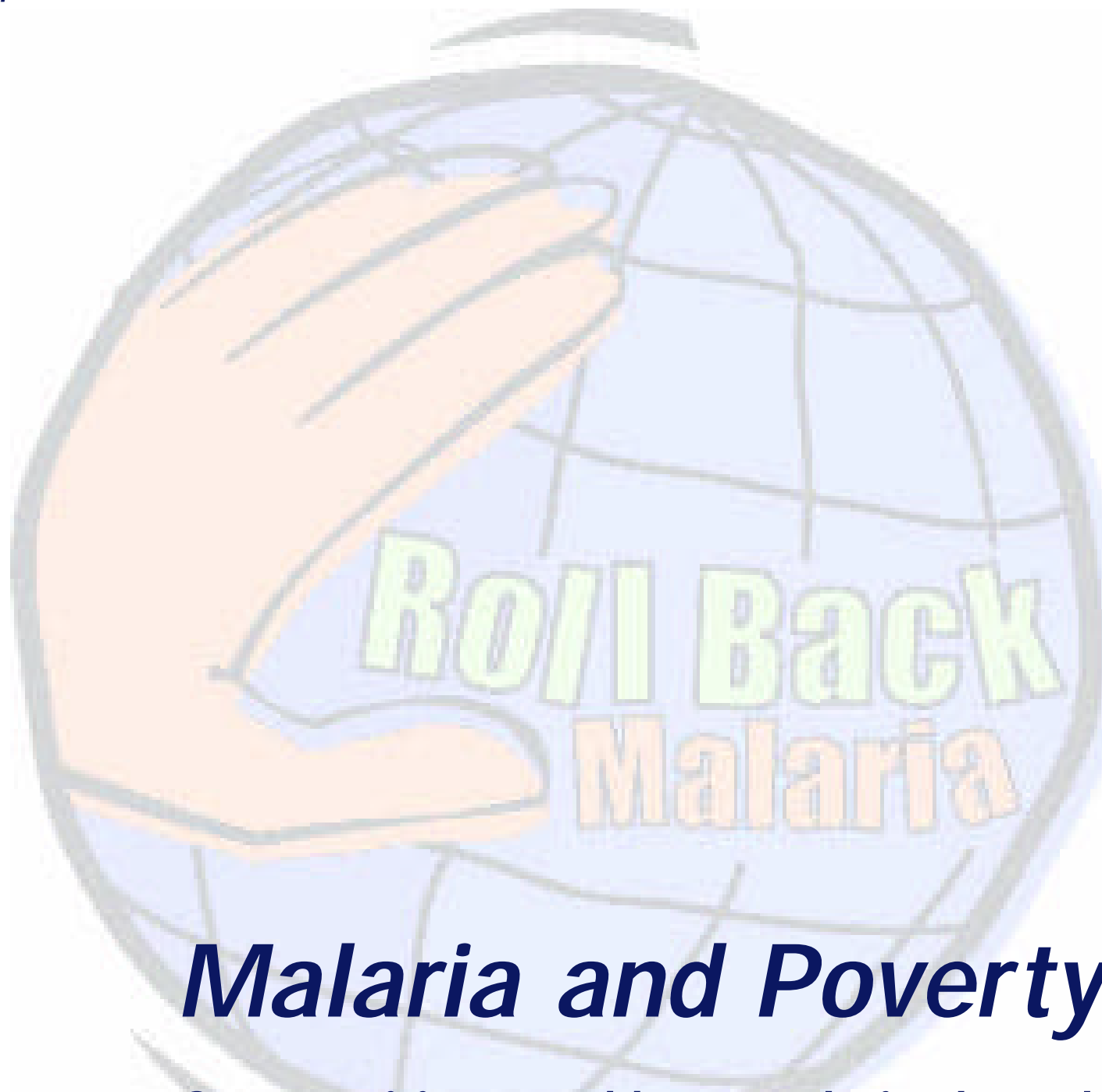


4th Global Partners Meeting

Washington DC

April 18-19, 2001



Malaria and Poverty

***Opportunities to address malaria through
debt relief and poverty reduction strategies***



**Working document prepared by
The Malaria Consortium**

Draft Working Paper for Discussion 13 April 2001

**Malaria and Poverty:
Opportunities to Address Malaria through Debt Relief
and Poverty Reduction Strategies**

**A background paper for the Fourth RBM Global Partners Meeting
18-19 April 2001, Washington DC**

including country experiences in Cameroon, Tanzania and Uganda

Malaria Consortium, April 2001

Commissioned by RBM Cabinet Project
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Executive Summary

This paper was prepared as part of a commission from the RBM Cabinet Project in Geneva to prepare background papers on key issues for the 4th Global Partners meeting in Washington in April 2001. The study investigated how Poverty Reduction Strategy Papers can support country plans to Roll Back Malaria with particular reference to case studies in three countries at different stages in the preparation of PRSPs: Cameroon, Tanzania and Uganda. Detailed reports on these are also available.

It is intended that the paper should raise issues for discussion in Washington, and assist those involved in RBM development and those involved in PRSP development to understand each other's approaches and needs better, and to highlight the areas where joint development is needed.

The study was short and the paper is not intended as an in-depth analysis of all the issues surrounding this topic. Instead it presents an overview of the current situation from the country perspective and an impression of the experiences so far with mobilising resources for RBM through PRSPs and debt relief, together with opinions and ideas that are developing in the countries studied.

The paper provides background on the development and rationale of Poverty Reduction Strategy Papers and debt relief under the enhanced HIPC initiative (Section 3) and the current status in the three countries studied (Section 4). It describes how Poverty Reduction Strategy Papers are tied in with enhanced debt relief for Heavily Indebted Poor Countries (HIPC). It assesses the impact they have had so far on the priority attached to malaria in policy and planning and on mobilising funds for health generally and malaria control in particular.

Cameroon and Tanzania have both produced interim PRSPs and passed the decision point for commitment of HIPC debt relief and interim support and are developing these further with a view to reaching completion point for full HIPC debt relief during 2001. Uganda reached completion point in 2000 and has produced a first annual report.

