ALMA summary report December 2018

Introduction

The fight to control and eliminate malaria is not new for the African continent. Indeed, even before The World Health Organization (WHO) adopted an ambitious proposal for the global eradication of Malaria at the World Health Assembly in 1955, Mozambique had already started indoor residual spraying (IRS) in its capital city in 1945.

The call for eradication served to catalyze action that led to the expansion of IRS throughout Southern Mozambique.

The Big Experiment

Whilst serious efforts were made in Europe and America, driven by a 4 step strategy of preparation, attack, consolidation, and maintenance; efforts in parts of Sub-Saharan African countries such as Mozambique were seen as experiments. These 'experiments' were limited in both scope (focusing on one intervention - IRS) and in scale (covering only part of the country). The comprehensive technical strategy in the US and Europe started with IRS, but included anti-malaria drug treatment, and surveillance. Indeed by the time WHO abandoned malaria eradication in 1969, The USA and Europe had already won the fight.

For 'experimental' countries like Mozambique, a yo-yo effect ensued. The country's large scale IRS programme in Southern Mozambique was abandoned in 1972 following the end of the WHO eradication campaign. The IRS was limited to the Capital but was halted at independence, due to transition and lack of resources. Limited IRS was re-introduced in 1976, following epidemics in the Maputo province, this was however disrupted by civil war

A New Commitment

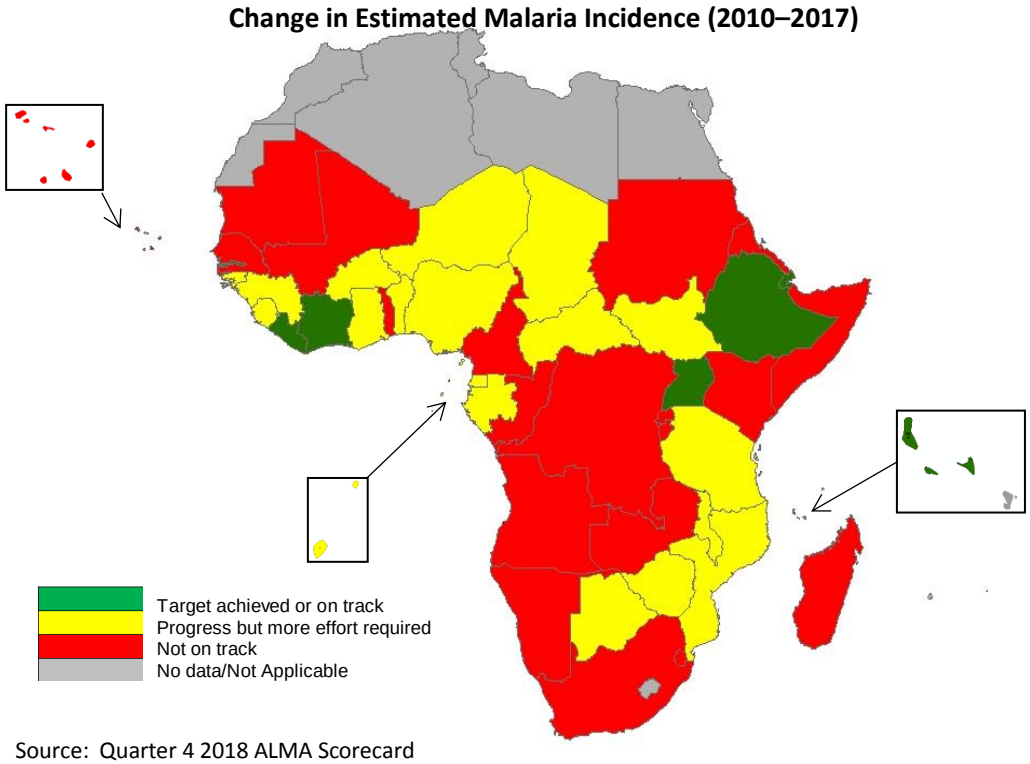
In 1994, with stability IRS began again in selected urban areas, and in most provincial capitals of Mozambique. The government formed a malaria advisory group under the department of Health. This commitment was reflected throughout the continent, with first the Abuja Declaration and then the commitment to the Millennium development goals.

