Promises once, promises twice: a view on the Abuja Declaration and a new opportunity for African malaria control

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Summary

In the recent Abuja Declaration, African leaders called on aid donors to deliver at least $1 billion annually for malaria control in Africa. This expenditure is small in light of malaria's devastating cost in attenuating economic growth and development. Yet development aid donors encounter barriers in increasing their disbursements for malaria control: the scientific and technical challenges of designing, implementing and monitoring malaria control programs can be overwhelming for these institutions. The malaria control community, working with Roll Back Malaria, is ideally placed to lend advice and assistance on these matters, which can help facilitate an increase in the available funds for malaria control in Africa.

Over one century into the history of scientific malaria control, too little has changed in Africa. The disease still has its claws firmly planted in the fabric of African life, where it causes untold suffering and impedes economic development. This state of affairs owes itself more to an unspoken political neglect than scientific failure, evidenced, for instance, by the world's agreement to leave Africa out of the malaria eradication and control era of the 1950s to 1970s, or the dearth of research on malaria drugs and vaccines today. The political will, and by extension, the resources, have simply not been available to do better.

Thankfully, malaria is gaining some new political saliency behind it, from African leaders themselves. This past April, over forty African governments, represented in many cases by their heads of state, gathered in Nigeria for the African Summit on Roll Back Malaria, where they signed the landmark *Abuja Declaration on Roll Back Malaria in Africa*. The Abuja Declaration leaves no doubt that African leaders perceive malaria as a serious problem. Among its the striking statements:

- Malaria is a "barrier…to development and alleviation of poverty" in Africa. Families living in endemic areas "are some of the continent's most impoverished", and may have to spend "up to 25% or more of [their] annual income on prevention and treatment". Consequently, malaria makes families poor, and once down, it "keeps them poor".

- "Malaria has slowed economic growth in African countries", to the extent that some countries are experiencing *negative* growth rates, and that since the 1960s, the

continent as a whole has sacrificed a third of its economic output (as GDP), for a loss now reaching about $100 *billion* annually.

Never before have African leaders personally acknowledged the malaria problem quite this way. The need to do so has somewhat been forced upon them. Malaria's microeconomic and macroeconomic effects in enforcing underdevelopment and poverty give the disease a new political importance: development and poverty, more than just public health, are the sorts of things that cause governments to endure or fall. They cannot be so easily ignored.

But of all the progress in the Abuja Declaration, the greatest is the recognition that Africa must have new resources if it is to carry out malaria control effectively. This is reflected in two bold requests to Western governments and aid donors:

- "Cancel in full the debt of poor and heavily indebted countries of Africa in order to release resources for poverty alleviation [and] Roll Back Malaria."

- "Allocate substantial new resources of at least $1 billion per year to Roll Back Malaria."

International donors responded positively in Abuja to the request for "substantial new resources" for malaria control. The World Bank, speaking though Vice President for Human Development Eduardo Doryan, pledged an additional $300-500 million toward malaria control in Africa, which the Bank will probably administer through International Development Association (IDA) low interest, long term loans (World Bank 2000). Similarly, the Canadian International Development Agency (CIDA) announced an additional Can$10 million (US$ 6.5 million) over a period of five years toward Roll Back Malaria in Africa (Canadian International Development Agency 2000).

These are very welcome new contributions to malaria control for which the Bank and CIDA deserve congratulations. They represent the first time in history that donors have responded explicitly to the economic cost of malaria. Certainly, the cost of malaria has been observed before without governments noticing. As long ago as 1910 Ross propounded the "sanitary axiom" that "for economic reasons alone, governments are justified in spending for the prevention of [malaria] a sum of money equal to the loss which the diseases inflict on the people". That logic is above contempt, but as Ross lamented, "it is the rule to grudge spending a hundred pounds for a disease which costs thousands" (Ross 1910).

Since that time, opinion has continued to wax and wane on whether the harsh economics of malaria are a barrier, or a call to action, for malaria control. Central to this debate is how one perceives the direction of causality between poverty and malaria: are countries poor and underdeveloped because they are malarious; or are they malarious because they are underdeveloped and poor?

For most of the century, the view has been that wealth must better itself, and then malaria would passively follow. The League of Nations Pan-African Health Conference of 1936 concluded that Africa received far less malaria control than did other parts of the world,

and that curiously, future success depended on an "improvement of the economic status of the African". It is curious how this theory took hold in the colonial era, when those who might have put it into action were instead engaged in emptying wealth *out* of Africa. Colonel S. P. James, dispatched from Britain to assess the malaria situation in Kenya, wrote that "the prime cause of malaria's diminution has always been and will continue to be the general raising of the human standard of life, which results in better houses, less contact with mosquitoes, more drainage, greater resistance, readiness to call in a doctor, and readiness to take more trouble about sanitary matters in general" (Litsios 1996).