Their experiences show that PRSPs and debt relief strategies present a considerable opportunity to address malaria as a poverty issue. In all cases but to different degrees PRSPs have helped raised the profile of health and malaria within Government and made the link between malaria and poverty. They have also helped bring additional resources to malaria control – directly to Malaria Control Programmes in Ministries of Health and indirectly through support to primary health care delivery and underpinning health sector development. The additional funds are being managed through a variety of different mechanisms. These are described in Section 4.

Key successes and obstacles that have appeared from experiences to date are described in Sections 5. They include:

- Country capacity to produce PRSPs, particularly countries affected by conflict
- Achieving country ownership, how this is key to success and sustainability
- Utilising existing processes and initiatives
- Costing poverty reduction

- Managing the tension between poverty reduction strategies and the need to maintain a consistent macroeconomic framework
- Flexibility of allocations and expenditure, in particular balancing the advantages of protecting funds through ring-fencing against the advantages of local decision making on pragmatic approaches focused on outcomes
- Vertical and horizontal approaches: the need for balance between these, and the particular problems associated with gearing funding decisions to deadlines for spending funds
- Timeliness and regularity of funding flows, the additional management load and administration burden created by protecting funds for poverty-sensitive activities
- Absorption capacity, and the need for balance between investment in systems, infrastructure etc. and direct investment in interventions

From these the issues following questions arise from country level for RBM partners (questions are detailed in Section 6):

Messages and questions

Supporting country ownership of the PRSP process

- as key to successful mobilisation of funds. How can RBM partners help?

Raising awareness of the potential of PRSPs for mobilising funds for health and malaria, and encouraging greater involvement in the PRSP processes

- this study shows that such awareness is not well developed and that opportunities to access a fair share of funds may be being lost.

Articulating arguments for greater attention to malaria in PRSPs

- without disadvantage to other health priorities. How can we capitalise on the growing profile of malaria?

Balancing investment in capacity building and investment in direct interventions

- in terms of achieving RBM and other health targets. This study suggests the balance is not right in terms of utilising resources for action – how can HIPC or other funds help redress the balance and how can RBM partners (at all levels) contribute? Can we change the way we work to address this?

Mobilising resources more effectively in decentralised systems

- in order to reach lower levels in the health system and the poorest in the community and not get caught up in bureaucracy? Novel approaches are needed.

Assessing the importance of debt relief compared with other sources of funding for malaria

- this study suggests considerable importance. But do fund-seeking strategies achieve the right balance between these and other sources? Can RBM partners support cohesive fund-raising strategies at country level taking into account all funding sources?

The potential effect of increasing funds for poverty reducing activities on macroeconomic stability

- could this become an issue? What potential mechanisms exist for managing this tension? What does this mean for global initiatives?

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Abbreviations

AMREF	African Medical and Research Foundation
CDF	Comprehensive Development Framework
DFID	Department for International Development (UK)
HIPC	Heavily Indebted Poor Country (Initiative)
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Diseases
IMF	International Monetary Fund
ITN	Insecticide treated net
JICA	Japanese International Co-operation Agency
MoH	Ministry of Health (Uganda and Tanzania)
MOPH	Ministry of Public Health (Cameroon)
MTEF	Medium Term Expenditure Framework
NPV	Net Present Value
NGOs	Non Governmental Organisations
PAF	Poverty Action Fund (Uganda)
PHC	Primary Health Care
PSI	Population Services International
PRSP	Poverty Reduction Strategy Paper
RBM	Roll Back Malaria
SWAp	Sector Wide Approach
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organisation

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The Malaria Consortium would like to thank the consultants who conducted the country case studies for their considerable work in a short time and the Roll Back Malaria Cabinet Project, Geneva for commissioning and supporting this work.

This paper attempts to represent the views, ideas and experiences of people working in the country studies, and information provided by them. However the authors remain responsible for any errors of fact or interpretation.

1 Purpose and scope of the Paper

In preparation for the fourth meeting of Roll Back Malaria (RBM) global partners in April 2001 (GP4), the WHO RBM Cabinet Project requested the Malaria Consortium to prepare a background paper describing country experiences on debt relief mechanisms through Poverty Reduction Strategy Papers (PRSPs) in Highly Indebted Poor Countries (HIPCs) and their effectiveness in providing appropriate support to country plans for rolling back malaria.

The purpose of the paper is to contribute to expansion of capacity of the RBM partnership to go to scale by describing the opportunities and bottlenecks created by Poverty Reduction Strategy Papers (PRSPs) and debt relief initiatives (HIPC) for supporting RBM plans in selected Districts. It is intended that the paper should assist those involved in RBM development and those involved in PRSP development to understand each other's approaches and needs better, and should highlight the areas where joint development is needed.

Terms of reference are attached at [Annex 1](#).

It includes a brief review across countries and an analysis based on case studies of the following countries: **Cameroon, Uganda and Tanzania**.

Detailed reports of the country case studies are available from the Malaria Consortium.

The paper is not intended as an in-depth analysis of all the issues surrounding this topic. In the time available, and given that PRSPs are a new concept, it was possible to obtain an overview of the current situation and flag up issues. The paper provides an impression of the experiences so far with mobilising resources for RBM through PRSPs and debt relief, together with opinions and ideas that are developing in the countries studied. It flags up some issues that appear to be common across countries, some indicators of success and apparent constraints, and topics worth discussion at the Washington meeting and for possible further study.

There is some overlap with the background paper on Sector-wide approaches (SWAp) and RBM. While not all countries that have PRSPs have a health SWAp (and vice versa) there are many mechanisms and issues in common. Some of the issues raised here are discussed in more detail in the SWAp paper.

2 Methodology

Preparation of the paper involved study of general reports and other literature on PRSPs, debt relief and RBM, and the country case studies. The case studies included short visits to the countries, which involved formal and informal interviews with key informants in country, and collection and study of reports and other literature. Short timescales limited the number of people seen and time spent with them, but an attempt was made to meet a reasonable cross-section of people involved in development and implementation of PRSPs, Health Sector plans, budgets and financial allocations, and malaria control policy and implementation. The case studies coincided with, but finished ahead of, joint missions on the health SWAp in Uganda and Tanzania and it was not possible to take full account of the missions'

discussions on some of the issues presented here. Some of the issues may therefore have been addressed and actions to address them agreed.

