to simplify and harmonise RDTs in the field. The Terms of Reference for the project, looking at the characteristics, challenges and opportunities for harmonization of RDTs, are being developed. CMWG diagnostics WS members are already working with the PSMWG on this activity.

- **Pharmacovigilance**: There was a discussion at the last PSMWG meeting on how to streamline PV across the working groups. It was proposed these activities should come under the CMWG.

- **mHealth work stream:** SMS for life pilot projects have resulted in a high level of interest from countries keen to implement this initiative for stock management follow up.

15.3 Harmonization Working Group (HWG)

Peter Olumese, Harmonization Working Group Co-Chair

- **Harmonization Working Group**: Aims to harmonize and co-ordinate partners' support in response to countries needs and supports the development of the strategic plan, operational plan and monitoring and evaluation plan at country level. The core members of the HWG comprise all board constituencies and the co-chairs of all working groups.

Updates and activities:

- **Strategic Plans:** Almost all countries have completed or are developing second generation strategic plans. Programme reviews are being used to develop plans upon which resource mobilization can be based.

- **GF Transition funding mechanism:** The transition funding mechanism was put in place after the cancellation of Round 11. The group is providing support to countries to prepare proposals for the transition mechanism. There have been 11 submissions for malaria (6 from AFRO region, plus Yemen, Indonesia, Laos, Nepal).

- **Moving from phase 1 into phase 2 of current grants:** Most countries are moving from phase 1 into phase 2 of their current grants. The process involved is like re-applying for a new grant in that all conditions/criteria need to be satisfied anew. This provides an opportunity for countries to consider their needs and re-programme where necessary.

- All Working Group Co-chairs are members of the HWG and there was an appeal for **greater participation from the CMWG in work streams**. It was proposed to assign CMWG representatives to specific work streams with the aim of strengthening communication between the groups. Concerns were raised about the feasibility of acting on behalf of the CMWG in a work stream because by nature they are more engaged in day to day activities.

- **Funding to attend HWG meetings:** An appeal was made for funding to be included in WG budgets to support the participation of Co-chairs in HWG meetings.

- The HWG has a platform and is well positioned to take up major strategic issues with key partners. Working groups should therefore feed such issues into the harmonization group so they can be taken forward.

16. Session Five: Case Management Working Group Work plan

16.1 Diagnosis

Facilitated by Dr Larry Barat, USAID/PMI, Work stream Focal Point

Planning for the latter half of 2012:

Activity 1: Assist PSM working group to develop global forecast of RDT requirements

- Need to check the PSMWG planning and the activity will be moved into the 2013 work plan.

Activity 2: Disseminate new and existing tools on diagnostic testing for malaria

- There is a need to consider different ways to effectively disseminate tools, especially when trying to reach the private sector.

Activity 3: Document and disseminate best practices for scaling up diagnostic testing for malaria

- An alternative way of delivering this activity is being explored. PSI has a meeting planned with the American Society of Tropical Medicine and Hygiene (AMTMH) in September to discuss scaling up of RDTs and it was suggested the CMWG could collaborate in this event.

Activity 4: Develop guidance for scaling up in the private sector

- There is currently no funding available for this activity and limited field experience to date. This activity will be moved into the 2013 work plan.

Priorities for the 2013 work plan:

1. Advocacy for increased priority for RDTs in country planning
2. Support PSMWG and HWG to roll out quantification guidance
3. Support WHO to update microscopy QA manual
4. Improve provider use and adherence
    - Develop advocacy paper on outcomes of withholding treatment in test negative patients
    - Organise state of the art meeting on technical and programmatic issues on non-malarial fevers (ACT consortium)
    - Review training and supervision tools (PMI)
5. Develop guidance on scaling up diagnostic testing in private sector
    - Coordinate with market dynamics advisory group (GF) to identify key areas for investigation
    - Convene meeting to review experiences and best practices/challenges
6. Explore with MERG approaches to capturing diagnostic test results in routine surveillance (advocacy)

Discussion:

- **Non malaria fevers:** ACT Consortium, Malaria Consortium and CHAI are already conducting studies on non-malaria causes of fever. Towards the latter half of next year there should be sufficient results to convene a meeting to bring these together and develop some consensus on guidance.

- **Provider use and adherence:** PMI is going to support the review of training and supervision materials used in-country, which may be part of the reason why providers do not adhere to test results. CHAI is also looking at this issue.

