Aidspan
Independent observer of the Global Fund

MALARIA: TWENTY YEARS OF INCREDIBLE PROGRESS, BUT THE HARDEST PART REMAINS

GFO: What progress have we made with the global response to malaria?

RG, BR: According to the World Health Organization's (WHO) 2020 report on malaria, global malaria mortality fell by 60 percent over the 2000–2019 period. The Africa region has seen a decrease in the annual number of malaria deaths from 680 000 in 2000 to 384 000 in 2019. Southeast Asian countries have made particularly strong progress, with a reduction in cases and deaths of 73 percent and 74 percent, respectively. India contributed to the largest reduction in cases at regional level: from 20 million to six million.

Twenty-one countries have eliminated malaria in the past two decades and, among them, 10 countries have been officially certified by the WHO as being malaria free. Countries in the Greater Mekong have made spectacular progress in reducing cases of Plasmodium falciparum malaria by 97 percent since 2000, which is a vital target given the ongoing threat posed by antimalarial resistance.

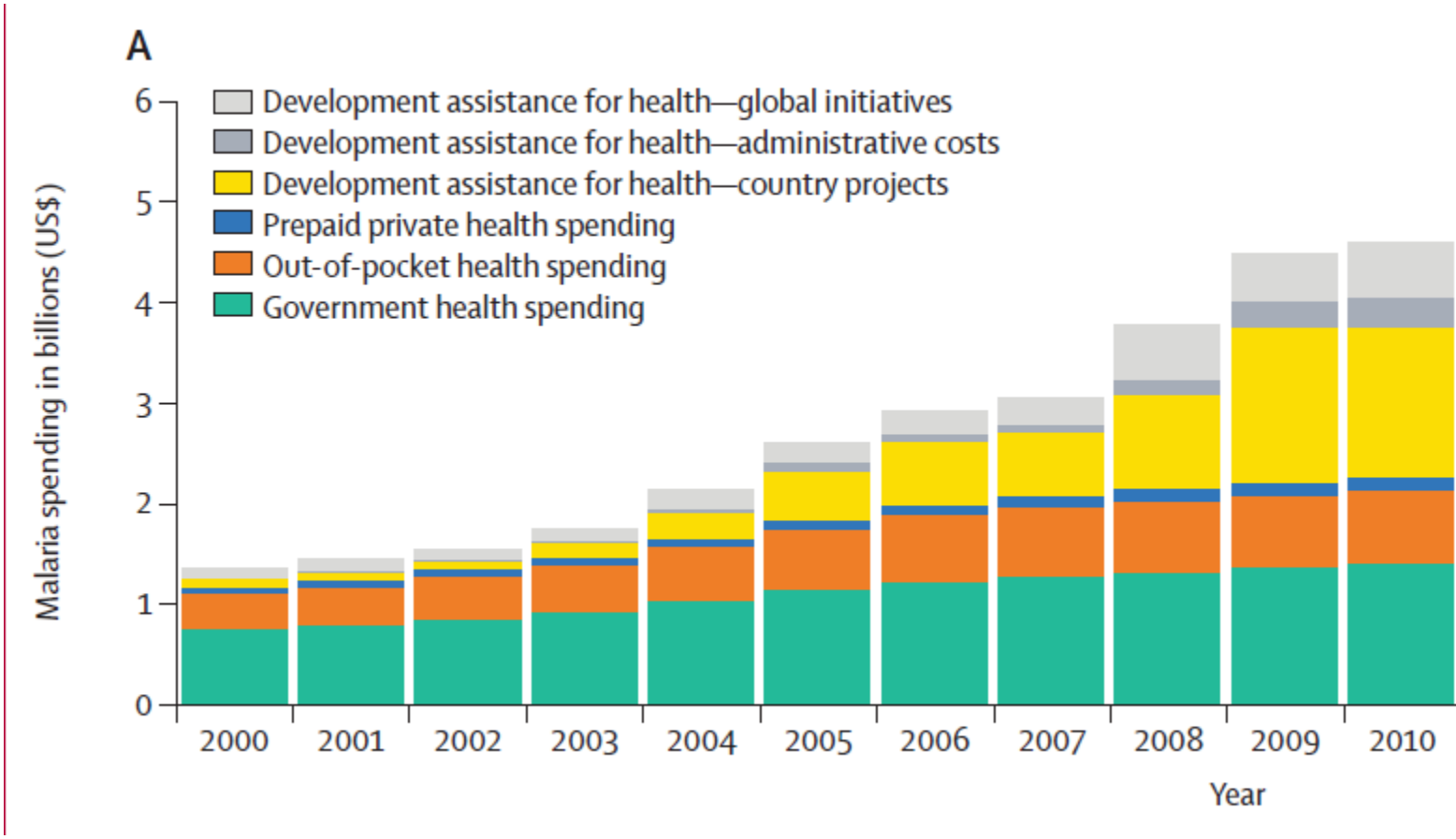
These results are clearly due to the financial investments and technical developments that national programs have benefited from to implement their intervention strategies. While there is no immediate solution (such as a vaccine), the end could be in sight in the near future. Malaria endemic countries have benefited from a large range of technical tools, which have advanced considerably in recent years. This includes, among others, prevention methods such as long-lasting insecticidal nets and insecticide spraying; screening, in particular thanks to rapid tests that are increasingly sensitive and easy to use; treatments using a therapy that combines artemisinin, seasonal malaria chemoprevention (SMC), and intermittent preventive treatment during pregnancy.