Information on experiences in other countries was also gathered from country case studies undertaken in preparation for another background paper on sector-wide approaches and RBM¹, from recent RBM country updates, and from the literature.

3 History and Definitions of main terms

3.1 Comprehensive Development Framework - CDF

The concept of a comprehensive development framework was proposed by the World Bank (WB) in 1999 and piloted in 13 countries². It is a process intended to provide a broad long-term development strategy for Governments and their partners, developed with participation from civil society and development partners and covering structural, social, governance and economic issues.

3.2 Poverty Reduction Strategy Papers - PRSPs³

The concept of the PRSP was developed as an operational plan linked to CDF, consistent with and reinforcing the CDF. PRSPs focus on poverty reduction as one of the objectives of the CDF. Its preparation should be a country led process with extensive participation from stakeholders and firmly based on the poverty situation in country. It is however used as a basis for decisions on debt relief under the Heavily Indebted Poor Country (HIPC) initiative (see below) and for concessional lending by the WB and the International Monetary Fund (IMF). It therefore needs to show how funds released through debt relief will be used to relieve poverty and to be endorsed (though not approved) by the Boards of the WB and the IMF in order to secure debt relief. PRSPs and debt relief are also seen as an important potential contribution to achieving international development targets⁴.

¹ Addressing Malaria Sector-Wide: Improving co-ordination and management of external support. A background paper for the Fourth RBM Global Partners Meeting, 18-19 April 2001, Washington DC. Malaria Consortium, April 2001

² Bolivia, Côte d'Ivoire, Dominican Republic, Ethiopia, Eritrea, Ghana, Jordan, Kyrgyz Republic, Morocco, Romania, Uganda, Vietnam and West Bank and Gaza

³ Key sources
<http://www.worldbank.org/poverty>
<http://www.imf.org/external/np/prsp/prsp.asp>

⁴ These are:

- ◆ A reduction by one half in the proportion of people living in extreme poverty by 2015
- ◆ Universal primary education in all countries by 2015
- ◆ Demonstrated progress towards gender equality and the empowerment of women by eliminating gender disparity in primary and secondary education by 2005
- ◆ A reduction by two-thirds in the mortality rates for infants and children under age five and a reduction by three-fourths in maternal mortality – all by 2015
- ◆ Access through the primary healthcare system to reproductive health services for all individuals of appropriate ages as soon as possible and no later than the year 2015
- ◆ The implementation of national strategies for sustainable development in all countries by 2005, so as to ensure that current trends in the loss of environmental resources are effectively reversed at both global and national levels by 2015

There is no formal blueprint for a PRSP but Box 1 shows some general underlying principles.

Box 1: General principles of a PRSP

- Preparation and implementation is country-driven with broad-based participation from line ministries, civil society, development partners and partnerships developed for implementation
- It should be results-oriented and firmly based on an understanding of poverty within the country and what are effective public actions
- It should be comprehensive in the sense that it recognises the multidimensional nature of poverty and integrates structural and sectoral interventions into a consistent macroeconomic framework in such a way that the poor can benefit from economic growth
- It should have both medium and long-term perspectives

3.3 Heavily Indebted Poor Countries initiative - HIPC¹

The HIPC initiative is a mechanism to provide debt relief to 41 highly indebted poor countries (listed at [Annex 2](#)) whose development is constrained by the burden of debt repayments. Thirty-five of these countries are classified as having unsustainable external debts (where the present value of the debt burden represents more than 150% of the value of exports). Two countries (Laos and Ghana) have opted not to seek debt relief under the HIPC initiative. Four HIPC countries are regarded as sustainable cases, that is able to achieve debt sustainability under existing, traditional mechanisms of debt relief.

The HIPC initiative was originally established, under the leadership of the World Bank and the International Monetary Fund (IMF), in 1996 and by September 1999 debt relief assistance had been committed to seven countries. In 1999, an enhanced HIPC initiative was introduced and a proposal made to link both debt relief and WB and IMF concessional lending to comprehensive development frameworks and Poverty Reduction Strategy Papers. The **enhanced HIPC** is intended to provide broader, faster and deeper debt relief to qualifying countries.

In addition the timescale of the “Sunset clause” for countries who have not yet met entry requirements for the HIPC initiative has been extended.

Debt relief through HIPC together with other existing debt relief mechanisms should ultimately reduce the debt of qualifying countries by two thirds.

Two main steps are involved:

When qualifying countries have met the criteria for a ‘**decision point**’ by the Boards of the WB and IMF some assistance under HIPC is committed. The criteria include a 3-year period of satisfactory macroeconomic adjustment and progress with reform.

An interim PRSP should cover:

¹ Key sources:

<http://www.worldbank.org/hipc>

<http://www.imf.org/external/np/hipc>

Department of International Development (UK) Background briefing: Debt relief for poverty reduction, September 2000

- ✓ Commitment to poverty reduction
- ✓ Strategy outline
- ✓ 3-year policy and macroeconomic framework
- ✓ timetable and participatory process for completing the PRSP

Under the enhanced initiative some interim debt relief begins at this point.

At the **'completion point'** the majority of debt relief available under HIPC begins. The enhanced initiative includes the concept of a 'floating completion point'. A fixed 3-year period between decision and completion has been abandoned and instead irrevocable debt relief has been linked to development and implementation of a full PRSP, maintenance of macroeconomic stability and the undertaking of key reforms and actions specified at the decision point. The floating concept and interim relief are intended to accelerate and provide more country ownership of the debt relief timetable as well as support implementation of reforms.

Debt relief funds come from both multilateral and bilateral creditors including: the WB's IDA, IMF, the African Development Bank, the Inter-American Development Bank, and Paris Club bilateral creditors (some of whom provide additional debt relief outside HIPC).

These steps are followed by implementation and monitoring and annual reporting and adjustments.

By February 2001 22 countries had reached the decision point for enhanced debt relief and were receiving some interim assistance with debt relief. One of these (Uganda) had reached completion point. Decision points are expected for a further 13 countries in 2001 or later. Annex 2 shows the current status of HIPC countries in terms of the enhanced HIPC initiative.

The total value of debt relief so far committed under HIPC is approximately \$34 billion or \$20 billion in net present value terms (NPV) terms.

