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ROLL BACK MALARIA AND MAINSTREAMING OF ANTI-MALARIA ACTIVITIES IN HEALTH SECTOR DEVELOPMENT

CONTENTS

Executive Summary

Roll Back Malaria is a global initiative against malaria implemented through health sector development that could foster broad-based support for effective anti-malaria intervention to achieve sustainable reduction in malaria cases, especially among the poor who have little access to health services.

As different from previous approaches to malaria control, RBM, as a social movement for better health, draws its strength through improved health sector development. This would facilitate the mainstreaming of malaria control activities into the health system, integrate its implementation through the provision of health care to the poor in a package delivering care, combined with other common diseases and linked with other health programmes.

Under the Ten Guiding Principles, RBM utilizes the existing infrastructure and available resources for malaria control to implement *the Six Strategies of RBM* in the SEA Region:

- Enhanced diagnosis and treatment of malaria (e.g. new diagnostic test, universal access to treatment, combination drugs)
- Disease transmission control (cost-effective integration of vector control tools, e.g., insecticide treated nets, selective vector control, bio-environmental methods)
- Enhanced surveillance (rapid response, policy making, border malaria, and monitoring progress)
- Health sector development (e.g., decentralization, health equity, package delivering care, changing role from implementers of malaria control to leadership, regulation and coordination).
- Community mobilization (empowerment of communities, evidence-based planning and ownership).
- Advocacy (forum for advocacy, strategic investments e.g., mapping, new drugs and vaccines, regional support networks e.g. drug policy, rapid response, etc., health impact assessment, research on reform in health system).

RBM Action Plan envisages political commitment at all levels starting at the highest level of governance. RBM functions through partnerships from the central to the local level and works in synergy based on an Action Plan developed and owned by all partners. The action plan for Roll Back Malaria is as follows:

- A preparatory phase of six months (ending 1999) for advocacy, establishment of partnerships and resource networks, mainstreaming RBM in the health system, and selection of endemic districts representing important malaria paradigms.
- A two-year (2000-01) period of piloting of RBM in selected districts and towns.
- Adoption of a countrywide RBM plan by all countries as a means of improving and reducing malaria-related mortality by half by 2010 and reducing it further in succeeding years.

1. INTRODUCTION

The fact that the poor and those with little access to health care are most affected, malaria is now seen as a developmental and poverty issue. Therefore, the RBM concept and partnership in malaria control as a social movement for better health should be addressed as an integral part of health sector development.

Further, the success of malaria control action will require a political commitment, establishment of a sound legislative foundation to control malaria, optimal use of available resources, establishment of intersectoral linkages, community empowerment, involvement of the private sector/NGO and other health-related programme. The district health system approach and decentralization of decision-making should form the strength of malaria control. Border malaria, multidrug-resistant malaria, population migration, urban malaria etc., are important issues that need to be addressed.

The Intercountry Meeting of National Malaria Programme Managers in Pattaya, Thailand, 22 – 27 February 1999, and the Meeting on Implementation of Collaborative Activities on Roll Back Malaria, held in New Delhi from 4-6 May 1999, concluded that mainstreaming of RBM into health sector development would enhance efforts in achieving the objectives of malaria control.

2. BACKGROUND

In the SEA Region, the overall malaria situation has remained almost static during the last decade with around 3 million confirmed cases annually. Distribution of malaria cases has been uneven and about 10% of the population is exposed to the risk of drug-resistant malaria. Malaria in Asia causes high morbidity, resulting in reduced productivity, loss of family income with impact on economy in general. Death rate is lower compared to Africa but it affects all age groups. In this Region, India contributes 80% of the cases while more than 65% of the deaths occur in Myanmar.

Appreciating the global concern about the deteriorating malaria situation, a Ministerial Conference on Malaria, held in Amsterdam in 1992, endorsed the WHO *Global Malaria Control Strategy* (GMCS). GMCS was subsequently endorsed by the Economic and Social Council (ECOSOC) of the United Nations in 1995, and adopted by the Member Countries.

