Political and Economic Underpinnings of the Implementation of the African Roll Back Malaria Declarations of April 2000

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Presentation Outline

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Purpose

The purpose of this presentation is to:

- analyze the socio-politico-economic impact of Malaria on the African continent
- evaluate the extent to which African governments have fulfilled their commitment to the African Heads of State Roll Back Malaria Declarations of April 2000.

Sources of Data

Data used in this study are:

a) The Roll Back Malaria Declaration of April 2000
   - Signed by all African Heads of State in Abuja, Nigeria, in April 2000

b) Policy documents relating to Roll Back Malaria from 53 African governments

Sources of Data

c) Interviews with -

- Selected African Heads of State and former OAU officials:
  - President Olusegun Obasanjo
  - President Thabo Mbeki
  - President Alpha Konare
  - Dr. Ahmed Salim, Former OAU Secretary-General
  - President Jerry Rawlings, etc.
    - Were all instrumental in calling for the summit
- Selected Ministers of Health
- Representatives of WHO in Africa and Directorate of the Roll Back Malaria Program in Geneva
- The World Bank and other multilateral financial institutions
- NGOs, CBOs, FBOs
- Supplemented by presenter's experiences as a Minister of Health who participated in the Roll Back Malaria Summit

Learning Objectives

I. Analyze the socio-politico-economic impact of malaria on the African continent.

II. Describe the circumstances leading to the creation of Roll Back Malaria (RBM).

III. Describe the Abuja Declaration of April 2000.

IV. Evaluate the extent to which African governments have fulfilled their commitment to the Abuja Declarations.

Background

- 1955-1969
  - WHO malaria Eradication Campaign. Largely unsuccessful due to
    a) Lack of sufficient information on the size of the problem
    b) Shortage of human and material resources
- 1987
  - Malaria Control Strategy for Africa formulated

Background

- 1991
  - Malaria Control Strategy for Africa was revised and developed at the Inter-regional Malaria Conference in Brazzaville, Republic of Congo
- 1992
  - Ministerial Conference on Malaria in Amsterdam created a Global Malaria Control Strategy
- 1994
  - Global Malaria Control Strategy was endorsed by the Economic and Social Council of the U.N.

Background

- 1996 (May)
  - World Health Assembly passed a resolution on controlling Malaria in Africa
- 1996 (June)
  - WHO Regional Office for Africa started the Africa Initiative for Malaria Control in the 21st Century
- 1997
  - WHO Africa Regional Office (AFRO) received $9M from the WHO Director - General's Special Fund for Accelerated Implementation of Malaria Control to support malaria programs in 21 countries

Background

- 1997 (June)
  - Africa Heads of State adopted the Harare Declaration on Malaria Prevention and Control in the context of African Economic recovery and development, committing themselves to efforts to control the disease on the continent
- 1997
  - Dr. Gro Harlem Brundtland, former WHO Director-General, in discussions with heads of state and senior public health professionals, in preparation to stand for the director-generalship, heard a lot about the burden of malaria

Background

- 1998
  - AFRO received an additional $9M to support malaria control activities in 27 countries
- 1998 (November)
  - Dr. Brundtland purposed RBM; together with UNICEF, UNDP, WB founded RBM
  - RBM became a “Cabinet Project” reporting directly to the DG
    - Loosely constructed partnership - to avoid the risks inherent in a top-heavy management structure
  - The African Initiative on Malaria Control was merged with it

Roll Back Malaria (RBM)

- Goals:

  Reduce deaths due to Malaria progressively by 50% by 2010, by another 30% by 2015 and by another 20% by 2025.
- Key feature:
  - Intersectoral
  - Inter-agency
  - Multi-disciplinary
  - Multinational

African Summit on RBM - April 25, 2000

- Initiated by Chief Olusegun Obasanjo, then president of Nigeria
- Attendees-
  - 44 of 50 nations; 19 heads of state
  - Director-General, WHO; VP of World Bank; Executive Director, UNICEF
  - Director UNDP, Africa
  - UNESCO
  - ADB; USAID; CIDA; DFID; French cooperation

African Summit on RBM - Objectives

i. To inform Heads of State and Governments about the situation of Malaria in Africa;
ii. To intimate Heads of State and Government about the economic burden of Malaria;
iii. To provide Heads of State and Government with the problems which their communities face and the possible self-help actions to be taken; and
iv. To adopt the Abuja Declaration and plan of action Against Malaria

Why Focus on Africa

1. Malaria accounts for about 1 million deaths in Africa.
2. 90% of the world's malaria burden is borne by Africa. It affects 3000 children under five in Africa each day, and kills about 800,000 of them annually.
3. Malaria reduces the productivity in agriculture, inhibits tourism, and reduces investment. Those who suffer most are the continent's most impoverished.

