

African Summit on Roll Back Malaria Summary Report

The African Summit on Roll Back Malaria was held in Abuja, Nigeria on the 25th of April 2000. It reflected a real convergence of political momentum, institutional synergy and technical consensus on malaria (and, to some extent, other infectious diseases issues).

Forty four of the fifty malaria-affected countries in Africa attended the summit. Nineteen country delegations were led by the Heads of State, while the remaining delegations were led by senior government officials including the Vice President, Prime Minister or, in some cases, the Minister of Health. The Summit was also attended by the senior officials from each of the four founding agencies -- Director General of the WHO, Vice President of the World Bank, Executive Director of UNICEF, and Director of UNDP Africa, as well as other key partners including UNESCO, the African Development Bank, USAID, DFID, CIDA, and the French Co-operation. The Heads of State and other delegates reviewed evidence, debated options and ratified an action-oriented declaration with strong follow-up processes. WHO, UNICEF, the World Bank, the African Bank, CIDA, DFID, USAID and other development partners worked as one in supporting the preparation and the Summit itself. The next stage for RBM in Africa will be intense: catalyzing more effective activity within communities, strengthening capacity in countries, managing expectations and finding mechanisms to ensure support for malaria actions within evolving health sector and human development strategies.

We sense that there really has been a step-up in prospects for the next decade: it certainly felt like it in Abuja as Heads of State, supported by Jeffrey Sachs, invited us all to re-appraise past thinking about the costs for Africa's development associated with ill health, and the benefits of global support for effective interventions, in Africa.

Technical Briefing

Preceding the summit, a technical session was held at the same venue on the 24th of April 2000. Ministers of Health, senior Ministry of Health officials and malaria control programme managers, attended the technical session. Participants heard presentations on:

- Overview of malaria in Africa (significance of RBM),
- Burden of malaria,
- Evaluation of different intervention measures for malaria control in Africa,
- Health systems reform, policies and resource mobilization for malaria control,
- Use of insecticide treated nets (UNICEF experience in five African countries),
- Home management of malaria,
- Malaria vaccine development and field evaluation in Africa, and
- Malaria research in Africa.

Finally, the draft Declaration and the Plan of Action were thoroughly reviewed and debated. In closing the session, a task committee was established to strengthen the draft Declaration and Plan of Action in preparation for the Heads of State Summit.

African Summit on Roll Back Malaria

His Excellency, Chief Olusegun Obasanjo the President of Federal Republic of Nigeria, chaired the Heads of State Summit. The Summit ran the full day on the 25th April 2000 from 8:00 AM to

19:00 PM. Delegates heard speeches from the Heads of State (or delegation), and the partner agencies. The Summit concluded with the review and signing of the Declaration and the Plan of Action (all countries present signed the Declaration).

By signing Declaration, the African leaders rededicated themselves to the principles and targets of the Harare Declaration of 1997. They committed themselves to an intensive effort to halve the malaria mortality for Africa's people by 2010, through implementing strategies and actions for Roll Back Malaria, as agreed at the Summit. In addition, they agreed:

- to catalyze actions at regional level to ensure implementation, monitoring and management of Roll Back Malaria;
- to initiate actions at country level to provide resources to facilitate realization of RBM objectives;
- to work with partners towards stated targets, ensuring the allocation of necessary resources from private and public sectors and from non-governmental organizations; and
- to create an enabling environment in their countries which will permit increased participation of international partners in malaria control actions.

The Leaders resolved to initiate appropriate and sustainable action to strengthen the health systems to ensure that by the year 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,
- at least 60% of those at risk of malaria, particularly children under five years of age and pregnant women, and 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, and
- at least 60% of all pregnant women who are at risk of malaria, especially those in their first pregnancies, have access to chemoprophylaxis or presumptive intermittent treatment.

The Heads of State called upon all countries to undertake and continue health systems reforms which will promote community participation and joint ownership of Roll Back Malaria actions to enhance their sustainability. Health systems should make diagnosis and treatment of malaria available as peripherally as possible, including home treatment, and accessible to the poorest groups in the community. In addition, countries must continue to maximize vigilance to prevent the re-emergence of malaria.

Development partners were called upon to cancel in full the debt of poor and heavily indebted countries within Africa in order to release resources for poverty alleviation programmes, such as Roll Back Malaria and to allocate substantial new resources of at least US\$ 1 billion per year to Roll Back Malaria. Additional resources are also needed to stimulate the development of malaria vaccines appropriate for Africa and to provide similar incentives for other anti-malaria technologies. The collaboration between research institutions within Africa and partners throughout the World should be strengthened and sustained to ensure the full utilization of research knowledge and programme experience.

The Leaders themselves pledged:

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

The Leaders mandated the Government of Nigeria to report the outcome of this Summit on Roll Back Malaria to the next OAU summit for follow up action. In addition, they requested the Regional Committees of the African and East Mediterranean Region to follow up the implementation of this Declaration and regularly report to the OAU and seek collaboration with UN agencies and other partners.

The Summit host, His Excellency Olusegun Obasanjo, President of Nigeria, in his closing remarks observed, "Today we have begun to write the final chapter of the history of malaria. We have raised the hopes and expectations of our people - we must not let them down. We cannot afford to let them down. May malaria be rolled out and development rolled in all African countries."

Reflections on Next Steps for the Global Partnership

The Abuja summit has provided both the momentum and tools required to transit into scaling up phase at country level. The RBM partnership should take advantage of this opportunity to provide much more clear information on available resources and procedures for accessing them, to swiftly and systematically bring to conclusion the inception phase with the necessary drama for partnership building, and to mount a concerted effort for inter-country activity.

1. Strengthening of country level resource base.

Several partners used the Summit as an opportunity to pledge additional resources to rolling back malaria. The Secretariat should work with these partners to make these resources available, informing countries as to the best method to access the resources.

2. Swift and Systematic conclusion of the inception phase with country-level joint missions and round table discussions

The RBM partnership should take advantage of the momentum generated by the Abuja summit to launch scaling up activity in over 30 malaria affected countries. This should be in line with agreed strategies, plans of work, milestones, resource management mechanisms and monitoring and evaluation frame and systems. This process has been facilitated by the adoption of the action plan, targets and monitoring frame by the 44 country delegations that signed the declaration.

The inception process has already led to: broad-based consensus within countries, structured situation analyses, and, in some cases, additional resources. The RBM partnership, working through a series of rapid consultations, could, for each country, agree:

- a. Base-line situation in relation to the indicators agreed in Abuja
- b. Milestones for scaling up of malaria interventions and strengthening of systems using the framework agreed in Abuja, and the draft strategy and situation analyses prepared by country partnerships
- c. Resources and sources to be committed in each country
- d. Financing arrangements and essential management capacities (paying particular attention to resource absorption issues) suited to each individual country scenario to ensure that the resources pledged in Abuja are disbursed efficiently and effectively.

It may be possible to stagger the commencement of the implementation phase across Africa:

1. June - July 2000

Country tracking information indicates that Botswana, Namibia, South Africa, Kenya, Ghana, Ethiopia, Eritrea, Mozambique, Mali, Zimbabwe, Sudan, Zambia, Uganda, have either finalized or are about to finalize their national strategy documents. These countries would then be ready to bring the inception phase to a close and allow the partnership to commence the implementation of activities for scaling up. This could take place in June - July 2000 in these countries.

2. October 2000

By August 2000, Senegal, Mauritania, Burkina Faso, Tanzania, Niger, will have completed situation analysis and will be ready for implementation. A second round could take place in October 2000.

3. November - December 2000

By October 2000, Benin, Côte d'Ivoire, Togo, Gabon, Cameroun, Gambia, Tchad, Nigeria, Djibouti will have completed situation analysis and should be ready for implementation which could take place in the November-December 2000 period.

4. January - February 2001

Angola, DRC, Sierra Leone, Liberia have already initiated intensive activity for rolling back malaria in a combination of approaches with some areas covered by government led partnerships and other through NGO activity. It should be possible working through the complex emergency network to mount a series of consultations towards more structured exercises for scaling up RBM activity by the beginning of next year.

Within the next nine months, scaling up activity could therefore be launched in over 30 malaria affected countries in line with agreed strategies, plans of work, resource management mechanisms, and monitoring and evaluation systems.

3. Scaling up of inter-country activity

The Declaration explicitly calls for neighboring countries to work together on cross border strategies. A plan for strengthening the existing multi-country initiatives should immediately be developed. In addition, other countries should be encouraged to explore areas/issues for inter-country cooperation and collaboration. Partners could work together intensively to plan a facility that will make this possible, establishing institutional mechanisms to manage it, new approaches

to enabling poor people to access goods and services, and mobilizing the necessary resources for this purpose.

Statement at the Summit on Roll Back Malaria in Africa

Abuja, Nigeria 25 April 2000

Honourable Mr President and heads of governments,
Excellencies,
Ladies and Gentlemen,

Thank you, your Excellency, for this extra-ordinary initiative - for bringing us together, to focus on health and development.

Before I became Director General of WHO in 1998 Africa's leaders told me that malaria undermines the development of their people. I was asked, several times, why the suffering and poverty caused by malaria was so often overlooked in development dialogue. I resolved that WHO should do much more to support Africa's efforts to control malaria.

Mr President

Professor Jeffrey Sachs has just presented to us his report on the economic effects of malaria. As I listened to him, I was struck by the enormity of the damage caused by this ancient disease. A loss of economic growth of more than one percentage point per year. A 20% reduction in GNP after 15 years. Short term benefits from malaria control of up to \$12 billion each year. These are staggering numbers.

I conclude that Malaria is taking a big bite out of Africa's economic growth. For every year that malaria is left unchecked, it will cause African nations to fall further behind the rest of the world. But malaria is not just an African issue. Malaria and its economic impact threaten our stability as a global community and threaten the future of our increasingly global economy.

I do not accept a future with ever widening differences in the growth of nations. Together we must fight for a future free from the burdens of malaria

- If we can control malaria, we will see an acceleration of Africa's development
- If malarious areas are free of the disease, family incomes will rise
- If there is less malaria in homes, school attendance will increase - sometimes dramatically.

At yesterday's technical meeting, Africa's scientists told us of the tools needed to roll back this cause of suffering and poverty, to banish this obstacle to economic growth.

- Insecticide treated nets in the home reduce transmission and prevent infection.
- Indoor spraying with safe insecticides prevents infection.
- Treatment during pregnancy protects the mother's health and improves birth weight.
- Rapid diagnosis and early treatment of someone with malaria shorten the illness and reduce death rates.

These interventions appear simple. Ensuring their success is not. To be effective they must reach all at risk.

In many countries malaria has been a fact of life and death for so long that individuals, families, communities and institutions tolerate its burden. Outspoken commitment, vision and energy are essential to overcome this sense of fatalism and resignation surrounding malaria.

Your excellencies:

I am delighted that you have come here today to turn the tide.

Over the last two years, your Governments have joined forces with the WHO, UNICEF, UNDP, the World Bank, the African Development Bank, with development agencies, research groups, non-governmental organisations and private corporations in starting to build a powerful movement. This is the movement to Roll Back Malaria. The spearhead for this movement is in Africa.

In more than 20 countries, malaria is now being tackled through all branches of government and with increasing involvement of the private sector.

However, much more remains to be done.

Malaria needs a high profile throughout African society. Everyone needs to realise the full impact of this disease, to agree on the goals, and to know how they can be realised in different settings.

We - the partners supporting the Roll Back Malaria Movement - must continue to support applied research to identify and apply the best anti-malaria therapies. This will help to counter the development of drug resistance. We need to find better ways to improve access to drugs, and to prevent counterfeiting. We need to work together to review taxes and tariffs on mosquito nets and other commodities. We need to coordinate the many contributions — financial and technical — of the Roll Back Malaria partners at country level. And, most importantly, we need to monitor achievements.

We need to involve the parts of the private sector that can help get goods and services to people. It has the distribution networks, the communications skill and the marketing resources. We would like private entities to be true partners in the movement. Several are already involved in the Medicines for Malaria venture.

In all this work, we count on you, the Heads of State and Governments, to lead us, so that we work together effectively in Rolling Back Malaria.

Mr President,

The turn of the century coincides with a remarkable shift in thinking about human development. I sense a growing realisation among decision-makers that to reduce poverty we must improve health. Illness - particularly malaria - keeps Africa's people and their nations poor. Bad health locks people into poverty. Healthy populations have better school attendance, higher incomes and more rapid economic development.