Dr Gro Harlem Brundtland, Director-General of WHO, initiated a new effort in May 1998 to *Roll Back Malaria* (RBM). RBM envisages better access to malaria interventions to millions of women, children and men, who suffer from poor health equity. Further, RBM draws its strength from past experience with emphasis on partnership, research groups, evidence-based action, political support and civil society organizations. Mortality due to malaria is expected to be halved by 2010 with sustained reduction in the succeeding years and the resultant disease burden due to associated diseases. During 1999, this initiative has been endorsed by resolutions EB103.R9 and WHA52.11.

To make a difference for the prospects of poor people, the focus would be on interventions that could achieve the greatest health gain possible. It would mean that during the implementation process, RBM will be guided by the following principles:

Box 1: Ten Guiding Principles for RBM

- RBM is a social movement supported by many partners, to reduce poverty and promote development.
- RBM is owned by all the partners
- Decisions are made by consensus
- Country priorities drive RBM
- Partners function independently, but in concert
- Partners contribute where they have a comparative advantage - or interest
- Action plans are clear, evidence based, prioritized and adapted to local realities
- RBM is about broadening and strengthening the capacity of health sectors to fight all diseases
- RBM is not a new agency or funding institution
- Mainstreaming of RBM in the health system cannot be judged to be functioning unless they have an impact on malaria.

In recognition of the fact that malaria is still a major public health problem, the governments in the South East Asia Region spend large sums of money on malaria control. Member Countries managed to shift malaria control from autonomous disease control programme by integrating it into the general health services. There is still a need to ensure appropriate priority and effective action to address malaria, within the context of health sector development. With the new emphasis on health-led development, it will require new ways of working and changes in the way resources are used. Therefore, RBM is relevant to SEA countries.

3. OPERATIONALIZATION OF RBM

The operationalization of RBM would be based on the following six strategies: (1) enhanced diagnosis and treatment, (2) disease transmission control, (3) enhanced surveillance, (4) health sector development, (5) community mobilization, and (6) advocacy. The health sector and national partners assume the responsibility to carry out situation analysis and to prepare RBM joint action plans at district, provincial and national levels, as appropriate.

3.1 Enhanced Diagnosis and Treatment of Malaria

(1) Early Detection and Prompt Treatment (EDPT)

New techniques, such as rapid antigen diagnostic tests, should be introduced on an operational scale in certain epidemiological settings. RBM should ensure universal access of drugs to the populations at risk, which means appropriate and affordable first-line

anti-malarial drugs and effective second-line treatment at the periphery level. Access to health care should also mean access to other effective anti-malaria measures, particularly reduction of transmission. Development of new drugs and drug combinations are needed to combat resistant malaria so as to prolong the life of existing drugs.

(2) Improving access to health care

Because of the poor quality of public sector facilities and the lack of public confidence, *private sector* plays a dominant role in treatment. There is thus a need for an effective regulatory function to protect public health interest and secure the quality of service rendered by the private sector.

(3) Drug resistance

The epicentre of multidrug-resistant strains in Thai-Cambodian and Thai-Myanmar areas along the international borders are considered a threat to the world as a potential source of multidrug-resistant malaria.

Assessment of the changing patterns of drug resistance through monitoring of therapeutic efficacy of anti-malarial drugs by using the WHO protocol should be conducted at regular intervals, particularly when drug failures are reported by clinicians.

3.2 Disease Transmission Control

Under RBM, countries should adopt a truly integrated vector management (IVM) approach and apply the best practices (Box 2) for sustainable transmission reduction.

Box 2: Application of Best Practices

- Expanding the use of GIS (geographical information system) and RS (remote sensing) for the monitoring of critical environmental determinants of malaria transmission risk.
- Obtain government commitment for IVM as best practice in vector control, including malaria in health sector development and intersectoral action.
- Strengthening of local environmental health services, where applicable, to perform essential functions in support of integrated vector management.
- Give ministries of health the proper regulatory powers within an effective legal framework, to ensure that other sectors comply with their responsibilities in risk management.
- Pursue an active partnership with the District Development Officer to achieve intersectoral action at the district level.