Despite this progress, when countries reach a low level of transmission, there is a period of diminishing returns for several years during which surveillance efforts must be sustained even if only a few cases are observed. For this reason, investments must be maintained when the disease becomes invisible or else countries and communities could be at risk of rapid resurgence. In addition, the emergence of resistance to both insecticides and treatments require programs to be vigilant in order to be able to adjust protocols regularly.

GFO: What is the funding context like for the malaria response?

RG, BR: The cumulative total expenditure on malaria in 2017 was estimated at $5.1 billion, with a breakdown as shown in Figure 1 below. This analysis shows that although domestic resources have only increased modestly, from $0.8 billion in 2000 to $1.7 billion in 2017, external financing has increased considerably (49 percent of total expenditure in 2017).

Figure 1: Total malaria spending by funding source, 2000 to 2017



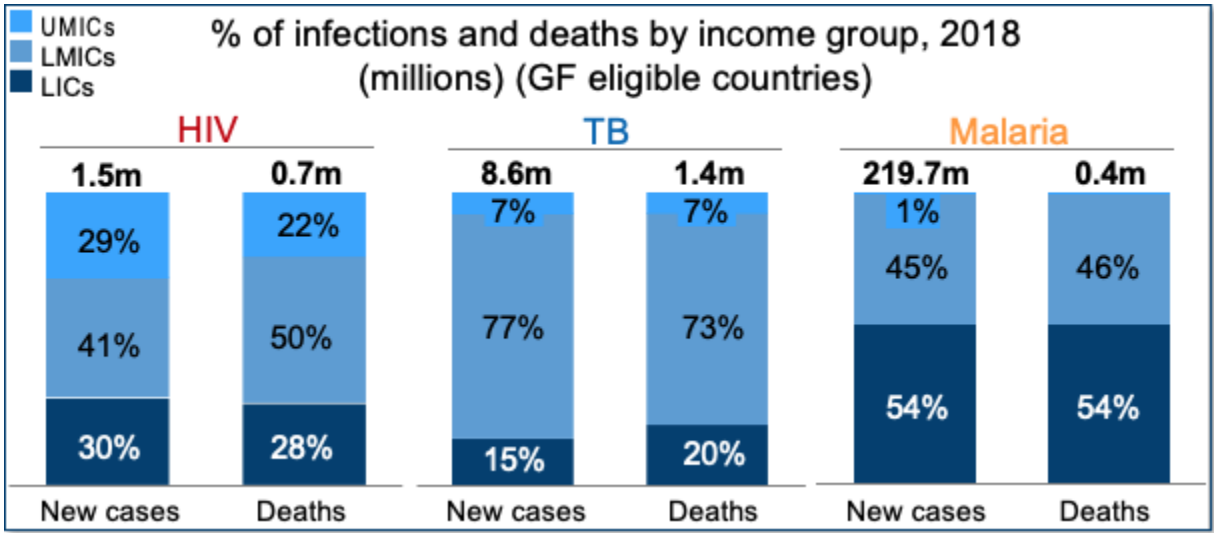
Source: Global Burden of Disease Health Financing Collaborator Network. Lancet 2020; 396: 693–724