- **Quality Assurance for RDTs and microscopy:** a question was raised about the possibility of having a joint manual. It was suggested the group should advocate to WHO GMP colleagues for these activities to be combined.

- **Health facility surveillance tool:** this is tick sheet completed by clinicians who often complete it before seeing the lab results. This is not sufficient. Greater efforts are needed to support the capture of lab results and look at best practices in this area.

16.2 Expanding Access to Treatment

Facilitated by Shannon Downey, CORE Group, Work stream Co-focal Point

Planning for the latter half of 2012:

General

- Resources for activities that involve bringing people together to discuss bottlenecks is potentially available from USAID funds given to SRNs specifically to address such issues and the Global Fund, which allows grants to be used for country representatives to attend relevant meetings.
- The overall approach of the group was discussed with the following emphasized:
  - Information sharing and dissemination
  - Practical questions and answers: responding to queries and identifying bottlenecks
  - Facilitating South-South learning when countries are implementing at scale
  - Targeted support to countries upon request

Activity 1: Write position paper directed towards RBM board and Partnership advocating for the rapid implementation of the updated WHO policy for management of severe malaria:

- A position paper directed at the RBM board is no longer considered the best way forward to support the roll out of the revised SM policy and guidelines. It was proposed the group should direct their efforts to support implementation of the revised recommendations. Bringing together partners in a **workshop to consider best practices in the implementation and scaling up of IV and rectal artesunate** was put forward as a potential activity.
- The group needs to **keep track of relevant upcoming meetings/events** and mobilise support for the CMWG to send a representative to attend (e.g. AFRO & SRN meetings, where slots are already allocated for case management issues) or if someone is already attending (self-funded) that the information is packaged in such a way that anyone can present on behalf of the CMWG.
- The development of a **one page sheet** detailing key messages was put forward as a more constructive activity that the group could undertake with no additional cost.
- Availability of drugs is identified as a key challenge. Many countries have purchased quinine as part of their routine procurement. There is presently no prequalified rectal artesunate. MMV or Guilin Pharmaceutical, presently the only manufacturer of WHO prequalified IV artesunate, can provide information on the countries in which IV artesunate is registered.
- Most countries are keen to implement the new SM guidelines but there are a few that have not changed their protocols. It was proposed the group could **offer more targeted support where the change seems to have been blocked**, e.g. by holding a national or regional workshop.

Activity 2: In line with WHO policy recommendations/update on the management of severe malaria – develop related /addendum community focused IEC/BCC guidelines/resources:

- There is currently no funding available for this activity.
- MSF have found there are many practical questions that are not addressed in the WHO guidelines. It was suggested the group could **develop a Q & A sheet**, at no additional cost. Working with GMP to validate the 'Answer' section, the Q & A could be made available on the WHO website rather than attached to the handbook, which is more difficult to update frequently.

Activity 3: Assess policy environment for CCM of malaria/iCCM in the 10 priority countries, diffuse lessons learned and actively advocate for positive policy changes in at least 3:

- Where **iCCM fits as part of the health system** can be complex and often dedicated malaria funding is used to fund more integrative approaches. There may therefore be a role for the group in **advocating for integrated funding.**

- It was suggested the group could **organise or take advantage of already existing meetings** to bring together iCCM related Ministry representatives to discuss challenges, solutions and implementation strategies.
- The work stream aims to bring together a **single information source** on the status of current iCCM related policy recommendations in each endemic country. Working with key partners (especially from maternal and child health) the group aims to **harmonise and complement the information already available** from ALMA, AFRO and UNICEF, which has recently (2011) conducted a desk review of the policy situation. Standard definitions, methodology and availability of data for Asia, West and Central Africa needs to be checked. Further consideration is required on mechanisms for updating and accessing the information.
- Updating the numerous tools and frameworks available is a key challenge. Many partners are working on CCM but **greater dissemination efforts** are required to ensure available information and lessons learned are shared.
- There was discussion about **whether or not to focus on the ten priority countries**, as per the activity description on the 2012 work plan. This narrower scope may be more achievable, but it does not have to be followed if no longer considered the best approach.