The process of IVM intervention should use evidence-based decision-making criteria to arrive at the most cost-effective mix of vector management methods. Methods should include the use of ITN, biological control and environmental modification.

3.3 Enhanced Surveillance

(1) Malaria epidemics

Prediction of and early response to epidemics in unstable malarious areas should be a national priority. Early recognition of epidemics is important in mobilizing resources to prevent deaths. Box 3 gives the core indicators to assess morbidity and mortality due to malaria on a continuing basis.

(2) Monitoring of drug resistant malaria

Regular assessment of changing pattern of drug resistance should be the basis for drug policy to ensure effective treatment for malaria.

(3) Border malaria

Synchronized control strategies. Malaria along international borders is a serious problem. Malaria control along the borders would greatly benefit from partnership under RBM through a dialogue with neighbouring countries to act jointly in a synchronized intercountry malaria control strategy.

(4) Monitoring progress

Box 3: Core Standard Indicators

Impact Indicators

(1) Morbidity attributed to malaria

- Number of cases of UM (clinical/confirmed) among target groups/unit population
- Number of cases of SM (clinical/confirmed) among target groups/unit population
- Number of MTF/per No. of treated patients. Reported according to each drug used

(2) Mortality attributed to malaria

- Number of malaria deaths (clinical/confirmed) among target groups/unit population
- Proportion of clinical/confirmed deaths due to malaria among patients with SM admitted to a health facility

Outcome and Output Indicators/Operational Indicators

(1) Management of antimalarial drugs (percentage of health facilities reporting no rupture of stock of antimalarial drugs during the past three months)

(2) Reporting coverage (percentage of districts regularly reporting the above to the national programme on a monthly basis for the past 12 months)

(3) Universal access to effective treatment (percentage of priority areas having access to treatment and referral system)

(4) Target population under personal protection (percentage of population in priority areas under personal protection)

(5) Rapid response team (percentage of priority districts having early warning system and trained rapid response teams)

UM: uncomplicated malaria, SM: severe malaria, MTF: malaria treatment failure

3.4 Health Sector Development

(1) RBM is a social movement for better health

RBM, as a social movement for better health, should focus on providing access to the poor who suffer from malaria the most. Therefore, RBM should be a part of poverty alleviation action. The community and the private sector would have the opportunity to play important roles in the delivery of effective anti-malaria interventions, particularly in primary prevention and treatment of malaria. As a consequence, RBM should also be part of the changing role of malaria control programme – from being a delivery agent to leadership, coordination and regulatory function. Quality control and standard setting should remain the responsibility of the government.

(2) Mainstreaming RBM

The RBM initiative has recognized the need to adhere to principles of decentralization and local ownership of health programmes as basic principles in health sector development.

RBM should be an integral part of health sector development and work through the primary health care (PHC) system for effective action against malaria. This will involve transfer of resources, delegation of authority to district or sub-district levels and empowerment of local authorities and communities to identify needs and priorities. Strengthening of health sector development would facilitate mainstreaming of RBM and benefit other health programmes.

(3) Strengthening district health system

RBM's managerial capacity should be the lead in developing district action plan in line with the package concept of health care. Information, education and communication (IEC) activities should be intensified for both the people and providers at all levels, and decentralized planning based on partnerships should lead to proactive action and optimal utilization of resources.

3.5 Community Mobilization

The programmes should address health issues arising through enhanced community awareness and knowledge about disease prevention, diagnosis and treatment, as well as through local operational research activities. Bottom-up planning should be the core principle where decision-making and planning capacity will be based at the level where the problem occurs i.e. local-level planning, disease surveillance, monitoring of programme activities, resource allocation, IEC, training, vector control etc. Epidemiological information would be analysed at the local level for proactive action in developing evidence-based planning. However, national-level competence and coordinating functions should be retained or developed at the central level during the process of decentralization and thereafter.

