Roll Back Malaria Case Management Working Group (CMWG)

WHO, Geneva 27th-28th July 2011

Meeting Report
# AGENDA

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I. Background

In 2009, in recognition of the emerging challenges in case management the Roll Back Malaria (RBM) Case Management Working Group (CMWG) was revitalised after having been inactive since 2004.

The role of CMWG is to achieve consensus on strategies for scaling up implementation of policies for case management. It provides a valuable forum for experts to:

- Discuss and advise the RBM Partnership;
- Coordinate partners on consensus on strategies and identifying strategic priorities;
- Assist in developing the research agenda;
- Facilitate communication related to case management among partners and advocacy.

At the Third CMWG Meeting (8th to 9th July 2009), the following priorities were identified:
1. Scaling up malaria diagnosis, including in the context of changing transmission intensities;
2. Address how to strengthen implementation to increase access. Countries need more detailed operational plans;
3. Preventing and managing the spread of artemisinin resistance;
4. Improving access and delivery systems including quality of services;
5. Improved case reporting;
6. Quality and safety of drugs and diagnostics.

II. Objectives of the 5th meeting

1. Update members on Case Management Working Group progress and key developments;
2. Review work stream 2011 work plans;
3. Reach consensus on priorities for CMWG over the next year;
4. Further develop and finalise work plans up to end of 2011;
5. Identify key issues and priorities post 2011;
6. Review and streamline processes for enhanced coordination between CMWG and other RBM mechanisms.
Introduction to RBM's Objectives and Targets till 2015

Professor Awa Coll-Seck opened the meeting and described the RBM objectives and targets. She wanted the group to think about what future contributions they were going to make. She said that RBM has ambitious targets for 2013. Universal access has boosted activities, and RBM during its 10 years has accelerated activities in the field. She stressed that the partners together can achieve targets, although not all the world has adopted targets, milestones, goals – RBM through its mechanisms needs to prepare and propose to the world the GMAP.

The CMWG can add value and contribute mostly to RBM Objective 1 but will have impact on the other objectives. There are clear targets for public, private and community sectors and we need to tackle all three to achieve objective 1. IMCI is important and health workers are to follow correct procedures. By 2012, all countries where CCM is appropriate need clear policies and by 2012 policies need to be implemented.

Challenges –
- Health system weaknesses need to be addressed
- Resistance surveillance required as loss of ACTs is a serious issue
- How to manage non-malaria fevers
- How to mobilise resources – GF, GFATM, PMI, DFID, UNITAID

Link to presentation - RBM Objectives and targets
http://www.rbm.who.int/partnership/wg/wg_management/ppt/5cmwg/IAMColl-Seck.pdf

Updated GMAP objective and targets relevant for working group:

RBM Objective 1. Reduce global malaria deaths to near zero by end 2015 in areas where public health facilities are able to provide a parasitological test to all suspected malaria cases

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.
Recommendations from RBM for Working Groups

Thomas Teuscher talked about how to keep partners accountable towards common targets. The CMWG needs to evaluate how well it is working towards the GMAP targets annually.

There are 8 large areas of work where progress needs to be made.

1. Funding
2. Disease Control Programmes
3. Programme Co-ordination
4. Advocacy
5. Commodity Supply and Distribution
6. Research and Development
7. Technical Standards and Guidelines
8. Convene, Coordinate & Facilitate

The group needs to identify what can be done to address strategic challenges.

Priorities:
1. Prioritize geographically 10 countries with 80% of all deaths.
2. Retain high vigilance for drug resistance and containment of resistance

Role of CMWG:
1. To get harmonized work to encourage lack of duplication and prevent fragmentation
2. Scaling up malaria diagnosis
3. Strengthen implementation
4. Improve access and delivery system included quality of care

Differences from GMP:
1. GMP provides norms and standards
2. CMWG provides steps for scale up, advice to partnership, research agenda assistance and facilitating communication among partners

Link to presentation:
http://www.rbm.who.int/partnership/wg/wg_management/ppt/5cmwg/2Background.pdf

III. Objective 1: Update members on Case Management Working Group progress and key developments

In this meeting the group needs to finalise the work plan for 2011 and decide what to do for 2012-2013 focusing on RBM targets. CMWG doesn’t have a high implementation rate of activities and we need to make an effort to increase it.