Why Focus on Africa

4. Malaria keeps societies poor, undermines development and reduces the income of families who are already among the poorest in the world.
5. Every family in Africa pays a ‘Malaria Tax’. This is because a poor family living in Malaria affected areas may spend up to 25% more of its income on prevention and treatment. This slows down the economic growth and community development in Africa.

Why Focus on Africa

6. Malaria cost Africa up to $12 billion yearly and slowed economic growth in Africa by up to 1.3% yearly.
7. At least 30% of all childhood deaths are due to malaria.
8. An estimated 2% of children who recover from cerebral malaria infections suffer from learning disabilities, epilepsy and spasticity.

Why Focus on Africa

9. 15-40% of children with cerebral malaria , malaria associated acidosis and anemia die, half of the deaths occurring within 12 hours after arriving at the hospital.
10. 25-40% of OPD clinic visits in Africa are due to malaria,, while 20-50% of hospital admissions are a consequence of malaria.
11. 60% of Harvests are lost in Africa due to malaria.

Leaders' Resolution

- Resolved to strengthen the health systems to ensure that by 2005:
  - At least 60% of those suffering from malaria have prompt access to, and are able to correctly use affordable and appropriate treatment within 24 hours of the onset of symptoms.

Leaders' Resolution

- At least 60% of those at risk for malaria, particularly children under five years of age and pregnant women, benefit from the most suitable combination of personal and community protective measures such as insecticide treated mosquito nets and other interventions which are accessible and affordable to prevent infection and suffering.
- At least 60% of all pregnant women who are at risk for malaria, especially those in their first pregnancies, have access to chemoprophylaxis or presumptive intermittent treatment.

Leaders' Pledge

- To implement the agreed Plan of Action within their own countries.
- To develop mechanisms to facilitate the provision of reliable information on malaria to decision-makers at household, community, district and national levels, to enable them to take appropriate actions.
- To reduce or waive taxes and tariffs for mosquito nets and materials, insecticides, anti-malarial drugs and other recommended goods and services that are needed for malaria control strategies.

Leaders' Pledge

- To allocate the resource (about $1 billion) required for sustained implementation of planned Roll Back malaria actions.
- To increase support for research (including operational research) to develop a vaccine, other new tools and improve existing ones.

Leaders' Pledge

- To commemorate the summit by declaring April 25th of each year as African Malaria Day.
- To call upon the United Nations to declare the coming decade 2001-2010, a decade for Malaria.
- To develop traditional medicine in the area of Malaria control.