One trouble with the "wealth first, malaria later" view is that it tends to legitimize an absence of malaria control effort in the poorest countries. This is devastating thinking, if in fact malaria itself is a factor in keeping countries poor. A more proactive view began to be expressed at the 1950 WHO Malaria Conference in Equatorial Africa in Kampala. Here delegates recognized that malaria "exerts a prejudicial effect on the development of Africa", and for this reason merits "an attack on the problem of African malaria with a view to opening up the continent to large-scale development" (WHO 1951).

Thus, fifty years ago the Kampala Conference left us philosophically exactly where we return today, in the wake of the Abuja Declaration. Yet Kampala was also an utter failure: it failed to usher in new resources to deal with African malaria and promote development, even as the rest of the world absorbed great resources in the enterprise of malaria eradication. Even if the aggression and sporozoite rates of African mosquitoes ruled Africa out of the eradication strategy, it does not follow that Africa should have been denied other control strategies as aid agencies (in today's funds) ladled out billions of dollars (Spielman, Kitron et al. 1993). *Why did this happen?* The answer to this question is vital, if only to ensure that the same thing does not happen again.

Part of the reason lies in the daunting technical complexity of scientific malaria control, which is off-putting to potential aid donors. Probably no other disease has so many guises – so many radically permuted facets of epidemiology, entomology, or genetics – that enable it to defeat the monolithic "silver bullet" approach attempted during the eradication era. Yet donors understand and are attracted to the drama of silver bullets, which far and away appeal more than the Byzantine complexity of a sustained malaria control program. And anyway, conflicting advice about these programs abounds, as with the futile debate over whether single-goal (vertical) control efforts or general health (horizontal) services are better at fighting malaria, when both clearly have a role (Bradley 1998).

This complexity poses special problems to development aid agencies whose institutional specialty is not science or medicine, but international finance. This is not to discredit the commendable efforts of aid donors to understand malaria, but to sympathize that difficult issues for malaria control practitioners must strain those on the periphery of the field even more. The confusing complexity of malaria thus leads to inconsistent or shifting policy choices, even within a single aid agency. An example is where World Bank's own research found that the transition from vertical to horizontal malaria control in the Philippines made the disease worse (World Bank 1992), and yet within the decade, the Bank was advocating horizontal malaria control programs (World Bank 1999).

Aid donors themselves are not unfamiliar with the problems of managing malaria control programs. Some more candid donors even admit to them, to their credit. The World Bank, for instance, is helpfully honest in identifying the problems standing in its way of better malaria control:

> "If countries prioritize national efforts to reduce the malaria burden, it would in most places be possible for the World Bank to readily increase the allocation toward those efforts… [However] the lack of financial resources is not the main constraint that impedes countries malaria programs. Although the resource constraint is real (human and financial), it is often precluded and/or compounded by poor use of existing resources, e.g., underdisbursement of external financing, poor coordination of resources, unrecognized opportunities to tap into other sectors and programs, and limited appreciation for expanding the system's capacity through the private sector (NGOs and for profit)"
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> "Weak implementation capacity, poorly understood systems and procedures likely combine with the human resource constraints in the public sector to produce disbursement lags or cancellations of undisbursed financing. This problem is well-known to the Bank…"
>
> (World Bank 1999)

These passages relate the Bank's problems *specifically* in the delivery and use of malaria control funds. These in turn may stem from more *general* problems in the selection of projects or the evaluation of their results, as these passages from a Bank review of health sector projects shows:

> "The Bank often does not adequately assess borrower capacity to implement planned project activities. This was the factor most commonly cited in Implementation Completion Reports as contributing to poor project performance, including 69 percent of projects [the Bank] rated unsatisfactory."
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> "Paradoxically, Bank project designs are usually the most complex – with a greater number of components and organizational units – in countries with weak institutional capacity."
>
> "Although nearly all World Bank project design documents *assert* that the project will improve [health] outcomes, system performance, or health service access for the poor, few Implementation Completion Reports provide evidence that these development objectives were actually achieved. Not only do we know little about what the Bank has 'bought' with its investments, but when progress toward objectives is not measured, they are less likely to be achieved."
>
> (World Bank 1999)

These passages are not quoted to criticize or single out the Bank, for many other donors experience the same problems, whether or not they have the candor to admit it. Rather, their purpose is as a helpful introduction to the frustrations and pitfalls that donors face in deepening their financial stake in malaria control. The limitations are both within the donor institution and within the recipient countries. From them a condensed story of difficulties emerges: Donors experience weakness in their ability to assess country capacity and the local malaria situation, and consequently approve project designs that are beyond the capacity of least developed countries to implement. The project therefore stimulates neither the public nor the private sector, and the project moves slowly. The donor, sensing the inactivity, cannot fully disburse the money. Finally the project reaches its end, but because progress was not measured, nobody is sure if it succeeded or failed.