Case management progress and working group processes

Link to presentation
http://www.rbm.who.int/partnership/wg/wg_management/ppt/5cmwg/3CMWGprogress.pdf
Progress Reports: Containment of Drug Resistance

Sylvia began by saying that members have so much to do that engagement is difficult. The meeting needs to define who can engage as clusters.

Link to presentation

Completed activities:
Sharing of WHO strategy
- GPARC – strategy developed
- Slide presentation of strategy developed
  - Need to pass information from WG to others, powerpoint to networks, was it presented anywhere? Need to make use of product

Funded but not begun
- Guide on strategies GPARC, plan what will best use, what is in it and how to operationalise it, looking at scaling up, this is a core activity
- Assessment of need of drug resistance networks that normally faded over time. Assessment to see if they worked and why they eventually failed.

Ongoing activities
- Review of management and containment efforts
  a. Current efforts informed by experience, identify key success factors and barriers to progress (case studies)
  b. Outline of document, few case studies on containment
  c. Three stage, mapping, review and data collection

Discussion - main points
- Status on advocacy for ACTS and away from monotherapies. Need a clearer plan on how CMWG interacts with RBM advocacy group to avoid duplication. MSF is also working on this subject so could liaise with them.
- Strengthening monitoring networks in African countries. There is a strong network supported by WHO, Mekong, HORN of Africa, Amazon, Pacific. Starting to have network meetings in Africa but difficult to get sustained funding, quite a lot of data coming in through networks
- Kenya NMCP: quality of antimalarials lead to resistance and there is no specific activity on this in GPARC
- RBM (Awa – highlights)
  - Need to ensure that what you are planning doesn’t duplicate activities. What are the gaps and how can we strengthen and support linkages, otherwise we are wasting time.
  - Need to document best practices and share them
  - This group has helped WHO review the GPARC; this is an added value of WGs
  - Register of drugs that have been registered will be kept by WWARN
- Motivate other partners, ACT Watch – need to provide standardized collection.
  MMV: investing time on market evaluation & development, availability status, is important in resistance but time consuming, database – focus on key countries what has been registered and what is in country. MMV will be happy to help on this but need to share responsibilities.
- WHO is tracking Artemisinin monotherapies, but this is limited on WHO database
• Mechanism of transparency of funding projects needs to be addressed and needs to be better integrated this into WG.

Progress Reports: Scaling up Diagnostics

Larry Barat presented work from the Diagnostics work stream. Most of the activities on the work plan have been completed or are nearing completion.

Link to presentation
http://www.rbm.who.int/partnership/wg/wg_management/ppt/5cmwg/5DiagnosisWS.pdf

Silvia Schwarte gave a presentation on Good practices for selecting and procuring rapid diagnostics tests for malaria.

Link to presentation
http://www.rbm.who.int/partnership/wg/wg_management/ppt/5cmwg/6SSchwarte.pdf

Discussion - main points

• RDT challenges in Cambodia. GF refused the RDT selected by Cambodia for high sensitivity and specificity for Cambodia context to one with lower specificity and sensitivity at low parasitaemia but couldn't get detect parasites. Criteria that was originally set out needs to be adjusted.
• It will often not be feasible to have only one RDT in a country as different agencies have different rules about sole-sourcing and competition. Group of agencies that procure 80% of RDTs – PMI, GFATM, WB, WHO, UNICEF, and MSF – plan to work with manufacturers to improve RDTs formats and standardize formats.
• Quantification – RDT quantification manual is under development in collaboration with the PSM working group, the manual will go step by step using different methods, depending on what data countries have available. Quantification can be based on morbidity data or consumption data.
• Tools – translation of job aids need to be correct for low level health workers. Clinicians and health workers need supervision on RDT performance. Quality of RDTs at periphery - not a lot of options, hope to soon have positive control wells as other methods especially comparative smears are flawed and, therefore, not recommended.
• Dissemination is major part of activity for the work stream – translation of advice to implementation. Member networks (e.g. PMI, GF, MSF, SRNs, WHO in country) can be used for dissemination. Key documents should be edited using plain English and translated into French and possibly Portuguese.
• What to do if a test is RDT negative and diagnostics for other diseases – should be included as area of work for CMWG.
• Mandate for this group is scaling up existing tools, advocacy in innovations in diagnostics for febrile illness.

