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ROLL BACK MALARIA IN THE AFRICAN REGION: A FRAMEWORK FOR IMPLEMENTATION

Report of the Regional Director

EXECUTIVE SUMMARY

1. Malaria remains a disease of major public health concern in the WHO African Region. There are 270 - 480 million cases annually in the continent, representing ninety per cent of global malaria deaths per year. In 1997 the total cost of the disease was more than US $ 2,000 million and is projected to reach $ 3,600 million per year by the year 2000. In recognition of this, OAU Heads of States adopted a Declaration in 1997 calling on Member States to intensify the fight against malaria. In response, the Director-General of WHO established Roll Back Malaria (RBM) in July 1998.

2. RBM in the African Region builds on the accelerated implementation of malaria control, the Regional Strategy for Malaria Control and the African Initiative for Malaria (AIM) Control in the 21st Century.

3. RBM approach emphasizes the technical aspects of malaria control as well as building of partnerships at all levels: regional, country and district. The implementation of RBM would be multisectoral, involving Governments, NGOs, the private sector, research institutions and, more importantly, the communities.

4. RBM in the African Region will contribute to strengthening the health systems. Capacity building at all levels with emphasis on managerial aspects constitutes one of the ways in which RBM would contribute to strengthening the health systems. In addition, RBM would lead to improved delivery of quality health care and address equity by focusing on the poor and marginalized people.

5. It is expected that RBM implementation in the African Region will bring stronger social mobilization and additional support so that by the year 2030, malaria will not be a significant public health problem.

6. This document proposes a framework for the implementation of RBM in our Region. It provides orientation on the implementation process and the roles of Member States, WHO and other partners. The Regional Committee is requested to consider the proposed framework and provide orientation for the adoption and implementation of RBM in the Region for the purpose of achieving the set objectives.

CONTENTS

INTRODUCTION

1. Malaria is a major public health problem in the WHO African Region. In 1991 and 1992 respectively, regional and global strategies for malaria control were developed. In 1995, the World Bank and the WHO Regional Office for Africa (WHO/AFRO) decided to develop long-term collaboration on malaria control.

2. The political support given to malaria control during the 1997 Organization of African Unity (OAU) Summit led to the establishment in April 1998 of the African Initiative for Malaria Control in the 21st century (AIM). In July 1998, the Director-General of WHO established Roll Back Malaria (RBM). Since the goals and the concept of the two programmes were similar, it was agreed that AIM would be called RBM in the African Region.

3. With its focus on health sector reforms and an enhanced role for communities in the implementation process, RBM is in line with the Regional Health for All Policy. The purpose of the current document is to provide Member States with an adaptable framework for RBM implementation.

SITUATION ANALYSIS

4. Estimated 270 - 480 million cases of the disease occur in the continent annually. This amounts to about one million deaths, representing 90% of global malaria deaths. Eighty per cent of these deaths occur among children under the age of five years. Malaria is a major contributing cause of poverty and absenteeism in endemic areas. It may account for loss of up to 5% of the Gross Domestic Product (GDP)

5. Weak health systems and inadequate coverage of control interventions complicate the scenario. Previous efforts to control the disease have suffered from fragmentation, lack of coordination, and inadequate consideration of socio-cultural factors.

6. The accelerated implementation of malaria control in the African Region took off in 1995, enhanced by funds of US $ 18 million from WHO in 1997 and 1998 and support from partners.

7. Some of the achievements of the accelerated implementation of malarial control are:

(a) plans of Action for Malaria Control developed in 38 African countries;
(b) development of monitoring indicators and establishment of monitoring and evaluation activities;
(c) improvement in malaria case management;
(d) development of antimalarial drug policies;
(e) increase in capacity building at the regional, national and district levels;
(f) introduction of Insecticide Treated Nets (ITNs) into 30 countries;
(g) increased advocacy, including increased visibility of national malaria control programmes;
(h) improved collaboration among partners.

8. The challenges encountered were:

(a) addressing epidemiological surveillance of malaria and other priority diseases as part of efforts to take technical interventions to scale within health sector reforms;

(b) improving accessibility and quality of care at facility level;

(c) sustaining and boosting the interest of key players in malaria;

(d) developing information, education, and communication (IEC) programmes based on local knowledge, attitudes, perceptions and beliefs in order to influence the behaviour and practices of individuals and communities;

(e) mobilizing resources at all levels;

(f) ensuring patient compliance with prescribed dosages;

(g) increasing the coverage of insecticide treated nets;

(h) assuring malaria control in emergency situations;

(i) integrating priority actions at operational level of primary health care;

(j) elaborating and implementing effective antimalaria policy;

(k) assuring mandatory intersectoral collaboration for effective result.

RBM IN THE AFRICAN REGION

Goal

9. The goal of Roll Back Malaria (RBM) in the WHO African Region is to reduce malaria burden to a level where it is no longer one of the major contributors to mortality and morbidity in the African region.