Positive Impact of RBM

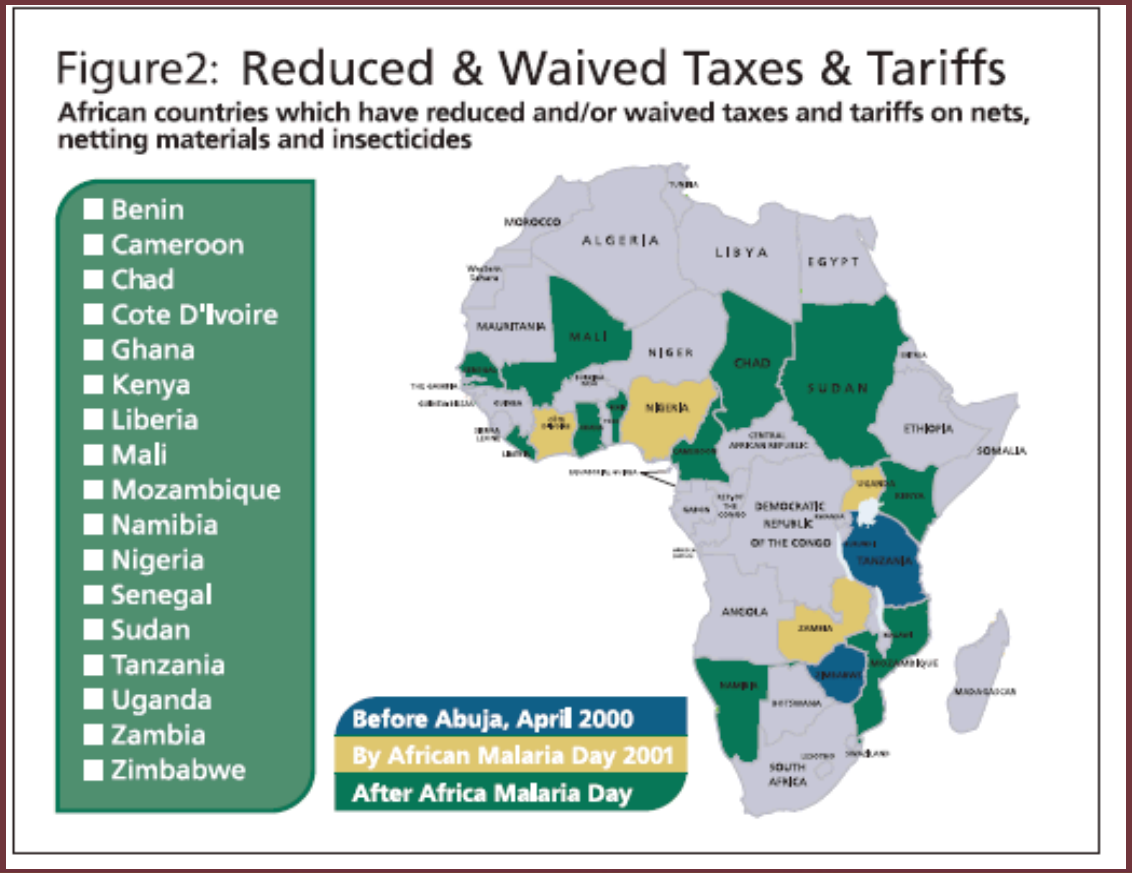
1. World embraced tackling Malaria problem with renewed vigor and optimism - e.g. the July 2000 pledge of the G8 at the Okinawa Summit to reduce the Malaria burden by 50% by 2010. International spending on Malaria doubled
2. UN General Assembly's declaration of 2001-2010 as the Decade of Malaria

Positive Impact of RBM

3. Inclusion of Malaria as one of the three diseases targeted by Global Fund to fight AIDS, TB and Malaria, and also included among the diseases to be tackled in the MDGs
4. RBM Partners collaborated to call for the elimination of taxes and tariffs on insecticide treated nets (ITNs) at the World Trade Organization (WTO) summit in Seattle in 1999

Positive Impact of RBM

5. To date 17 African countries have either reduced/eliminated taxes and tariffs on the importation of ITNs.



Positive Impact of RBM

6. Declaration of April 25th as Africa Malaria Day.
7. RBM worked with African countries to complete 15 country strategic plans.
8. 25 out of the 44 African countries who signed the Abuja Declaration in 2000 have submitted successful proposals to the Global Fund to Fight AIDS Tuberculosis and Malaria for funding support to scale-up implementation of their national malaria control plans.

Why Non-fulfillment of Commitment

I. Lack of political/ economic will: the nature of the disease makes it very easy to ignore its impact

II. Inadequate financial resources to fight malaria; annual per capita external funding for Malaria in Africa is between $0.07 and $0.08. Commission on Macroeconomics and Health estimates an additional annual investment of $0.90 by 2015

III. Disconnect between RBM activities on the ground and the major health sector planning and budgeting cycles of the countries

Why Non-fulfillment of Commitment

IV. Some countries e.g. Tanzania, Cameroon, Zambia, accord RBM low priority

V. Most African countries rely on National Program Offices (NPOs) to lead RBM activities at the country level - NPOs are typically not senior enough to engage in high level advocacy work to bring Malaria to the top of the health and development agenda; WHO has appointed 28 NPOs in 26 countries

Why Non-fulfillment of Commitment

VI. Domination of the health sector agenda by HIV/AIDS - therefore more time and effort devoted to HIV/AIDS related activities

VII. Clear deficiencies in the relationships between WHO in Geneva and AFRO, stemming from a lack of clarity about areas of responsibility

Why Non-fulfillment of Commitment

VIII. Due to cultural and bureaucratic problems even the much touted AFRO created sub-regional inter-country teams are not performing as effectively except the Southern African Malaria Control team (SAMC).