Progress Reports: Monitoring and Evaluation
The M&E group has not progressed with its activities due to challenges with membership. A co-focal person is required to help out Aziza (the current focal person).

Link to presentation
http://www.rbm.who.int/partnership/wg/wg_management/ppt/5cmwg/7MEWS.pdf

Richard Cibulskis from WHO-GMP and MERG gave a presentation on the current CM indicators and work that MERG has done to date.

Link to presentation

Discussion- main points
- Can support MERG for access quality to care indicators and clinical indicators through routine systems are important and indicators should be similar
- Household are not necessarily the best way to be information about treatment as they rely too much on recall and therefore, could do HF surveys. Integrated demographic survey on treatment seeking behaviours, treatment and diagnostics - exit interviews might be best.
- In Nigeria, change is fast and National programmes are not really catching up. Some countries are not deploying RDT. Therefore indicator for fever and antimalarial is okay. However, fever cases outnumber the number of RDTs so treatment indicator does not always give true picture.
- MERG – should be a mutual sharing of information. Bringing people together and platform for discussion.
- CM indicators are different in different parts of world, Asia has used indicator framework with specifics for that region and no focus on < 5.

Progress Reports: Expanding Access to Treatment and Service Delivery

It has been difficult to get a quorum for this group and therefore hard to meet and define activities.

Link to presentation
http://www.rbm.who.int/partnership/wg/wg_management/ppt/5cmwg/9ServiceDeliveryWS.pdf

Only one activity for this work stream is currently funded ‘Support update of WHO manual for treatment of severe malaria’ which is being undertaken by Peter Olumese.

Discussion- main points
- In Kenya, for AS IV at country level, no upper limit for loading dose. Aquamat study – median time 3 days for discharge, what is the recommended number of doses? Need at least 24 hours therefore 3 doses, but people might need more until they can take oral medicine. There needs to be clear guidelines at country level.
- Comment on FEAST – flaws on definitions from pediatric studies and therefore premature to extrapolate.
- WG should work through HWG to give guidance to TRP
- Effective treatment requires good quality antimalarials – 12 countries in Africa where 60% of drugs are substandard and this will impact on effective treatment. Need to include in WP.
- Demand side creation, public user approach, SOS for Life – use of it for quantification, to avoid stock outs. Mobilise communities and social networks to work with RBM to check on stock outs.
- Stock outs are only one part of case management delivery. There is a problem of commodities getting into countries. How do we support countries to get appropriate number of required commodities to increase access.
- Context of Malaria in Pregnancy and IMCI – do we have specific points of action. IM quinine v rectal artesunate. Access globally, rectal artesunate is for pre-referral treatment only. ICCM should be reflected in the work plan. New definition guidance is needed for level of care of key diseases.

**IV. Objective 2: Review work stream 2011 work plans**

The working groups had a 90 minute break out session to:
- Identify activities which can be delivered
- Modes of dissemination of products
- Work plan for 2011/2012

**Presentation and Discussion of work stream work plans**

Summary of work stream breakout session and working group discussion

**Diagnosis**

2012 work stream plans:

1. Operational Manual and Tool Kit for Achieving Universal Diagnostic Testing, and RDT Quantification manual disseminated through CMWG
2. Best practices and lessons learned on scale-up of diagnostic testing assessed and synthesised
3. Strategy for scaling up quality diagnostics in the private sector

- Diagnostic Work stream – highly productive in a timely manner- how much of this will be done without WG? Active engagement for other partners to develop manuals
- Increase criteria for panel detection rate? Are we over emphasising this? Other limits of quality chain/parameters should be included? How much competition do we want? Just giving an idea of what would happen if modified the parameter. Important for case management maybe not important to change criteria but for screening, it will be important.
- Recommendation – tests that differentiates bacterial v viral pneumonia, will affect use of RDTs.
- Sep 2-7, meeting of WGs, need to prioritize and request funding, only in December will know which activities have been funded for 2012
- Update on new tools for malaria as agenda item. This group is about scaling up existing tools. We can identify gaps in the diagnosis of diarrhoea and pneumonia and recommend development of new tools.
Drug Resistance work Stream