3.4 Medium Term Expenditure Framework (MTEF)

The Medium Term Expenditure Framework or its equivalent (terminology varies) is the financial framework for government expenditure, generally covering a period of about three years and regularly updated. It is set within an overall macroeconomic framework and is intended to guide all public expenditure (including debt relief and donor commitments). Medium term objectives in the MTEF are intended to be consistent with longer-term Government objectives such as those contained in a PRSP and allocations should be guided by those objectives. Sectoral strategies should in turn reflect those objectives and help guide annual allocations under the MTEF.

4 Overview of PRSP/HIPC and RBM status in case studies

In all three countries (Cameroon, Tanzania and Uganda) malaria is a major cause of morbidity and mortality. All three countries are signed up to the Abuja declaration on Roll Back Malaria.

Summary information on the malaria situation and RBM status in the three countries is given in [Annex 3](#), and more detailed information in the full case study reports.

The following paragraphs give an overview of the PRSP and debt relief situation in the three countries studied. More information is given on Uganda since it has a longer experience with a PRSP. More detailed information on all three will be available in the full case study reports.

4.1 Cameroon

Cameroon is currently coming out of a period of slow and sometimes negative growth related. A household survey in 1996 indicated that 50.5% of people were living in poverty.

An interim PRSP¹ was completed in August 2000 following a participatory process involving ministries, civil society, development partners, the private sector and NGOs. The expected date for completing the final PRSP is November 2001. Before then, a national living standards survey will be conducted to provide a baseline poverty level against which to measure progress.

Additional resources made available under the HIPC initiative will be used to strengthen delivery of services in health and education, improve access to potable water, and rehabilitate the road infrastructure. Rural development and social affairs will also be areas of focus under the HIPC initiative. Strengthening governance is a strong feature addressed in the iPRSP consultative process.

Allocation of funds under the HIPC initiative will be the responsibility of an Advisory and Follow-up Committee of HIPC Resources, headed by the Minister of Finance. This Committee has not yet been fully constituted. The Committee will appraise the eligibility of HIPC financing for projects presented by the relevant ministries, and it will provide advice on HIPC expenditure programmes.

Within the health sector, the PRSP identified the control of the spread of HIV/AIDS (approximately 7% rate of infection in the population according to the iPRSP) as one of the primary means for reducing poverty. Other priorities include control of communicable diseases (including malaria), vaccination campaigns, and completing a health map of the country. Malaria is mentioned in the iPRSP as a priority although no indicators with respect to malaria have been identified.

The estimated total debt relief is \$ 2 billion (\$1.26 billion in net present value terms). This represents 27% of the NPV of debt outstanding as of June 1999. Under HIPC assistance, FCFA 6.6 billion will be made available to the health sector in the first year, rising to FCFA 9.4 billion in each of the two subsequent years, for a total of FCFA 25 billion for the three-year period. HIPC funds account for an estimated 12% of the current health budget (FCFA 55 billion)

¹ Interim Poverty Reduction Strategy Paper, Republic of Cameroon, August 2000

A budgeting exercise for HIPC funds for the RBM initiative covered: training of personnel on treatment of malaria; establishing a revolving fund for ITNs for pregnant women; implementing Information, Education and Communication (IEC) strategies; contracting with NGOs for social marketing; establishing a drug resistance surveillance system; and monitoring by community management committees.

This exercise allocates FCFA 1.065 billion in 2000/01, FCFA 769 million in 2001/02 and FCFA 770 million in 2002/03, for a total of FCFA 2.6 billion (\$3.5 billion at an exchange rate of 720 per US\$). The allocation for the RBM initiative 2000/01 represents 1.9% of the current health budget and 8.2% of budgeted HIPC funds.

According to information in the Cameroon RBM country update report, US\$2.8 million from the core Ministry of Public Health budget for 2000/01 is shared across more than one programme, including malaria, but this allocation had yet to be confirmed. The RBM country update also reports other sources of direct funding for malaria, including extrabudgetary support from WHO (\$170,000 in 2000).

4.2 Tanzania

Poverty has been increasing in Tanzania during the 1990s, according to a series of household surveys, with over 50% of people living in absolute poverty. An interim DHS in 1999 suggested that child mortality was rising again, with an increasing gap between rich and poor.

Preparation of a PRSP began in October 1999 overseen by a Committee of 12 ministers (including health) and the Governor of the Bank of Tanzania, supported by a Technical Committee and co-ordinated by the Vice President's Office. Cabinet approved an interim PRSP in February 2000 following a wide consultative process.

The decision point for the enhanced HIPC was reached in April 2000 and the completion point is expected to be reached during 2001. A PRSP¹ was presented to the World Bank and the IMF in October 2000. The estimated total debt relief is approximately \$3 billion or \$2 billion in net present value terms.

Health was ranked third after education and agriculture in the consultation exercise for production of the iPRSP. The poverty reduction strategy concentrates on:

- (i) reducing income poverty;
- (ii) improving human capabilities, survival and social well-being;
- (iii) containing extreme vulnerability among the poor.

Malaria has some mention in the PRSP as part of the health strategy and includes it as a specific indicator but there is no specific analysis of the link with poverty. On health the PRSP states the following:

"In order to raise the productive life of Tanzanians, the Government will place special emphasis on reducing morbidity, improving nutrition, and strengthening access to health services and safe water. The national goal in this regard will be to arrest the decline in life expectancy (owing to the impact of HIV/AIDS), and then raise it to 52 years by the year 2010. In line with this overarching goal, the Government intends to pursue policies and programs, which will:

¹ http://www1.worldbank.org/prsp/PRSP___Country_Documents/TanzaniaPRSP.pdf

- ✓ Lower infant mortality rate from 99 per 1000 to 85 per 1000 by 2003;
- ✓ Reduce under-five mortality from 158 to 127 per 1000 by 2003;
- ✓ Lower maternal mortality from 529 per 100,000 to 450 per 100,000 by 2003;
- ✓ **Reduce malaria-related fatality for under-five children from 12.8 percent to 10 percent by 2003;**
- ✓ Raise the proportion of the rural population that has access to safe and clean water from 48.5 percent in 2000 to 55 percent in 2003.”