The decline in malaria transmission worldwide to date has largely been due to external funding. With a cumulative investment of $13.5 billion by August 2020, the Global Fund contributes 65 percent of all external funding for malaria.

Looking at financial projections, the WHO estimates that the investment needed to meet elimination targets is $ 7.7 billion per year by 2025 and $8.7 billion by 2030. Alternatively, the more recent Lancet Commission on malaria eradication projects an additional annual requirement of $2 billion for global eradication by 2050.

It is important to note that almost two-thirds of the global malaria burden is in fragile states, and more than half of malaria cases and deaths occur in low-income countries (Figure 2), which increases funding gaps.

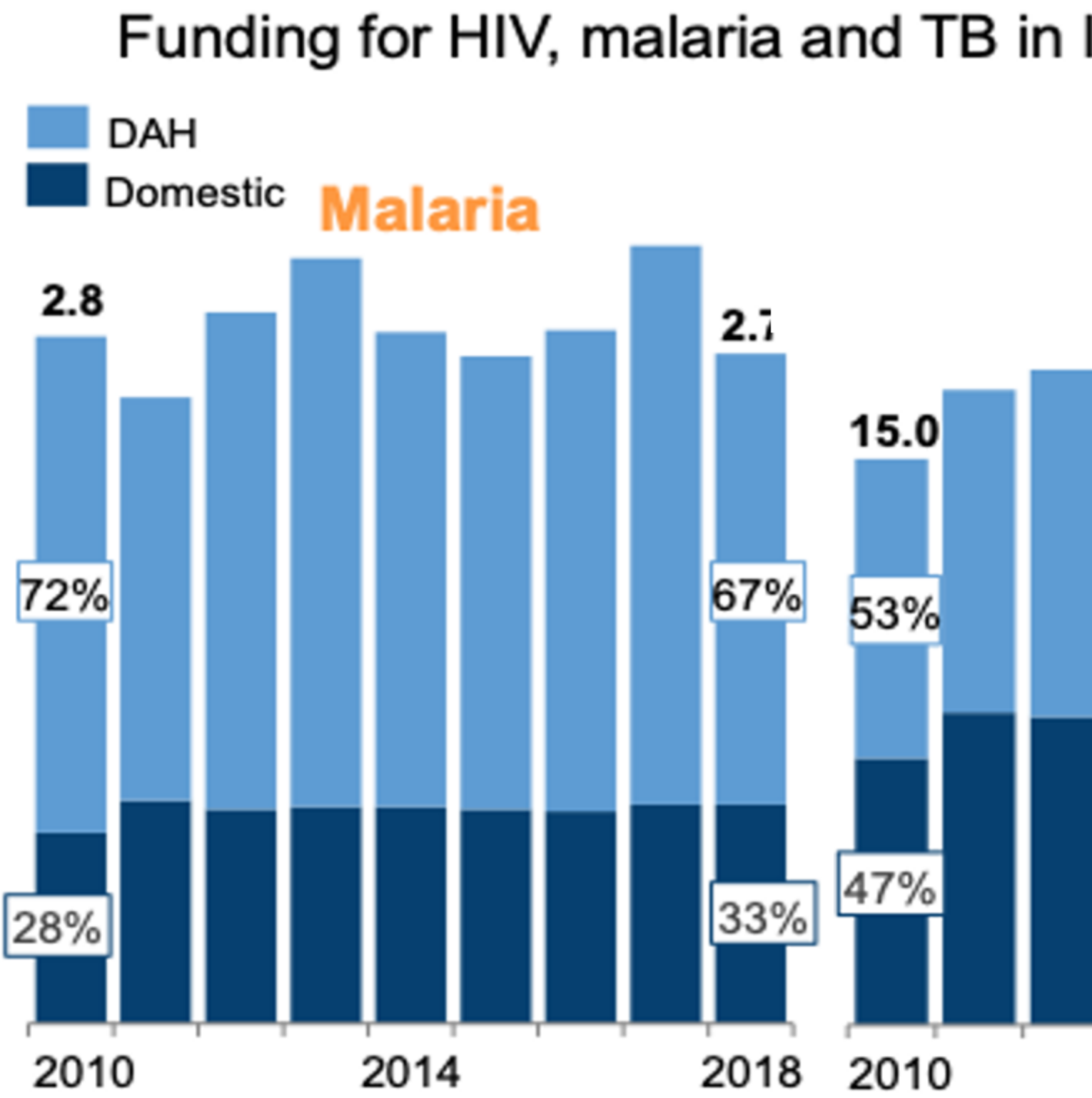
Figure 2: Morbidity and mortality from diseases according to country income classifications