3.6 Advocacy

Creation of a forum for joint advocacy and resource mobilization as a common ground to bring malaria to the forefront in health sector development. The forum would institutionalize a mechanism for maintaining partnerships aimed at agreed joint action plan and implemented in a concerted effort, exploring the possibility of redirecting some resources and giving access to those who need them.

4. REGIONAL SUPPORT NETWORKS

4.1 The Assets

The SEA Region has a strong infrastructure available for the implementation of RBM, as for example:

- indigenous production of insecticides, drugs, mosquito nets, equipment, transport;
- training facilities for all categories of health staff and other functionaries;
- experienced technical personnel in malaria control and related areas;
- well-developed grassroots health infrastructure
- advanced centres of basic, applied and field research;
- a network of educational and research institutions, colleges, universities;
- W H O collaborating centres;
- indigenous resources to sustain the RBM initiative.

4.2 Support Networks

(1) Technical support

To countries to address core issues, review, monitor and act as channel of information on priority issues such as:

- drug policy and monitoring drug efficacy;
- monitoring and evaluation of surveillance systems and epidemic preparedness and response;
- disease transmission control, and
- advocacy through media communication and country partnerships.

(2) Regional network for rapid responses

In case of emergencies/epidemics, regional support network provides assistance with emphasis on surveillance system, reviews of epidemics, dissemination of information, and provision of emergency supplies.

(3) Strategic investments

New areas of strategic investment should be closely linked with partnership initiative as to ensure concerted and sustainable efforts for RBM. The areas identified include the following:

- Regional networks that will support multi-centre studies and fund-raising advocacy to facilitate vaccines and new drugs development research and operational research. Health policy research, such as socioeconomic research on malaria integrated intervention and sustainable strategies; health indicators (incorporating malaria) for situation analysis and rapid response incorporating information technology; GIS (and possibly remote sensing) for analysis of the epidemiological and ecological situation, including mapping of drug resistance based on monitoring therapeutic efficacy.
- Utilization of health impact assessment in projects and mitigating strategies in the improvement of health and research on reforms in health systems for planning and implementation of RBM.
- There is an urgent need for more coordinated work in search of new drug with partners e.g., the industry, UN Agencies (WHO, UNICEF) World Bank, research organizations, etc. WHO should take the lead in negotiation with RBM partners in the industry to convince them to make available the techniques at an affordable price for developing countries.

5. INITIATING RBM ACTION AT COUNTRY LEVEL

National commitment for action against malaria would indicate RBM is instrumental in reducing inequity and promoting human development through mobilization of all resources.

Policy-making. National governments determine the goals, strategy, organization and operating procedures for RBM. RBM involves a situation analysis and strategy development, a process led by national authorities and involving partners. Action against malaria mainstreams into the health system with partners in RBM providing support within the context of sectorwide approach to health development. RBM should now be seen as a social movement for better health. Instead of being sole implementers, the National Malaria Control Programme should *assume a new role* of leadership, regulation and coordination.

Working with partners. Working in partnership for common objectives, using agreed strategies in a transparent manner with emphasis on local solutions to local problems. Within the context of these principles, attempts are made to ensure that partners have sufficient flexibility and autonomy to make the fullest possible contribution in a concerted effort to RBM. WHO will establish a functioning partnership with a range of organizations at global, regional and country levels. This will result in the development of a sustained capacity to address malaria (and other priority health problems). WHO's partnership in RBM will include malaria endemic countries, UNDP, UNICEF, World Bank, bilateral development agencies, nongovernmental organizations (NGOs) and the private sector.

Improve access to health care. Wider distribution of anti-malarial (first-line) drugs through public and private sectors would reduce morbidity and mortality due to malaria. Efforts to educate communities and individuals in the home treatment of malaria and on strengthening support and supervision of treatment services, collaboration with professional associations for quality assurance would prove rewarding and should be encouraged under

RBM. Realizing that malaria is the disease of the poor who have little access to health services, RBM should be considered as one of the priority areas in providing health care to the poor. In this case, provision of health services should be a package delivering care to other common diseases affecting local communities, such as anaemia, acute respiratory infection, diarrhoea and intestinal worms, and it should be linked with other health programmes such as MCH, IMCI, school health, health education, etc.

