

**WORLD HEALTH ORGANIZATION**



**Address**

**by**

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Honourable Senators,

I wish to express my thanks and appreciation to you for giving me the honour of participating in this briefing today. This is a very special visit for me, because it is a homecoming. I spent three very rewarding years studying at the Ecole de Santé Publique Erasme here in Brussels.

I am also very pleased to have the opportunity to speak to your committee, because malaria is a disease that affects everyone on earth and requires a global approach.

This is a group of boys in Diaba, a rural village in eastern Senegal. They are lucky to have reached this age without experiencing a fatal bout of malaria. Malaria takes the lives of nearly a million children each year in Africa before they can reach the age of five. And Senegal is a country with a particularly serious malaria problem.

I am lucky to have survived, too. I grew up in Mali, where malaria also takes a tremendous toll on the lives of young children. I am lucky that I was able to do my best to fight malaria while I was Minister of Health of Mali and that I am now able to fight it at the global level. If we can commit to working together we can move forward against this scourge.

Today people living in 107 countries and territories are at risk of malaria. Worldwide there are up to half a billion cases of malaria each year. Most of them occur in Africa south of the Sahara. And as I noted earlier, most fatal infections are in children.

Children who survive malaria do not escape unharmed. Repeated episodes of fever and anemia take a toll on their mental and physical development, impairing their education, their growth into productive adults.

Pregnant women and their unborn children are also particularly vulnerable to malaria, which is a major cause of low birth weight, anaemia and infant death.

Malaria has a devastating effect on adults, as well, because repeated infections drain their capacities. It is a disease that ruins lives.

The terrible toll of malaria should inspire indignation in all of us, because it is so unnecessary. We know how to prevent malaria, and we know how to cure it, and neither intervention costs very much. Malaria control involves four basic strategies.

The first is prevention. How do we prevent malaria? Mainly by reducing people's exposure to the mosquitoes that carry the disease. We do that foremost by seeing to it that people sleep under insecticide-treated mosquito nets. We tie education about mosquito nets with education about malaria overall, and it helps people understand the problem and how to protect themselves. The nets don't cost much – about 5 U.S. dollars for a long-lasting net that should remain effective for four years. Research has shown that in African children under the age of five, use of insecticide-treated nets reduces the rate of deaths from all causes by 20 percent.

Another effective prevention is indoor spraying with insecticides that leave an active residue inside people's dwellings.

The second important strategy is prompt treatment of malaria cases with effective medicines. As you may have heard, chloroquine and other medicines we formerly used against malaria have lost their effectiveness because the malaria parasite has developed resistance to them. That is why we must turn to combined treatment with artemisinin – a medicine derived from the sweet wormwood plant, *Artemisia annua* – and a second antimalarial medicine. This artemisinin-based combination therapy -- which we call A-C-T for short -- is highly effective but 10 times more costly than chloroquine.. Still, the price is low, when you consider that

malaria is often lethal if not treated promptly ... just 1 to 2 U.S. dollars to treat a child, and a dollar-fifty to two-fifty to treat an adult.

The third strategy is protecting all pregnant women living in areas where malaria is prevalent by treating them preventively, twice during their pregnancy, with effective antimalarial drugs.

The fourth and last strategy is to monitor crises that make countries ripe for a malaria epidemic, make all attempts to prevent an epidemic, and intervene swiftly if one arises.

We know how to prevent and treat malaria. We just need to improve vulnerable people's access to that prevention and treatment. That is our greatest challenge, and our greatest opportunity.

For prevention, we need to see dramatically stepped up production and distribution of insecticide-treated nets, especially the newer long-lasting nets, which represent an important step forward because they require no retreatment with insecticides. By the end of 2005, the worldwide capacity to produce the long-lasting nets will reach more than 4 million per month. One promising new development is a movement toward producing nets in Africa. The first African factory to manufacture long-lasting insecticide-treated nets, which is located in Tanzania, recently celebrated the first anniversary of its opening, and will produce seven million long-lasting nets in 2005. Still, supply is not sufficient to meet the need at present.

We also need greater emphasis on distribution of insecticide-treated nets, free of charge, to children under the age of five, pregnant women, and people living with HIV/AIDS—the people most vulnerable to dying of malaria. WHO and UNICEF recently released a joint statement calling for worldwide commitment to this policy, which could save tens of thousands of lives every year.

For treatment, there is an urgent need to get ACTs to people in need. More than 40 countries have changed their drug policies and adopted ACTs as their first line of treatment since 2001, when WHO recommended these medicines as the treatment of choice for *falciparum* malaria – the most serious form of the disease. The resulting surge in demand led to a shortage of ACTs, beginning last fall. The reason for the shortage was a lack of sufficient supplies of the plant *Artemisia annua* – the source of the raw material needed to make these medicines.

We are still facing that shortage, but we expect that by the end of 2005 there will be sufficient medicine to meet demand. This year, cultivation of *Artemisia annua* has been stepped up considerably, thanks in large part to large-scale cultivation projects in East Africa.

It is vital also that the price of ACTs be reduced to less than a dollar for a course of treatment, and that subsidized or free distribution be arranged for vulnerable people who can't afford this life-saving treatment.

Malaria control cannot move forward without the help of the international community. A total of a 2 billion dollars annually is needed for effective malaria control in Africa, an additional 1 billion dollars for the rest of the world. In 2004, just \$400 million was available, thanks in large part to the Global Fund to fight AIDS, Tuberculosis and Malaria.

Money is not the whole answer, however. Many developing countries, African countries in particular, don't have the health care personnel needed to implement malaria prevention and treatment. To reach our goals for controlling malaria, political commitment is paramount and partnership is crucial. The RBM movement has accomplished a great deal, as have the partnership between malaria control programmes and reproductive health and immunization campaigns. Also we need to

make a concerted effort to reinforce malaria control in areas of intense economic development--because the two can synergize each other.

I hope I have helped make you aware how a relatively small investment in malaria control could save and change the lives of millions of the world's most vulnerable people.