Source: Malaria Focused Analytical Review to inform RBM Partnership Position on the Global Fund Strategy Development and Investment Case – Annex 1 – Rapid literature review and case studies. HMST, Jessica Rockwood – 5 November 2020. Data extracted from The Global Fund

Indeed, the 29 countries classified as low income by the World Bank have received $7.1 billion (roughly half of the total external funding for malaria) since 2002. Among the highest 10 beneficiaries, six are priority countries for the High Burden to High Impact (HBHI) approach, as set out by the WHO and the RBM Partnership to End Malaria in 2019.

Figure 3: Dependence on external funding for each of the three diseases: financing for malaria, HIV and TB control in low- and middle-income countries ($ billion)



Source: Malaria Focused Analytical Review to inform RBM Partnership Position on the Global Fund Strategy Development and Investment Case – Annex 1 – Rapid literature review and case studies. HMST, Jessica Rockwood – 5 November 2020. Data extracted from The Global Fund.

In summary, although this contribution to SDG 3.3 is both unique and essential, it is, however, unrealistic to expect that the funding gaps in low-income countries will be filled by the Global Fund or other donors in the coming decade. It is not realistic to expect that countries themselves will be able to fund the required

levels. Therefore, national strategies will have to evolve if we want to avoid donor “fatigue”, and this includes a change in programmatic approaches (more targeted) and a change in the current funding model (more integration).

GFO: In your opinion, what strategies will improve impact in the next decade?

RG, BR: Malaria, unlike tuberculosis (TB), and HIV and AIDS, is transmitted by a vector (mosquito). Therefore, to cut transmission, the complexity consists of both tackling mosquitoes through vector control interventions (mosquito net distribution campaigns, insecticide spraying, repellents and other protection measures) and tackling parasites in the hosts (such as early diagnosis and treatment to eliminate the parasite in the blood, and SMC campaigns).