- GPARC well developed and disseminated
- Slide presentation – completed, Pascal to share GPARC slide presentation from Boston Consulting Group
- Review containments efforts – Malaria Consortium leading and review in advanced stage
- GPARC Operational framework guide– tailored to NMCPs, clear simple and adaptable set of activities. Three steps:
  1. Writing workshop in Jan 2012 following from CMWG meeting but money available in 2011
  2. Needs money for finalization meeting - 2012
- Review of functionality and added value of drug monitoring networks – look at current active good networks, review good practices – 2012 (moved to 2011)
- Track phase out AMTs – web based platform is somewhat in place and is updated regularly, drugs used and registered in countries. Heads of State signed to ban AMTs, need further advocacy to reemphasize to deregister AMTS.
- 2012 look into places where there is a range of information like AMFm Phase 1 and ACT Watch, to look at progress at minimizing availability of AMTS. Poor drug quality as contributing to drug resistance and also not decreasing mortality
- Drug resistance monitoring indicator in GFATM, removal of AMTS, and advocacy – consensus statement
- Kenya – need following up of regulatory action once banned
- Need to coordinate with other groups e.g. procurement, often AMTS still used as countries can't import sufficient ACTS
- DFID- clarity on drug monitoring in Africa (AR) - every two years, grant from Gates, at least 10 countries this semester have tested efficacy through sentinel sites. Some countries do it routinely, such as Cambodia, others have to be pushed. GFTAM must make it a high priority by putting it as part of top 10 indicators for countries.
- Where is RBM in developing partnerships with China on drug development and in other areas?

M&E work stream

- Richard Cibulskis discussed with the group plans for defining indicators; he pointed out that both MERG and GMP are considering redefining indicators at the moment and so a joint discussion would be timely and we should ensure they are involved in deciding indicators. The MERG indicators and those presented in the GMP Annual Malaria report present higher level indicators on access to malaria treatment. There is a gap on the detail of case management indicators.
- The breakout group discussed the role of the work stream, and what it should contribute to. Given the target of zero deaths, we identified that there are a number of indicators in the process of achieving this through case management specifically. These include indicators of quality of care received specific to malaria, including whether patients are tested, whether providers follow results, whether treatment prescribed is appropriate, whether patients are referred if recommended. These data may be possible to be collected routinely through updated health management information systems.
• Then, a number of other indicators that reflect the issues upon which the association between case management and zero deaths include efficacy and quality of the drug dispensed, the safety profile of that drug, whether referrals are completed etc. These data may not be collected routinely and may require other M&E activities. We discussed that the role of the working group could be to provide a framework for indicators that can track progress of case management activities towards zero deaths and co-ordinate activities towards defining these indicators and advocating for the uptake of these indicators and framework.
• Work stream 2011 work plan move forward with the activities planned, to develop a concept note on indicators and coordinate a consultative meeting on the development of case management indicators.
• Work stream 2012 work plan- there were questions over what should happen. None of the members of the work stream this year had previously been involved and so didn’t feel in a position to make decisions on the future direction of the group. A co-focal person was not appointed. Therefore, we suggested options (1) to continue with current plans but with a greater emphasis on liaison with members of the other work streams who can define indicators important to that field, e.g. diagnostics or resistance (2) to continue for the meantime but consider whether the M&E activities should be absorbed into each of the other work streams in the longer term.
• M&E work stream/taskforce needs to work closely with other work streams who can contribute their expertise and MERG.
• M&E of CM is very weak and therefore required
• Suggestion-M&E of CMWG to provide TA to countries

Expanding Access to service delivery and treatment

2012 work stream plans:

• Investigate and compile success factors and barriers to rapid scale up of timely and effective diagnosis and treatment (within 24 hours of symptoms) concentrating on 3-4 high burden countries
• Investigate and compile evidence relating to the management of severe malaria from village level to a facility that can manage the case and investigate means of improving uptake of pre-referral treatment and referral systems
• Send a representative of the access work stream to participate in the PSM WG to discuss how to improve procurement supply and distribution of ACTs and RDTs to low level health facilities and the community.
• Send a representative of the access work stream to participate in the MIP WG to discuss how to improve implementation of the recommendations of the MIP group at ANC-community level.
• To develop a position paper for the HWG to include commodities for ICCM in GF grants
• To ensure a member of the Access WS is included in the TEC discussion of the new manual on management of severe malaria to ensure that aspects of implementation, advocacy and BCC/IEC are included in the new manual
V. Objective 3: Reach consensus on priorities for CMWG over the next year

Update presentations were given on areas of interest to the CMWG to help shape new priorities for CMWG in 2012.