IX. AFRO staff- more reactive than proactive. Respond to country requests on ad-hoc basis. Unable to sustain intensive programs of support to countries. Staff not assigned to specific countries. Engage in frequent trips to Geneva, report writing and administrative duties - this does not happen in other WHO regional offices.

Why Non-fulfillment of Commitment

X. Chronic and severe weakness in the healthcare infrastructure in respective countries.

XI. Lack of effective communication and advocacy especially at country level.

XII. Inadequate human resources and capacity development - compounded by lack of national Health Information Systems and Database of Baseline Indicators for Evaluation of Malaria in Africa.

XIII. Increase in resistance of parasites to drugs and vectors to insecticides.

Why Non-fulfillment of Commitment

xiv. Low rate of ITN usage - only 1 in 7 children sleep under the net; only 2% of children use a net treated with insecticide.

Note: only 17 countries have waived/reduced taxes on the importation of ITNs

xv. Recent survey data between 1999 and 2006 indicate that 18.4million ITNs are available in households in 43 African countries (JAMA May 23/30, 2007, Vol.297, p2248)

xvi. To cover all Africans at risk, an estimated total of 260 million bed nets would be needed (Africa Malaria Report, 2003, p3)

Table 1. Estimates of Household (HH) Possession of Mosquito Nets and ITNs in 43 Sub-Saharan African Countries