I anticipate that today we will agree an approach on rolling back malaria that also applies whether we are tackling tuberculosis, HIV/AIDS, maternal ill-health, tobacco-related ill-health or other priority problems. It means:

- Information campaigns, to increase knowledge and understanding and empower people to act to improve their health
- Access to essential drugs, vaccines, and other commodities;
- Effective health services - close to the home; and
- A healthy environment - with clean water and sanitation

It certainly includes actions within communities, responsive to the needs of poor people, supported by all sectors of society.

We partners are working together to mobilise large increases in resources for health, to reduce the prices of drugs and commodities, to minimise tariffs and taxes on these goods, to support the discovery and development of effective drugs and vaccines, and to back-up effective action at country level.. These are all concrete and target-oriented actions. They bring results.

Mr President:

Your vision has brought us here today, to focus on malaria. But I am sure you would agree that poverty is our real enemy.

We now have an extraordinary window of opportunity.

We have Governments, international organizations, NGOs and the private sector ready to work together to achieve agreed health goals, and so contribute to prosperity.

We have a potential for dramatic increases in resources for health.

That means, the number of malaria deaths can be halved within ten years.

There will be further health gains. This summit will help us move forward.

The impact will be extraordinary. Africa will have stronger health systems, healthier populations and faster-growing economies.

Thank you.

PRESS RELEASE

April 25 2000

Abuja, Nigeria - African Leaders today called on the world to cancel the debt of poor and heavily indebted countries to enable them to fight the poverty caused by malaria.

The leaders were gathered in Abuja, Nigeria, for the first ever summit on malaria.

The African heads of state signed a declaration calling for at least one billion US dollars a year to be made available to the Roll Back Malaria movement in Africa to help achieve its aims of halving malaria deaths by the end of the decade.

By the end of the two day summit up to 750 million dollars extra funds were already promised to be made available. Funds were identified by Canada, UK, US, the World Bank and other sources.

The summit declaration also called on development partners to invest in malaria vaccine development in Africa and strengthen research.

Summit host, His Excellency Olusegun Obasanjo, President of Nigeria, in his closing remarks said: "Today we have begun to write the final chapter of the history of malaria.

"We have raised the hopes and expectations of our people - we must not let them down. We cannot afford to let them down. May malaria be rolled out and development rolled in in all African countries."

The Plan of Action includes a structure to tackle malaria at all levels from the whole of Africa to the smallest village community with an emphasis on simple but effective technologies, in the home, implemented by public, private and voluntary groups.

MONDAY 24TH APRIL, 2000
PROGRAMME FOR TECHNICAL SESSION

- 12:00-12:05 NATIONAL ANTHEM
- 12:05-12:10 INTRODUCTION OF THE HON. MINISTER OF HEALTH AND OTHER OFFICIALS
- SUMMIT MANAGER — **DR EDUGIE ABEBE**
- 12:10-12:25 WELCOME ADDRESS, OBJECTIVES AND EXPECTED OUTCOME
- CHAIRMAN - HON. MINISTER OF HEALTH, NIGERIA — **DR. TIM MENAKAYA**
- 12:25-12:35 STATEMENT
- THE DIRECTOR GENERAL, UNESCO — **MR KOICHIRA MATSUURA**
- TECHNICAL PRESENTATION
- 12:35-12:55 Overview of malaria in Africa, significance of RBM WHO/AFRO
- **Dr. A. KABORE**
- 12:55-13:05 Burden of malaria
- **DR N. B. MOLTA**
- 13:05-13:15 Evaluation of different intervention measures for malaria control in Africa
- **PROF. W. N. OGALA**
- 13:15-13:25 Health systems reform, policies and resource mobilisation for malaria control
- **PROF. J. D. ADENIYI**
- 13:25-13:35 Use of insecticide treated nets: UNICEF experience in five African countries
- **Dr K. MULKELABAI**
- 13:35-13:45 Home management of malaria
- **DR. R. E.UMEH**
- 13:45-13:55 Malaria vaccine development and field evaluation in Africa
- **PROF. W. KILAMA**
- 13:55-14:05 Malaria research in Africa
- **PROF. L.A SALAKO**
- 14:05-14:15 Taxes and Tariffs
- **PROF. J. SIMON**
- 14:15-15:15 DISCUSSION
- 15:15-16:15 LUNCH BREAK
- 16:15-18:15 PRESENTATION AND DISCUSSION OF THE DRAFT DECLARATION AND THE PLAN OF ACTION
- HON. MINISTER OF HEALTH, REPUBLIC OF BENIN

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| 18:15-18:25 | REMARKS • HON. MINISTER OF HEALTH, MOZAMBIQUE |
| 18:25-18:30 | CLOSING STATEMENT • HON. MINISTER OF HEALTH, NIGERIA DR. TIM MENKAYA |
| 18:30 | NATIONAL ANTHEM |

**TUESDAY 25TH APRIL 2000
FIRST SESSION**

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| 8:00-9:00 | TRADITIONAL AFRICAN WELCOME AT CONGRESS HALL |
| 8:00 | GUESTS TO BE SEATED |
| 8:15 | ARRIVAL OF HEADS OF INTERNATIONAL AGENCIES |
| 8:30-9:00 | ARRIVAL OF HEADS OF STATE AND GOVERNMENT |
| 9:00-9:10 | NATIONAL ANTHEM/WELCOME SONG BY SCHOOL CHILDREN |
| 9:10-9:15 | INTRODUCTION AND OBJECTIVES OF THE SUMMIT HON. MINISTER OF HEALTH NIGERIA • DR. TIM MENAKAYA |
| 9:15-9:25 | ECONOMIC IMPACT OF MALARIA • PROF. JEFF SACHS , Harvard university, USA |
| 9:25-9:40 | MALARIA IN AFRICA - VIDEO PRESENTATION |
| 9:40-9:50 | STATEMENT BY THE DIRECTOR GENERAL, WHO • DR. IBRAHIM M. SAMBA |
| 9:50-10:00 | STATEMENT BY THE REGIONAL DIRECTOR, WHO/AFRO • DR GRO HARLEM BRUNDTLAND |
| 10:00-10:10 | STATEMENT BY THE SECRETARY GENERAL OF OAU • DR SALIM AHMED SALIM |
| 10:10-10:15 | SELF-HELP PROJECT ON MALARIA - VIDEO PRESENTATION |
| 10:15-10:35 | WELCOME ADDRESS/OPENING OF THE SUMMIT • HIS EXCELLENCY, CHIEF OLUSEGUN OBASANJO PRESIDENT OF THE FEDERAL REPUBLIC OF NIGERIA |

SECOND SESSION

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| 11:15-11:25 | ADDRESS - THE CHAIRMAN, OAU • HIS EXCELLENCY ABDULAZIZ BOUTEFLIKA, PRESIDENT OF ALGERIA |
| 11:25-13:00 | STATEMENTS FROM HEADS OF STATE AND GOVERNMENT |
| 13:00-15:00 | LUNCH BREAK |

THIRD SESSION

15:00-16:00 STATEMENTS FROM HEADS OF STATE AND GOVERNMENT
STATEMENT FROM PARTNERS

16:00-16:10 UNDP - ADMINISTRATOR
• **MARK MALLOCH BROWN**

16:10-16:20 UNICEF - EXECUTIVE DIRECTOR
• **CAROL BELLAMY**

16:20-16:30 WORLD BANK - VICE PRESIDENT
• **EDUARDO DORYAN**

16:30-16:35 UNESCO - DIRECTOR GENERAL
• **KOICHIRO MATSUURA**

16:35-16:45 ADB - PRESIDENT
• **OMAR KABBAJ**

16:45-16:50 DFID -SECRETARY OF STATE
• **HON. CLARE SHORT, MP**

16:50-16:55 USAID

16:55-17:00 JAPAN -DEPUTY DIRECTOR GENERAL
• **YASAAK NOGAWA**

17:00-17:05 CIDA - MINISTER OF INTERNATIONAL COOPERATION
• **HON. MARIA MINNA**

17:05-17:35 TEA/COFFEE BREAK

READING AND ADOPTION

17:35-18:15 **ABUJA DECLARATION ON ROLL BACK MALARIA AND THE PLAN OF ACTION**

18:15-18:30 **SIGNING OF THE DECLARATION**

18:30-18:45 CLOSING REMARKS
• **CHIEF OLUSEGUN OBASANJO PRESIDENT FEDERAL REPUBLIC OF NIGERIA**

18:45 NATIONAL ANTHEM

WELCOME

Dear Colleagues,

Welcome to the second news bulletin on the African Summit on Roll Back Malaria. Since I last wrote to you much has happened, not only in Nigeria, where plans are well advanced for the Summit, but also in the rest of Africa and also in Europe as the countdown to the Summit continues.

The Roll Back Malaria teams in Harare, Alexandria, Lagos, Abuja, Johannesburg, Geneva, London and Washington hope you find this bulletin both interesting and informative. Most of all we hope it conveys our excitement at the historic event now just a matter of days away.

The Summit Secretariat is now operational at the Hilton Hotel in Abuja and the staff there will be happy to answer any questions you may have.

With best wishes,

Dr David Nabarro
Executive Director
Office of the Director General, WHO Geneva

GOVERNMENT GUESTS...

Many African leaders responding to the malaria challenge will be in Abuja. At the time of writing 18 countries have agreed to attend the Summit and new acceptances are coming in to the Summit Secretariat every day. The United Kingdom's Secretary of State for International Development Clare Short will attend as will the Honourable Maria Minna, Minister for International Cooperation of Canada.

... AND AGENCIES ATTENDING

UNICEF's Executive Director, Carol Bellamy has accepted President Obasanjo's invitation to the African Summit. She will be joined by other agency leaders including the Director General of WHO, Dr Gro Harlem Brundtland, UNDP Administrator Mark Malloch Brown and Director General of UNESCO Koichiro Matsuura.

Roll Back Malaria partners will be present at the Summit. The World Bank will be represented by the Vice President of Human Development, Mr. Eduardo Doryan. The President of the African Development Bank Mr Shabbaj will also attend to reinforce one of the Summit's key messages — the economic impact of malaria on the development of Africa.

BIG, BIG NET

An exciting media event is scheduled to take place in Abuja on 18th April to draw attention to the Summit and one of its main messages.

A group of 225 Nigerian school children will lie under a giant bednet — 225 times larger than the standard insecticide treated nets used to protect against malaria — in an attempt to set a world record.

The bednet measures a massive 20 metres by 20 metres and three metres high. So far there is no record for the largest bednet. Usually bednets are made to cover the area above a standard double bed. An ordinary net will be positioned next to the record-breaking giant. Guinness World Records will be on hand to validate the attempt.

The event, in Abuja, takes place exactly one week before African Heads of State meet there for the first-ever Summit on malaria. Nigeria's First Lady Chief Mrs Stella Obasanjo has been invited to lead the ceremony. It will also act as a reminder that 225 African children die of malaria every two and a half hours.

PRIVATE SECTOR

A meeting to encourage private sector involvement in the implementation of RBM in Nigeria is being hosted by the local UNICEF office set in Abuja on 19th April.

RBM IN THE AIR

The very next day after the African Summit on Roll Back Malaria another important meeting — the United Nations Education Summit — gets underway in Dakar, Senegal. In order to make transfers from Abuja to Dakar as smooth as possible, a specially chartered aircraft will be available.

The flight will leave Abuja at 10 p.m. on Tuesday 25th April, arriving in Dakar at 01.00 Wednesday morning. This allows our guests to be in Dakar in time for the opening of the Education Summit.

If you wish to take advantage of this direct connection, there are still remaining seats. Cost is US\$ 900 for a first class seat and US\$ 600 for an economy fare. Please contact Obi Nwaorgu or Norma Johnston at the Summit Secretariat on +234 9 523 9125; +234 9 523 0225 or +413 1811/40. A table will be set up at the Nicon Hilton during the Summit. Reservations can be confirmed or made at that time. Payment by cash or travellers check will be made at that time.

Please note that Senegal is one hour ahead of Nigeria.

DECLARATION OF INTENT

A draft of the Declaration to be agreed by attending Heads of State or their representative has already been sent to those who have indicated that they will be attending. The four-page document and its accompanying Plan of Action are vital reading for all attendees.

For those with a technical interest in the Summit's content, an invaluable Working Document has been produced by the Summit's Technical Sub Committee.

FULL PROGRAMME

Another item in the delegate pack is the programme for the Summit on 25th April and also for the Technical Meeting on 24th April. The Technical Sub Committee meeting on the 24th April is to be attended by African Ministers of Health.

An outline for the 25th is given below. A full programme will be available by 14th April from the Summit Secretariat.