Priority areas for the 2013 work plan:

1. **Referral systems**: collaborate with the diagnostics work stream on key issues such as how to treat patients with a negative test result;
2. **Common challenges specific to CCM**: e.g. staff/volunteer motivation, working with different cadres of staff/volunteers;
3. **Policy environment issues:** e.g. coverage, CCM provides access to those living beyond the 5km catchment area of a health centre, but there is an issue when people within the 5km zone are not covered;
4. **mHealth**

Discussion:

- There was a discussion regarding the challenges of co-ordination and prioritisation of activities in the group, as Access is an extremely broad area. The group also need to **consider Access issues in the public and private sectors** as well as at community level.
- Members were requested to **communicate dates of relevant meetings/events** that are taking place to the group (e.g. meeting with NMCP representatives hosted by Novartis at the end of the month; there is another meeting in October organised by Sanofi Aventis)
- A **conference call** will be scheduled for week of **9th July 2012** for work stream members to further discuss these priority areas and develop activities for the 2013 work plan in more detail. In future work stream conference calls will be arranged quarterly.

16.3 Drug Resistance

Facilitated by Dr Sylvia Meek, Malaria Consortium, Work stream Co-focal Point

Planning for the latter half of 2012:

Activity 1: Develop consensus statement for RBM board advising GFATM TRP to require funded countries to track TES every 2 years as an indicator of performance:

- The statement was read out in the RBM board meeting held in Wuxi, P.R. China last year and reflected in the meeting minutes.
- The WHO GMP Malaria Policy Advisory Committee (MPAC) also communicated the requirement of 2 year efficacy testing to the Global Fund (GF).
- In response, Scott Filler at the GF agreed to take forward the initiative to include 2 year monitoring as an indicator that GF will track.
- This activity under the CMWG is therefore considered complete.

Activity 2: Collate existing sources of data on whole range of AM drugs registered/available in a limited number of countries

- The amount allocated (7,000USD) is not sufficient to make country visits.
- A useful exercise may be to develop a document that brings together information on products available in the market compared to those registered in a target number of countries, particularly those participating in the AMFm and where market data are already available.
- Moving forward in 2013, the CMWG could support WHO GMP to expand this database to eventually cover all countries and develop a mechanism to ensure it is continuously updated.

Activity 3: Develop consensus statement for RBM Board to reemphasize implementation of AMT ban

- AMT ban is already included in the ALMA and RBM score cards that relevant heads of state report back on every quarter. Almost all countries have either stated their intention to initiate a ban or already have a policy in place. The consensus statement for the board is therefore not as relevant, as the issues are less about willingness at a political level and more about implementation of the policy.
- The CMWG could instead support WHO in acquiring information on what is available on the market; WHO could enhance its mechanisms for informing manufacturers.

Activity 4: Develop a consensus statement for RBM Board to recommend drug quality assurance as a key component of minimizing resistance

- A statement had already been prepared and will be revisited by the group.
- A recent Lancet article (Poor-quality antimalarial drugs in south-east Asia and sub-saharan Africa (2012) *The Lancet Infectious Diseases*, 12 (6) 488-496) reviewed results of various drug quality studies, but the data were insufficient to draw conclusions about the production of substandard drugs. However, it attracted significant media attention and provides an opportunity to raise the profile of this issue internationally.
- There are resources available with more current data. WWARN maintains a database (http://www.wwarn.org/aqsurveyor/) that includes scientifically published information and media reports whenever this issue is raised. WHO resources on antimalarial drug quality are available at (http://www.who.int/malaria/diagnosis_treatment/quality/en/index.html). The CMWG would like to raise awareness of these resources.

Priority areas for the 2013 work plan:

1. Carrying forward Activity 2 and 3 from the 2012 work plan, as indicated above
2. Continuing advocacy and ensuring communication around drug resistance containment and management efforts
3. CMWG members are contributing to the TEG for GMP concerning antimalarial drug resistance (meeting next week)
4. Conference calls for the work stream to further develop the work plan

Link to presentation <Summary presentation of work stream planning>

16.4 General issues to be addressed by the CMWG 2012/2013

1. Review membership of the CMWG to ensure it reflects changing needs and priorities.
2. Liaise with the Procurement and Supply Management Working Group co-chairs and work stream focal points to agree the way forward with the Pharmacovigilance work stream.
3. Consider the CMWG role in assisting country partners to submit requests to the Chinese drug donation programme.
4. Strengthen engagement of the CMWG in other RBM mechanisms (i.e. SRNs, HWG, MERG, MiPWG, PSMWG). Include funds in the 2013 work plan to support co-chairs to attend the HWG meetings.