New WHO policies and structures
A presentation on new WHO-GMP policies and structures was given by Pascal Ringwald.

Link to presentation
http://www.rbm.who.int/partnership/wg/wg_management/ppt/5cmwg/1PRingwald.pdf

- Setting policy, norms and guidance on malaria control is the primary role of WHO/GMP
- GMP is strengthening the policy setting process to be more timely, transparent and accountable
- A Malaria Policy Advisory Committee (MPAC) has been proposed which will provide independent strategic advice and technical input to WHO for the development of policies related to malaria control and elimination
- MPAC ToRs drawn up in April and now waiting for WHO approval, nominations in August, appoint members in September, meeting in January 2011
- MPAC – 15 members broad range, meet twice a year, open call for nominations, 3 year terms renewable once.

Comment: New structures relate to policy development but how is this translated into action at the community level? The link will be through the country offices

Update and discussion on AMFm

Megumi Gordon from CHAI presented data from the AMFm work stream for the HWG

Link to presentation
http://www.rbm.who.int/partnership/wg/wg_management/ppt/5cmwg/2AMFm.pdf

- ACTm uptake at country level has exceeded expectations (29.4 million in December 2010 to 125.1 in July 2011)
- Majority of orders are for AL
- 6 prequalified manufacturers, most have similar market share
- Big difference between orders and deliveries – only 40 million delivered but 125 million ordered
- Diagnosis activities are in place in all phase 1 countries except Kenya and Madagascar and a lot of OR is being conducted on equity and access
- Main lesson learned – hard to get off the ground
- Private sector moves at different speed, external support to catalyze supporting interventions, establish country taskforces to provide oversight function, cross sector dialogue essential, countries to establish dynamic responses.
- Countries and work stream need to focus on incorporating private sector into tracking, integrating AMFm into case management communication activities and strengthening regulatory capacity
Discussion - main points

- Progress of an AMFm for diagnostics. Global Fund should look at sustainability of AMFm and looking at costing of RDT complementation.
- There should be monitoring of end prices and also have a monitoring system in place for quality of treatment
- Countries asked to suggest monitoring activities, and there is a lot of variation, some do surveys, others integrating into national monitoring.
- It is unclear the percentage of ACTs that go to non-malarial fevers
- Organizations need to enforce that the green leaf (quality and accessibility) when doing training and communications in AMFm areas
- Effect on market – need to increase lead time from 3 to 6 months (PMI advice), as there will be stock outs in public sector due to orders in private sector

Experience from 4 phase I countries on implementation of AMFm

Zanzibar

Link to presentation
http://www.rbm.who.int/partnership/wg/wg_management/ppt/5cmwg/3ZMCP.pdf

- Launched June 2011
- Private outlets have to record by prescription as drug only available by prescription
- Marketing campaign for use of diagnostic testing
- RDTs are not in all facilities
- 200,000 AS/AQ ordered and 150,000 received, distribution begun and demand has increased
- AL not yet been delivered and is not available in public sector either
- Main challenge is on compliance of recommended price – needs monitoring and working with regulatory authorities

Discussion - main points

- Burden of malaria – how is it calculated. Is there an overestimation of need in a country with low endemicity like Zanzibar? First line buyer did calculations based on consumptions and morbidity data. Worked together based on number of outlets and requirements of different doses.
- Price compliance challenge – is it a large number of facilities? – Not many but mainly it is few peripheral outlets that are charging the higher price and they say its transport cost (increase of between 300 Sh and 900 Sh). The same problem will be faced in Pemba due to ferry costs. NMCP is talking to first line buyer to put outlet in Pemba.
- No leakage detected to Tanzania mainland but there is reverse leakage of mainland drugs to Zanzibar. Currently working together with first line buyer to address this.
- Need to address the question what is the proportion of those buying subsidized ACTs who actually have malaria. From CHAI – Regular (limited) survey every 2 months in Uganda. 70% of people with fever had malaria and got ACTs. The public sector in Uganda also treats people with fever with ACTs.
- UNITAID- if we used RDT what would the consumption of ACTs be? This is an important question. DFID response: OR, monitoring of impact evaluation and knowledge management is essential.
- WB- AMFm not really followed properly as systems don’t exist within countries to follow it. Use of RDTs is just beginning and we still have the challenge to use ACTs appropriately.

