AFRICAN UNION

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**"FIGHT MALARIA:
AFRICA GOES FROM CONTROL TO ELIMINATION BY 2010"**

AFRICAN UNION LAUNCH OF

THE

AFRICA MALARIA ELIMINATION CAMPAIGN

during the 3rd Session of the AU Conference of Ministers of Health
Johannesburg, South Africa
April 9th-13th, 2007

1. Introduction

1. Despite being both preventable and curable, malaria remains one of the most serious public health problems in Africa. The burden of malaria in the African continent and the benefits that would accrue, both in terms of human and economic development, if malaria were to be controlled, have been adequately described in previous reviews, reports and programme strategies.

2. An estimated 74% of the population in Africa lives in areas that are highly endemic for the disease and 19% in epidemic prone areas. Only 7% of the region's population lives in low risk or malaria-free areas. Malaria in Africa accounts for approximately 270 million clinical cases each year, of which 70% to 80% are children under-five. About 95% of the global two to three million deaths occur in Africa. Twenty four percent (24%) of all deaths in children under-five years in Africa are from malaria and malaria related illnesses. Malaria is one of the commonest causes of hospital visits accounting for 30-40% of out-patient visits and 10-15% of all disease admissions to hospitals. In some settings as many as 80% of malaria cases are managed at the community level.

3. Malaria has been on the agenda of African Leaders and the WHO for a long time. In April 2000, the Heads of States and Governments adopted the Abuja Declaration and Plan of Action on Roll Back Malaria (RBM). In July 2000 at their regular Summit in Lomé, Togo, the Heads of State and Government declared "*25 April, Africa Malaria Control Day*". The aim was to intensify advocacy for collective action and well-coordinated action at all levels.

4. In May 2006, under the theme *"Universal Access to HIV and AIDS, Tuberculosis and Malaria Services by a United Africa by 2010"* the Heads of States and Governments met in Abuja to review the progress that countries had made in achieving the targets set in 2000. Almost all countries have established national malaria partnerships to enhance collaboration and coordinated efforts in controlling malaria. A third of the African countries have allocated at least 10% of their national budget to health while one country has attained the target of 15%. Several countries have been able to access funds from the GFATM, and other bilateral and multi-lateral sources.

5. Although, some improvement has been made with regard to access to effective anti-malarial treatments and anti-malarial preventive services, the scale and progress has been limited. Moreover, at the Abuja Special Summit of May 2006, the Heads of State expressed concern about the continued morbidity, mortality and debility attributed to HIV/AIDS, Tuberculosis and Malaria.

6. The African Union acknowledges the contribution made by the RBM Secretariat, the Millennium Project (UNMP) and WHO towards this launch.

2. The Africa Malaria Elimination Campaign

7. This Launching document of the Africa Malaria Elimination Campaign consolidates previous relevant resolutions, strategies, programmatic orientations and documents approved by Member States and builds mainly on the Abuja Call for Accelerated Action adopted in May 2006. The campaign is also in line with the other Abuja Summit targets, the Global Strategic Plan 2005-2015 of the RBM Partnership, the WHO Africa Regional Strategy and those of RECS.

8. In May 2006, countries committed themselves to the Abuja Call to ensure universal access to anti-malarial interventions through well-organized and well-funded national malaria control to reduce malaria as a public health problem. The main goal of the Africa Malaria Elimination Campaign is to eliminate malaria by reducing the burden of malaria with the ultimate aim of eradication through ensuring universal free or highly subsidized access to prevention and treatment interventions, and to contribute to the socio-economic development of the people of Africa in support of making progress towards the Millennium Development Goals by 2015. Through incremental steps, African countries will subsequently aim to eliminate malaria and interrupt local transmission. The planning needs to be country specific in order to deal with the timelines required to reach the preparatory stages of elimination.

2.1 Africa's move from Malaria Control to Elimination

9. The Africa Malaria Elimination Campaign takes into account the variation in the burden and epidemiology of malaria in the different regions of the continent. It defines the focus of malaria control and elimination through incremental programming for elimination by region within the Member States. Countries with high burden of malaria will aim at disease control thus reducing malaria as a public health problem with a long-term goal of eliminating malaria, while the immediate direction in countries with low burden of malaria will be elimination of malaria. Countries that succeeded malaria elimination as well as those countries currently free of malaria will aim to maintain the malaria-free status.