While they are looking for long-term external funding, national programs must simultaneously set out new ways of carrying out the response. First of all, national malaria control strategies will have to demonstrate more effectively that they know their epidemic and that their interventions are targeted to the specific context. This means tailor-making interventions to the specific nature of transmission, by better defining the risk areas and levels. The HBHI approach has initiated this crucial discussion around targeting and prioritizing interventions through a stratification approach, that is already reflected in the recent New Funding Mechanism 2021–2023 (NFM3) funding request. Such targeting efforts will need to be scaled up and refined in future annual grant reviews. This is even more important and urgent as resistance to insecticides increases and pushes countries to increasingly opt for new formulations (for example, piperonyl butoxide (PBO) mosquito nets) at a high cost. Finally, national programs will have to adapt to the new global health financing context that is emerging. Donors may no longer have the same appetite to finance the current silo approach to responding to malaria.

GFO: Should we not also rethink investments in health systems strengthening for malaria?

RG, BR: The Global Fund has made substantial investments in supporting health systems; approximately $5.8 billion since 2014. However, we note that most of these investments mainly cover structural gaps in the health system (such as additional salaries, supervision, purchase of essential products), which are often disconnected from long-term health systems strengthening (HSS) processes. There is a clear lack of strategic direction to ensure that these funds have a lasting impact. The recent Technical Review Panel (TRP) evaluation found that around 75 percent of HSS investments were focused on systems support interventions, including program and grant management costs (TRP Global Fund 2019). It is important to note that, in theory, investments in HSS should address common systemic constraints to improve short-term outcomes for the three diseases, while also strengthening systems to support long-term gains. Although Global Fund guidance encourages countries to shift focus from short-term (input-driven) systems support to more strategic investments in systems strengthening (such as strengthening management, improving accountability mechanisms, and information systems), the reality is quite different.

The situation is particularly complicated for malaria because transmission takes place mainly on the periphery, where the health system structure in the broad sense often does not have the capacity to provide optimal vector control coverage or effective management of screening and treatment. Effective case management does require that remote and sometimes difficult to access geographical areas are reached, where it is much more difficult to overcome “broad and deep-seated” systemic barriers with modest, sporadic investments.

In this context, identifying HSS investments that simultaneously meet the needs of the three diseases is a challenge and perhaps not the right approach for malaria. While HIV and TB have a natural affinity, both due to co-infection and outpatient service delivery, there are fundamental differences in the operating environment for malaria. Malaria requires synchronized vector control, SMC, and case management interventions. By its nature, the response to malaria requires a vertical approach, to a certain extent. In

order to avoid entering into an ideological debate on the virtues of "vertical" versus "horizontal" approaches , national malaria control programs must urgently set out a diagonal approach and identify the specific elements that need – or don't need – to be integrated.

The COVID-19 pandemic has been a stark reminder of why the International Health Regulations (IHR) exist. With the growing global attention given to universal health coverage, we must see this new context as an opportunity to break out of a silo mentality. It is highly likely that in the very near future new global resources related to health security will emerge, and this will likely include donor support to have (i) real-time data, and (ii) community level screening for febrile illness.

Several malaria control programs now have digital surveillance tools that are operational at the community health worker level, allowing near real-time data collection and entry at the local, provincial and national levels. In Lao People's Democratic Republic, malaria surveillance begins at the grassroots level and information is escalated to be coordinated by the national Public Health Emergency Operations Centers (PHEOC).

Through networks of community workers located in villages, the malaria community can play a leadership role in health security if it operates at the sector level, cleverly moving out of the vertical silo. The malaria programs should be able to demonstrate that they have real skills to perform community testing, surveillance and logistics in the community: quickly and on a large scale. If they chose to play this role, the resulting strengthened community health systems could have a significant impact. Community health workers would expand their role to integrated community case management (iCCM) by becoming an integral part of the surveillance system for diseases with pandemic potential (as is already the case in some countries, for example, in Ethiopia, Haiti, and Myanmar). If they do not buy into this vision, national malaria programs risk marginalization as the world moves towards health security.

Finally, to be sustainable, HSS investments must be aligned with the government's strategic planning and medium-term funding processes. The extent to which Country Coordinating Mechanisms (CCMs) are aligned and empowered to engage in national sector strategic planning processes varies considerably from country to country. This again implies the need for an analysis of the capacity of CCMs to play this role in their current design. The CCM Evolution initiative is opening up this discussion.