Objectives:

10. The objectives of RBM in the African Region are to:

(a) reduce mortality due to malaria;
(b) reduce morbidity due to malaria;
(c) maintain malaria free areas;
(d) expand areas where malaria is controlled;
(e) reduce the adverse socio-economic consequences of malaria.

Targets:

11. The targets of RBM are:

By 2001:

50% of 42 malaria endemic countries in the Region will have introduced RBM and developed plans of action;

75% of 42 malaria endemic countries will have introduced Integrated Management of Childhood Illness (IMCI);

80% of 42 malaria endemic countries will have increased the coverage of Insecticide-treated nets (ITNs) to 25%;

Countries that are malaria free in 2000 will remain malaria free.

By 2005:

50% of households in targeted districts will have at least one ITN;
25% of childhood fevers will be correctly managed using IMCI;

Countries that are malaria free in 2000 will remain malaria free.

By 2010:

All countries in the Region would be fully implementing RBM;
Reduction of malaria morbidity by 50% of the 2000 levels;*
Reduction of malaria mortality by 50% of the 2000 levels;*
Countries that are malaria free in 2000 will remain malaria free.

By 2015:

Further reduction in malaria mortality by 50% of the 2010 figures;
Further reduction in malaria morbidity by 75% of the 2010 figures;
Areas where malaria is controlled in the countries will increase by 50% of 2000* figures;
Countries that are malaria free in 2000 will remain malaria free.

By 2025:

Further reduction of malaria mortality by 50% of the 2015 figures;
Further reduction in malaria morbidity by 80% of the 2015 figures;
Areas where malaria is controlled in the countries will increase by 20% of 2015 figures;
Countries that are malaria free in 2000 will remain malaria free.

By 2030

Malaria mortality reduction maintained at the 2025 levels;
Malaria morbidity reduction maintained at the 2025 levels;
Countries that are malaria free in 2000 will remain malaria free.

IMPLEMENTATION STRATEGIES

12. The seven pillars of RBM implementation are:

(a) ownership;
(b) contributing to health sector reform and socio-economic development activities;
(c) integration of malaria control activities into primary health care (PHC),
(d) increasing the coverage of cost-effective technical interventions;
(e) building and strengthening partnerships;
(f) strengthening community participation;
(g) strengthening health information system and research.

Ownership

13. RBM will have to be country-driven to ensure that malaria control efforts are planned and implemented according to country priorities and community needs as well as to assure sustainability. This requires the ownership of the RBM by countries, including active total involvement of communities.

*The level will be determined through surveys undertaken in the year 2000

Contributing to health sector reforms and socioeconomic development activities

14. RBM in the African Region will contribute to the overall national health system performance through:

(a) capacity building for malaria programme management;
(b) improved planning and management as part of ongoing health sector reforms;
(c) increased decision capacity for malaria programme managers;
(d) coordination and implementation of RBM activities within a decentralized health system.

15. Integration of malaria control within health sector reform will assist to ensure:

(a) improved access to and availability of services, through appropriate design of services for effective coverage, including for groups at greatest risk;

(b) improved quality of care and utilization of services;

(c) linkage to human development and poverty reduction and the promotion of mechanisms to enhance utilization of services by targeted groups;

(d) improved overall health structure, including better organization and management systems for drugs, personnel, equipment, referrals, transport, communications, and maintenance, thus impacting positively in other programmes such as safe motherhood, HIV/AIDS, EPI, IMCI etc.

Integration of malaria control activities into primary health care

16. To achieve the targets in the African Region, RBM will be implemented within evolving national health systems. Its activities will be integrated into PHC, to ensure wide accessibility to the communities and address equity issues.

Increasing the coverage of cost-effective technical interventions

17. In order to achieve the RBM targets, an appropriate mix of proven cost-effective technical interventions must be taken to scale. These interventions must target the following priorities:

(a) early diagnosis and prompt effective treatment at home, the community and health facility;
(b) preventive measures, including selective cost-effective anti-vector control activities e.g. ITNs;
(c) promotion of health information and education activities;
(d) epidemiological surveillance;
(e) forecast, early detection, prevention and control of epidemics;
(f) research on traditional medicines;
(g) drug development from traditional medicines;
(h) regular assessment of country malaria situation in order to improve control activities.

Building and strengthening partnerships

18. A broad-based, multi-sectoral RBM partnership forum will be established under country leadership. It will promote and ensure:

(a) coordination of national efforts;
(b) comprehensive RBM policies;
(c) point planning, monitoring and evaluation;
(d) improvement in mobilization and allocation of resources;
(e) enhanced public and private sector collaboration.

Strengthening community participation

19. At the community level, RBM will promote:

(a) ownership of malaria control activities by the communities;

(b) improved quality in home care;

(c) capacity building of communities for implementation and sustainability of activities;

(d) linkage of malaria activities with gender-based development activities;

(e) broadening of the resource base at community level by facilitating community-based financing initiatives to ensure sustainability of malaria activities;

(f) mobilization of all segments of the society for relevant activities;

(g) integration of RBM activities into other community-based activities such as Bamako Initiative, IMCI, EPI, etc.;

(h) linking of community activities with national efforts to control malaria

Strengthening of Health Information System and Research.