2.2 Incremental programming elimination

10. The general direction to move from malaria control to elimination through incremental programming is presented below and summarized in table 1.

a) High Transmission Areas (referred to as Group 1)

11. In most of the African countries, malaria transmission is intense with high levels of malaria morbidity and mortality. Although the 2006 Progress Report on the implementation of the Abuja Declaration and Plan of Action found that considerable

progress had been made, the current status of coverage with anti-malarial interventions is unlikely to produce impact by 2010. For the countries not mentioned below (the rest of Africa) they are considered to have high transmission of malaria event though some countries may have some malaria free areas within their borders.

12. For these countries, the direction of the Africa Malaria Elimination Campaign is to have universal coverage of preventive and treatment interventions against malaria in order to reduce the burden of malaria to levels where it is no longer a public health concern. The interventions would consist of indoor residual spraying (IRS), use of insecticide treated materials (ITMs), intermittent preventive treatment (IPT) including other related prevention measures, and diagnosis and treatment (combination therapies) of malaria with universal access to these interventions.

13. Sustainable financing for the implementation of malaria interventions and strong advocacy for social and community mobilisation for sustained delivery and use are critical for achieving impact. In addition, strong surveillance and health information systems as appropriate and strong inter-country and cross border collaboration are critical in order to achieve reduction in the burden. Once this stage is completed, the duration of which depends on the efforts and achievements of individual countries, this group of countries would subsequently aim to move on to the stage of malaria elimination.

b) Low Transmission Areas (referred to as Group 2)

14. The intensity of transmission and incidence of malaria in countries such as Algeria, Botswana, Namibia, South Africa, Swaziland, the Comoros, Cape Verde, Sao Tome and Principe is relatively low and involves parts of the countries. There have been improvements in access to anti-malarial measures, as well as promising impacts on malaria prevention and control efforts. For these countries, the immediate direction of the Africa Malaria Strategy is to move from malaria control to elimination, as a logical extension of the successes in malaria control achieved by these countries.

15. The approach in these countries should be the implementation of anti-malaria program deliberately aimed at elimination. These programmes combine intensive efforts to control the disease locally through facility based case management, active case detections and treatment approach, strong surveillance system and targeted vector control with extensive inter-country collaboration for screening and follow-up of imported cases. Through the incremental stage, these countries will subsequently aim to maintain a malaria-free status.

c) Transmission has been interrupted (referred to as Group 3)

16. Countries including Egypt, Libya, Tunisia, Mauritius and the Seychelles in which interruption of malaria transmission was declared recently, the policy of the Malaria Strategy will be prevention of malaria re-introduction and, subsequent certification of malaria elimination.

3. Goal and Objectives

3.1 Goal

17. The goal of the Africa Malaria Elimination Campaign is to eliminate malaria by reducing the burden of malaria with the ultimate aim of eradication through ensuring universal free or highly subsidized access to prevention and treatment interventions, and to contribute to the socio-economic development of the people of Africa.

3.2 General Objective

18. The main objective of the Campaign is to accelerate implementation of universally accessible malaria control interventions in order to reduce the malaria burden in the context of strengthening of health systems. Antimalarial commodities such as ITMs, IRS, diagnostics and combination therapies, as well as correct and timely information should be considered as public goods and should be available to all residents in need in endemic sites.