25th April programme

- 8:30 a.m. Summit welcome: African dancers and musicians
- 9:00 a.m. Arrival of Heads of State
- 9:30 a.m. Introduction by the Nigerian Honourable Minister of Health Dr Tim Monakaya
- 9:40 a.m. Economic Impact of Malaria — Jeff Sachs, Harvard economist
- 9:50 a.m. Video Presentations — African villagers appeal to Heads of State
- 10:15 a.m. Speeches by Regional Director WHO/AFRO, Director General WHO, Secretary General OAU and His Excellency the President of Nigeria
- 3:00 p.m. Presentations by donor countries and international agencies

4:15 p.m. Reading and Signing of Declaration
5:15 p.m. Closing remarks
5.25 p.m. Press Conference and interviews

ON ARRIVAL

A warm Nigerian welcome awaits you on arrival at Nnamdi Azikiw International Airport in Abuja. Transport will be provided to take participants to the hotels in Abuja which are a 30-minute drive from the airport.

GALA EVENING

After a hard day's work a state gala dinner is to be hosted by His Excellency President Olusegun Obasanjo at Abuja's Sheraton Hotel and Towers. Cultural displays and music from the Brigade of Guards will get the evening off to a flying start at approximately 8 p.m. Dress is national or formal.

ROOMS, ROOMS, ROOMS

Accommodation for the Summit is being offered at various locations throughout Abuja. A full list of accommodation has been included in each delegate pack. For further information please contact the Summit Secretariat. The Federal Government to Nigeria has kindly agreed to reserve and cover the cost of accommodation for each Head of Delegation plus two other delegates. All other delegates attending are invited to indicate their preferred accommodation from the official list of hotels and contact the Summit Secretariat to secure a booking or alternatively contact the hotel direct to make a reservation (**please inform the Secretariat if you have done so**). The list of hotels is attached to this copy of *MaSum*.

PUBLICITY MATTERS

A global network of communications point people has been set up to help provide Summit information to the media.

Please note: If you are aware of any journalists or news crews from outside Nigeria wishing to attend either the massive bednet event or the Summit they need to alert either Austine Oghide or Andy Seale to ensure Nigerian Government Accreditation.

For those involved in securing coverage for events from outside of Nigeria the following contacts will be useful.

For Nigeria and AFRO region publicity

Austine Oghide WHO Nigeria
Tel. +234 1 545 3662/3 or +234 9 314 8776/7

Sam Ajibola WHO AFRO
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For WHO HQ and foreign reporters attending the Summit

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RBM on the World Wide Web

Check out the **Press Pack** on the Roll Back Malaria Website www.who.int/rbm

TO FIND OUT MORE

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African Summit on Roll Back Malaria

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GREETINGS

Dear Colleagues,

Welcome to this our first news bulletin on the African Summit on Roll Back Malaria. This ground-breaking Summit for African Heads of State is to be held in Abuja, Nigeria on 25th April 2000. It will be preceded by a Technical Meeting on the afternoon of Easter Monday 24th April, also in Abuja. This bulletin gives you all the information currently available about the Summit, and details of how to contact us if you have any questions. On behalf of the Roll Back Malaria teams in Geneva, Harare, Cairo, Lagos and Abuja, I look forward to hearing from you. With best wishes,

Dr David Nabarro
Project Manager, Roll Back Malaria

AFRICAN LEADERSHIP

Why is this malaria summit being held? What prompted it?

In the past decade, Africa's leaders have called for concerted action to address the impact of malaria on their people. In June 1997, African Heads of State signed the Harare Declaration on Malaria. This was followed by the African Initiative on Malaria (AIM), which was endorsed by the African Region of the World Health Organization in 1998. The World Bank, the African Development Bank, WHO, UNICEF and UNDP have responded and were supported by several member nations of the Organization for Economic Co-operation and Development (OECD) thereby, accelerating malaria control efforts throughout the continent.

Renewed backing for malaria control by WHO began with the election of Dr. Gro Harlem Brundtland, former Prime Minister of Norway, as Director General of WHO in 1998. She committed the organization to intensified support of malaria control - especially in Africa, and through her leadership the Roll Back Malaria (RBM) initiative was launched by WHO, UNICEF, the World Bank and UNDP on October 28, 1998. Partnerships between Governments, development agencies and private groups are now supporting RBM action in more than 20 countries.

SUCCESSFUL SITUATIONS

More vigorous action is needed, particularly in communities within tropical Africa. Success has been reported in situations where Governments work closely with other bodies, both public and private, in movements to Roll Back Malaria.

NIGERIA LEADS THE WAY

African Heads of State are now providing the political leadership required of RBM movements. In particular, President Olusegun Obasanjo of Nigeria proposed in 1999, that an African Summit on Malaria be held and offered to host the Summit with the date set for April 25, 2000, in Abuja, Nigeria. The President has invited WHO and other development partners to work with the Nigerian Government to plan the Summit. At the Summit, Heads of State will reflect on the economic and social burden of malaria and commit themselves to strategies and targets for its reduction.

VIP PARTICIPANTS

More than 50 African Heads of State, G8 Heads of State, the Heads of 10 international development agencies, and more than 12 Development and Health Ministers from OECD countries have been invited to the Summit, and many have already accepted.

BEATING THE BURDEN

Malaria causes more than one million deaths each year. The majority who die are the children of Africa. Deaths linked to malaria in Africa are on the increase due to changes in climate, movement of populations arising from political instability and civil strife, resistance of malaria to common and inexpensive medicines, resistance of mosquitoes to insecticides, and limitations in national health services.

POVERTY

Malaria keeps Africa's people poor. It prevents adults from working and children from attending school. Each year a family spends several months' earnings on malaria treatment and prevention. Malaria turns pregnancy, a normal life process, into a nightmare, in which the mother may die or her baby born too small to survive.

TOWARDS A SOLUTION

It does not have to be like this. Malaria is preventable, treatable and curable. Four elements of the Roll Back Malaria (RBM) strategy point to a solution:

1. People at risk can prevent malaria if they sleep under insecticide treated mosquito nets.
2. Pregnant women, especially those who are pregnant for the first time, can take medicines to prevent and treat malaria.
3. People can treat malaria with a wide variety of effective medicines, and they can cure malaria if they seek and receive treatment early, with effective medication and finally,
4. Families and communities can be empowered to predict and prevent a malaria epidemic and contain it within one week of its being confirmed.

PEOPLE NEED PARTNERS

But, people cannot prevent and treat malaria alone. Governments, health services and all development partners must make sure that low cost mosquito nets, genuine and inexpensive medicines, and timely and accurate information about malaria are available in every neighbourhood and village.

PEOPLE AND PLANNING

Intensive planning is in progress with input from various African Countries and international agencies. A high-level inter-governmental steering committee meets weekly in Abuja, Nigeria. Several subcommittees including a Technical Committee and a Publicity Committee have been established. A Summit Secretariat has been set up to meet the needs of invited dignitaries and guests. A Summit venue with capacity for 1000 persons is being prepared. A communication campaign to highlight the aims of the Summit is underway.

COMMITMENT TO CITIZENS

The Technical Committee is developing scientific papers on various aspects of malaria in Africa. These papers will form the basis of a Declaration that will be considered by African Heads of State at the Summit. In general terms, the Declaration will call for a re-commitment to the intent and goals of the Harare Declaration and a renewed commitment to Rolling Back Malaria. Specific issues that the Heads of State will address include alleviating poverty through reducing the burden of malaria on the citizens of Africa, setting realistic targets based on the four elements of the RBM strategy, supporting needed research that will make RBM strategies more effective, and encouraging development partners to work with governments and communities to mobilise and better manage the financial and human resources needed to Roll Back Malaria.

TIME TO ACT

Heads of State will also be called upon to adopt an Plan of Action based on the provisions of the Declaration and to commit themselves to the implementation, monitoring and evaluation of the Plan of Action. To this end, the Declaration and Plan of Action will be submitted to the Organization for African Unity (OAU) for adoption at its next General Assembly.

MALSUM IN THE NEWS

News Agency of Nigeria, Abuja, 14.1.2000

"The Federal Government of Nigeria has released N100 million (USD 1 million) towards the successful hosting of the Summit of African Heads of State on Roll Back Malaria...Minister of Health Dr Tim Menakaya said that 30 % of childhood mortality was attributable to malaria in Nigeria. He added that more than 50 per cent of outpatients in the country's hospitals were treated for malaria-related cases. The News Agency of Nigeria (NAN) learnt that the idea of the Summit is the initiative of President Olusegun Obasanjo."

MALARIA IN THE NEWS

CNN 22.2.2000

President Clinton speaking with President Nelson Mandela on the occasion of the Burundi peace talks: "Just last week I attended the opening in Washington of our National Summit on Africa...All came because they believe in Africa's promise, and because they want to work with Africans to realise it...by lifting the burden of debt, by supporting education in Africa and fighting malaria..."

FIND OUT MORE

Further information can be obtained from:

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AFRICAN SUMMIT ON ROLL BACK MALARIA, ABUJA, NIGERIA, 25TH APRIL 2000

BRIEF FOR INTERNATIONAL DEVELOPMENT ORGANISATIONS: 2nd MARCH 2000

SUMMARY

Nigeria will host a Summit Meeting of African Heads of State on April 25th 2000. This will set targets for action to tackle Malaria. It will focus on actions to increase the impact of malaria control, through partnerships to "Roll Back Malaria". Working closely with Heads of Development Agencies, and in co-operation with WHO, Heads of State will demonstrate their political commitment to this intensified effort. They will demonstrate the level of resources that they propose to make available. Events taking place at the same time as the summit are likely to attract international interest. Roll Back Malaria is committed to a halving in the world's malaria burden by the year 2010.

THE CHALLENGE OF MALARIA

Malaria causes more than one million deaths each year. The majority who die are the children of Africa. Deaths linked to malaria in Africa are on the increase due to changes in the environment, movement of populations arising from political instability and civil strife, resistance of malaria to common and inexpensive medicines, resistance of mosquitoes to insecticides, and limitations in national health services.

Malaria keeps Africa's people poor. It prevents adults from working and children from attending school. Each year a family spends several months' earnings on malaria treatment and prevention. Malaria during pregnancy is also of great concern, since it adversely affects the mother's health and may result in a baby born too small to survive.

It does not have to be like this. Malaria is preventable, treatable and curable. Four elements of the Roll Back Malaria (RBM) strategy point to a solution:

1. People at risk can prevent malaria if they sleep under insecticide treated mosquito nets.
2. Pregnant women, especially those who are pregnant for the first time, can take medicines to prevent and treat malaria.
3. People can treat malaria with a wide variety of effective medicines, and they can cure malaria if they seek and receive treatment early, with effective medication, within - or close to - their homes, and finally,
4. 4) Families and communities can be empowered to predict and prevent a malaria epidemic and contain it within one week of its being confirmed.

But, people cannot prevent and treat malaria alone. Governments, health services and all development partners must make sure that low cost mosquito nets, genuine and inexpensive medicines, and timely and accurate information about malaria are available in every neighbourhood and village.

AFRICAN LEADERSHIP

In the past decade, Africa's leaders have called for concerted action to address the impact of malaria on their people. In June 1997, African Heads of State signed the Harare Declaration on Malaria. This was followed by the African Initiative on Malaria (AIM), which was endorsed by the African Region of the World Health Organization in 1998. The World Bank, the African Development Bank, WHO, UNICEF and UNDP have responded and were supported by several member nations of the Organization for Economic Co-operation and Development (OECD) thereby, accelerating malaria control efforts throughout the continent.

Renewed backing for malaria control by WHO began with the election of Dr. Gro Harlem Brundtland, former Prime Minister of Norway, as Director General of WHO in 1998. She committed the organization to intensified support of malaria control - especially in Africa, and through her leadership the Roll Back Malaria (RBM) initiative was launched by WHO, UNICEF, the World Bank and UNDP on October 28, 1998. Partnerships between Governments, development agencies and private groups are now supporting RBM action in more than 20 countries.

More vigorous action is needed, particularly in communities within tropical Africa. Success has been reported in situations where Governments work closely with other bodies, both public and private, in movements to Roll Back Malaria.

African Heads of State are now providing the political leadership required of RBM movements. In particular, President Olusegun Obasanjo of Nigeria proposed in 1999, that an African Summit on Malaria be held and offered to host the Summit with the date set for April 25, 2000, in Abuja, Nigeria. The President has invited WHO and other development partners to work with the Nigerian Government to plan the Summit. At the Summit, Heads of State will reflect on the economic and social burden of malaria and commit themselves to strategies and targets for its reduction.

