Refined/Updated GMAP Objectives, Targets, Milestones and Priorities Beyond 2011 [1]

Vision: Achieve a malaria-free world.

Objectives, Targets and Milestones

Objective 1. Reduce global malaria deaths to near zero[2] 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.

Milestone: none, as the target is set for 2013.

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.

Milestone: By end 2013, in endemic countries, 50% of persons seeking treatment for malaria-like symptoms in the private sector report having received a malaria diagnostic test and 100% of confirmed cases having received 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.

Milestone 1: By end 2012, all countries where CCM of malaria is an appropriate strategy have adopted policies to support CCM of malaria (including use of diagnostic testing and effective treatment).

Milestone 2: By end 2013, in all countries where CCM of malaria is an appropriate strategy, 80% of fever cases receive a malaria diagnostic test and 80% of confirmed cases receive treatment with effective anti-malarial drugs.

Objective 2. Reduce global malaria cases by 75% by end 2015 (from 2000 levels)

Target 2.1 Achieve universal access to and utilization of prevention measures[3].
By end 2013, in countries where universal access and utilization have not yet been achieved, achieve 100% access to and utilization of prevention measures for all populations at risk with locally appropriate interventions.

---

[1] As agreed upon by the RBM Board on 12 June 2011 based on the recommendations of the RBM Task Force on Priorities and Targets Beyond 2011.

[2] In areas where public health facilities are able to provide a parasitological test to all suspected malaria cases, near zero malaria deaths is defined as no more than 1 confirmed malaria death per 100,000 population at risk.

[3] Universal access to and utilization is defined as every person at risk sleeping under a quality insecticide-treated net or in a space protected by indoor residual spraying and every pregnant woman at risk receiving at least one dose of intermittent preventive treatment (IPTp) during each of the second and third trimesters (in settings where IPTp is appropriate).

Milestone: none, as the target is set for 2013.

Target 2.2 Sustain universal access to and utilization of prevention measures[3].
By 2015 and beyond, all countries sustain universal access to and utilization of an appropriate package of preventive interventions.

Milestone: From 2013 through 2015, universal access to and utilization of appropriate preventive interventions are maintained in all countries.

Target 2.3 Accelerate development of surveillance systems.
By end 2015, all districts are capable of reporting monthly numbers of suspected malaria cases, number of cases receiving a diagnostic test and number of confirmed malaria cases from all public health facilities, or a consistent sample of them.

Milestone: By end 2013, 50% of malaria endemic countries have met the 2015 target.

Objective 3. Eliminate malaria by end 2015 in 10 new countries (since 2008) and in the WHO Europe Region

Milestone: By end 2013, malaria is eliminated in 3 new countries.

Priorities

Priority 1: Accelerate progress and impact in countries with the highest burden of malaria-related deaths.

Priority 2: Fully implement the Global Plan for Artemisinin Resistance Containment (GPARC).

Priority 3: Develop and launch a Global Plan for insecticide resistance management in malaria vectors.

Priority 4: Revise GMAP for the years beyond 2015.

Assumptions

The Board recognizes that the objectives, targets, and milestones for 2012-2015 are aspirational but asserts that any effort short of achieving universal access to and utilization of available and effective preventive, diagnostic, and treatment measures is accepting continued intolerable suffering from malaria.

Sufficient and timely domestic and international funding is available to accomplish and sustain scale-up of the interventions needed to meet the objectives, targets and milestones.

Scale-up of preventive measures and greater access to diagnostic testing and treatment through the public and private sectors and community case management, along with referral when needed, are sufficient to allow effective treatment of all cases of confirmed malaria.

Political commitment to sustain malaria control interventions and high-quality surveillance - including the elimination of malaria where that is technically, operationally, and financially feasible - continues even as malaria cases and deaths decline significantly.

Access to vulnerable populations and the safety and security of health workers are preserved to ensure surveillance, outbreak response, and delivery of diagnostic, treatment, and preventive interventions to populations in fragile and conflict-affected states.

Annex 1: Report on the work carried out by the RBM Task Force on Priorities and Targets Beyond 2011

1. Introduction

1.1 At its 19th meeting in December 2010, the RBM Board decided to create a Task Force chaired by the Bill and Melinda Gates Foundation and by the World Health Organization with the objective of producing recommendations on specific targets for the second phase of implementation of the Global Malaria Action Plan (GMAP). The Board provided guidance that the Task Force's work would end with the submission of a report, at which point any outstanding activities might be absorbed into other existing mechanisms.

1.2 The Task Force met on 13 January 2011 and held teleconferences on 9 February and 10 March 2011. The Task Force submitted its recommendations on refined GMAP Objectives, Targets, Milestones and Priorities to the Board in May 2011. Based on the Board's request, the Task Force made subsequently some changes to the Objectives, Targets, Milestones and Priorities and re-submitted them to the Board, which approved them by electronic vote in June 2011.