3.3 Specific Objectives and Targets

19. The specific objectives and targets are as follows:

3.3.1 To reach global, continental, regional and national targets by 2010 by reducing malaria morbidity and mortality by 50% compared to the 2000 level and to reach MDGs by reducing malaria morbidity and mortality by 75% compared with 2000 levels in all endemic countries through universal access to malaria prevention and control interventions.

a) All people at risk will have universal access to free or highly subsidized effective diagnostics and anti-malarial treatment by 2010
b) All people at risk will have universal access to appropriate free or highly subsidized anti-malarial preventive services such ITMS, IRS and IPT (where appropriate) by 2010
c) All malaria epidemics will be detected and responded to within two weeks by 2010; and the frequency of epidemics would be reduced by 50% by 2015
d) By 2010, reduce malaria morbidity and mortality by 50%
e) By 2015, reduce malaria morbidity and mortality by 75%

3.3.2 To eliminate malaria from countries such as Algeria, Botswana, Namibia, South Africa, Swaziland, the Comoros, Cape Verde, Sao Tome and Principe by 2015.

a) By 2010, all the countries in the group two will have finalized planning for the attack phase
b) By 2013, all the countries in the group two will have finalized attack phase
c) By 2015, all the countries in the group two will have stopped transmission in their countries

3.3.3 To prevent reintroduction of malaria in areas where malaria transmission has been stopped such as in Egypt, Libya, Tunisia, Mauritius and the Seychelles.

All countries will have maintained the malaria free status

4. Strategies for Africa Malaria Elimination

4.1 Key Strategies:

20. The package of interventions in the context of universal access to prevention, treatment and care and health system strengthening are the following:

a) Population groups such as pregnant women, children under five years of age, migrant workers, and displaced people, those affected by draught and famine, and travellers from non malarious areas to the lowland malarious areas are the most at risk of malaria. The campaign will ensure that these population groups and other vulnerable groups are a priority for universal access to preventive, treatment and care measures.

b) Free or highly subsidized mass distribution of insecticide treated materials to achieve 100% coverage of the population at risk of malaria. Although mass campaigns are the primary approaches to ensure rapid scale up of access to reach the targets, other delivery mechanisms that were successfully used in certain countries distribution systems such as social marketing, voucher schemes, private formal and informal distribution systems may be applied in addition to mass campaigns when appropriate.

c) Application of targeted Indoor Residual Spraying (IRS) with effective insecticides, including the use of DDT.

d) Free or highly subsidized access to effective antimalarial drugs such as ACTs, and diagnostics in all health facilities and at community level. Emphasis will be given to community-based malaria prevention and treatment programs to ensure that communities get the necessary service in their respective villages.

e) Early epidemic detection and control

f) Strong HMIS and surveillance

g) Active case detection and treatment

h) Building of inter-country and cross border initiatives and efforts including encouraging cross border cooperation and management to sustain areas freed of malaria.

i) Operational research focussing on enhancing program effectiveness of SUFI implementation.

4.2 Cross Cutting and Supporting Strategies

(a) Strengthening malaria advocacy and communication: Strengthening social and community mobilisation is an important component of the malaria elimination strategy to ensure sustained effective utilisation of malaria preventive and treatment services, including the enhancing of the competence of communities to deal everyday and on a sustainable basis with malaria or through national, regional and global advocacy. e.g. on Africa Malaria Control Day.

(b) Sustainable Financing: Sustainable financing for the implementation of malaria interventions is necessary. Countries and their programmes will make deliberate efforts to mobilise sustained resources from national governments, bilateral organisations and other partners in malaria control. Most important will be increasing health funding to move towards the target of 15% of the national budget devoted to health and to access additional global resources (Global Fund Tuberculosis, AIDS and Malaria, World Bank Booster, PMI (in full!!!!!!!!and UNITAD) through program performance based applications by engaging all in-country delivery capacities available such as antenatal care services, expanded programmes of immunization, national campaigns, community outreach programs and public and private health care delivery services.

(c) Surveillance, Monitoring and Evaluation: In order to be able to know the coverage of interventions and the impact the interventions are having on the morbidity and mortality countries will further strengthen their surveillance systems, health management information systems and programme monitoring in line with their health system strengthening priorities with regard to health information systems.

(d) ***Partnerships:*** The success of the Campaign will depend on effective and well-coordinated partnerships among stakeholders at community, national, regional, continental and international levels.

5. Launch

5.1 At Continental Level

21. The Africa Malaria Elimination Campaign which aims to tackle Malaria in Africa with renewed zeal and commitment, is being launched on 10 April 2007, during the 3rd Session of the African Union Conference of Ministers of Health in Johannesburg, South Africa, 9-13 April 2007 on the theme: *"Strengthening of Health Systems for Equity and Development".* Stakeholders at all levels were called upon to scale up efforts and supplement each other's role. The AU Commission should ensure that Malaria Elimination for eventual Eradication is kept high on the agenda of the AU, RECs and international organisations.