The PRSP proposes that to achieve effective poverty alleviation through health would require a per capita health expenditure of \$9 and a doubling of the health budget allocation.

The PRSP estimates that HIPC debt relief will contribute approximately \$62 million to the Government budget in 2001/02.

Health MTEF budget estimates at the time of the case study were that HIPC debt relief would contribute \$5.6 million to a total recurrent budget of approximately \$36 million in 2001/02, although figures were not finalised. Provisional plans for allocation of the \$5.6 million were to provide additional budget support as follows:

HIV/AIDS advocacy and IEC	\$3.5 million
EPI	\$1.5 million
Malaria control	\$0.6 million

The malaria funds within this would be allocated to: capacity building, IEC, implementation of new antimalarial guidelines, and national scaling up of insecticide treated mosquito nets.

4.3 Uganda

Uganda has seen a high economic growth rate since the late 1980s but the benefits of this were felt not to be trickling down to the poor. A household survey in 1992 showed that 56% of people were living in absolute poverty.

Uganda has so far gone further than other HIPC countries with PRSPs and with mechanisms to allocate HIPC and other poverty-oriented funds. This is mainly because Uganda had a well-developed poverty strategy before HIPC and the concept of PRSPs. A detailed Poverty Eradication Action Plan (PEAP) was produced in 1997 and updated in 2000. A summary of the 2000 version was produced as the PRSP¹.

The decision point for enhanced HIPC was reached in February 2000 and completion point in May 2000. A PRSP progress report was produced in early 2001 and reported signs of poverty reduction, though progress has been patchy, particularly in the health sector. The estimated total debt relief is approximately \$1.3 billion or \$650 million in net present value terms.

The pillars of the PEAP/PRSP are:

- Sustainable economic growth
- Good governance and security

¹ Uganda's Poverty Eradication Action Plan: Summary and Main Objectives, Ministry of Finance Planning and Economic Development, Kampala, March 2000

- Raising the incomes of the poor
- Improving quality of life of the poor.

Health has a high profile in the PRSP. The PRSP is implemented through a Poverty Action Fund¹, which includes HIPC funds (34%), GOU revenue (35%) and donor contributions to budget support (31%). The PAF provides protected funds for activities that are considered directly poverty reducing and covered by the PEAP. The process is overseen by the Poverty Monitoring Unit, which advises the Permanent Secretary and Minister of Finance on progress, sectoral proposals and allocations. The process is supported by a Poverty Working Group which represent the Ministries of Finance and Gender, development partners and civil society and provides advice independently of line ministries.

The main beneficiaries are

- ✓ Rural roads
- ✓ Agriculture
- ✓ Primary Health Care (PHC) including national programmes supporting PHC
- ✓ Safe water and sanitation
- ✓ Universal Primary Education
- ✓ Accountability/monitoring
- ✓ (Other – including land reform, adult literacy)

The main beneficiaries of PAF funds within the health sector are:

- ✓ National programme support to PHC (including malaria control programme, budget increased x7 to 540m shillings)
- ✓ PHC conditional grant to Districts (budget increased x15)
- ✓ District support to NGO facilities

HIPC funds are not directly earmarked within PAF funds and so not directly attributable to specific activities. In addition Uganda's highly decentralised health system means that the majority of malaria control resources will be at district level and incorporated within service delivery budgets. It is therefore not possible to set a precise figure against HIPC support for malaria control.

Malaria is mentioned in several places in the PRSP as a contributor to poverty. It receives a higher profile in the 2001 progress report following the results of a household survey. This showed that household reporting of malaria or fever had increased since the early 1990s, while data from the Malaria Control Programme indicated an increasing proportion of fever cases among total medical cases.

¹ Fighting Poverty in Uganda: The Poverty Action Fund, Ministry of Finance Planning and Economic Development, Kampala, February 2001

The table and graphs below present the trends in the total MTEF budget, PAF funds within the budget, debt relief within that and the total and PAF-funded health budgets. It should be noted that these figures are kept under review and subject to revision.

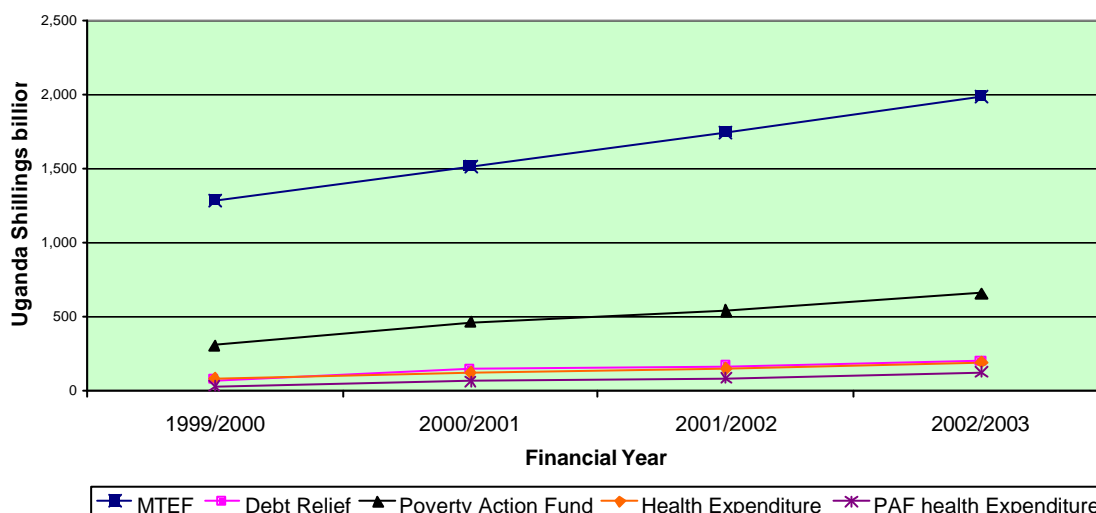
Uganda Medium Term Expenditure Framework and Poverty Action Fund

	1999/2000	2000/2001	2001/2002	2002/2003
Total MTEF	1,281	1,517	1,750	1,988
Poverty Action Fund within MTEF	302	459	539	655
Debt Relief within PAF	67	140	164	196
Total MTEF Health Expenditure	83	116	146	189
PAF Health Expenditure within MTEF	29	61	82	122