17. Session Six: Summary and Closure of the CMWG 6th Meeting

17.1 Summary of Follow up Actions:

Action Item:	Responsible:	By:
1. Work streams to submit to CMWG Co chairs & secretariat activities with budget to be completed by latter half of 2012.	Work streams WS focal points	13th July 2012
2. CMWG co-chair to contact WS focal points to discuss funding availability for 2012 by mid-July.	CWMG Co-chairs	Mid-July
3. Work streams to submit work plans including priority activities and indicative budgets to CMWG co-chairs and secretariat for 2013.	Work streams WS focal points	31st August 2012
4. CMWG co-chairs to follow up with PSMWG co-chairs and WS focal points to agree way forward with the Pharmacovigilance work stream	CMWG co-chairs	TBC
5. RBM secretariat to take forward co-chair election process	J. van Erps	TBC
6. **Next meeting February 2013.** Venue and dates to be confirmed.	CMWG secretariat	TBC

17.2 Closing remarks:

After more than 2 years, Dr Franco Pagnoni announced he is stepping down as Co-chair of the Case Management Working Group. Dr Pagnoni explained to WG members that new work obligations in the coming year will mean he is unable to dedicate the necessary time that co-chairing such a group requires.

RBM secretariat is responsible for organising the election of a new Co-chair. Each institutional core member will receive notification and be given 15 days to nominate a candidate and a further 15 days to vote. Votes are cast by secret ballot.

Dr Pagnoni thanked everyone for their support during his time in the role and will continue to participate as a member of the Expanding Access to Treatment work stream, once a new Co-chair has been elected. Dr Patrick Kachur, Roll Back Malaria secretariat and Malaria Consortium secretariat thanked Dr Pagnoni for his dedication and leadership during his tenure.

Annex 1: Agenda

The Sixth Meeting of the RBM Partnership
Case Management Working Group
11th-13th June 2012
Geneva, Switzerland
Agenda

Overall objectives of the meeting

1. To share knowledge and exchange experience with partners from around the world on all aspects of case management
2. To determine ways that the CMWG can improve the implementation of case management strategies in endemic countries to achieve GMAP Objective 1.

GMAP Objective 1: Reduce global malaria deaths to near zero by end 2015

Target 1.1 Achieve universal access to case management in the public sector.
By end 2013, 100% of suspected cases receive a malaria diagnostic test and 100% of confirmed cases receive treatment with appropriate and effective antimalarial drugs.

Target 1.2 Achieve universal access to case management, or appropriate referral, in the private sector. By end 2015, 100% of suspected cases receive a malaria diagnostic test and 100% of confirmed cases receive treatment with appropriate and effective antimalarial drugs.

Target 1.3 Achieve universal access to community case management (CCM) of malaria
By end 2015, in countries where CCM of malaria is an appropriate strategy, 100% of fever (suspected) cases receive a malaria diagnostic test and 100% of confirmed uncomplicated cases receive treatment with appropriate and effective antimalarial drugs, and 100% of suspected and confirmed severe cases receive appropriate referral and treatment.

Specific objectives of the meeting:

1. Update members on Case Management Working Group progress and key developments
2. Identify key issues and priorities in case management post 2011
3. Reach consensus on priorities for CMWG for 2012 and 2013
4. Review work stream 2012 work plans in light of revised GMAP targets
5. Develop work plans for 2013
6. Review the collaboration efforts between the CMWG and other RBM mechanisms and decide how these can be further improved to ensure a cost effective and coordinated RBM response to key issues, particularly the likely reduction in overall funding for malaria programmes

Expected outputs:

1. Shared understanding of current issues relating to case management
2. Identification of priorities and development of CMWG roadmap for 2012-2013
3. Updated CMWG work plans for 2012-13 that address GMAP objectives
4. Improved and effective coordination between the CMWG and other RBM mechanisms

DAY ONE:	Monday 11th June 2012	
13.30 – 14.00	**Registration**	
Session 1	**Introduction to the 6th CMWG meeting (Chair: P. Kachur/F. Pagnoni)**	
14.00 – 14.15	**Welcome and introductions**	*P.Kachur/F. Pagnoni*
14.15 – 14.30	**Introduction to RBM Objectives and Targets till 2015**	*T. Teuscher*
14.30 – 15.00	**Background and objectives of the meeting**	*P. Kachur/F. Pagnoni*
15.00 – 15.30	***Coffee Break***	
Session 2	**CMWG Progress Reports from Work streams (Chair: P. Kachur/F. Pagnoni)**	
15.30 – 16.15	**Progress Report: Diagnostics**	*L. Barat*
16.15 – 17.00	**Progress Report: Expanding access to effective treatment**	*S. Downey*
17.00 – 17.45	**Progress Report: Drug resistance**	*S. Meek/P. Ringwald*
17.45 – 18.00	**End of Day 1**	

DAY TWO: Tuesday 12th June

Session 3 Update on Key Malaria Case Management Themes (Chair: P.Kachur)

Key partners working on specific themes have been invited to give short presentations (10 min) to stimulate a general discussion. The objective is to give everybody the chance to express their views on the theme and reach a consensus within the CMWG.