5.2. At National Level

22. All Member States are urged to organise respective national launches on 25 April 2007 which is the Africa Malaria Control Day. This year's theme will be "*Leadership and Partnership for Results"* with the slogan *"Free Africa from Malaria NOW!"*

23. The Campaign slogan will be “Fight Malaria: Africa goes from Control to Elimination by 2010”. Every year, a fresh call will be disseminated to all stakeholders and partners on the occasion of the Africa Malaria Control Day to review the activities of the past year and to strengthen the campaign. More efforts should be made to reach all communities with information and services, laying emphasis on the most vulnerable groups, particularly, children and pregnant women. Governments, Private Sector and development partners are urged to ensure universal access to affordable and timely services. The Media and Civil Society should be mobilized to play their role in the promotion of Information, Education and Communication (IEC).

5.3. At Regional level

24. The RECs and Regional Health Organizations should ensure that the Malaria Elimination Campaign for eventual Eradication is kept high on the agenda of national governments and their own organisations. They should also play their mandate roles more effectively.

5.4. At International Level

25. The WHO, the Roll Back Malaria Partnership, other UN and International Organisations and Development Partners should also scale up efforts to provide support at national, regional and continental levels. More resources should be mobilized for Malaria related projects and programmes, including the Global Fund to fight HIV/AIDS, TB and Malaria (GFATM), which should also allocate more funding to Malaria efforts.

Table 1: Moving From Malaria Control to Elimination

Countries	Burden of disease	Current status of access to anti-malarial interventions	Immediate direction of Malaria Strategy	Key ingredients for implementing the Malaria Strategy	Outcome of Malaria Strategy	
GROUP 1	• High malaria transmission (perennial/ seasonal) • High malaria morbidity and mortality	• Low level of access to anti-malarial drugs and prevention services	• Universal access to anti-malarial interventions • Strong advocacy	• Free access to effective anti-malarial drugs such as ACTs and diagnostics • Free mass distribution of ITMs • Free application of targeted IRS with effective insecticides including DDT • Access to IPT • Advocacy for concerted effort and behavioral change • Resource allocation	• Significant reduction (75%) in malaria morbidity and mortality • Prerequisites for initiation of elimination satisfied	MOVE TO GROUP 2
GROUP 2	• Low malaria transmission • Malaria morbidity and mortality low	• High levels of access to anti-malarial interventions • Strong inter-country collaboration	• Preparatory phase for elimination • Attack phase • Consolidation phase	• Provision of early diagnosis and adequate treatment of malaria • Scale up free ITMs distribution to all people at risk • Increase operational and population coverage with IRS • Detect and prevent malaria epidemics • Reliable and sensitive malaria surveillance • Active case detection and treatment • Strong cross-border cooperation	• Elimination of malaria	MOVE TO GROUP 3
GROUP 3	• Transmission has been eliminated	• Malaria transmission interrupted	• Prevention of reintroduction • Certification	• Efficient surveillance system • Active epidemiological investigation • Continuous assessment of preventive measures • Good coverage and involvement of health services • Availability of reagents, anti-malarial medications, materials and equipment • Training and retraining of personnel	• Prevention of reintroduction • Certification	CONTINUE MALARIA FREE STATUS

HEAVY MALARIA BURDEN → MALARIA ELIMINATED

APPENDIX

WHAT IS MALARIA ELIMINATION?

Moving from Malaria Control to Malaria Elimination

Most countries that are achieving malaria elimination started by implementing control measures aimed at seriously decreasing their malaria burden, subsequently advancing to a situation where malaria would no longer be a public health problem. Some of the critical ingredients for successful certification of elimination are high-quality surveillance with full coverage of all populations in the operational zones, high-quality laboratory services, well-defined protocols for case investigation to provide evidence of the absence of indigenous cases, and solid, continuous communication between the national elimination programme and local health services.