Cambodia

Link to presentation http://www.rbm.who.int/partnership/wg/wg_management/ppt/5cmwg/4AMFmCambo dia.pdf

- AMFm no access to drugs as there is no GMP approved ACT suitable for Cambodia in existing drug resistance landscape so there is a need to mobilise resources
- Regulation and confiscation of counterfeit drugs
- Securing supplies- ACTS (AS-MQ) and RDTs for public and private sectors
- Reprogramming of funds to adapt national malaria strategic plan to elimination

Discussion- main points

- PSI experience demonstrates that subsidized drugs didn’t drive out monotherapies.

Nigeria

Link to presentation http://www.rbm.who.int/partnership/wg/wg_management/ppt/5cmwg/5BCoker.pdf

- AMFm officially launched on the 31st, March 2011
- Sensitization, mass media developed, 3PRS, TA-CHAI and others TF/Secterariat.
- Sub recipients engaged SHI, NAFDAC
- 46 first line buyers and training carried out (will include M&E)
- 69m drugs expected; 17.5m private sector and 3.5m public sector delivered.
- M&E and PSM strengthened reporting and tracking commodities (18 M&E officers hired)
- Implementation research

Challenges

- Awareness low
- HS weak
- Coordination and monitoring private sector
- Attitude of people - cheap commodities may not be original
- Concern about integrity in price and waiver application (2$ adult dose)
- Poor profit margin for retailers hence they stock more expensive commodities
- Delay in import
Kenya
Link to presentation
http://www.rbm.who.int/partnership/wg/wg_management/ppt/5cmwg/6ANyandigisi.pdf

- 6 first line buyers – sufficient and enough for country total 13m ordered and 8 million received up until March 2011.
- Availability of ACTm in April, 240 outlets, 78% availability
- About 2/3 samples were non ACTm, prices for non-ACTm was 247 Sh and ACTm 49.4 Sh (about 60c), max price was 350 Sh. Non ACTm max price 3250 Sh ($50). Average wholesale price for ACTm was 28.6 Sh

Challenges

- Full price adherence
- Delayed fund disbursement, procurement delays
- Proliferation of unregistered pharmacies, training targeting challenges (illegal to support unregistered outlet but are delivering service)
- Staggered training funds

Lessons learnt

- Partnerships important – CHAI
- Private sector informed and involved from start
- Involve professional associations
- Local manufacturers (antimalarials are often core product) are be driven out of market. Trying to bring them up to Standard.
- Alignment of AMFm work plan to fund disbursement

Discussion - main points

- No counterfeits found, some quality issues.
- When expanding access – margins come into play, when the margins become too small to be profitable? Rural areas attract less margin due to competition and distance. When markets established, prices decrease. Rural outlets sell more as there are less of them, so they make up their margins there.
- Again people are prepared to pay more as they perceive that it is a quality product
- Access work stream could document the implementation of AMFm effectiveness

Update and discussion on IPTc
Link to presentation
http://www.rbm.who.int/partnership/wg/wg_management/ppt/5cmwg/7FPagnoni.pdf

- IPTc changed to SMC (Seasonal Malaria Chemoprevention) full treatment doses during malaria season when most at risk.
- Attractive sites – 50% are in sub-Saharan Africa, few rounds, high impact and high level of malaria control
- CHWs can give SMC (mass treatment) during rainy season
- Still debate on which drug should be used for SMC- could be a non-ACT
- Age range? 6m – 5years
• Discussion of fevers attributable to malaria in rainy season – require a definition to be a SMC country.