1.3 This report reflects the discussion and the consensus reached by the Task Force through these consultations.

2. Review of draft Terms of Reference; Clarification on the scope of work of the Task Force

2.1 The Task Force, based on the analysis of the existing framework of objectives, targets and priorities of the GMAP, decided that there was a need for clarifying and making consistent the terminology in the framework, in order to make it more suitable for the challenges ahead in the second phase of the GMAP implementation from 2012 to 2015.

2.2 The Task Force recognized that reviewing and making a recommendation on how to refine the framework would be its key deliverable. This exercise could be used as a reference for the work of the Performance Work Stream of the Finance and Performance Committee, the 2010 Progress and Impact Oversight Committee and other RBM Mechanisms in developing the 2012-2013 and 2014-2015 Partnership Work Plans and related Key Performance Indicators.

3. Review of the GMAP Targets and Priorities.

3.1 A clarification was recommended on the terminology used to define the various components of the GMAP framework. The Task Force concluded by distinguishing between the GMAP Vision (highlighting the long-term goal of achieving a malaria-free world), the (impact) Objectives, the (outcome) Targets, related Milestones (or intermediate targets at mid-way) and cross-cutting Priorities (areas of special attention to achieve milestones, targets and objectives).

3.2 In addition to organizing the old GMAP targets in a clearer and more logical structure, and to defining a set of related milestones, the Task Force identified four high-level, cross-cutting priorities in order to concentrate efforts in pursuing the GMAP objectives.

3.3 During the discussion that unfolded, general comments were made on:

3.3.1) Population growth. It was noted that the expected population growth in malaria-affected countries should be factored in when defining the objectives, targets and milestones, because of the significant impact that demographic changes may have on the malaria control and elimination efforts. Burden estimates should therefore be adjusted to account for population growth.

3.3.2) Funding. Assessing and filling the financial gap from different sources, while not a GMAP objective/target in itself, was recognized as an essential requirement to achieve the GMAP objectives. Fundraising challenges and opportunities are expected to be addressed in the work of the Sub-Committee on Resource Mobilization and to be a key component of the Partnership Work Plan.

3.3.3) Return on investment. The issue was raised as to how best to communicate the return of the investment on malaria - e.g. in terms of impact on health systems, on the gross domestic product, on education and on maternal and child health. It was considered that the positive impact of malaria control on health system strengthening would be expected to be dealt with in the context of the ongoing work of the 2010 Progress and Impact Oversight Committee, when looking at how to communicate in the most compelling way the results and

impact of the GMAP for advocacy purposes. This should include, for example, reference to the fact that the ability of health care providers at health facilities and communities to deliver commodities, such as nets, diagnostics and effective treatment, and the ability of district health management teams to track malaria burden and plan and coordinate efforts, is being strengthened by the increased funding and infusion of training and resources for malaria. In this way, malaria should be viewed as an entry point for health system strengthening.

3.3.4) Mid-term review. It was decided that it would be advisable to identify a mid-way point to assess progress made towards the 2015 objectives. The Task Force concluded that 2013 could be a good date for a mid-term evaluation, and 2014 to begin a general review and updating of the GMAP, based on the review of the recommended technical strategies to be conducted by the WHO Global Malaria Programme in 2013, and considering that reviews are also planned in 2013 by the Global Fund, the United Kingdom (mid term review of the implementation of the Framework for Results for Malaria, with an evaluation expected in 2015) and the US President's Malaria Initiative. The aim would be to have a revised GMAP for the years beyond 2015 aiming at progressive elimination in more countries and eventual global eradication.

3.4 Comments were also made by the Task Force's members on the various objectives:

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

3.5 The Task Force decided that the objective originally stated in the GMAP should be made more precise as compared to the original GMAP formulation "Reduce global malaria deaths from 2000 to near-zero preventable deaths in 2015", though it recognized the conceptual and methodological complexities behind the definition of this objective.

3.5.1 Some participants advocated for maintaining the word "preventable" as part of this objective, as the intention when the objective was originally developed as part of the GMAP process had been to reduce mortality to near-zero deaths in health facilities, and not to reduce all deaths to near zero, as this was not seen to be possible by 2015, given poor access to health facilities in many countries. As originally worded in the GMAP, "near-zero preventable deaths" from malaria is potentially in line with the objective from the World Health Assembly that calls for a 75% reduction in malaria deaths by 2015 when compared with 2000. On the other hand, it was commented that all deaths from malaria are preventable, and so this word should be dropped.

3.5.2 The comment was also made that the objective of “zero deaths” was powerful for advocacy with the general public, and, as such, it had been promoted by both the UN Secretary General and the UN Special Envoy for Malaria. However, the Task Force discussed how the measurement of the achievement of zero/near-zero deaths was challenging, since systems of malaria death reporting are weakest where the malaria burden is the highest. Hence, all available data sources should be examined (health facilities, vital registration, and demographic surveillance sites) as well as estimates developed through modeling. Considerable concern was expressed as well on the fact that achieving near-zero deaths could not happen if business were to proceed as usual, even if scale-up were to continue at its current pace of rapid increase. Instead, achieving a goal of zero deaths would require an enormous mobilization of human and financial resources across the malaria endemic world, not only to achieve and maintain universal coverage targets, but also to provide universal access to health services.