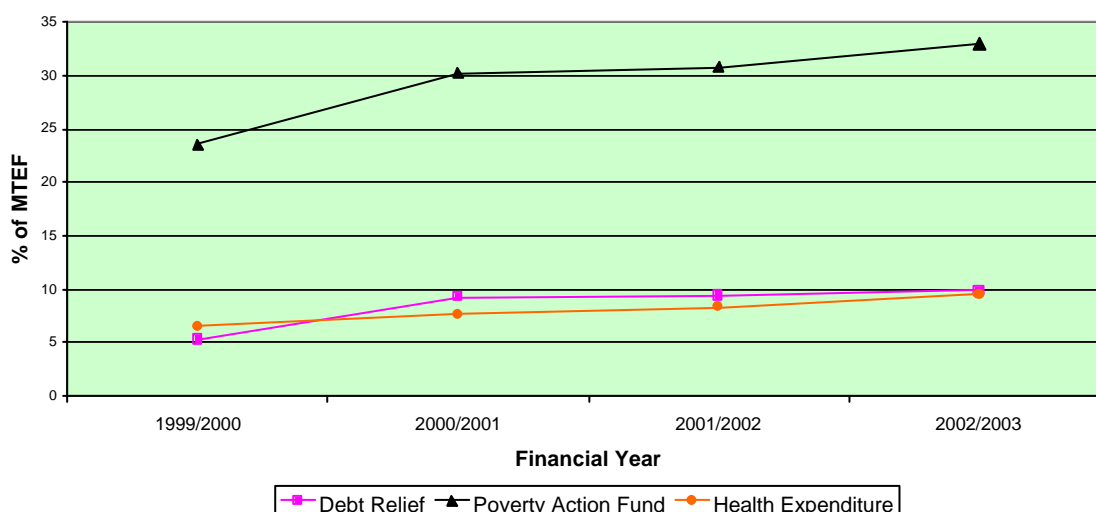
Uganda Shillings billion

Source: Ministry of Finance

Medium Term Expenditure Framework, Poverty Action Fund, Debt Relief and Health Expenditure: Trends over time



Debt relief, Poverty Action Fund and Health Expenditure as percentage of MTEF: Trends over time



5 Mobilisation of funds for RBM through PRSPs and debt relief

The potential for PRSPs to mobilise funds for malaria control activities is clear. PRSPs can help raise money for, and shift budget allocations to, poverty-reducing activities generally and can do this over the long term (potentially about ten years). HIPC funds can be used more flexibly than some other forms of external support, for example for human resources, and so have potential for filling resource gaps. They are tied in with country-owned plans and priorities and the MTEF, and can support health sector reform generally. Malaria has a strong case for a share of these funds: the relationship between malaria and poverty has been addressed in a number of studies¹ and is frequently cited in policy documents. Effective strategies for tackling malaria are known but capacity is weak and constrained by insufficient resources, even without scaling up. The country case studies examined what was happening in practice.

In all the cases studied health is a prominent feature of the iPRSP or PRSP. Malaria is mentioned in all three PRSPs and is incorporated as a specific target for monitoring the PRSP in the cases of Tanzania and Uganda. In Uganda the information gathering and consultation that has informed the PRSP and continues to inform poverty fund allocations has raised the profile of the malaria problem and drawn attention to the need for increased funding. The Poverty Working Group has recommended increased funding for malaria independently of the MOH on the basis of the Bureau of Statistics' household surveys. The high priority that malaria now receives in the health sector strategic plan and budget is partly due to these PEAP processes as well as to the MoH's own analyses and evidence based planning.

It is important to note that PRSPs have been successful in increasing support for the health sector generally and particularly for primary health care (PHC). Since inadequate capacity to deliver a basic package of care is a major obstacle to RBM (and other programmes), increased resources generally for health systems, infrastructure and service delivery should benefit achievement of RBM targets even if HIPC and other PRSP funds are not earmarked specifically for malaria interventions.

However there are signs in all three countries that more needs to be done to argue for a higher profile for malaria within poverty reducing strategies. While awareness and involvement is high at top management levels within Ministries of Health it is poor at programme level (see below).

The mechanisms proposed or in place for allocation of HIPC funds and other poverty-linked funds vary between the countries. In Tanzania the mechanisms are not yet fully worked through but potential HIPC funds are being quite specifically earmarked at subsectoral level, with a particular emphasis on HIV/AIDS in the case of the health sector. In Uganda, poverty action funds are earmarked at health sector level for poverty-sensitive activities but with less pronounced earmarking and with the majority of funds going to Districts in the form of the PHC conditional grant. Moreover, within the poverty action fund, debt relief funds are part of the total fund and are not allocated separately.

In the case of Tanzania and Uganda allocation of these funds is strongly tied to the health sector strategic plan and budget as part of relatively well developed sector-wide approaches. In Cameroon there seems to be parallel, and not integrated budgeting activities between the PRSP/HIPC process and planning for malaria

¹ Press Release WHO/28, 25 April 2000, Economic costs of malaria are many times higher than previously estimated

control and RBM initiatives. Need and desire for greater donor co-ordination of technical assistance to malaria control was expressed. For example both WHO and the World Bank were planning separate exercises for planning and budgeting the malaria initiative.

There is a question how far increased funds for malaria in all three countries are attributable to the PRSP and debt relief. Uganda has shown that PRSPs can mobilise other funds, not just debt relief, and so have much wider potential for shifting budgetary allocations to poverty-sensitive activities generally and malaria in particular. Increased funds for malaria through the PAF (directly to the national malaria control programme and through the PHC conditional grant) cannot be attributed entirely to debt relief although debt relief has certainly contributed to the Government's ability to increase finances for poverty-focused activities. Both Tanzania and Cameroon have other sources of funds for malaria control. How important advocating for HIPC funds will be relative to other potential sources of funding will depend on several factors. One is the extent to which funds from all sources for the health sector generally, or malaria control specifically, are co-ordinated. In other words, how far is it possible to advocate for all funds needed in one exercise against a single plan? Another factor is the likely magnitude and long-term sustainability of other potential sources of funding, particularly where there is no established sector-wide approach to planning and budget allocation, or where some major donors are not participating in a sector-wide approach. Such funds may be easier to access and more direct, but may in some cases divert effort away from country owned plans and priorities and may be less predictable and sustainable and so difficult to plan around. (See also the background paper on SWAps and RBM.)