Selective vector control. Working with partners in implementing selective vector control towards an integrated approach should replace traditional routine residual spraying operations. Chemical control remains, nevertheless, the mainstay in this concept.

Forum for advocacy. RBM advocacy for change in the organizational set-up should address the new role of district health managers. Emphasis should be on multi-sectoral involvement and partnership development, community participation, local leadership for participatory planning and supervision, political support e.g. Panchayat, Union Parishad, other local government bodies, village development committees, etc., coordination of NGOs and other social organizations, including the private sector. The forum represents all possible leaders, e.g. political, administrative, technical, traditional, corporate, private sector; interested groups, e.g. trade unions, environmentalists etc., and partners, e.g. international, national, regional, provincial, district and local levels. At the district level, this forum may be called District Malaria Society or District Health Forum etc., while at the national level, it may be called Inter-ministerial Coordinating Committee or RBM Core Group for Partnerships.

6. ROLL BACK MALARIA ACTION PLAN

The strategic action plan for the SEA Region would comprise three phases:

(1) Preparatory phase (Till the end of December 1999)

- Development of guidelines for implementation of the strategies
- Political commitment at all levels
- Formulation of national strategies and development of partnerships plan
- Situation analysis leading to the selection of districts for the piloting of RBM
- Establishment of resource networks to address the core issues in malaria.

(2) Piloting phase (1999-2001)

- Situation analysis of the districts and identification of problems at the local level
- Time-bound action plan for RBM
- Advocacy for RBM, identification of partners, assignment of responsibilities and resource mobilization
- Integrated malaria control in synergy with health development
- Assessment and lessons learnt.

(3) Operational phase (2001-2006)

- A five-year RBM action plan to be developed by countries involving all partners, vital inputs to come from the pilot phase and resource networks.

7. POINTS FOR CONSIDERATION

(1) National commitment to support the new role of malaria control programme

In the context of RBM, the malaria control programme will assume a new role of leadership, regulation and coordination instead of being the sole implementer and delivery agent. To meet these objectives, Member Countries need to develop sustainable broad-based partnership with the private sector, health-related industries, medical associations, teachers' associations, local governments and other related civil societies as well as other potential partners, including donors.

What new policies are needed to sustain effective partnerships for RBM?

(2) A social movement for better health

RBM should draw its strength by mainstreaming malaria control activities as part of health sector development. RBM should facilitate the provision of health care to the poor and those who have little access to health care. Priority will be on the delivery of the package of health care to malaria and other common diseases and linked with other health programmes. The way in which the health system tackles malaria – particularly among poor people – is the key element of the assessment of that system's overall performance.

What changes may be needed in policies and mechanisms within the ministry of health to facilitate mainstreaming of RBM in health sector development?

(3) Capacity building

Capacity building needs to be accorded the utmost priority. The RBM approach to capacity development should ensure that malaria expertise should be available, wherever it is needed, throughout the health sector. WHO's assistance can be explored to support training activities to create a core of motivated individuals with upgraded skills who would, in turn, impart training to health personnel at different levels of health care.

How can the required human and other resources be mobilized?

(4) Strategic investment

The development of appropriate technology would strengthen RBM implementation. New areas of strategic investment should be evidence-based and closely linked with partnership initiative to ensure concerted and sustainable efforts in RBM.

How can partnerships in strategic investment be initiated?

(5) Regional support network

The available resources and expertise in the Region should be fully utilized. In order to promote regional exchange of experience and information, there must be ways to create a network of expertise among Member Countries to address priority issues, such as drug policy and monitoring surveillance systems, epidemic preparedness and response, disease transmission control and advocacy through media communication and country partnerships.

Under what mechanism could WHO foster regional support?