GFO: What role does civil society play in the malaria response?

RG, BR: One of the main strengths of the Global Fund has been its focus on meeting the needs of excluded groups by involving affected communities and their advocates at various levels of decision making. This model was built around the urgent response to HIV and AIDS, in particular, by placing social justice at the center of the response. Malaria control programs (which have been around longer) have benefited from this massive influx of new financial resources but have not taken full advantage of it to reinvent their approach. As a disease of poverty, the malaria community is built on technical networks rather than activists. This translates into a lack of influential advocates in governance bodies at country level, including CCMs, but also within the Global Fund (Board, committees, and Secretariat). In addition, there is little overlap between voices calling for HIV and TB prevention and treatment, and those focused on women, children and the rural poor who are most affected by malaria. While such a strong malaria "activist" group is unlikely to develop, it does not mean that a broader movement to end malaria–involving influential advocacy networks for the poorest populations vulnerable to malaria–cannot be actively supported. Recently created platforms, such as the Civil Society for Malaria Elimination (CS4ME) or the malariafreemekong CSO platform linked to the Regional Artemisinin-resistance Initiative for the Greater Mekong region have this ambition.

GFO: How do we mobilize citizens and activists for malaria when vulnerable populations are less stigmatized than those exposed to HIV?

RG, BR: Large-scale mobilization of this kind must serve those who do not have access to quality health services. Globally, around 40 percent of suspected malaria patients receive a diagnostic test and first-line treatment from private providers, and the same percentage of fever cases in children in sub-Saharan Africa are estimated to go undiagnosed. We are talking about hard-to-reach and often excluded communities (including migrants) who seek support from private sector providers, with little or no training, and who sometimes provide counterfeit drugs. This formal and informal private sector is often off the radar of ministries of health. To bridge this gap, it is necessary to identify structural barriers (access, regulations, practices) and encourage (or even set conditions) for national programs to consider the private sector as "part of the solution" rather than as "a problem". It is a long-standing challenge that some countries have tackled head on, particularly in Southeast Asia (Cambodia, Lao, Myanmar), where three-pronged approaches (public, private, and community sectors) are supported to manage diagnosis and treatment. Unfortunately, too few national strategies have clear and budgeted plans, which notably include social marketing approaches in order to better understand the epidemic and provide quality care. As a result, these components are often not included in funding requests. The TRP clearly noted this issue in its report on the NFM2 HSS. Although this component generates little appetite among national programs and the WHO, advocacy by civil society in CCMs to include well defined private sector approaches in the national program's strategic plans would constitute a considerable step forward.

GFO: Is elimination or (better still) eradication possible?

RG, BR: According to the Lancet Commission on malaria eradication, of which Dr Ben Rolfe is a commissioner, it is possible to achieve eradication by 2050, in the space of a generation. The prospect of eradicating malaria could also strengthen the case for investment and maintain political momentum. We think that it will also be necessary to move away from the country-specific financing approach and to think more and more about investing in regions. In recent years, we have seen the birth of funding by the Global Fund for regional initiatives for malaria elimination (Elimination Eight (E8), Mozambique, South Africa and Swaziland (MOSASWA), Regional Malaria Elimination Initiative (RMEI), the Regional Steering Committee of the Mekong RAI (RSC-RAI). These initiatives make it possible to better respond to the mobility of transmission areas, which is reliant on vectors and hosts crossing national borders. Countries can therefore coordinate their approaches and plan for regional elimination. The other advantage of these initiatives is that they can leverage the interest of new funders. This is particularly the case for RMEI with significant involvement from the Carlos Slim Foundation, or MOSASWA who are supported by private companies through Good Bye Malaria. This will be necessary to broaden the funding base, make countries less dependent on the Global Fund, and to finally make eradication a more realistic possibility.

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