In October 2014, the new head of the WHO Global Malaria Program, Dr Alonso, wrote as follows in a Barcelona Institute for Global Health blog: ".....it is essential to first demonstrate that it is feasible, that elimination is possible not only in regions where there are very few cases, but also in areas of high transmission with fragile health systems and complicated economic and social conditions." Indeed Sub-Saharan Africa demonstrated exactly this when at the end of the Millennium Development Goals period, the region had reduced Malaria incidence and mortality by 40%.

MEMBERS
Angola
Benin
Botswana
Burkina Faso
Burundi
Cameroon
Cape Verde
Chad
Comoros
Republic of Congo
Côte d'Ivoire
Democratic Republic of Congo
Djibouti
Egypt
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Gabon
Ghana
Guinea
Kenya
Lesotho
Liberia
Madagascar
Malawi
Mali
Mauritania
Mauritius
Mozambique
Morocco
Namibia
Niger
Nigeria
Rwanda
Sahrawi Arab Democratic Republic
São Tomé and Príncipe
Senegal
Seychelles
Sierra Leone
Somalia
South Africa
South Sudan
Sudan
The Gambia
Togo
Uganda
United Republic of Tanzania
Zambia
Zimbabwe

A new Challenge

Sub-Saharan Africa and its partners need to substantially increase their Malaria investment in order to attain and sustain Universal coverage with all recommended interventions.



Source: Quarter 4 2018 ALMA Scorecard

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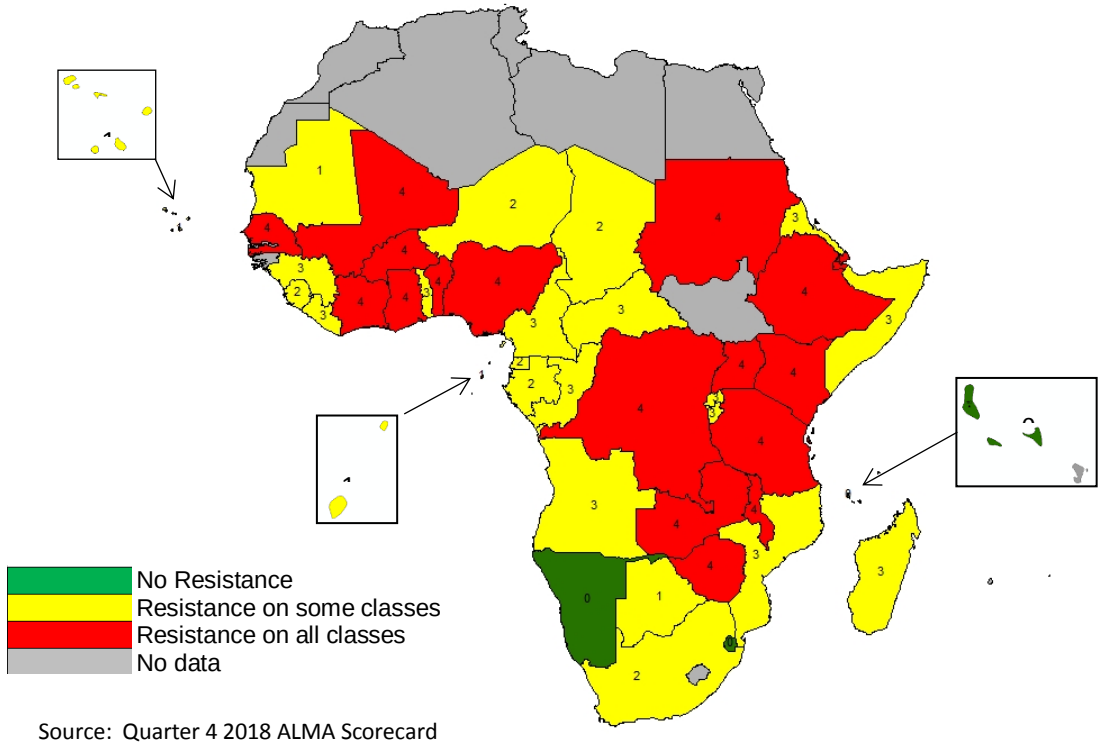
This is proving to be difficult. The World Malaria Report 2018 was launched in Maputo towards the end of 2018. The picture it paints is that of stagnation and regression.

Governments continue to contribute just 28% of the funding for malaria programs. As a result overall funding has now stagnated for the first 3 years of the SDG period. Given that the expense of essential interventions has increased with the rise in insecticide resistance, and number of required interventions; the funding is not adequate to sustain coverage levels achieved during the MDG era.