09.00 – 09.30 **Theme 1: The use of diagnostics in the private sector**
Invited Presenters: *Elizabeth Streat (Malaria Consortium)*
Nora Petty (Clinton Health Access Initiative)

09.30 – 10.00 **Theme 2: WHO Global Malaria Programme's T3: Test. Treat. Track. Initiative**
Invited Presenters: *Robert Newman (WHO/GMP)*

10.00 – 10.30 **Theme 3: Integrated Community Case Management of Childhood Illness**
Invited Presenters: *Cathy Wolfheim (WHO) on behalf of the iCCM taskforce*
Ngashi Ngongo (UNICEF)
Yves Cyaka (Population Services International)

10.30 - 11.00 ***Coffee Break***

11.00 – 11.30 **Theme 3 cont.: Discussion on Integrated Community Case Management**

11.30 – 12.00 **Theme 4: Information session on Seasonal Malaria Chemoprevention and its implications for case management**
Invited Presenters: *Peter Olumese (WHO/GMP)*

12.00 – 13.00 **Theme 5: Severe Malaria**

- Feedback from WHO GMP on progress with the update of severe malaria guidelines
- Challenges of implementing the new guidelines for treating severe malaria
- The use of rectal artesunate

Invited Presenters: *Peter Olumese (WHO/GMP)*
Penny Grewal Daumerie /Renia Coghlan (MMV)
Martin De Smet (MSF)

13.00 – 14.00 ***Lunch***

14.00 – 15.30 **Theme 6: The global landscape for malaria control: opportunities and challenges for malaria case management.** Panel discussion moderated by Patrick Kachur

Invited Panel members: *Andrea Bosman (WHO/GMP)*
Josephine Namboze (WHO/AFRO)
Nora Petty (Clinton Health Access Initiative)
John Sande (Malawi NMCP)
Po Ly (Cambodia NMCP)
Benjamin Matindii Atua (DRC NMCP)

- Challenges of implementing and scaling up an effective case management programme in the current financial climate and decreased Global fund resources
- How can malaria programmes be made more cost effective including broad areas for prioritisation
- How to expand community and private sector delivery in light of reducing funds
- AMFm in the context of the global landscape for malaria control

15.30 – 16.00 ***Coffee Break***

16.00 - 16.30 **Decreased funds and the position of the CMWG** *J. Van Erps*

16.30 – 17.15 **Theme 7: Pharmacovigilance** *P.Kachur*

- The role of the CMWG in PV – possible creation of a PV work stream
- The PV work stream in the PSMWG *S. Pal*
- Focal point/s and members of the group

17.15 – 18.00 **Case Management Indicators** *R. Cibulskis/ P. Kachur*

- Update on progress from the Monitoring & Evaluation Reference Group

18.00 **Evening Reception**

DAY THREE:	Wednesday June 13th	
Session 4	**Harmonisation (Chair: F. Pagnoni)**	
08.30 – 09.30	**Harmonisation with other RBM mechanisms** • Harmonisation between work streams and other working groups • Harmonisation with external partners and stakeholders Invited Presenters: *CMWG Co-Chairs and Work stream focal points* *P. Olumese (Harmonization Working Group)* *V. Mangiaterra (Malaria in Pregnancy Working Group)* *R. Cibulskis (Monitoring & Evaluation Reference Group)* *Procurement & Supply Management Working Group*	
Session 5	**CMWG Work Plans (Chair: P.Kachur)**	
09.30 – 10.30	**Work stream break out to discuss activities and dissemination of products** • Work plan for 2012/2013 • Identify activities which can be delivered • Modes of dissemination of products	
10.30 – 11.00	***Coffee Break***	
11.00 – 12.00	**cont.: Work stream break out to discuss activities and dissemination of products** • Work plan for 2012/2013 • Identify activities which can be delivered • Modes of dissemination of products	
12.00 -13.00	***Lunch***	
13.00 – 15.00	**Presentation and discussion of work stream work plans** • Diagnostics • Expanding access to effective treatment • Drug resistance • General discussion	*L. Barat* *S. Downey* *S. Meek/P. Ringwald*
15.00 -15.30	***Coffee Break***	
Session 6	**Summary and Closure of the CMWG 6th Meeting (Chair: F. Pagnoni/P.Kachur)**	
15.30 – 16.45	**Summary of the CMWG Meeting** • Key priorities post 2012 • Identify next steps • Date of the next meeting	*P.Kachur/F. Pagnoni*
16.45 – 17.00	**Closing Remarks**	*P.Kachur/F. Pagnoni*
17.00	**Close of the 6th CMWG Meeting**	