More than 50 African Heads of State, G8 Heads of State, the Heads of 10 international development agencies, and more than 12 Development and Health Ministers from OECD countries have been invited to the Summit, and many have already accepted.

PLANNING THE SUMMIT

Intensive planning is in progress with input from various African Countries and international agencies. A high-level inter-governmental steering committee meets weekly in Abuja, Nigeria. Several subcommittees including a Technical Committee and a Publicity Committee have been established. A Summit Secretariat has been set up to meet the needs of invited dignitaries and guests. A Summit venue with capacity for over 1000 persons is being prepared. A communication campaign to highlight the aims of the Summit is underway.

EXPECTED OUTCOME

The Technical Committee is developing scientific papers on various aspects of malaria in Africa. These papers will form the basis of a Declaration that will be considered by African Heads of State at the Summit. In general terms, the Declaration will call for a re-commitment to the intent and goals of the Harare Declaration and a renewed commitment to Rolling Back Malaria. Specific issues that the Heads of State will address include alleviating poverty through reducing the burden of malaria on the citizens of Africa, setting realistic targets based on the four elements of the RBM strategy (as mentioned above), supporting needed research that will make RBM strategies more effective, and encouraging development partners to work with governments and communities to mobilise and better manage the financial and human resources needed to Roll Back Malaria.

FURTHER INFORMATION FOR PARTICIPANTS FROM INTERNATIONAL ORGANIZATIONS AND OECD GOVERNMENTS

A Proposed Summit Objectives and Technical Programme for the Summit:

This Summit is crucial for securing political commitment to the scale up of activity needed for Rolling Back Malaria in Africa. The President wants a working Summit dedicated to addressing, and preparing to solve, a major impediment to Africa's development.

The following Summit objectives have been proposed and are being examined (late February 2000) by the Summit Technical Sub-Committee and technical advisers from WHO:

- a. Heads of State recognise that malaria is a major impediment to the development of Africa's people.
- b. Heads of State rededicate themselves to the agreements made at the Harare Heads of State meeting and declaration on malaria in 1997.
- c. Heads of State could commit themselves to a goal and targets. These are currently under discussion. The proposed goal would be halving Africa's malaria burden over the next 10 years

Fulfilment of the following targets to enable this goal to be fulfilled:

- 1. a substantial increase, throughout Africa, in the proportion of children and women who are protected through the use of insecticide-treated mosquito netting (desired proportion: at least 60%)
 - 2. a ten-fold increase in the proportion of persons who can access effective treatment for their malaria within 24 hours of the onset of symptoms
 - 3. a substantial increase in the proportion of pregnant women at risk who receive protection from malaria's effects during pregnancy (desired proportion: at least 60%)
 - 4. all African nations to have capacity to detect, and respond effectively - within one week - to malaria outbreaks, and to prevent re-introduction of malaria into areas from which it has been eliminated
 - 5. greater emphasis on research capacity to develop cost-effective anti-malaria products in Africa
- d. Heads of State identify, and propose, a series of policy and programme emphasis necessary for these targets to be fulfilled (greater emphasis on home care, on community-based movements and inter-sectoral action, on responding to the interests and needs of poor people, and on partnerships with the private sector).
 - e. Heads of State secure the support of development partners to the goal, targets and policy/programme changes needed. At least one significant financial commitment to scaling up Roll Back Malaria efforts in Africa should be made at the summit.
 - f. Heads of State agree follow-up mechanisms

The timing is as follows: the sub-committee will establish proposed targets by end February. The draft declaration is due to be prepared March first week. The Technical issues will be presented in a background technical document. This will include outlines of a plan of action for Rolling Back Malaria in Africa, and proposed follow- up mechanisms (an annual report to Heads of State). The declaration and plan of action will be circulated for comment in advance of the Summit: it is expected that they will be modified and then endorsed in Abuja by Ministers of Health before the Heads of State summit (April 24th).

B Proposed Technical Programme for the Summit

It has been proposed that the Summit itself will take place over one long day on April 25th (8am start 7pm finish) with four sessions of - say - one and a half hours each, separated by 30 minute refreshment breaks and a one and a half hour lunch break. It is suggested that the presentation of issues will be split between all four sessions: the first could focus on issues, sessions 2 and 3 on responses and session 4 on future action (including the declaration). Some Heads of State and leaders of development organisations will be asked to present during these plenary sessions. The President and Dr Brundtland would make keynote speeches and contribute to the declaration part at the end. There will be more opportunities for Heads of State and International leaders to make scheduled public statements and answer questions about their particular contributions and plans in parallel media events. It is proposed that the President will host a dinner on the night of the Summit (25th).

C Summit Venue

The Summit will take place in the NICON Hilton hotel. This has capacity for 1500. The Summit is likely to have around 400 official participants, many of whom will be hosted by the Government of Nigeria. It is not yet clear whether there will be opportunities for others (private sector, researchers etc) to participate through the summit in parallel sessions.

D Management of Summit Preparation:

A high-level inter-governmental steering committee meets each week, with the involvement of several subcommittees. Several international and bilateral development organisations are members of this steering committee. The Summit secretariat will handle the expected 50 Heads of State, and their teams, the 20 Heads of international agencies active in health, and the many others who will participate. WHO is participating fully in the preparations for the Summit - particularly the Steering Committee and the various sub-committees. The Summit preparation plan and budget have been agreed, and the communications infrastructure for the Secretariat will be in place within a week. WHO has offered to support the strengthening of capacity both within the Government of Nigeria and the WHO country representative's office to help with Summit preparation. The budget for WHO's contribution includes resources for technical advisers and a consultant summit manager.

Dr Evarist Njelesani (WHO country representative) is based in Lagos and is spending most of his time working on preparations for the Summit. In his office, Malaria is handled by Dr Lola Sadiq. The capacity of Dr Njelesani's office has been strengthened with the secondment from WHO headquarters of Norma Johnston, Roll Back Malaria Campaign Manager (based in Abuja till the Summit: in Geneva 25th February till March 1st) and Obi Nwaorgu, attached to Roll Back Malaria on a Rockefeller Fellowship (similarly based in Abuja). Both stay at the Sheraton Hotel. Melville George, from the WHO Africa Regional Office in Harare, has also been seconded to the WHO country office, with particular responsibility for supporting Technical aspects of summit preparation.

E Handling Invitations:

The GON has sent invitations to the Heads of State of all African nations - through their embassies in Nigeria. The OAU has been invited, also Heads of State of G8, heads of African and international development agencies, development co-operation Ministers from many OECD countries, president of the EC etc.

The President plans to speak personally with a number of African leaders to explain his intentions for the Summit. He will ensure that details of his intentions are circulated to Embassies of African and G8 nations so that they know the objectives and significance of the Summit. An up to date list of attendees will be maintained by the Summit Secretariat: this will be equipped to with effective communications, for handling enquiries about the summit, for tracking responses, for sending follow-up information to those who want to know more before making decisions etc. WHO country

representatives will receive detailed briefings about the Summit objectives and agenda during early March 2000.

F Accommodation, logistics, security and protocol Arrangements

The accommodation sub-committee has made plans to ensure the accommodation for invited guests. The transportation sub-committee will ensure that Heads of State, Heads of International Agencies and other invitees will have the vehicles they need. The Government is paying a great deal of attention to security matters.

Transportation for international guests is receiving special attention. The Summit on Roll Back Malaria in Africa comes straight after Easter, and there are limited direct flights from Europe to Abuja on April 24th. The Summit is followed by a conference on Education in Dakar Senegal on April 26th.

Some of the key guests (International organisations and development partners) need additional air connections into and out of Abuja if they are to come to the Malaria summit. British Airways is being asked to extend its London to Lagos flight on to Abuja on 24th April evening. In the absence of scheduled flight connections, participants will be able to buy tickets for a special flight from Abuja to Dakar late evening 25th April or early morning 26th April. A 30 seater plane will be arranged for the Abuja to Dakar segment in the first instance: additional capacity will be made available if there is demand (WHO Geneva would like to know of demand as soon as possible).

G Communication, publicity and PR

A major programme of publicity is planned and is being worked on jointly by WHO and the publicity sub-committee.

1. The manufacture and display of the world's largest FUNCTIONING mosquito net, together with competitions for different designs on mosquito nets (there will be opportunities for a variety of messages to be displayed on the millions of mosquito nets that will be used by people throughout Africa over the next decade)
2. The launch of an association between African football (particularly goalkeeping) and Roll Back Malaria over the next 10 years, with the theme "GET IN THE NET"
3. The launch of a major report on the economics of malaria in Africa prepared by teams led by Jeffrey Sachs (Harvard University) and Ann Mills (London School of Hygiene and Tropical Medicine)
4. A "people speak to the summit" event in which people of Africa speak to the Summit about the malaria problems they face

There is a possibility that a commemorative postage stamp will be released to coincide with the summit. Documents for the Summit will be prepared in French, English, Portuguese and Arabic.

Further Information:

Dr Eduge Abebe (Summit Manager), Director, Primary Health Care & Disease Control
(Tel/fax +234 9 523 8190)

Dr Antoine Kaboré, Director of Communicable Diseases, WHO Africa Region, Harare, Zimbabwe (Tel +1 407 733 9244, Fax +1 407 726 5062)

Dr Evarist Njelesani, Dr Lola Sadiq, Dr Melville George and Dr Obi Nwaorgu,
WHO Country Office, Lagos, Nigeria
(Tel +234 9 774 1718, Fax +234 9 545 2179)

Ms Norma Johnston, Campaign Manager, Roll Back Malaria, [Attached to WHO country office -

c/o Sheraton Hotel, Abuja]:

(Tel +234 9 523 0225 - 244, Fax +234 9 523 1570 - 1)

Dr David Nabarro, Manager, Roll Back Malaria, World Health Organisation Geneva

(Tel +41 22 791 2769, Fax +41 22 791 4824)

ECONOMIC COSTS OF MALARIA ARE MANY TIMES HIGHER THAN PREVIOUSLY ESTIMATED

Africa's GDP would be up to \$100 billion greater this year if malaria had been eliminated years ago, according to new research by Harvard, London School and WHO

Abuja, Nigeria – The control of malaria in Africa would significantly increase the continent's economic productivity and the income of African families, according to the findings of a new report released today by the World Health Organization, Harvard University and the London School of Hygiene and Tropical Medicine.

"The evidence strongly suggests that malaria obstructs overall economic development in Africa," said Dr Jeffrey Sachs, Director of the Center for International Development at Harvard University. "Since 1990, the per person GDP in many sub-Saharan African countries has declined, and malaria is an important reason for this poor economic performance."

According to statistical estimates in the report, sub-Saharan Africa's GDP would be up to 32% greater this year if malaria had been eliminated 35 years ago. This would represent up to \$100 billion added to sub-Saharan Africa's current GDP of \$300 billion. This extra \$100 billion would be, by comparison, nearly five times greater than all development aid provided to Africa last year.

According to the report, malaria slows economic growth in Africa by up to 1.3% each year. This slowdown in economic growth due to malaria is over and above the more readily observed short run costs of the disease. Since sub-Saharan Africa's GDP is around \$300 billion, the short-term benefits of malaria control can reasonably be estimated at between \$3 billion and \$12 billion per year.

"Malaria is hurting the living standards of Africans today and is also preventing the improvement of living standards for future generations," said Dr Gro Harlem Brundtland, Director General of the World Health Organization. "This is an unnecessary and preventable handicap on the continent's economic development."

The report also finds that:

- Malaria-free countries average three times higher GDP per person than malarious countries, even after controlling for government policy, geographical location, and other factors which impact on economic well-being.
- One healthy year of life is gained for every \$1 to \$8 spent on effectively treating malaria cases, which makes the malaria treatment as cost-effective a public health investment as measles vaccinations. This analysis, carried out by Dr Ann Mills, LSHTM, demonstrates that malaria control tools and intervention strategies provide good value for money.

"Malaria is taking costly bites out of Africa," said Dr David Nabarro, executive director at WHO. "It is feasting on the health and development of African children and it is draining the life out of African economies."

The report recommends that \$1 billion annually be devoted to malaria prevention and control and that most of this expenditure be focused in Africa. This is many times greater than the amount which is currently being spent. It argues that spending this amount is economically justifiable as the short-term benefits of malaria control can reasonably be estimated at between \$3 billion and \$12 billion per year.

"The benefits of committing substantial new economic resources to malaria will greatly exceed the costs," said Sachs.