Insecticide classes with mosquito resistance confirmed since 2010



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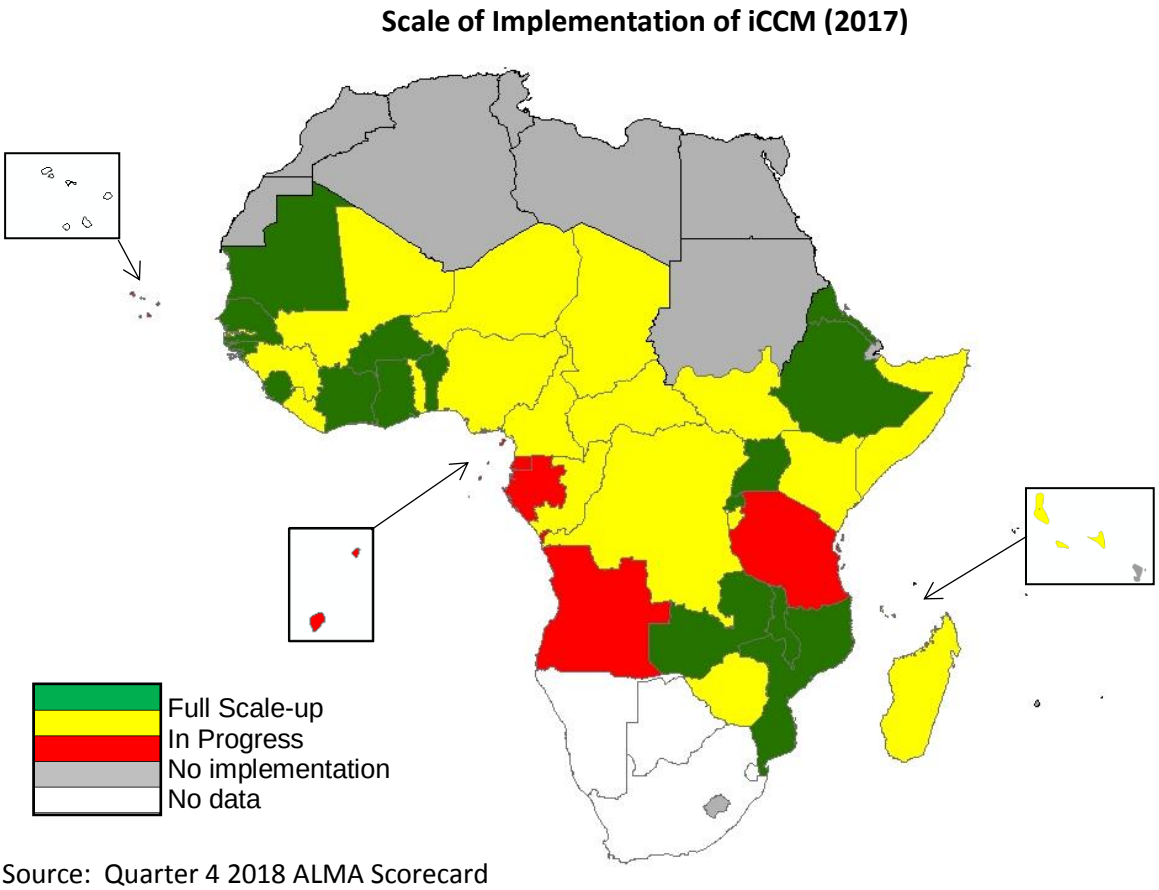
The ten high burden countries in Sub-Saharan Africa, all reported an increase in malaria cases in 2017

An unfolding Crises

Perhaps we need to remind ourselves why we want to end Malaria on the African continent. The World Malaria Report does exactly that. There were 200 million malaria cases in Africa in 2017. An alarming 404,550 of Africa's people died of malaria; out of whom 247,000 were children under the age of 5years.



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Let us remind ourselves of how debilitating malaria is. When the Malaria parasites enter our blood stream they head straight for the liver, where they very rapidly multiply. They attack the red blood cells aggressively and relentlessly, causing extreme sweating, chills, fevers, muscle aches, vomiting, and diarrhea. In some, especially children, it can lead to cerebral malaria). Falciparum malaria can damage the central nervous system, lead to liver and kidney failure, cause bleeding problems and lead to death.