Annex 2: Referenced Resources

WHO GLOBAL MALARIA PROGRAMME'S T3: TEST.TREAT.TRACK. INITIATIVE

T3 launch and T3 brochure
http://www.who.int/malaria/test_treat_track/en/index.html
http://www.who.int/malaria/publications/atoz/test_treat_track_brochure.pdf

WHO CORE DOCUMENTS

Universal Access to Malaria Diagnostics Testing: An operational manual 2011
http://whqlibdoc.who.int/publications/2011/9789241502092_eng.pdf

Guidelines for the Treatment of Severe Malaria
http://whqlibdoc.who.int/publications/2010/9789241547925_eng.pdf

Disease Surveillance for Malaria Control
http://whqlibdoc.who.int/publications/2012/9789241503341_eng.pdf

Disease Surveillance for Malaria Elimination
http://whqlibdoc.who.int/publications/2012/9789241503334_eng.pdf

COMMUNITY CASE MANAGEMENT

CCMCentral website: *http://www.ccmcentral.com*

The CCMCentral website is a product of the **global iCCM Task Force**. The website aims to centralize resources, provide examples of best practices and give access to tools on planning, implementation and monitoring of community case management of childhood illnesses. It also provides a forum for answers to questions and discussions of challenges related to iCCM. The website is currently managed by the USAID flagship Maternal and Child Health Integrated Program (MCHIP).

Components include:

- Tools for Advocacy, Programming and M&E
- iCCM Benchmarks and Indicators
- Operations Research Information
- Links Compilation
- Documents Bank

WHO/UNICEF JOINT STATEMENT - Integrated Community Case Management (iCCM) – An equity-focused strategy to improve access to essential treatment services for children

This statement presents the latest evidence for integrated community case management (iCCM) of childhood illness, describes the necessary programme elements and support tools for effective implementation, and lays out actions that countries and partners can take to support the implementation of iCCM at scale.

CORE Group CCM Resources Page: *http://www.coregroup.org/our-technical-work/initiatives/ccm*

CORE Group: sign up to working and interest groups listservs aimed at sharing information on specific topic areas such as malaria, community child health, mHealth amongst others.

http://www.coregroup.org/get-involved/listserv-sign-up

Malaria Consortium – Innovations at Scale for Community Access and Lasting Effects (inSCALE): inSCALE aims to demonstrate that government led ICCM can be rapidly expanded without compromising on quality, leading to a sustained increase in the number of children receiving timely and appropriate treatment for diarrhoea, pneumonia and malaria. inSCALE is working to:

- Assess the feasibility of identified innovations and their acceptability among community members, CHWs, facility-based health workers, sub-national and national health authorities
- Evaluate innovations with the potential to increase coverage of ICCM and improve its quality through better CHW performance and retention
- Cost the innovations which demonstrate effectiveness in improving ICCM coverage and quality through better CHW performance and retention and investigate the potential for economies of scale and scope
- Promote implementation spread of ICCM by collaborating with ministries of health, sub-national health authorities and stakeholders, experiences and findings that improve coverage of ICCM and improve its quality.

Related reports and documents available at: *http://www.malariaconsortium.org/inscale/pages/research-and-publications/reports-and-documentations*

MHEALTH:

MHealth Alliance: championing the use of mobile technologies to improve health throughout the world *http://www.mhealthalliance.org/*

SEVERE MALARIA

WHO: *Guidelines for the treatment of malaria, second edition*
http://www.who.int/malaria/publications/atoz/9789241547925/en/index.html

WHO: *Guidelines for the treatment of malaria, second edition—Rev. 1*
The following sections, form 8.4 to 8.6 have been revised to reflect the change of treatment of severe falciparum malaria in children
http://www.who.int/malaria/publications/atoz/mal_treatchild_revised.pdf

MSF: *Malaria: Making the Switch:* This report highlights some of the important challenges in making the switch to artesunate for the treatment of severe malaria especially in children, and provides some recommendations for the way forward.
http://www.msf.org/msf/articles/2011/04/malaria-making-the-switch.cfm