This chain of events largely explains why aid donors are slow to commit or disburse their resources for malaria control. More than the average health project, successful malaria control in Africa demands extraordinary technical skills, and this elevates the risk of failure. Nobody disputes that it takes vast expertise and knowledge to match the right interventions to the local epidemiology, entomology, and country capacity for implementation and monitoring – and getting it wrong is not hard. This makes malaria control a comparatively daunting enterprise, and so long as it is easier or less risky for aid donors to be involved in other investment sectors (e.g. transport) or other health priorities (e.g. reproductive health), underdisbursement and a lack of finance for malaria control will remain a problem.

Thus, if the opportunity brought by the Abuja Declaration and the economic realization of malaria's impact is not to be lost – if the failure of the Kampala Conference is not to be repeated – then ideas and mechanisms will be necessary to ease the burden on donors. This means finding ways to improve the chances of success for malaria control programs, by assuring scientifically appropriate programs that are within the capacity of countries to implement, and which can be monitored to show gains in health status. This will reduce the risk for donors, both in entering into individual malaria control programs, and in having demonstrable, positive results at the end of the day. With those changes, malaria control programs will become more attractive to fund.

The malaria control and community (comprising scientists, doctors and health economists) is uniquely positioned to help deliver these improvements. No other group of people is so well informed about the entomological, epidemiological, and biostatistical issues relevant to malaria project design and evaluation; and in many cases, the same persons are already performing malaria control or research in Africa and have a thorough understanding of country or regional capacities. Also, thanks to health aid databases such as SHARED (http://www.shared.de), it is easy to know who is working in a country and is well placed to assess country capacity.

The malaria community, in other words, is a powerful, underutilized source of expert and country knowledge that can support malaria control program selection and evaluation, where no single consultant or in-house specialist can advise development aid donors as thoroughly. The community should therefore take it upon itself to organize an

interdisciplinary review panel, drawing from the sciences, medicine and economics, to perform these tasks for donors. Such a panel could greatly improve the quality and probability of success for malaria control programs, and this would boost donor confidence immeasurably. Expert review would be especially helpful to the majority of donors who have little or no in-house capacity for the scientific design or evaluation of malaria control programs (e.g. Canada, the Nordic countries, Japan, and others); and it will also augment the capacity and alleviate the problems experienced by donors who have in-house malaria capacity (e.g the World Bank and USAID).

Implementing an expert review panel of this kind raises several practical questions that need to be discussed at the present meeting. Among these are:

- The institutional home of the review panel: While the review panel could in theory be totally independent, the Roll Back Malaria partnership offers an institutional home that is both germane and highly regarded by donors. In addition, WHO has both mechanisms to facilitate the hosting of expert panels, and considerable reach in endemic countries through its regional offices. The meeting needs to decide whether, given these advantages, the panel will be associated with RBM.

- The range of interventions to be considered: The Abuja Declaration calls for enhancing prompt access to malaria treatment, and also "the most suitable combination of personal and community protective measures…which are accessible and affordable to prevent infection". A partial list of interventions mentioned in the accompanying Plan of Action includes drugs, insecticides, house screening, insecticide treated nets, environmental measures and chemoprophylaxis (the Declaration also endorses "other interventions"). The choice among these interventions is based on scientific, clinical and economic considerations. The meeting needs to decide what expertise will be required on the review panel to successfully wield this variety of interventions.

- The roles of specific malaria control programs and/or system-wide delivery, or what are known as "vertical" or "horizontal" programs, respectively. Current trends emphasize the need to build health systems from among the many ministries of the public sector, and favor delivering malaria control from within that system. While there are large benefits to building a health system in its own right, it is also true that some important malaria control activities (*e.g.* mosquito biology, residual spraying, net impregnation) are unique to malaria, meaning that there is no economy of scale or synergy gained by integrating them into a multi-tasking health system. Thus it may be that reliance on health systems detrimentally limits the types of malaria control interventions that may be used. The meeting needs to decide whether these limits are of concern, and if so, when they may be outweighed by benefits of health system development.

- The process from recommended malaria control programs to funding: If the review panel works as hoped, it will process, evaluate and recommend a number of high-quality malaria control programs for funding. How these will proceed to funding

depends on the possible donors. Some donors will provide "block funding" to international agencies such as RBM/WHO, which in turn disburses those funds. Other donors prefer to control disbursements themselves. Many donors do both. The meeting needs to decide how to access the different modalities of funding, and what policies should be agreed to maximize the efficient use of resources among potentially duplicative funding agencies.

- The timelines for progress: The Abuja Declaration and all of the members of the Roll Back Malaria partnership have endorsed short timelines (from 2005-2010) to attain major improvements in health outcomes and treatment access for malaria. The time pressures on RBM are enormous and require rapid progress. The meeting should decide the frequency of the review panel's meetings to consider proposals, and it should also set goal dates for at least two milestones: (1) the full operation of the review panel and the first approval of a malaria control program, and; (2) the first complete funding of such an approved program

In conclusion, it should be the systematic involvement of the malaria control community that enhances the quality and monitoring of malaria control programs in Africa. This is the helping hand that RBM, its partners, and Africans need. We should provide it unstintingly.

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