Country (Source of Data on Net Possession or Use)	No. of HHs, ×1000	Mean HH Size, No. of People	No. (%) of HHs With ≥1 Net, ×1000	Mean No. of Nets, per HH	No. (%) of HHs With ≥1 ITN, ×1000	Mean No. of ITNs per HH	Nets in HHs, ×1000	ITNs in HHs, ×1000
Angola (MICS, 2001)	2815	5.1[a]	463 (16.5)[b]	0.29[c]	118 (4.2)[b]	0.10[c]	815	273
Benin (DHS, 2001)	1428	5.2	574 (40.2)	0.74[c]	193 (13.5)	0.27[c]	1058	381
Botswana	351	5.1[a]	106 (30.2)[d]	0.55[c]	40 (11.5)[d]	0.23[c]	193	81
Burkina Faso (DHS, 2003)	1910	6.5	772 (40.4)	0.70	88 (4.6)	0.10	1337	191
Burundi (MICS, 2000)	1426	4.6	111 (7.8)[b]	0.12[c]	34 (2.4)[b]	0.06[c]	177	91
Cameroon (DHS, 2004)	3341	4.8	675 (20.2)	0.30	47 (1.4)	0.05[c]	1002	154
Central African Republic (MICS, 2000)	771	4.9	309 (40.1)[b]	0.74[c]	21 (2.7)[b]	0.07[c]	570	54
Chad (DHS, 2004)	1750	5.4	1123 (64.2)	1.20[c]	25 (1.4)[e]	0.05[c]	2094	81
Comoros (MICS, 2000)	111	6.3	51 (46.4)[b]	0.86[c]	19 (17.0)[b]	0.33[c]	95	37
Congo (DHS, 2005)	769	5.2	581 (75.5)	1.50	62 (8.0)	0.10	1154	77
Democratic Republic of Congo (MICS, 2001)	8017	6.4	1466 (18.3)[b]	0.32[c]	103 (1.3)[b]	0.04[c]	2599	351
Côte d'Ivoire (MICS, 2000)	2699	6.2	426 (15.8)[b]	0.28[c]	54 (2.0)[b]	0.06[c]	746	154
Equatorial Guinea (MICS, 2000)	75	6.0	17 (22.4)[b]	0.40[c]	1 (1.3)[b]	0.04[c]	30	3
Eritrea (MSS, 2003)	844	4.8	770 (91.2)	1.46	600 (71.0)	1.31[c]	1232	1108
Ethiopia (DHS, 2005)	18 436	4.2	1051 (5.7)	0.07	627 (3.4)	0.02	1291	369
Gabon (DHS, 2000)	254	5.0	38 (14.8)[b]	0.26[c]	3 (1.3)[d]	0.04[c]	66	11
Gambia (MICS, 2000)	261	5.1[a]	138 (52.9)[b]	0.98[c]	70 (26.9)[b]	0.51[c]	256	133
Ghana (DHS, 2003)	5303	4.0	933 (17.6)	0.26	170 (3.2)	0.08[c]	1379	417
Guinea (DHS, 2005)	1541	6.1	413 (26.8)	0.67	8 (0.5)	0.03[c]	1037	46
Guinea-Bissau (MICS, 2000)	270	5.1[a]	219 (81.1)[b]	1.52[c]	37 (13.5)[b]	0.27[c]	411	72
Kenya (DHS, 2003)	7613	4.3	1660 (21.8)	0.40	206 (2.7)	0.10	3045	761
Liberia	638	5.1[a]	138 (21.6)[d]	0.39[c]	53 (8.2)[d]	0.17[c]	247	109
Madagascar (DHS, 2004)	3938	4.6	1532 (38.9)	0.72[c]	340 (8.6)	0.18[c]	2819	700
Malawi (DHS, 2004)	2866	4.4	1201 (41.9)	0.70	785 (27.4)	0.40	2006	1146
Mali (DHS, 2001)	2263	5.3	1231 (54.4)	1.01[c]	33 (1.4)	0.05[c]	2287	106
Mauritania (DHS, 2004)	514	5.8	288 (56.0)	1.00	1 (0.1)	0.40	514	206
Mozambique (DHS, 2003)	3888	4.9	692 (17.8)	0.31[c]	292 (7.5)	0.16[c]	1225	611
Namibia (DHS, 2000)	389	5.1	51 (13.1)	0.23[c]	19 (5.0)[d]	0.11[c]	88	43
Niger (MICS, 2000)	1997	5.9	475 (23.8)[b]	0.43[c]	37 (1.8)[b]	0.05[c]	856	107
Nigeria (DHS, 2003)	25 182	5.0	2972 (11.8)	0.23	554 (2.2)	0.06	5792	1524
Rwanda (DHS, 2005)	1965	4.6	358 (18.2)	0.30	289 (14.7)	0.20[c]	589	393
Sao Tome and Principe (MICS, 2000)	28	5.1[a]	15 (53.4)[b]	0.99[c]	12 (41.7)[b]	0.78[c]	27	22
Senegal (DHS, 2005)	1340	8.7	509 (38.0)	0.90	271 (20.2)	0.40	1206	536
Sierra Leone (MICS, 2000)	893	5.1[a]	198 (22.2)[b]	0.40[c]	24 (2.7)[b]	0.07[c]	355	63
Somalia (MSS, 2005)	1629	5.1[a]	228 (14.0)	0.24[c]	33 (2.0)	0.06[c]	396	93
South Africa	11 171	4.2	1230 (11.0)[d]	0.19[c]	470 (4.2)[d]	0.10[c]	2077	1083
Sudan, North (MICS, 2000)	4985	6.6	1555 (31.2)[f]	0.57[c]	36 (0.7)[f]	0.03[c]	2840	168
Swaziland (MICS, 2000)	203	5.1[a]	10 (5.0)[b]	0.07[c]	0.4 (0.2)[b]	0.02[c]	15	4.8
Togo (MSS, 2005)	1138	5.4	747 (65.6)	1.22[c]	711 (62.5)	1.16[c]	1392	1318
Uganda (AIS, 2005)	6003	4.8	1561 (26.0)	0.50	43 (0.7)[e]	0.03[c]	3002	201
Tanzania (DHS 2004)	7679	4.9	3555 (46.3)	0.90	1735 (22.6)	0.40	6911	3072
Zambia (MIS, 2006)	2244	5.2	1124 (50.1)	0.90	996 (44.4)	0.78	2020	1750
Zimbabwe (DHS, 1999)	2970	4.2	303 (10.2)	0.17[c]	771 (3.9)[d]	0.09[c]	507	1464
Mean, population-weighted		5.2	23.8	0.44	6.7	0.13		
Median		5.1	26.0	0.50	3.9	0.10		
Total	**143 908**		**31 867**		**9373**		**57 754**	**18 371**

Abbreviations: AIS, AIDS Indicator Survey[21]; DHS, Demographic and Health Surveys[21]; ITN, insecticide-treated net; MICS, Multiple Indicator Cluster Surveys II[22]; MIS, Malaria Indicator Surveys[23]; MSS, malaria-specific survey.[24-26]

[a] In the absence of data, the median household size (5.1 people) across countries with data points (from the DHS) was used instead.