WHO/MMV/MSF: *Saving more lives with artesunate injection:* Injectable Artesunate Stakeholders' Meeting Report Geneva,11th November 2011
http://www.msfaccess.org/sites/default/files/MSF_assets/Malaria/Docs/Malaria_Report_SavingMoreLives_ENG_2012.pdf

PHARMACOVIGILANCE

Malaria Pharmacovigilance toolkit
http://www.pvtoolkit.org/index.php?option=com_content&view=article&id=43&Itemid=50

Annex 3: Participant List

The 6th Meeting of the RBM Partnership
Case Management Working Group
11th-13th June 2012
Geneva, Switzerland
Participant List

	Institution	Names	Email	Work stream
1	RBM Executive Director a.i.	Thomas Teuscher	teuschert@who.int	
2	TDR (CMWG Co-Chair)	Franco Pagnoni	pagnonif@who.int	Expanding Access to Treatment
3	CDC (CMWG Co-Chair)	Patrick Kachur	spk0@cdc.gov	Drug resistance Expanding Access to Treatment
4	Core Group (Co-focal point)	Shannon Downey	sdowney@coregroupdc.org	Expanding Access to Treatment
5	USAID/PMI (Focal point)	Lawrence Barat	lbarat@usaid.gov	Diagnosis
6	WHO/GMP (Co-focal point)	Pascal Ringwald	ringwaldp@who.int	Drug Resistance
7	Malaria Consortium (Co-focal point)	Sylvia Meek	s.meek@malariaconsortium.org	Drug Resistance
8	Accordia Foundation	Kelly Willis	kwillis@accordiafoundation.org	Expanding Access to Treatment
9	ACT Consortium	Toby Leslie	Toby.Leslie@lshtm.ac.uk	Diagnosis
10	CDC	Laura Steinhardt	iyp6@cdc.gov	Expanding Access to treatment
11	CDC	Eugenie Poirot	irh9@cdc.gov	Expanding Access to Treatment
12	Clinton Health Access Initiative	Alexandra Morris	amorris@clintonhealthaccess.org	Diagnosis
13	Clinton Health Access Initiative	Nora Petty	npetty@clintonHealthAccess.org	Diagnosis
14	Global Fund	Oluwatoyin Jolayemi	oluwatoyin.jolayemi@theglobalfund.org	
15	NMCP, Cambodia	Ly Po	poly@cnm.gov.kh	Expanding Access to Treatment
16	NMCP, DRC	Benjamin Matindii Atua	atuabenjamin@gmail.com	Expanding Access to Treatment
17	NMCP, Malawi	John Sande	jhsande@yahoo.com	Diagnosis
18	NMCP, Nigeria	Godwin Ntadom	ntadomg@yahoo.com	Diagnosis
19	Malaria Consortium	Elizabeth Streat	E.Streat@malariaconsortium.org	Diagnosis

20	Malaria Consortium	Kirsty Buchanan	k.buchanan@malariaconsortium.org	
21	Malaria Consortium	Prudence Hamade	p.hamade@malariaconsortium.org	Diagnosis / Expanding Access
22	Malaria Consortium (SuNMaP)	Ebenezer Baba	e.baba@malariaconsortium.org	Expanding Access to Treatment
23	Medical Care Development International	Luis Benavente	lbenavente@mcd.org	Diagnosis
24	Medicines for Malaria Venture	Renia Coghlan	coghlanr@mmv.org	
25	Medicines for Malaria Venture	Penny Grewal	grewalp@mmv.org	Expanding Access to Treatment
26	Medicines for Malaria Venture	Stephan Duparc	duparcs@mmv.org	
27	Médecins Sans Frontières	Martin De Smet	martin.de.smet@brussels.msf.org	Diagnosis/Expanding Access
28	Novartis	Paul Aliu	paul.aliu@novartis.com	Drug resistance
29	PSI	Yves Cyaka	ycyaka@psi.org	Expanding Access to Treatment
30	RBM Secretariat	Jan Van Erps	VanErpsJ@who.int	Diagnosis
31	RBM Secretariat	Magali Babaley	babaleym@who.int	Diagnosis
32	Sanofi-aventis	Andre Tchouatieu	Andre.Tchouatieu@sanofi-aventis.com	Expanding Access to Treatment
33	Swiss TPH Institute	Valerie Dacremont	Valerie.Dacremont@unibas.ch	Diagnosis
34	WHO/AFRO	Josephine Namboze	nambozej@zw.afro.who.int	Expanding Access to Treatment
35	WHO/GMP	Andrea Bosman	bosmana@who.int	Diagnosis
36	WHO/GMP	Peter Olumese	olumesep@who.int	Expanding Access to Treatment
37	WHO/GMP	Michael Lynch	lynchm@who.int	Diagnosis
38	WHO/GMP	Richard Cibulskis	cibulskisr@who.int	Co-Chair, RBM MERG
39	WHO/GMP	Robert Newman	newmanr@who.int	
40	WHO/MCA	Viviana Mangiaterra	mangiaterrav@who.int	Co-Chair, RBM MIPWG
41	WHO/TDR	Jane Cunningham	cunninghamj@who.int	Diagnosis
42	WHO	Shanthi Pal	pals@who.int	Pharmacovigilance WS, PSMWG
43	WHO	Cathy Wolfheim	wolfheimc@who.int	On behalf of iCCM task force
44	WWARN	Philippe Guerin	philippe.guerin@wwarn.org	Drug Resistance
45	LSHTM	Shunmay Yeung	Shunmay.Yeung@lshtm.ac.uk	Drug Resistance