Uganda does highlight something which, though not an issue for most HIPC countries in the short or medium term, may become an issue later. Debt relief and other external funds have, together with improved economic performance, contributed to recent and projected increases in the MTEF in Uganda. However, the overall expenditure under MTEF cannot increase further in any major way without an impact on macroeconomic stability. There are issues here for new global initiatives, including RBM. Greatly increased resources and capacity building will be needed to scale up RBM and other priority health areas.

The terms of reference for this study include determining the influence of PRSP/debt relief funds on RBM priorities and expenditure. This depends a great deal on the how much funding is managed through the PRSP, mechanisms for budget setting and allocation within Government, and the policies of development partners. Two extreme models can be envisaged.

In Model 1, both the PRSP and RBM planning are closely tied in with intersectoral, sectoral and district/local level planning and plans develop at each level through a consultative and iterative process. RBM planning is done within this framework. All funds come into the MTEF to support the plans that develop, or if not within the MTEF then support the plans by filling resource gaps in the MTEF. Few projects lie outside the system. Funds flow within the public sector and to implementing partners according to their comparative advantages

In Model 2, PRSPs and HIPC have a marginal impact on patterns of RBM expenditure. Alternative sources of funding and planning mechanisms predominate and influence priorities and expenditure. RBM partners (funders and implementers) may plan jointly as a group or there may be direct bilateral arrangements between individual funders and implementers.

Clearly no countries match either of these extremes. Generally a mix is seen but with a move towards the first model. However there are some constraints and problems with this, discussed below.

6 Bottlenecks in flows of PRSP/debt relief funds to RBM.

While PRSPs in the country studies have increased flows of funds there are some real and potential bottlenecks and limitations. Various general issues with PRSPs are recognised in the literature. The following have been highlighted during country reviews. Many would apply equally to any disease-oriented programme with a historically vertical approach.

a) Capacity to produce PRSPs

In some countries the availability of good data on poverty, the institutional and analytical capacity to prepare PRSPs and the capacity of civil society and other partners to participate, may delay full HIPC debt relief. This is particularly the case for the 9 HIPC countries currently affected by conflict and those emerging from conflict.

b) Achieving genuine country ownership

There is potential and real conflict between country ownership and external endorsement and funding of the PRSP. This inevitably creates some tensions, which can be reduced through emphasis on building on existing initiatives mechanisms, a key feature of Uganda's success and Tanzania's progress and still an issue in Cameroon. There is also tension between speed and sustainability: the desirability of accelerated debt relief and early delivery of outcomes on the one hand, does not sit well with the need for assurances on strategy, process and monitoring mechanisms that reduce the risk of resources being used ineffectively for poverty reduction. This is related to some of the following issues.

c) Utilising existing processes and initiatives

There is a recognised need to build on, and not undermine, existing processes and initiatives. In the cases studied, different models have been developed for handling funds released through HIPC. Some tie in with existing mechanisms more than others. Tanzania intends to use existing mechanisms established as part of health sector reform including the health SWAp. Uganda's Poverty Action Fund is a new mechanism well integrated in the overall MTEF. Cameroon appeared to have a number of different mechanisms for different sources of funding for malaria.

d) Costing poverty reduction

The multidimensional nature of poverty means that identifying and costing poverty-reducing interventions is difficult. This is well illustrated when considering malaria. Like poverty, it is a multidimensional and intersectoral problem requiring a concerted effort across many disciplines. It is difficult to tease out specific poverty reducing interventions within it. Experience is developing and needs to be shared.

e) Poverty reduction strategies cf. maintaining a consistent macroeconomic framework

There may be considerable short and medium term tensions between investing in poverty reduction strategies and maintaining a consistent and stable macroeconomic framework and desirable levels of economic growth. The most important in this context is the limitation on expenditure required to maintain macroeconomic stability discussed above.

f) Flexibility of allocations and expenditure

HIPC funds can be allocated reasonably flexibly in support of poverty reducing activities. However once they are allocated, there is less flexibility in terms of expenditure decisions. There is a real tension between protecting funding flows for specific poverty-reducing activities and providing reasonable flexibility for local decisions in response to local needs and changing circumstances. A balance between conditionality/protection and flexibility is difficult to achieve. An example is Uganda where poverty action funds are protected from cuts to which other parts of the budget are vulnerable if revenue is less than anticipated. This protection makes this source of funding attractive, but it come with conditionalities that reduce freedom of action and increase administration, particularly at District level where conditional grants now make up the bulk of health expenditure.

This inevitably creates tensions in an environment of increasing decentralisation and risks stifling the development of local pragmatic approaches to disease control that focus on outcomes.

Flexibility to respond to epidemics has been raised as an issue in several countries. In general, response to epidemics is not well covered in budget planning and conditionalities prevent virement of funds. There hence remains a tendency to rely on seeking emergency funding from donors able to provide direct support, with consequent and costly (in terms of loss of life and suffering) while such funds are mobilised.

g) Vertical and horizontal approaches

In general HIPC funds offer greater flexibility than other funds and can be used for longer term investments in, for example, human resources and sector development. In some cases however, HIPC or other poverty funds are earmarked within the health sector in ways that may promote vertical processes. This may be valid if they fill important resource gaps. However, there is a risk that they cut across reforms aimed at better integration of programmes such as malaria into general service delivery (a key theme of RBM). Timescales for spending funds, and risks that funds would be reallocated elsewhere if not spent, can shift allocation decisions towards short-term interventions or procurement that do not have strong country ownership or fit well in overall plans and objectives and where planning and budgeting is done in haste. The problem is exacerbated where other funding sources impose similar constraints and there is an inadequate balance between short and long term funding commitments and timescales (see also 'absorption capacity' below). 'Planning fatigue' can be seen as a general problem across countries.