3.5.3 It was decided that WHO would lead a discussion with a small task team to identify parameters for the definition of the concept of "zero/near-zero" deaths. A discussion took place at the Monitoring and Evaluation Reference Group's Household Survey Task Force on 5-6 April 2011. Taking into account the complexities of this measurement and the limitations of many vital registration systems, the Task Force concluded that near-zero deaths could be defined as around 1 confirmed death per 100,000 population.

3.6 The Task Force recommended three targets that would capture the need for strengthening countries' accountability with regard to diagnosis and treatment, and highlight the gaps that need to be filled in the public sector, in the private sector and at the community level. At all levels, the need was stressed to pay special attention to the challenge of managing or, when relevant, ensuring appropriate referral of, severe and complicated cases of malaria:

3.6.1) Public sector: the target should be universal access to diagnostic testing and treatment for confirmed malaria. The comment was made that reaching this target was challenging, as only a few countries in Africa have achieved nation-wide scaling up of universal diagnostic testing prior to treatment of confirmed cases with artemisinin-based combination therapy. Mention was made of the role of health system strengthening in supporting the achievement of universal access to diagnosis and treatment in the public sector, as well as the role of malaria control in strengthening health systems.

3.6.2) Private sector: this should focus initially on the formal private sector, as comments were made on the challenge of capturing the (relevant) role of the informal private sector, in which it is difficult to assess compliance and performance towards the GMAP objectives.

3.6.3) Communities: a key target will be wide-scale use of community-based diagnosis and treatment, which has proven successful in several countries, especially in Africa. It was emphasized that appropriate pre-referral treatment and referral of severe and complicated cases should be highlighted as a key element of community case management.

Objective 2. Reduce global malaria cases by 75% by end 2015 (from 2000 levels)

3.7 It was agreed that scaling up prevention would be key to achieve this objective. Accordingly, the Task Force identified three targets to apply in all malaria-affected countries:

3.7.1) Achieve universal access to and utilization of preventive measures for all populations at risk where not yet achieved. This would be achieved through expansion of coverage with Insecticide Treated Nets (ITNs), Indoor Residual Spraying (IRS), Intermittent Preventive Treatment (IPT) – IPTp, IPTi, IPTc, as appropriate, and other tools, such as larvicides where local evidence exists to support their use;

3.7.2) Sustain universal coverage with preventive measures where universal coverage has been already achieved (including timely and continuous replacement of worn ITNs);

3.7.3) Accelerate development of surveillance systems that can document progress towards the objective and enable partners to address constraints in a timely manner. In addition to better reporting of suspected and confirmed malaria cases, it was suggested that surveillance strengthening should also include treatment follow-up to detect different malaria strains, such as resistant parasites, as well as socio-anthropological research to improve prevention approaches. It was stressed again that the improvement of health systems is a requisite for ensuring the impact of national programs.

Objective 3. Eliminate malaria in 10 new countries (since 2008) and in the WHO Europe Region by end 2015.

3.8 The Task Force decided that this objective would also be considered as a target, and recommended adding reference to the elimination of malaria in the WHO Europe Region, which has the stated objective of eliminating malaria by 2015 and is making steady progress.

Annex 2: Glossary of planning terminology used by the Task Force on Priorities and Targets Beyond 2011

Activity: Structured undertaking of limited duration and narrow scope. It mobilizes inputs such as commodities, technical assistance, training or resource transfers in order to produce specific outputs that will contribute to achieving an objective[4].

Goal: Broad, general results to be achieved by the end of a planning period.

Impact: Impact refers to the effects, usually medium and long-terms, produced by a project/ program. The impact can be intended or unintended, positive and negative[4].

Input: A resource, such as technical assistance, commodities, training, or provision of staff that is used to create an output[4].

Key Performance Indicator (KPI): Quantifiable measurements on characteristics/dimensions critical for success of an organization or a project. KPIs are used to observe progress and to measure actual results compared to expected results. Performance indicators help answer how or if there is progress towards the objective(s), rather than why such progress is or is not being made[4].

Milestone/Intermediate Target: Points in time when progress against a target can be 'measured'.

Measure: Quantifiable component, usually expressed as a number and/or a percentage.

Objective: The result that an organization, a team, or a person can materially affect, and for which it can be held accountable[4].

Outcome: A higher level or end result at the objective level. An outcome is expected to have a positive impact on and lead to change in the development situation[4].

Output/ Deliverable: A tangible, immediate, and intended product or consequence of an activity within the organization's control[4].

Priority: Area requiring special attention in moving towards milestones, targets and objectives

Resource: Personnel, materials, equipment, supplies, and support services that are assigned to each of the activities in a project plan. Along with the schedule, they are the basis for creating the project budget.

SMART: An acronym to test whether objectives are Specific, Measurable, Actionable, Realistic and Time-bound.

Target: Specific, planned level of result to be achieved within an explicit timeframe[4].

Vision: An organisation's strategic aspiration for the future (very long term goals).

[4] Source: USAID: ADS Chapter 200, Introduction to Programming Policy, Revision Date: 04/02/2010, http://www.usaid.gov/policy/ads/200/200.pdf