The findings of the report will be presented today at the first ever summit to focus on malaria. The heads of state of twenty African nations and the executive directors of the African Development Bank, World Bank, UNDP, UNICEF, UNESCO and WHO are expected to be present to hear the findings. The Summit is being hosted in Abuja, Nigeria by the country's president, His Excellency Olusegun Obasanjo, and is co-sponsored by WHO.

Malaria accounts for nearly one million deaths each year in Africa; an estimated 700,000 of these deaths are among children. Research has found that the wider availability and use of insecticide treated bednets would result in 50 percent less malaria illness among children. Yet presently, only 2% of African children are protected at night with a treated bednet.

"Roll Back Malaria aims to help African families create a mosquito free zone in the home through the use of nets, drapes, or bednets treated with insecticide," said Dr Awash Teklehaimanot, acting project manager for Roll Back Malaria. "Our goal is to ensure that every person at risk of malaria in Africa is protected with an insecticide-treated bednet within the next five years."

In addition to ensuring wider availability of treated nets, Roll Back Malaria is also working to provide greater access to rapid diagnosis and quick treatment with the appropriate therapies -- ideally in the home; preventing malaria illness during pregnancy; and detecting and responding to epidemics quickly.

"Halving the burden of malaria is realistic and achievable," said Dr Gro Harlem Brundtland, Director-General of WHO. "We have the tools. We have the economic justification. We now need leaders from both the public and private sectors stepping forward to make this happen."

For further information please contact Gregory Hartl, WHO Press Spokesperson, WHO, Geneva, telephone: (+41 22) 791 4458, mobile + 41 79 293 6715, fax: (+41 22) 791 4858. E-mail: hartlg@who.int In the U.S., Jim Palmer at +1 202 262-9823. In the U.K., Janice Muir or Amanda Barnes at +44 171 407 3313. In Abuja, Nigeria, Andy Seale at

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**PRESS RELEASE
PHOTO AND FILM OPPORTUNITY**

Record-Breaking Giant Mosquito Net – with a Message

Two hundred and twenty-five Nigerian schoolchildren will gather under a giant mosquito bednet - **225 times larger** than the standard insecticide treated nets used to protect against malaria – in an attempt to set a world record.

The bednet measures a massive 20 metres by 20 metres and is three metres high. So far there is no record for the largest bednet. Usually bednets are made to cover the area above a standard double bed. An ordinary net will be positioned next to the record breaking giant.

The event, in Abuja, takes place exactly one week before African Heads of State meet there for the first ever Summit on malaria. It will also act as a reminder that **225** African children die of malaria every two and a half hours. More than 2,173 children under the age of five die of malaria every day.

The record breaking attempt takes place at Eagle Square, Abuja, Nigeria on Tuesday **April 18th** from 9.30am and will be hosted by the country's First Lady, Chief (Mrs) Stella Obasanjo, with an official from Guinness World Records monitoring events.

A group of 30 children from the Drama Club of the Federal Government Girls College Bwari in Abuja will also perform "Roll Back Malaria – Roll in Development" at the special ceremony. The specially written drama includes song, dance and a mock protest with placard wielding "demonstrators", all under 10 years-old, demanding the world wakes up to the scourge of malaria – a preventable disease that increasingly continues to burden dozens of African countries.

The Abuja schoolchildren hope to remind the world that malaria kills more than one million people a year with 9 out of 10 of the deaths in Africa. Unlike some areas of the world, malaria is on the increase in Africa, with under five year olds and pregnant women most at risk.

African Heads of State, Ministers from G8 countries and the Heads of international development agencies are meeting in Abuja a week later on Tuesday April 25th for the African Summit on Roll Back malaria to explore ways to accelerate action to roll back malaria in Africa and rededicate themselves to cutting malaria deaths by at least half by the year 2010.

Once the bednet has been measured and recorded by Guinness World Records it will remain in Eagles Square up until the 24th. On the 24th it will be moved to the Nicon Hilton where it will be used as a dramatic backdrop to the Summit and a constant reminder to Heads of State that malaria deaths can be prevented using cost effective and simple methods like insecticide treated bednets.

-Ends-

Photo/Film Programme - April 18th World Record Attempt
(MC – Nigerian TV celebrity Omotayo Omotosho)

9am

Press arrive.

9.30-9.50am

Arrival of guests at Eagle Square.

9.55am

Nigerian First Lady, Chief (Mrs) Stella Obasanjo, arrives.

10am

National Anthem.

10.10am

Dr Edugie Abebe, Nigeria's Director of Primary Health Care and Disease Control, welcomes press and special guests and introduces the Bednet project.

10.20am

Performance of "Roll Back Malaria – Roll in Development" by the Drama Club of FGGC Bwari – including under 10s wielding placards that read "Malaria Kills African Children" etc

10.55am

The Honourable Minister for Health, Dr Tim Menakaya speaks about the forthcoming Summit

11.05am

Chief (Mrs) Stella Obasanjo speaks

11.15am

Chief (Mrs) Stella Obasanjo is joined by schoolchildren under the bednet to officially mark its launch

11.30am

Guinness World Records award the World Record Certificate

11.40am

The Honourable Minister for Health, Dr Tim Menakaya concludes

11.55am

National Anthem

12noon

Party leaves Eagle Square

12.30pm

Press Conference in the Lagos Room at the Nicon Hilton

Dr Edugie Abebe and The Honourable Minister Dr Tim Menakaya

Journalists or news crews wishing to attend the bednet event need to alert either Austine Oghide or Andy Seale by April 14th to ensure Nigerian Government Accreditation.

Details over.

For further information about the bednet event or Summit

Austine Oghide WHO Nigeria

00 234 1 545 3662/3 or 00 234 9 314 8776/7

Andy Seale WHO Geneva

00 41 22 791 3670 (until 14th April) Sheraton Hotel Abuja 00 234 9 523 0225

Summit Secretariat

00 234 9 523 9323/8190

Chuddy Odueni Arcay Corporate Communications Lagos

00 234 1 497 0128

Kim Hudson Arcay Corporate Communications Johannesburg

00 27 11 480 8555

Janice Muir (UK)

00 44 171 407 3313

Jim Palmer (US)

00 1 202 262 9823

Check out the **Press Pack** on the Roll Back Malaria Website www.who.ch/rbm

Notes to Editors

1. The Summit Meeting on the 25th , hosted by the Nigerian President Olusegun Obasanjo, is being co-ordinated by the World Health Organisation (WHO) which also co-ordinates the global Roll Back Malaria Partnership movement.
2. African countries who have so far confirmed they will be represented include Libya, South Africa, Chad, Benin Republic, Togo, Ghana, Sierra Leone, Senegal, Botswana, Namibia, Sudan, Tanzania, Mauritania, Equatorial Guinea, Central African Republic, Egypt, Mozambique and Zimbabwe.
3. The UK, US and Canada are sending representatives.
4. WHO Director General Dr Gro Brundtland will be representing both the WHO and the United Nations. Other Roll Back Malaria Partners UNICEF, World Bank and UNDP will also attend.
5. A standard sized bednet is 4-5 cubic metres. The world record breaking bednet is 1,200 cubic metres. The net was produced in Thailand by Siamdutch and Chongsam Industries.
6. Roll Back Malaria is a global partnership movement that advocates a four point strategy to prevent, treat and control malaria that includes increased use of bednets. The four elements are...
 - People should sleep under insecticide treated mosquito nets.
 - Pregnant women can take medicines to prevent and treat malaria.
 - Diagnosis should be fast to allow effective treatment.
 - Malaria should be monitored as epidemics can be contained within one week.

Economic analyses indicate that the burden of malaria is great

Malaria takes an enormous toll on human health and well-being, in tropical regions including Africa south of the Sahara, South and Southeast Asia, Oceania, and parts of the Americas. In many of these regions, the burden has been increasing even further in recent years.

The costs of malaria are also enormous when measured in economic terms. Highly malarious countries are among the very poorest in the world, and typically have very low rates of economic growth; many have experienced outright declines in living standards in the past thirty years. Malaria has played a significant role in the poor economic performance of these countries.

Malaria imposes a heavy cost not only on a country's current income, but also on its rate of its economic growth, and therefore on its level of economic development in the long run.

The evidence strongly suggests that malaria obstructs overall economic development. Statistical analysis shows that during the period 1965-1990, highly malarious countries suffered a growth penalty of more than one percentage point per year (compared with countries without malaria), even after taking into account the effects of economic policy and other factors that also influence economic growth. The annual loss of growth from malaria is estimated to range as high as 1.3 percentage points per year. If this loss is compounded for fifteen years, the GNP level in the fifteenth year is reduced by nearly a fifth, and the toll continues to mount with time. (see table 1)

These considerations indicate that the cost of malaria is substantially greater than economists have previously estimated. Traditional estimates have looked at some of the short-run costs of malaria without taking into account the longer-term effects of malaria on economic growth and development. Short-run costs— including lost work time, economic losses associated with infant and child mortality and morbidity, and the costs of treatment and prevention— are typically estimated to be higher than one percent of a country's gross national product.

Traditional analyses have underestimated the short-run costs of malaria.

These estimates, however, neglect many other short-run costs. For instance, very few studies include the economic costs of the pain and suffering associated with the disease. Yet researchers have found that households might be willing to pay several times the direct income loss caused by malaria in order to avoid it, suggesting that the pain, suffering and uncertainty associated with the disease is very high and should certainly be included among its short-term costs.

Furthermore, these short-run costs are likely to have risen in recent years due to the increasing number and complexity of cases in many countries. Moreover, the spread of drug-resistant malaria is substantially raising the costs of treatment in many cases, as well as the burdens of morbidity and mortality. Children and adults needing blood transfusions due to malaria are too often inadvertently infected with HIV, hepatitis C virus, and other infectious agents which taint the blood supply.

Furthermore, these analyses have completely neglected the long-run costs.

Beyond these high and rising short-run costs, malaria impedes economic growth and long-term development in many ways. Malaria may impede the flows of trade, foreign investment, and commerce, thereby affecting a country's entire population. Multinational firms choosing the location of foreign investments shun regions with high malaria, as might many potential tourists. Also, the economic effect of malaria on infected individuals may greatly exceed the direct costs of any single episode of the disease. Repeated bouts of malaria tend to hinder a child's physical and cognitive development, and may

reduce a child's attendance and performance at school. Furthermore, repeated bouts of malaria may expose individuals to chronic malnutrition, anemia and to increased vulnerability to other diseases.

Malaria may have adverse demographic consequences as well. Malaria substantially raises the chances of infant and child mortality. Households respond to this increased risk by having more children, thereby increasing the overall rate of population growth. In addition, the investments which parents of many children can afford to make in the well-being of each child is limited— so that average levels of health care and education per child tend to be reduced. Moreover, mothers of large numbers of children are less able to participate in the formal labor force, thereby also reducing the household income.

Malaria interventions should be an important part of poverty alleviation.

Individual households in malarious regions do not escape the risk of malaria infection simply by being relatively well off. In surveys of households from 22 countries in Africa, no correlation could be found between the incidence of childhood fever in households and their relative wealth. Malaria is not a simple consequence of poverty. The wealth of the household, however, does play a substantial role in determining whether a child receives treatment for fever and influences the kind of treatment. Poor families very often lack the resources to obtain proper treatment of the disease even in complicated and life-threatening cases. Poverty alleviation strategies should therefore recognize the importance of effective antimalaria interventions, since the poor by themselves are unable to escape the burdens of the disease.

The burden of malaria is very high and rising. Short-term costs alone are likely to result in economic losses of several percent of GDP in a single year. Moreover, malaria hinders long-term economic growth, so that the burden of the disease increases over time as countries are deprived of the rise in living standards that they would experience if not for malaria.

There are important differences in malaria across regions and countries

The patterns and costs of malaria incidence are highly place-specific.

No single biological, economic or political reason can be adduced for the observed patterns and trends in malaria transmission. No single intervention, therefore, is appropriate in all contexts. Interventions should be adapted to specific local ecological, epidemiological, economic, and social conditions. Even the goals of malaria interventions should be place-specific.

The effects of human behavior on malaria are similarly place-specific. Anthropogenic changes such as deforestation, road-construction and agricultural development often increase the intensity of malaria transmission. But the specific effects of such ecological disturbances vary from place to place, due to geographical diversity in the biology of the mosquitoes that transmit the disease.

Any drug therapy strategy should be designed to minimize the threat of resistant parasites. Specific strategies, however, must be tailored to the patient, the community and the region in which they are employed. The selection of drugs and treatment protocols must be based on reliable clinical and epidemiological assessments of efficacy.

Therefore, the patterns of incidence of malaria, and the costs associated with it, are different in different contexts. No magic bullet can be applied universally.