BOX 1: Prerequisites for establishing successful national malaria elimination programme

The feasibility of malaria elimination in a country depends on a careful analysis of malaria control experiences in conjunction with a detailed analysis of the environmental, epidemiological and socioeconomic factors related to malaria. In general, the duration of elimination depends strongly on the initial situation: the number of people at risk, the size and type of geographical areas affected, the infrastructural, social and economic situation of the affected areas, including conflict or criminal activities that might hamper access, the situation in neighbouring countries and the possibilities for border collaboration. Countries might decide to opt for a staged approach, gradually involving more provinces in the elimination effort.

Recent experience with national malaria elimination programmes has shown a number of commonalities for establishing a successful programme.

Successful contemporary malaria elimination programmes:

a) are based on sufficient knowledge of the epidemiological aspects such as local malaria species, local vector species and their ecology, biting and resting habits, eco-epidemiological type(s) of malaria, e.g. by stratification, patterns of malaria transmission; and susceptibility of malaria parasites and vectors to the anti-malarial drugs and insecticides respectively, that are planned to be used;
b) are based on a political decision supported by fund allocation;
c) are included as a component of the country's social development plan;
d) have the support of a single national coordination mechanism;
e) benefit from harmonized international support aligned with national development policies, including official bilateral and inter-country cooperation; and
f) report on a common monitoring and evaluation framework reflecting national achievements in reducing the burden of disease in all populations at risk to malaria

BOX 2: IMPLEMENTATION STAGES

Phases and time frames in malaria elimination: country experiences from around the world

Experience in different regions of the world indicates that countries have gravitated towards similar, well-defined stages in terms of activities, time frames and evaluations:

(i) ***Preparatory phase*****:** usually 2 years, for clearly stating goals and objectives of a national SUFI strategic and operational plan; analysing the situation and strengthening the capacity of the programme to design and update strategies; developing a time-bound work plan, including the necessary infrastructure and logistics; and assessing the information needed to obtain more financial resources and to calculate the numbers and skills of human resources needed for the programme at all levels;

(ii) ***Attack phase***: usually 3–5 years, depending on the malaria species, for full implementation of SUFI plans and monitoring of all planned strategies to reach a low incidence level (usually defined as an annual parasite index of less than one case of malaria per 10 000 population in areas at risk); and

(iii) ***Consolidation phase***: of unlimited duration, for interruption of local transmission during about 3 years, by strengthening surveillance and, possibly, focal indoor residual spraying to clear remaining residual foci.

These are followed by a:

(iv) ***Maintenance phase***: for prevention of reintroduction after the last identified ‘autochthonous’ case with no evidence of local malaria transmission for 3 consecutive years, usually aiming at strengthening a proactive surveillance system and vigilance, and maintaining selected vector control operations, inter-sectoral collaboration and awareness and skills of health care workers, including from the private sector.

BOX 3. DEFINITIONS OF DISEASE ELIMINATION

Experience gained in attempts to eradicate diseases, successful or not, led to widespread discussion on disease eradication in general. The International Task Force for Diseases Eradication revised the terminology, describing types of action against particular diseases[1] as a ‘spectrum’, including:

- ***Control*****:** reduction of disease incidence, prevalence, morbidity or mortality to a locally acceptable level as a result of deliberate efforts;
- ***Elimination of disease***: reduction to zero of the incidence of a specified disease in a defined geographical area as a result of deliberate efforts;
- ***Elimination of infection*****:** reduction to zero of the incidence of infection caused by a specified agent in a defined geographical area as a result of deliberate efforts;
- ***Eradication*****:** permanent reduction to zero of the worldwide incidence of infection caused by a specific agent as a result of deliberate efforts; and
- ***Extinction*****:** The specific infectious agent no longer exists in nature or in the laboratory.

The definition of ‘elimination’ of the International Task Force for Diseases Eradication is similar to the WHO concept of elimination of disease through interruption of transmission, although it does not clearly take into account the probable persistence of the incidence of disease due to the presence of imported cases.

[1] Malaria was not among the parasitic diseases considered by the International Task Force for Diseases Eradication, other than the mention ‘legacy of a failed programme’.