20. RBM, in collaboration with the Integrated Disease Surveillance, will contribute to strengthening of health information systems through:

(a) capacity building in data collection, analysis, interpretation, information sharing and decision making and practice at district and national levels;

(b) capacity building in research, particularly operational research, at all levels;

(c) strengthening epidemiological surveillance capacity and capability, particularly at the operational level.

ROLES AND RESPONSIBILITIES

Countries

21. Countries will develop five- or six- year evidence-based RBM plans of action that confer priority on capacity building in order to ensure sustainability. They will also play the following roles:

(a) advocacy;
(b) consensus building;
(c) resource mobilization and coordination;
(d) human resource development;
(e) planning and implementation;
(f) monitoring and evaluation.

World Health Organization

22. WHO will:

(a) facilitate building of sustainable partnerships at the regional and country levels by:

- strengthening and expanding collaboration with multilateral and bilateral agencies, NGOs and the private sector;

- strengthening collaboration with IMCI, Integrated Disease surveillance and other programmes and sectors that have malaria related activities;

(b) contribute to advocacy and resource mobilization for country and inter-country activities;

(c) provide technical support, including orientation, to countries in the implementation of RBM.

23. National capacity and capability building will receive high priority.

24. Technical support will include:

(a) provision of technical guidelines;
(b) development of strategy documents;
(c) strengthening country-level expertise;
(d) support to implementation of planned activities;
(e) monitoring and evaluation.

25. The country Office will provide active support to countries for the coordination of RBM activities.

Other Partners

26. Other partners' support to the development and implementation of country RBM plans of action will be through their efforts in:

(a) areas of comparative advantage;
(b) national capacity development;
(c) resource mobilization;
(d) agreed plan of work.

27 Eleven countries will serve as "spotlight" for developing the RBM experience.

28. A Regional level partnership for RBM will be built and developed through the annual meeting of the Task Force for malaria control in Africa.

RESOURCES

29. The level of resources required to support country plans of action is expected to grow significantly to cover major investments for RBM activities. Countries will be expected to increase the levels of resources allocated to RBM activities. RBM partnership at global, regional and country levels will also be expected to mobilise financial, human, and material resources for the implementation of the planned

activities.

30. Investment in malaria control currently stands at about $ 12 million. To meet the commitments of RBM, the resources needed at country level between 2000-2005 have been put at more than 10-15 times the current investments. When in full implementation by the year 2015 RBM might require resources 40 times the current budget.

31. Resources will therefore need to be mobilised at all levels. Given the need for RBM to remain country-driven and sustained, country partnerships will be significant for mobilizing in-country resources, including untapped private and community resources.

32. A clear system to ensure easy flow of resources as well as accountability, transparency and information sharing would be set up at country, regional and global levels. Emphasis will be on allocation of resources to country and local levels.

PHASES OF IMPLEMENTATION

33. The districts will constitute the first level for the implementation and evaluation of RBM as follows:

Phase 1: Introduction and Implementation - 2000 to 2015

Stage 1: Preparatory and planning (Period up to end of 2000): In this phase, the priority processes will be:

(i) inception meetings;
(ii) strengthening of priority actions;
(iii) development and assessment of strategy and plan of action.

Stage 2: Implementation from 2001 to 2005 and expansion from 2005 to 2015.
Activities will focus on strengthening implementation, assuring availability of services and monitoring. Expansion will follow by 2005, drawing on lessons learned.

Phase 2: Consolidation - 2016 to 2025

Countries, with the support of RBM partnerships, will have instituted sustainable mechanisms for disease control and strengthened the health systems. The results from country level would have started to have impact on mortality and morbidity.

Phase 3: Maintenance - 2026 to 2030

During this stage, efforts would be made to keep the burden of disease low and maintain gains made. This will include efforts at continued capacity building reorientation and re-training of personnel.

MONITORING AND EVALUATION

34. For the evaluation process, the following indicators will be used at country level:

(a) malaria-related mortality among the under-five;
(b) percentage of the under- five sleeping under ITNs;

- (c) number of malaria epidemics detected within two weeks of onset and control measures initiated;
  (d) percentage of severe malaria cases properly managed in clinics;
  (e) Percentage of malaria-free areas.

35. Monitoring is, of course, a continuing process. However, programme monitoring will be on an annual basis and programme evaluation every five years. Programme review will take place at intervals determined by the countries and the Regional Office.

CONCLUSIONS

36. RBM with its additional resources will bring to scale technical interventions for malaria control, with emphasis on community-based activities.

37. RBM will be country-specific and country-driven. It is expected to contribute to the strengthening of health systems for the purpose of ensuring equity, accessibility, efficiency and delivery of quality services.

38. The development of multi-sectoral partnerships, including opportunities like IMCI, will feature high in the implementation strategy of RBM in Africa.

39. The implementation of RBM in the African Region will contribute to the control of the disease and to assuring the socio-economic well being of the society.

40. The Regional Committee is therefore requested to approve the present framework as a tool to ease and facilitate the implementation of RBM in the Region.