Many cost-effective malaria interventions are available

Various available cost-effective interventions may strengthen efforts designed to prevent and treat malaria, including:

- interventions that improve case management, such as prepackaging drugs and improving access to second and third line drugs for treatment failures;
- chemoprophylaxis or intermittent treatment during pregnancy;
- anti-vector activities through insecticide-treatment of mosquito nets and indoor residual spraying.

All have been demonstrated to provide excellent value in terms of the health gains achieved per dollar spent.

More effective treatment is a first priority

Although improved treatment in the public sector is essential, we must recognize that most malaria cases are first treated through self-administration of drugs purchased in a variety of private outlets. Improving the quality of treatment for all will require interventions targeted at both households and providers:

- careseekers should be better informed about appropriate treatment
- providers in both the public and private sectors should be provided with reliable information concerning drug choice and dose, as well as incentives to act on this information
- the availability of effective antimalarial drugs should be increased
- prepackaging of drugs can help improve both prescribing practices and household use of drugs.

Much can, thereby, be done to improve care using existing drugs and technologies.

In addition, various promising technologies are becoming available:

- Artesunate suppositories can help reduce the most dangerous symptoms of severe malaria while the patient is being transported for further care.
- New rapid malaria tests can expand access to accurate diagnosis and should help reduce the cost of treating malaria where more expensive antimalarials (such as mefloquine) are used as a first line drug. Improved diagnosis may also improve health outcomes and potentially reduce selection pressure favoring resistance.

Addressing the problem of drug resistance requires intensive attention. Replacing an ineffective first line drug brings substantial and immediate health benefits, but strategies must be put in place to prevent resistance growing rapidly to the replacement, as there are few effective, safe and affordable antimalarials available. There are a range of implementation issues to consider, such as the effects on compliance of changing drug regimens, and the need to inform public and private providers about the new policy. Combination therapy, which has the potential to protect new drugs from the development of resistance, is a promising new development, but needs to be introduced together with strategies to promote rational drug use in the public and private sectors.

A substantial expansion of preventive interventions is required

Although insecticide-treated mosquito nets (ITNs) provide a cost-effective means of ameliorating the effects of malaria, this measure will be expensive if large human populations must be protected. Innovative mechanisms for financing and providing ITNs are needed to increase their

use. In many places there are well-established commercial markets in nets, although coverage levels are inadequate in most rural communities. Insecticide for net treatment, by contrast, is a new commodity, and the idea that it could be sold as a form of domestic insecticide, along with coils or sprays, is only now beginning to be explored. It is essential to find ways of expanding such markets sustainably:

- the development of dip-it-yourself insecticide retreatment kits as a mass market product provides a promising approach, and a variety of strategies is being developed for expanding access to, and coverage by, existing commercial markets for nets. These measures include social marketing and public/private partnerships with commercial firms.
- governments should introduce complementary interventions to encourage the development of commercial markets, such as large scale promotion activities, and tax and tariff reforms that would reduce prices and create a level playing field for domestic producers attempting to compete with international firms.

Although commercial markets for ITNs can be expanded substantially, the poorest households will be unable to afford to purchase nets and insecticide at commercial prices, and innovative mechanisms will be required to subsidize the purchase of ITNs by such people:

- voucher schemes can help direct subsidies to needy mothers and children
- targeting through maternal and child health clinics is also a promising approach.

Social marketing can help raise awareness of the value of ITNs and encourage their appropriate use.

Enhanced commitment to research will improve the effectiveness of existing technology

Research is essential at every level, from basic scientific studies to social science and policy analysis, in order to design, evaluate and reevaluate new and existing malaria intervention strategies. Any effective strategy will require enhanced scientific capacity at the local level to monitor the disease and its ecology, and to evaluate the effectiveness of alternative strategies.

Ongoing research is a vital part of any intervention.

No strategy should ever be exempt from scrutiny by the research community. Any policy has unintended consequences—ongoing program analysis is essential to identify these consequences and mitigate their costs. Implementation of any intervention is an adaptive process, requiring performance evaluation and operational research. This includes identifying the reasons for low compliance, and finding more efficient and cost-effective implementation strategies.

Even one of the most promising antimalaria intervention strategies, employing the use of insecticide treated nets (ITNs) will benefit from further ongoing research. ITNs constitute a cost-effective means for ameliorating the effects of malaria. Their effectiveness in different epidemiological conditions, however, must be reassessed continually. In addition, the mechanisms of morbidity reduction by incomplete ITN coverage, and the potential for similar effects by other incomplete interventions should be explored.

Research helps to identify unintended consequences, to refine even the most promising strategies, and to streamline the use of existing resources.

Research into underutilized technologies is important. Analysis of the historical record indicates that many successful interventions employed techniques which were highly effective, but have since been abandoned, possibly due to socioeconomic upheavals and loss of interest among donors. In certain cases, these techniques may still be useful, although research is essential to adapting them for specific contexts. Many of these approaches would

require research input by epidemiologists, environmental scientists, entomologists, agronomists, and economists.

Research is also necessary in order to understand what communities are already doing on their own to defend themselves against malaria vectors. Many residents of malarious areas buy commercial products for this purpose even in the absence of externally designed interventions. In many cases, the market in these products may be worth much more, and may save more lives, than publicly financed interventions. Researchers and policy makers must learn all they can from local communities.

A commitment must be made to track status and trends in malaria more closely.

There is a dire lack of extensive and comparable data about malaria. For example, there is inadequate information available on the status and trends in incidence and prevalence, epidemic outbreaks, clinical epidemiology, and interactions with other conditions (including for example other diseases, nutrition, and growth). The absence of this information is very costly to advocacy, policy design and implementation, epidemic preparedness, and resource allocation. A commitment must be made to ongoing, sustainable collection of these data in order to replace the existing gross extrapolations, widely varying estimates, and missing information.

Interventions against malaria can have synergistic beneficial effects. Research is essential for designing programs which provide increasing returns to scale.

Economic analysis can provide support for targeted interventions designed to produce additive or synergistic beneficial effects even beyond their direct impact on human well-being. As first shown a century ago, for example, where important ports or centers of economic activity are malarious the economic burden of disease tends to be particularly high; interventions which target such locations are likely to improve economic conditions directly, in addition to improving individual well-being.

Similarly, malaria infection can aggravate underlying micronutrient deficiencies in children; interventions aimed at such malnutrition are likely to improve the nutrition and decrease the impact of malaria on children.

Malaria requires a commitment to applied as well as basic research as much as it does to a broad implementation of existing intervention methods.

There is an urgent need for developing powerful new technologies.

In addition to increased research into existing technologies, new antimalaria intervention tools are required. In the long run, a vaccine is likely to provide the best, most cost-effective, and safest approach to radically reducing the burden of malaria. Interest in developing such a vaccine among private pharmaceutical and biotechnology firms, however, is limited.

One important policy initiative to spur private sector interest in this effort would be for donor governments, international organizations and private foundations to ensure a profitable market for a malaria vaccine, if one were to be developed. Such a policy would ensure that those with the most information would decide which projects are to be pursued. In addition, it would ensure that no public funds are expended unless the technology were successfully developed.

In order to encourage the development of a malaria vaccine, donors should commit in advance to purchase an appropriate malaria vaccine, if one is developed.

President Clinton has proposed a policy along these lines, involving a tax credit for companies that develop new vaccines. James Wolfensohn, President of the World Bank, has said that through its International Development Agency, the Bank plans to

set up a \$1 billion revolving fund to be made available to buy specified vaccines if and when they are invented.

These proposals should be expanded with commitments from donor governments, foundations, and international agencies into a Malaria Vaccine Purchase Fund. This fund would provide guarantees to the private sector and to the research community that any successful malaria vaccine will have a large market, thereby encouraging the necessary outlays on research and development in future years.

Even with these efforts, however, a useful vaccine may not be available for many years. In the meantime, new medicines are essential to address problems of spreading drug resistance as well as drug affordability. These projects are also of little interest to firms. The dynamics of drug markets are not identical to those of vaccine markets, but enhancing private sector interest in drug development is just as necessary. Any effort to spur the development of new drugs must explicitly take market dynamics into account.

In the meantime, new therapeutic, preventive, and diagnostic tools must be developed—particularly drugs, insecticides, and dipstick tests.

Similarly, few general purpose insecticides suitable for use in entomological malaria interventions are under development now. These insecticides are essential to future antimalaria programs, due to widespread and intensifying insecticide resistance among anopheline vector populations. Market-based policies to facilitate insecticide development projects must be designed and implemented. In the meantime, however, the use of DDT in malaria interventions should *not* be banned.

Inability to diagnose malaria quickly is often a contributing factor to increased mortality, prolonged morbidity, the spread of drug resistance and delayed response to emerging epidemics. Dipstick tests and other rapid, user-friendly field diagnostics are necessary for addressing these challenges. Enhanced effort should be given to producing these tests at lower cost and increasing their availability in developing countries. Private sector interest in developing new, cheaper, and harder diagnostics should be encouraged.

It is important not to forget that the primary objective is improving human well-being.

Development of new intervention methods, however, should not occur at the expense of new and innovative uses of existing technology. Ethical issues in clinical research and development must be acknowledged in any policy that is adopted, and ethical guidelines must be strictly enforced.

Therefore, new technologies can provide important avenues for mitigating the burden of malaria, provided that appropriate markets can be created for these technologies.

These considerations call for an integrated global effort against malaria.

Global investment in antimalaria activities must be increased many times over. Incremental increases are not sufficient.

Anti-malaria programs, whether at the national, regional, or global level, suffer from a chronic lack of funding. Funding decisions have been based on dramatic underestimates of the real costs of malaria. The international community of nations, together with the multilateral agencies and private foundations, should commit to increased current expenditures for malaria interventions and research programs of at least \$1 billion per year, in the coming years. This level of effort should be sustained for an indefinite period, and concentrated primarily in Sub-Saharan Africa. Today, the level of effort worldwide amounts to only a small fraction of this amount.

In addition to greatly increased current expenditures, the donor governments, foundations, and international agencies, should establish a Malaria Vaccine Purchase Fund. Such a fund would only disburse money if an effective malaria vaccine becomes available, but its establishment now would greatly increase research and development incentives, and thereby greatly reduce the time until such a vaccine is available.

An increase of \$1 billion per year, sustained for many years, is clearly justified in economic terms.

The amount of \$1 billion per year, heavily concentrated in Sub-Saharan Africa, is appropriate based even on traditional assessments of the burden of malaria which do not take the economic growth penalty into account. Such traditional assessments suggest that malaria's economic costs are likely to exceed one percent of GDP and could well be several times higher than that. Since Sub-Saharan Africa's GDP is around \$300 billion, and since malaria affects nearly the entire region, the short-term benefits of malaria control can reasonably be estimated at greater than \$3 billion per year. Thus, interventions costing \$1 billion per year which substantially reduce the disease burden are justified.

The case for the large increase in expenditures is further strengthened by taking into account the sustained growth penalty associated with malaria, which greatly multiplies the true economic burden of the disease. Taking into account the growth effects of malaria, the benefits of controlling the disease are in the dozens of billions of dollars per year after a few years of malaria control. These benefits would exceed the costs by a widening margin over time, as the program supports a sustained increase in economic growth with cumulative benefits to the level of national income.

This money must be committed to a multifaceted program, including capacity enhancement in malarious countries.

The international community, working closely with the countries of Sub-Saharan Africa and other malarious regions, must immediately begin to elaborate the interventions which would make the most effective use of this additional \$1 billion per year. Efforts would focus on the increased use of impregnated bednets, improved case management, enhanced vector control programs where feasible, basic research into drugs and vaccines, and ongoing massive disease surveillance and project evaluation efforts.

In addition, international cooperation in training and research in epidemiology, ecology, entomology, immunology, economics, program evaluation, and other relevant fields must be enhanced. This training and research should be designed to enhance technical capacity in developing countries, and should involve interaction between the public and private sector, and between developed and developing countries. The combination of direct interventions (e.g. bednets) with increased surveillance, project evaluation, basic research, and training constitute an integrated approach to malaria control that will be vital for a long-term, successful, and sustainable effort.

The benefits of committing substantial new economic resources to malaria will greatly exceed the costs. Furthermore, the benefits will be greatest when the new resources are deployed in an integrated and multifaceted program of anti-malaria interventions, enhanced surveillance, and greatly intensified research and training programs.