Update and discussion on GPARC
Link to presentation
http://www.rbm.who.int/partnership/wg/wg_management/ppt/5cmwg/8PRingwald.pdf

• Build on existing activities
• Tier based on degree of AR threat
• No Artemisinin marker for resistance but based on phenotype which is delayed clearance. Lots of factors produce delayed response to Artemisinin e.g. HIV
• Trend of 3% delayed clearance 10 years ago to 50% now.
• Testing of next generation for drugs

Update and discussion from PSM working group
Link to presentation
http://www.rbm.who.int/partnership/wg/wg_management/ppt/5cmwg/1PSMWG.pdf

Discussion - main points

• Pharmacovigilance work stream of PSM – developed web based toolkit, primary reactions to ACTs. What about monitoring in the private sector? Shouldn’t this be a CMWG activity? Is this considered a priority intervention, when paucity of information on adverse events on ACTs but PMI doesn’t think so. Kenya thinks it’s important but we need a system that is simple and feasible, like passive reporting through NDA. Back to priorities and limited resources (time consuming for small amount of data generated).
• Very good coordination between PSM and diagnostic work stream. PMI allocated funds for global RDT forecast, will develop ToRs with PSM group. However, need ToRs to avoid duplication between CMWG/diagnostics and PSM/diagnostic work streams. Has anyone from CMWG attended PSM full meetings? Yes, Sylvia Schwarte from GMP.

VI. Objective 5: Identify key issues and priorities post 2011

The key area to consider for 2012 of all work streams were reported in a presentation.
Link to presentation

• HWG supposed to be a forum where co-chairs meet and coordinate working group activities. Need work plan and calendars/timelines to help coordinate activities. Need someone representing CMWG in the HWG.
• GF Round 11 Orientation meeting – slides on indicators etc. Diagnostics work stream will use to disseminate new tools/manuals.
• Diagnostic work stream – until critical mass of products are prequalified, then product testing is essential to give direction to countries
• Regular meetings and contacts – reorientation of what CMWG is doing. Format was difficult, and targets need to be achievable
Opportunity of internal evaluation of CMWG especially looking towards work streams. Feedback sessions valuable and hasn’t led necessarily to work plans, GPARC, AMFm some suggestions how CMWG can be get more involved in.

VII. Objective 6: Review and streamline processes for enhanced coordination between CMWG and other RBM mechanisms

- M&E work stream has been disbanded but key CMWG members will work with MERG. Meeting scheduled with MERG in September (now postponed until 2012); Franco, David Schellenburg, Sylvia Meek, Aziza Mwisongo, will represent CMWG and Andrea Bosman will represent CMWG and GMP in the meeting. Focal Person in MERG is Richard Cibulskis.
- Strengthen HWG interaction – hasn’t been systematic, and neither co-chair has been involved. Peter Oluemese to be nominated to be Focal person from CMWG to HWG.
- MAWG, MIP, RBM Secretariat communications – need to be more involved and CMWG will contact focal persons.

VIII. Next Steps

- Need to get info to Mallika by September 1 on WS plans and budgets, and prioritization of plan. Include all activities even those that don’t need a budget.
- Orientation for GFATM Round 11 – inclusion particular indicators to be placed as priority.
- Next meeting: Plan to have 2 meetings/year, maybe January and June.
IX. Annex 1- Agenda

RBM Objective 1  Reduce global malaria deaths to near zero by end 2015 in areas where public health facilities are able to provide a parasitological test to all suspected malaria cases

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.

Objectives of CMWG Conference:

1. Update members on Case Management Working Group Progress and Key Developments
2. Review Work stream 2011 work plans in light of RBM Targets
3. Further Develop and Finalise Work plans up to End of 2011
4. Identify key issues and priorities post 2011
5. Reach consensus on priorities for CMWG for 2012 and 2013
6. Review and streamline processes for enhanced coordination between CMWG and other RBM mechanisms

Expected outputs:

1. Updated CMWG 2011 Work plans that address RBM ojectives
2. Identification of key issues and CMWG roadmap and workplans 2012-2013
3. Mechanisms for improved coordination between the CMWG and other RBM mechanisms
<table>
<thead>
<tr>
<th>Time</th>
<th>Session 1</th>
<th>Presenter</th>
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<tbody>
<tr>
<td>9:00</td>
<td>Welcome and Introductions</td>
<td>F. Pagnoni</td>
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<tr>
<td>9:05</td>
<td>Introduction to RBM’s Objectives and Targets till 2015</td>
<td>A. Coll-Seck</td>
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<tr>
<td>9:15</td>
<td>Recommendations from RBM for Working Groups</td>
<td>T. Teuscher</td>
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<td>9:30</td>
<td>Fifth CMWG Meeting</td>
<td>L. Slutsker</td>
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<td>9:40</td>
<td>CMWG Progress and Working Group Processes</td>
<td>M. Kaviratne</td>
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<td>9:50</td>
<td>Progress Reports: Containment of Drug Resistance</td>
<td>S. Meek</td>
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<td></td>
<td>- Presentations (25 mins) and Discussion (15 mins)</td>
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<td>10:30</td>
<td>Coffee/Tea Break</td>
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<tr>
<td>11:00</td>
<td>Progress Reports: Diagnostics</td>
<td>L. Barat</td>
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<tr>
<td>11:45</td>
<td>Progress Reports: Monitoring and Evaluation</td>
<td>M. Kaviratne/ R. Cibulskis</td>
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<tr>
<td>12:25</td>
<td>Progress Reports: Expanding Access to Effective Treatment and management of severe malaria</td>
<td>P. Kachur</td>
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<td>Presentations (30 mins) and Discussion (20 mins)</td>
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<td>13:15</td>
<td>Lunch Break</td>
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**Session 2  CMWG Work plans 2011**

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<tr>
<th>Time</th>
<th>Session 2</th>
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<tbody>
<tr>
<td>14:00</td>
<td>Workstream Break-Out to discuss Implementation of Activities and dissemination of products</td>
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<td>- Identify activities which can be delivered</td>
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<td>- Modes of dissemination of products</td>
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<td>- Workplan for 2011/2012</td>
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<td>15:45</td>
<td>Coffee/Tea Break</td>
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<tr>
<td>16:15-18:00</td>
<td>Presentation and Discussion of Workstream Workplans</td>
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<td>- Diagnosis Workstream (25 mins)</td>
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<td>- Drug Resistance Workstream (25 mins)</td>
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<td>- Monitoring and Evaluation Workstream (25 mins)</td>
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<td></td>
<td>- Expanding Access to Effective Treatment (25 mins)</td>
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<tr>
<td>18:00-18:10</td>
<td>Introduction of co-chair nominees</td>
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<tr>
<td>18:10-20:00</td>
<td>Evening Reception</td>
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8:30-9:00 **Work stream Harmonisation Meeting**
Invitees: Co-Chairs, Secretariat, Focal Persons
- Reporting on Harmonisation of Work stream Activities
  - To Focus on:
    - Harmonisation Between Work streams
    - Harmonisation with External Partners and Stakeholders

**Session 3  Update on key CMWG themes**

Session Chair: (Chair: L. Slutsker)

9:00-9:20 Presentation on new WHO policies and structures  
P. Ringwald

9:20-10:15 Update and discussion on AMFm  
M. Gordon/Endemic country representatives

10:15-10:40 Update and discussion on IPTc  
F. Pagnoni

10:40-11:05 Update and discussion on GPARC  
P. Ringwald

11:05-11:25 Coffee/Tea Break

**Session 4  CMWG Priorities for 2011 and beyond**

Session Chair: (Chair: F. Pagnoni)

11:25-11:45 Update and discussion from PSM working group  
C. Morris

11:45-12:15 CMWG Scope of Objectives, Outputs and Activities  
L. Slutsker
Harmonisation of Work stream Activities and among other RBM Mechanisms

12:15-12:45 CMWG key issues and priorities post 2011  
F. Pagnoni
Discussion on key issues and priorities

12:45-1:20 **Summary of CMWG Meeting**  
S. Meek
Identify Next Steps
Dates of next meeting  (17/18 or 24/25 January)

13:20-13:30 Thank you to Larry/Close meeting  
F. Pagnoni

**13:30 Close of Fifth CMWG Meeting**
# X. Annex 2- Participants list

<table>
<thead>
<tr>
<th>Institution</th>
<th>Names</th>
<th>Email address</th>
<th>Work Stream</th>
</tr>
</thead>
<tbody>
<tr>
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<td>World Vision</td>
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