[b] Estimated from reported use in children younger than 5 years according to (1) percentage of mosquito net use in children younger than 5 years = –4.2% + 0.875 × (percentage of households possessing ≥1 mosquito nets) and (2) percentage of ITN use in children younger than 5 years = 0.55 × (percentage of households possessing ≥1 ITNs).[19]

[c] Approximated from the relationship between the proportion of households with at least 1 net or ITN and the corresponding mean nets or ITNs per household (Figure 1).

[d] In the absence of survey data, estimated as the mean among neighboring countries.

[e] The surveys from Chad (DHS, 2004) and Uganda (AIS, 2005) did not report on the treatment status of nets available in households. We therefore estimated ITN possession based on the relative net vs ITN coverage from the previous surveys (MICS, 2000, and DHS, 2000-2001, respectively) available for these countries.

[f] Data reflect only northern Sudan.

Why Non-fulfillment of Commitment

XVII. Unequal distribution of resources - in some situations even when nets are available, the children from the richest fifth of the population are twice as likely to receive appropriate anti-malarial treatment than those from the poorest fifth of the population e.g. rural Tanzania

XVIII. Mixed and confused information on the efficacy of ITNs as opposed to LLINS

- ITNs are mosquito nets that have been dipped into a WHO recommended insecticide.
- LLINS are factory treated mosquito nets made with netting material that has insecticide incorporated around the fibers.

WHO's own Problems

I. RBM's 'Cabinet Project' designation has been lost over time - now seen as just another WHO program

II. RBM Partnership - no clear meaning of partnership - partners avoid responsibility for RBM, blame WHO when something goes wrong

III. Initial problem with RBM governance structure - RBM now has a governance structure headed by an Executive Director answerable to the RBM Partnership Board of 23 members.

WHO's own Problems

IV. Initial plan to create Resource Networks (RNs) was not matched with the $200,000 budgets. Technical Support Networks (TSNs) replaced RNs but have poor performance records - only 4 active TSNs remain

V. World Bank's role- Lackluster- only 16% of its Malaria activities commitments are to Africa despite its pledge of $300-$500million towards malaria control in Africa. Problem with sourcing these WB Funds is that countries had to request them, take steps to prepare plans, and drive process forward

What is To Be Done?

I. Governments, African especially, should pump more money into the program:

- Comprehensive malaria control in Africa is achievable by 2010 at a minimal cost of $3billion annually - Earth Institutes' Malaria Program
- Long-lasting insecticide bed-nets (LLINs) which have proven effective in malaria control can be acquired for as little as $0.60 per person per year - Earth Institutes' Malaria Program

What is To Be Done?

II. Strengthen WHO/AFRO RBM leadership.

III. Develop a critical mass of technical expertise.

IV. Expand community access to prevention tools as the newly formed group, Mobilizing Against Malaria (MAMA) is advocating.

V. RBM should develop clear strategies with respective countries' input.

What is To Be Done?

VI. Encourage more research into effectiveness of anti-malaria drugs.

VII. African countries should work with Clinton Foundation which has succeeded in negotiating a 90% reduction in the market price of life-saving anti-malaria artemisinin combination therapy (ACT) drugs;

- Even with this the price, of $8-$10 per treatment is too high for many Africans. More negotiations are needed to reduce the prices further.

What is To Be Done?

VIII. African governments and the International community should support the ff initiatives:

- Nets for Life launched in 16 African countries by Standard Chartered Bank, Coca-Cola Africa Foundation, Exxon-Mobile, and The Anglican Church to distribute 1million bed-nets in the 16 countries at a cost of $12milion
- The UN Foundations, Sports Illustrated, the NBA's NBA Cares and the United Methodist Church's campaign for donations for nets through a website - www.nothingbutnets.net

What is To Be Done?

IX. African countries should seek funds to establish factories for producing bed-nets as it is being done in Tanzania.

X. The Bill and Melinda Gates Foundation should be commended for the funds (about $800million) it has committed to the fight against malaria

- More funding should be committed to research on malaria - the current malaria research funding of about $325million (Malaria Research Alliance), which constitutes about less than 0.3% of total health research spending is grossly inadequate (Bill and Melinda Gates Foundation 2006)

What is To Be Done?

XI. President Bush's $1.2billion, 5-year Malaria Initiative launched in June 2005 should be expanded to cover all the malaria endemic African countries.

XII. The controversies surrounding DDT must be resolved. The International Innovative Vector Control Mechanism Consortium must be supported with more funds for research.