Table 1. Loss from the economic growth penalty of malaria endemicity in 31 African countries, 1980-1995

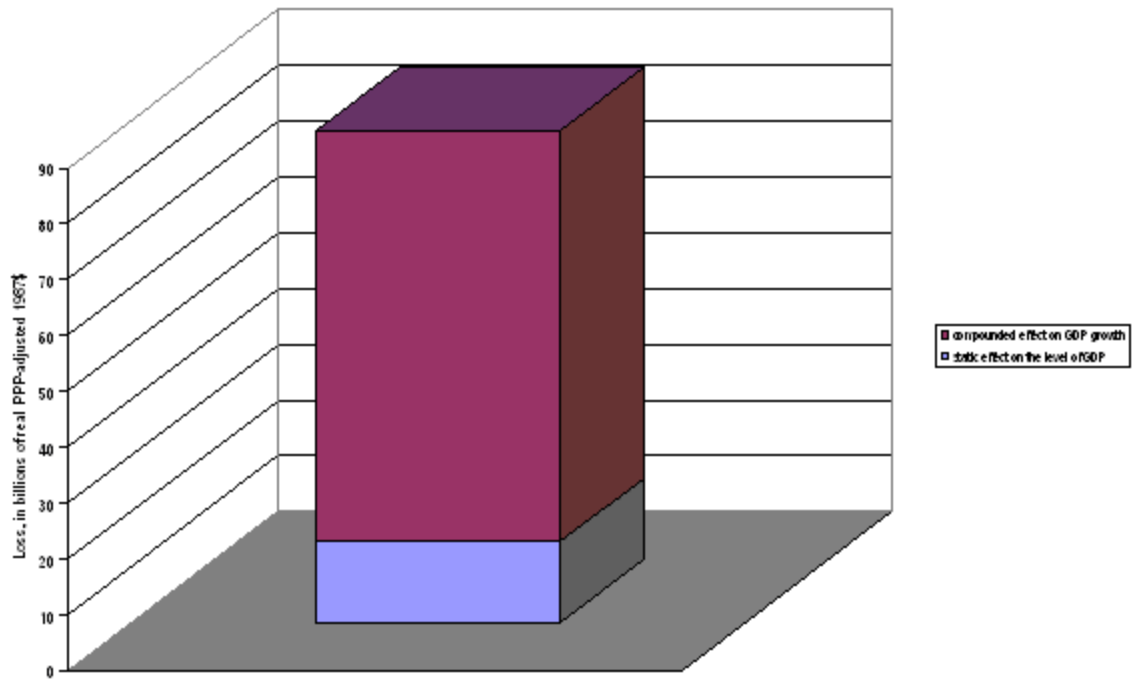
| Country | Aggregate loss (millions of PPP-adjusted 1987 \$) | Per person loss (PPP-adjusted 1987 \$) | As a fraction of actual 1995 income |
|---------|---|--|-------------------------------------|
| | | | |

| | | | |
|--------------------------|---------------|------------|------------|
| Benin | 1172 | 214 | 18% |
| Botswana | 503 | 347 | 5% |
| Burkina Faso | 1684 | 162 | 18% |
| Burundi | 730 | 117 | 18% |
| Cameroon | 4227 | 318 | 18% |
| Central African Republic | 884 | 270 | 18% |
| Chad | 995 | 154 | 17% |
| Congo | 759 | 288 | 18% |
| Congo, Dem. Rep. | 7125 | 162 | 18% |
| Cote d'Ivoire | 4107 | 294 | 18% |
| Gabon | 1389 | 1290 | 17% |
| Gambia | 251 | 226 | 18% |
| Ghana | 5355 | 314 | 18% |
| Guinea Bissau | 152 | 142 | 14% |
| Kenya | 5272 | 198 | 18% |
| Lesotho | 0 | 0 | 0% |
| Madagascar | 2280 | 167 | 18% |
| Malawi | 1072 | 110 | 18% |
| Mali | 1222 | 125 | 17% |
| Mauritania | 611 | 269 | 15% |
| Mauritius | 0 | 0 | 0% |
| Namibia | 832 | 539 | 10% |
| Niger | 1457 | 161 | 17% |
| Nigeria | 17315 | 156 | 18% |
| Rwanda | 656 | 102 | 18% |
| Senegal | 2426 | 286 | 18% |
| Sierra Leone | 366 | 87 | 17% |
| South Africa | 4056 | 98 | 1% |
| Togo | 1166 | 285 | 18% |
| Zambia | 1359 | 151 | 18% |
| Zimbabwe | 4214 | 383 | 18% |
| Total | 73 638 | 185 | 10% |

Based on results in John Luke Gallup and Jeffrey D. Sachs, "The Economic Burden of Malaria" in *Economics of Malaria* (forthcoming).

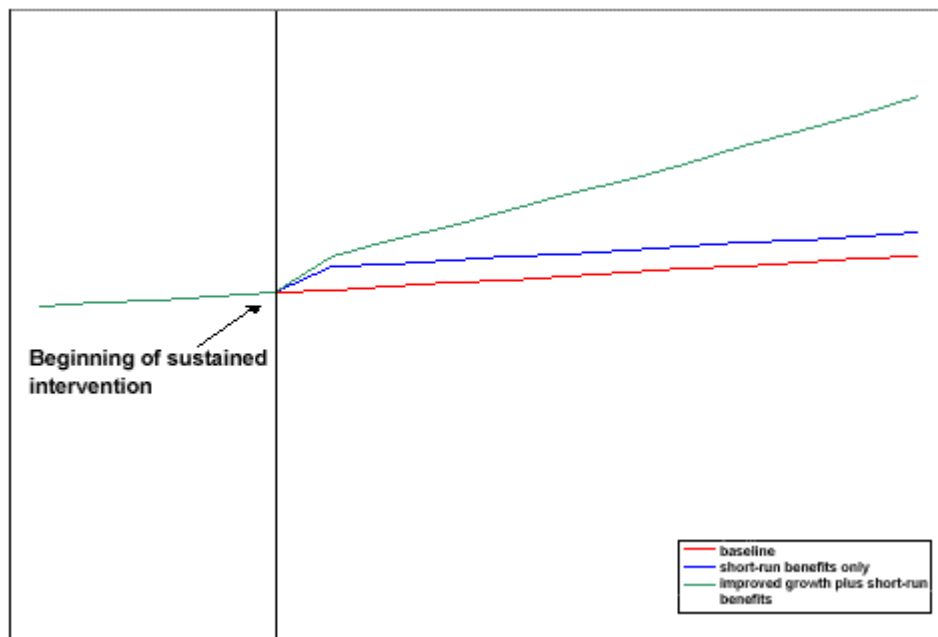
Please note that these figures are reported in purchasing power parity (PPP) adjusted dollars held constant at 1987 prices. This corrects for the effects of price inflation, as well as the fact that in Africa, non-traded goods and services (for example, health services or land) are cheaper relative to internationally traded goods than they are in the United States. In order to convert these units into current US dollar terms, it would be necessary to divide by a factor of about 3, then multiply by the rate of price inflation between 1987 and 1995.

Figure 1. Loss associated with the malaria growth penalty, compared to traditionally estimated static effects, in 31 African countries, 1980-1995



Based on results in John Luke Gallup and Jeffrey D. Sachs, "The Economic Burden of Malaria" and Pia Malaney, "Microeconomic Approaches to Evaluating the Burden of Malaria" in *Economics of Malaria* (forthcoming)

Figure 2. Hypothetical benefits of sustained malaria intervention, incorporating only the short-run benefits, and improved economic growth



Roll Back Malaria: Spotlight on Africa

Political will and new partnerships of action for rolling back malaria in Africa

Africa is the continent most severely affected by malaria. It is for this reason that [Roll Back Malaria](#) (RBM) has Africa as its main focus. The RBM movement has now been in existence for 18 months or so. What has been happening in Africa under this banner?

From the vantage point of building on past initiatives in malaria in Africa, of which a not insignificant number have materialized in recent years, several indicators of RBM activity are apparent. A prime sign is that greater political will has manifested. Of the 50 countries and territories in Africa affected by malaria, 24 heads of state have committed themselves to active participation in the RBM partnership. Ministers of health have taken part in RBM inception activities, and governments have taken steps to increase financial and human resources for malaria. In April 2000, the government of Nigeria hosted the African Summit on RBM in Abuja, demonstrating political commitment at the highest level (see box).

African summit on Roll Back Malaria

Forty-four of the 50 malaria-affected countries in Africa were represented at the summit in Abuja. Nineteen heads of state were present, as well as prime ministers, vice-presidents, ministers of health, and many other partners.

African leaders committed themselves to halving malaria mortality in Africa by 2010 and to ensuring that, by 2005:

- at least 60% of those suffering from malaria have prompt access to affordable and appropriate treatment within 24 hours of the onset of symptoms
- at least 60% of those at risk of malaria – particularly pregnant women and children under five – benefit from personal protective measures such as insecticide treated bednets, and
- at least 60% of all pregnant women at risk of malaria have access to chemoprophylaxis or preventive intermittent treatment.

Amongst other things, they pledged to promote community participation in rolling back malaria, make diagnosis and treatment available and accessible for the poorest groups, prevent re-emergence of malaria, provide reliable information on malaria to decision makers at all levels (from household to national level), and reduce or waive tariffs for mosquito nets, insecticides, antimalarial drugs, etc.

April 25th was declared African Malaria Day, and the partners present pledged up to US\$750 million extra funds for rolling back malaria in countries. The President of Nigeria observed that the final chapter of the history of malaria had begun to be written.

Another indicator of RBM action is that, in the last 18 months, existing partnerships in malaria have been strengthened and new partners have become involved - at global, regional and country levels. In African countries, there has been an increase in NGO, private sector, and non-health sector involvement (e.g. collaboration with ministries of education, communication, finance, agriculture, environment), and non-traditional partners have become involved too e.g. UNESCO (United Nations Educational, Scientific and Cultural Organization) in Sudan. Also, joint actions in malaria between neighbouring countries have taken shape, e.g. the Health for Peace Initiative in West Africa (The

Gambia, Senegal, Guinea-Bissau, Guinea Conakry), the Lumbombo Development Initiative in Southern Africa (South Africa, Mozambique, Swaziland), and a North African initiative (Morocco, Algeria, Tunisia, Libya, Egypt).

Countries have also begun to develop RBM strategy. Whereas many countries in Africa are hyperendemic for malaria, others, in the North, have already eradicated, or nearly eradicated, the disease – so the strategy varies with the local situation. Within countries, technical committees and networks have sprung up to help develop local strategies to roll back malaria, or prevent its return, according to the situation. So far five countries have completed strategy development while many others are reviewing their national strategies in line with RBM. Most are placing emphasis on boosting interventions based on evidence.

Africa is a continent which often faces complex emergency situations in malaria, e.g. drug resistance, epidemics, war situations - at least ten countries south of the Sahara have experienced malaria epidemics with unacceptably high mortality rates in the last few years. Under the RBM banner, two of these countries were able to report, by the end of 1999, adequate preparedness for anticipated malaria epidemics in the second quarter of 2000. Four other countries have pushed forward accelerated malaria control activities to cope with complex emergency situations, and at least ten others are in the process of doing so.

These activities so far constitute the 'inception' phase of RBM. Soon the 'implementation' phase will commence, when the strategies will be implemented. This will be the real testing ground for the RBM concept and strategy, when mortality and morbidity indicators become important.

Is there any reason to believe that these latest WHO efforts, under RBM, will have more lasting effects than earlier WHO efforts in Africa? 'The beauty of RBM is that there is no blueprint', says Dr Kabir Cham of RBM/WHO, 'There is no one way of going about things any longer - challenges are addressed depending on the situation and resources of the country; the emphasis is on dialogue and flexibility. RBM targets high-risk populations - such as under-fives and pregnant women - so today the country and its people are the centre of the action. Another new focus is on processes leading to sustainability rather than sustainability itself'.

How much emphasis is placed on research in RBM in Africa? TDR and RBM work together in a number of areas, such as product research and home management of malaria. The Abuja plan of action promotes, amongst other things, strengthening of research, and in particular, development of vaccines and exploration of traditional medicines for malaria. At the summit, the heads of state and government in African countries called upon development partners, amongst other things, to:

- invest additional resources to stimulate the development of malaria vaccines appropriate for Africa and provide similar incentives for other anti-malaria technologies
- strengthen and sustain collaboration of research institutions within Africa and with partner institutions throughout the world, and
- foster the collaboration of research institutions with agencies implementing Roll Back Malaria to ensure full utilization of research knowledge and programme experience.