Annex 4: CMWG Work plan and KPIs 2012

CASE MANAGEMENT WORKING GROUP WORK PLAN 2012				
Work stream	**Activity**	**Approved**	**SAF**	**Notes**
Diagnosis	Assist PSM Working Group to develop global forecast of RDT requirements	-	-	PSMWG
	Disseminate new and existing tools on diagnostic testing for malaria	-	9,750	
	Document (in 2 countries) and disseminate best practices for scaling up diagnostic testing	37,500	-	
	Develop guidance for scaling up diagnostics in the private sector	-	32,750	
Drug Resistance	Develop consensus statement for RBM Board advising GFATM TRP to require funded countries to track TES every 2 yrs as an indicator of performance	-	-	
	Collate existing sources of data on whole range of AM drugs registered/ available in a limited number of countries	7,000	-	
	Develop consensus statement for RBM Board to reemphasize implementation of AMT ban	-	-	
	Develop a consensus statement for RBM Board to recommend drug quality assurance as a key component of minimizing resistance	-	-	
Access	Write position paper directed towards the RBM Board and Partnership advocating for the rapid implementation of the updated WHO policy for management of severe malaria	-	-	
	In line with WHO policy recommendation/update on the management of severe malaria – develop related/addendum community-focused IEC/BCC guidelines/resources	-	3,020	
	Assess policy environment for CCM of malaria/iCCM in the 10 priority countries, diffuse lessons learned and actively advocate for positive policy changes in at least 3 target countries	-	22,010	
M&E	Development of "Case management and data quality indicators and methodologies for measurement	-	29,250	MERG
General	CMWG Secretariat costs	55,700	-	
	CMWG meeting 1/year	13,550	-	
WP TOTAL		**113,750**	**96,780**	

CASE MANAGEMENT WORKING GROUP KEY PERFORMANCE INDICATORS (KPIs) 2012									
GMAP* area	**No.**	**Output**	**Accountability level 1 KPIs- Impact**	**Accountability level 2 KPIs - Outcome**	**Accountability level 3 KPIs for Mechanisms**	**Means of verification**	**Baseline (1/1/12)**	**Target (Nov. 2012)**	**CMWG**
Disease Control	5	Country plans (strategic, operational and workplans) alligned with the Objectives, Targets of GMAP.	Global Impact:Number of malaria deaths (by region) – (near zero deaths: **Obj.1)** Number of malaria cases (by region) – (reduction of cases by 75% from 2000 levels **Obj.2)** Number of countries in the elimination phase that achieve 0 local transmitted infection (by region) – (10 new countries since 2008 in Europe **Obj.3)** Progress & Results in SSA*:Progress against universal access / coverage Reporting capability & Data quality	Proportion of countries and territories (107) with national malaria strategic plans aligned with GMAP	Proportion of country plans assessed to align with GMAP.	Strategic & operational plans validated at country level (Aide-mémoires) and global level, CMWG reports	17 countries	30 countries	$106,750
	9	GPARC implementation is monitored in public sector.		% of endemic countries with resistance monitoring activities	Number of countries implementing drug resistance containment plans	SRNs reports, RBM website, GMP website	0	Great Mekong region	$7,000
Activity Budget									**$113,750**