The impact on family development and wellbeing of communities is staggering. There is lost productivity in sectors such as agriculture, manufacturing and mining; learning outcomes are reduced, and cognitive development of children is impaired. Household expenditures are increased, even as earning potential is reduced.

Ending malaria is a development, social, economic, and ethical imperative.

Africa's hope, our children

Encouraging progress was made during the MDG era in reaching children and pregnant women, the most vulnerable populations in the fight against malaria. It is estimated that in 2015, 68 per cent of Africa's children under the age of 5yrs were sleeping under Long Lasting Insecticide-treated nets (LLINs). In 2000, the figure was 2 per. Over the 15-year MDG period, the under-five malaria death rate fell by 40-65 per cent.

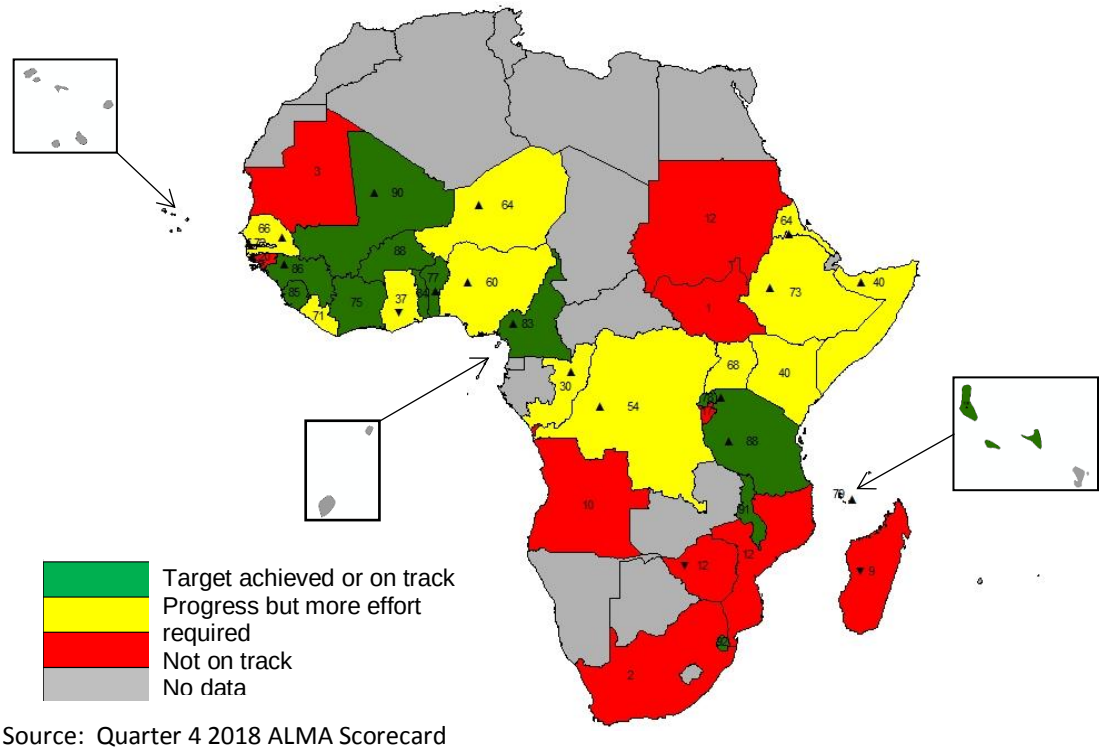
The World Malaria Report reminds us that we must not only build on and increase these gains, but we must appreciate the toxic symbiotic relationship between malaria and anaemia; which poses a serious threat to this vulnerable group. There is high 61% anaemia in children under the age of five; and even higher 79% anaemia in those that are suffering from malaria. It is these same children that are victims of undernutrition and malnutrition, making them not just vulnerable to malaria, but to other neglected tropical diseases as well.

Conclusion

It is time that we put our children first, time that we invest in our continents greatest asset in order for Africa to reap the demographic dividend that they deserve.

The first time that the world tried to eradicate Malaria, Africa was under colonial rule, and was not prioritized. In this new millennium, the continent is in the drivers' seat. We are at a point in time where we can truly shape our own destiny.

Mass Treatment Coverage for Neglected Tropical Disease (NTD index, %)(2017)



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The Africa we want is malaria free, NTD free, thriving and transforming with a healthy well educated and skilled, youth driving growth and development.