AFRICAN SUMMIT ON ROLL BACK MALARIA ABUJA, NIGERIA - 25TH APRIL 2000

SECOND BRIEF FOR INTERNATIONAL DEVELOPMENT ORGANISATIONS: 2nd MARCH 2000

SUMMARY

Nigeria will host a Summit Meeting of African Heads of State on April 25th 2000. This will set targets for action to tackle Malaria. It will focus on actions to increase the impact of malaria control, through partnerships to "Roll Back Malaria". Working closely with Heads of Development Agencies, and in co-operation with WHO, Heads of State will demonstrate their political commitment to this intensified effort. They will demonstrate the level of resources that they propose to make available. Events taking place at the same time as the summit are likely to attract international interest. Roll Back Malaria is committed to a halving in the world's malaria burden by the year 2010.

THE CHALLENGE OF MALARIA

Malaria causes more than one million deaths each year. The majority who die are the children of Africa. Deaths linked to malaria in Africa are on the increase due to changes in the environment, movement of populations arising from political instability and civil strife, resistance of malaria to common and inexpensive medicines, resistance of mosquitoes to insecticides, and limitations in national health services.

Malaria keeps Africa's people poor. It prevents adults from working and children from attending school. Each year a family spends several months' earnings on malaria treatment and prevention. Malaria during pregnancy is also of great concern, since it adversely affects the mother's health and may result in a baby born too small to survive.

It does not have to be like this. Malaria is preventable, treatable and curable. Four elements of the Roll Back Malaria (RBM) strategy point to a solution:

- 1) People at risk can prevent malaria if they sleep under insecticide treated mosquito nets.
- 2) Pregnant women, especially those who are pregnant for the first time, can take medicines to prevent and treat malaria.
- 3) People can treat malaria with a wide variety of effective medicines, and they can cure malaria if they seek and receive treatment early, with effective medication, within - or close to - their homes, and finally,
- 4) Families and communities can be empowered to predict and prevent a malaria epidemic and contain it within one week of its being confirmed.

But, people cannot prevent and treat malaria alone. Governments, health services and all development partners must make sure that low cost mosquito nets, genuine and inexpensive medicines, and timely and accurate information about malaria are available in every neighbourhood and village.

AFRICAN LEADERSHIP

In the past decade, Africa's leaders have called for concerted action to address the impact of malaria on their people. In June 1997, African Heads of State signed the Harare Declaration on Malaria. This was followed by the African Initiative on Malaria (AIM), which was endorsed by the African Region of the World Health Organization in 1998. The World Bank, the African

Development Bank, WHO, UNICEF and UNDP have responded and were supported by several member nations of the Organization for Economic Co-operation and Development (OECD) thereby, accelerating malaria control efforts throughout the continent.

Renewed backing for malaria control by WHO began with the election of Dr. Gro Harlem Brundtland, former Prime Minister of Norway, as Director General of WHO in 1998. She committed the organization to intensified support of malaria control - especially in Africa, and through her leadership the Roll Back Malaria (RBM) initiative was launched by WHO, UNICEF, the World Bank and UNDP on October 28, 1998. Partnerships between Governments, development agencies and private groups are now supporting RBM action in more than 20 countries.

More vigorous action is needed, particularly in communities within tropical Africa. Success has been reported in situations where Governments work closely with other bodies, both public and private, in movements to Roll Back Malaria.

African Heads of State are now providing the political leadership required of RBM movements. In particular, President Olusegun Obasanjo of Nigeria proposed in 1999, that an African Summit on Malaria be held and offered to host the Summit with the date set for April 25, 2000, in Abuja, Nigeria. The President has invited WHO and other development partners to work with the Nigerian Government to plan the Summit. At the Summit, Heads of State will reflect on the economic and social burden of malaria and commit themselves to strategies and targets for its reduction.

More than 50 African Heads of State, G8 Heads of State, the Heads of 10 international development agencies, and more than 12 Development and Health Ministers from OECD countries have been invited to the Summit, and many have already accepted.

PLANNING THE SUMMIT

Intensive planning is in progress with input from various African Countries and international agencies. A high-level inter-governmental steering committee meets weekly in Abuja, Nigeria. Several subcommittees including a Technical Committee and a Publicity Committee have been established. A Summit Secretariat has been set up to meet the needs of invited dignitaries and guests. A Summit venue with capacity for over 1000 persons is being prepared. A communication campaign to highlight the aims of the Summit is underway.

EXPECTED OUTCOME

The Technical Committee is developing scientific papers on various aspects of malaria in Africa. These papers will form the basis of a Declaration that will be considered by African Heads of State at the Summit. In general terms, the Declaration will call for a re-commitment to the intent and goals of the Harare Declaration and a renewed commitment to Rolling Back Malaria. Specific issues that the Heads of State will address include alleviating poverty through reducing the burden of malaria on the citizens of Africa, setting realistic targets based on the four elements of the RBM strategy (as mentioned above), supporting needed research that will make RBM strategies more effective, and encouraging development partners to work with governments and communities to mobilise and better manage the financial and human resources needed to Roll Back Malaria.

FURTHER INFORMATION FOR PARTICIPANTS FROM INTERNATIONAL ORGANIZATIONS, OECD GOVERNMENTS AND BILATERAL DEVELOPMENT AGENCIES

A Proposed Summit Objectives and Technical Programme for the Summit:

This Summit is crucial for securing political commitment to the scale up of activity needed for Rolling Back Malaria in Africa. The President wants a working Summit dedicated to addressing, and preparing to solve, a major impediment to Africa's development.

The following Summit objectives have been proposed and are being examined (late February 2000) by the Summit Technical Sub-Committee and technical advisers from WHO:

- a) Heads of State recognise that malaria is a major impediment to the development of Africa's people.
- b) Heads of State rededicate themselves to the agreements made at the Harare Heads of State meeting and declaration on malaria in 1997.
- c) Heads of State could commit themselves to a goal and targets. These are currently under discussion. The proposed goal would be halving Africa's malaria burden over the next 10 years

Fulfilment of the following targets to enable this goal to be fulfilled:

- 1 a substantial increase, throughout Africa, in the proportion of children and women who are protected through the use of insecticide-treated mosquito netting (desired proportion: at least 60%)
 - 2 a substantial increase in the proportion of persons who can access effective treatment for their malaria within 24 hours of the onset of symptoms (desired proportion: at least 60%)
 - 3 a substantial increase in the proportion of pregnant women at risk who receive protection from malaria's effects during pregnancy (desired proportion: at least 60%)
 - 4 all African nations to have capacity to detect, and respond effectively - within one week - to malaria outbreaks, and to prevent re-introduction of malaria into areas from which it has been eliminated.
 - 5 greater emphasis on research capacity to develop cost-effective anti-malaria products in Africa
- d) Heads of State identify, and propose, a series of policy and programme emphasis necessary for these targets to be fulfilled (greater emphasis on home care, on community-based movements and inter-sectoral action, on responding to the interests and needs of poor people, and on partnerships with the private sector).
 - e) Heads of State secure the support of development partners to the goal, targets and policy/programme changes needed. At least one significant financial commitment to scaling up Roll Back Malaria efforts in Africa should be made at the summit.
 - f) Heads of State agree follow-up mechanisms

The timing is as follows: the sub-committee will establish proposed targets by end February. The draft declaration is due to be prepared March first week. The Technical issues will be presented in a background technical document. This will include outlines of a plan of action for Rolling Back Malaria in Africa, and proposed follow-up mechanisms (an annual report to Heads of State). The declaration and plan of action will be circulated for comment in advance of the Summit: it is expected that they will be modified and then endorsed in Abuja by Ministers of Health before the Heads of State summit (April 24th).

B Proposed Technical Programme for the Summit

It has been proposed that the Summit itself will take place over one long day on April 25th (8am start 7pm finish) with four sessions of - say - one and a half hours each, separated by 30 minute refreshment breaks and a one and a half hour lunch break. It is suggested that the presentation of issues will be split between all four sessions: the first could focus on issues, sessions 2 and 3 on responses and session 4 on future action (including the declaration). Some Heads of State and leaders of development organisations will be asked to present during these plenary sessions. The President and Dr Brundtland would make keynote speeches and contribute to the declaration part at the end. There will be more opportunities for Heads of State and International leaders to make scheduled public statements and answer questions about their particular contributions and plans in parallel media events. It is proposed that the President will host a dinner on the night of the Summit (25th).

C Summit Venue

The Summit will take place in the NICON Hilton hotel. This has capacity for 1500. The Summit is likely to have around 400 official participants, many of whom will be hosted by the Government of Nigeria. It is not yet clear whether there will be opportunities for others (private sector, researchers etc) to participate through the summit in parallel sessions.

D Management of Summit Preparation:

A high-level inter-governmental steering committee meets each week, with the involvement of several subcommittees. Several international and bilateral development organisations are members of this steering committee. The Summit secretariat will handle the expected 50 Heads of State, and their teams, the 20 Heads of international agencies active in health, and the many others who will participate. WHO is participating fully in the preparations for the Summit - particularly the Steering Committee and the various sub-committees. The Summit preparation plan and budget have been agreed, and the communications infrastructure for the Secretariat will be in place within a week. WHO has offered to support the strengthening of capacity both within the Government of Nigeria and the WHO country representative's office to help with Summit preparation. The budget for WHO's contribution includes resources for technical advisers and a consultant summit manager.

Dr Evarist Njelesani (WHO country representative) is based in Lagos and is spending most of his time working on preparations for the Summit. In his office, Malaria is handled by Dr Lola Sadiq. The capacity of Dr Njelesani's office has been strengthened with the secondment from WHO headquarters of Norma Johnston, Roll Back Malaria Campaign Manager (based in Abuja till the Summit: in Geneva 25th February till March 1st) and Obi Nwaorgu, attached to Roll Back Malaria on a Rockefeller Fellowship (similarly based in Abuja). Both stay at the Sheraton Hotel. Melville George, from the WHO Africa Regional Office in Harare, has also been seconded to the WHO country office, with particular responsibility for supporting Technical aspects of summit preparation.

E Handling Invitations:

The GON has sent invitations to the Heads of State of all African nations - through their embassies in Nigeria. The OAU has been invited, also Heads of State of G8, heads of African and international development agencies, development co-operation Ministers from many OECD countries, president of the EC etc.

The President plans to speak personally with a number of African leaders to explain his intentions for the Summit. He will ensure that details of his intentions are circulated to Embassies of African and G8 nations so that they know the objectives and significance of the Summit. An up to date list of attendees will be maintained by the Summit Secretariat: this will be equipped to with effective communications, for handling enquiries about the summit, for tracking responses, for sending follow-up information to those who want to know more before making decisions etc. WHO country representatives will receive detailed briefings about the Summit objectives and agenda during early March 2000.

F Accommodation, logistics, security and protocol Arrangements

The accommodation sub-committee has made plans to ensure the accommodation for invited guests. The transportation sub-committee will ensure that Heads of State, Heads of International Agencies and other invitees will have the vehicles they need. The Government is paying a great deal of attention to security matters.

Transportation for international guests is receiving special attention. The Summit on Roll Back Malaria in Africa comes straight after Easter, and there are limited direct flights from Europe to Abuja on April 24th. The Summit is followed by a conference on Education in Dakar Senegal on April 26th.

Some of the key guests (International organisations and development partners) need additional air connections into and out of Abuja if they are to come to the Malaria summit. British Airways is being asked to extend its London to Lagos flight on to Abuja on 24th April evening. In the absence of scheduled flight connections, participants will be able to buy tickets for a special flight from Abuja to Dakar late evening 25th April or early morning 26th April. A 30 seater plane will be arranged for the Abuja to Dakar segment in the first instance: additional capacity will be made available if there is demand (WHO Geneva would like to know of demand as soon as possible).

G Communication, publicity and PR

A major programme of publicity is planned and is being worked on jointly by WHO and the publicity sub-committee.

- 1) The manufacture and display of the world's largest FUNCTIONING mosquito net, together with competitions for different designs on mosquito nets (there will be opportunities for a variety of messages to be displayed on the millions of mosquito nets that will be used by people throughout Africa over the next decade)
- 2) The launch of an association between African football (particularly goalkeeping) and Roll Back Malaria over the next 10 years, with the theme "GET IN THE NET"
- 3) The launch of a major report on the economics of malaria in Africa prepared by teams led by Jeffrey Sachs (Harvard University) and Ann Mills (London School of Hygiene and Tropical Medicine)

- 4) A "people speak to the summit" event in which people of Africa speak to the Summit about the malaria problems they face

There is a possibility that a commemorative postage stamp will be released to coincide with the summit. Documents for the Summit will be prepared in French, English, Portuguese and Arabic.

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