h) Timeliness and regularity of funding flows

It is too early to say how well mechanisms for release of funds freed up through HIPC will operate. In Uganda, early signs of how the Poverty Action Fund is working within the health sector indicate that Districts have been given a considerable administrative burden as the price for additional and protected funds. This has resulted in delayed release of funds to Districts and to facilities within Districts, especially NGO facilities. These are partly temporary problems associated with adjustment to new mechanisms and accountability processes, inadequate mechanisms for dealing with capital expenditure, and the rapid pace of public sector reform and decentralisation in Uganda. This is also related to absorption capacity (see below). It may take considerable time for capacity to be built at district level and the new systems to become workable and familiar, but the MOF has been willing to relax rules at least to some degree to allow poverty sensitive funds to flow. Even then there is some feeling that the mechanisms place far too great a burden on districts. This was an issue for

the current joint mission on the health sector SWAp in Uganda. A new proposal on fiscal decentralisation (which would take away sector earmarking) further complicates this. Similar issues also complicate the picture in Tanzania. This raises a general question for RBM global partners about the priority that needs to be attached to investment in health sector development and capacity building generally so that available funds can be well utilised.

i) Absorption capacity

This is a recurring theme in the case studies and in experiences presented at RBM roundtables and in country updates. Cameroon in particular was reported to be under pressure to spend funds for malaria and the programme at risk of losing the funds. Problems, described more fully in case study reports, include procurement difficulties and competing demands on limited manpower. In general capacity to implement plans has not kept pace with transfer of responsibilities and resources. This raises the question whether RBM can help redress this balance through increased support for capacity development.

Absorption capacity is also affected by the capacity to contract out to partners and establishing effective and novel avenues for getting resources to where they can be used. NGOs reported that contracting out by government at national and District level was not replacing work lost as a result of donors diverting funds to pooled funds. This may be an area where RBM partners can help build capacity.

7 The influence of RBM on the content and development of PRSPs

This will depend very greatly on how PRSP development, planning and budget allocation harmonises with sector development and planning and in turn how far malaria control staff and partners at that level participate in that process. While involvement of senior officials and planning officers in Ministry of Health has generally been good, direct involvement of Malaria Control Programmes and other RBM partners in development of PRSPs and budget allocation has been patchy. There is generally low awareness of PRSPs and the resources available through debt relief among those directly involved in malaria control policy and implementation in the MoH and in partner organisations, and therefore low awareness of the potential benefits of investment in advocacy. There is also low awareness of RBM in Ministries of Finance and elsewhere outside the health sector. In addition the in-country information collection and analysis that has led to malaria being included in PRSPs as a poverty issue is not being communicated to planners and implementers of malaria control programmes. Valuable information that would supplement MoH routine collection, including important community level information, is therefore being underused.

Related to this is the question of competition with other health priorities – in Tanzania there was real competition with HIV/AIDS for HIPC resources and this will probably be the case for Cameroon as well. A greater share for health (with malaria as a component of that) rather than a greater share within health may be the most important focus of advocacy.

8 Outstanding questions and actions

This study was just an overview that has flagged up issues possibly worth examining in more detail - through debate at the GP4 and other fora and through further detailed study and development. Many of the issues raised are generic to health programmes not just RBM and are already being considered in other contexts at country and international levels. It will be important to draw on and contribute to these rather than duplicate effort.

Some key questions include:

How can RBM partners help improve ownership of the PRSP process – for PRSPs already being developed where ownership is lacking, and for PRSPs yet to be developed? There have been successes.

How can RBM partners help raise awareness among those involved in malaria control of the potential of PRSPs for mobilising funds for health and malaria, and encourage greater involvement in PRSP processes? This study shows that such awareness is not well developed and that opportunities to access a fair share of funds may be being lost.

How can RBM partners help synthesise arguments for greater attention to malaria in PRSPs and generally – how can this be done without disadvantage to other health priorities? How can we capitalise on the growing profile of malaria? This means demonstrating the malaria and poverty link in practice and promoting real success stories.

Is the balance between investment in capacity building for management and implementation, and in infrastructure and system development, and investment in direct costs of interventions correct - in terms of achieving RBM and other health targets? This brief study suggests not – how can HIPC or other funds help redress the balance and how can RBM partners (at all levels) contribute? Can we change the way we work to address this?

How can resources be mobilised more effectively in a decentralised system in order to reach lower levels in the health system and the poorest in the community and not get caught up in bureaucracy?

How important is debt relief compared with other sources of funding for malaria? This study suggests considerable importance, particularly in terms of flexibility, sustainability and protection of funds. But do fund-seeking strategies achieve the right balance between these and other factors (e.g. speed and bureaucracy of funding flows, magnitude of funds etc.)? Can RBM partners support cohesive fund-raising strategies?

How serious generally is the potential effect of increasing funds for poverty reducing activities on macroeconomic stability. What potential mechanisms for managing this tension? What does this mean for global initiatives?

Annex 1: Terms of Reference for the study

Consultancy to develop a background paper for the Fourth Global Partners' Meeting of Roll Back Malaria

The role of Poverty Reduction Strategy Papers (PRSPs) in supporting country plans to Roll Back Malaria

1. Background

The Fourth Global Partnership Meeting to Roll Back Malaria will be held in Washington, DC, USA on 18 and 19 April 2001 hosted by the World Bank.

The objective of the meeting is: "expanding the capacity of the RBM Partnership to get to scale". It will aim to address the following: How can malaria-affected countries and their partners mobilise action beyond malaria control programmes, beyond the public health sector and beyond the public sector?

In preparation for the meeting the WHO Cabinet Project has requested the Malaria Consortium to prepare a background paper describing country experiences on debt relief mechanisms through Poverty Reduction Strategy Papers (PRSPs) in Highly Indebted Poor Countries (HIPC) and their effectiveness in providing appropriate support to country plans for rolling back malaria.

2. Purpose of the paper

To contribute to expansion of the capacity of the RBM partnership to go to scale by describing the opportunities and bottlenecks created by Poverty Reduction Strategy Papers (PRSPs) and debt relief initiatives (HIPC) for supporting RBM plans in selected countries, and to highlight key issues for discussion during the GP4 meeting. Here PRSPs include interim PRSPs.

It is intended that the paper will assist those involved in RBM development and those in PRSP development to understand each other's approaches and needs better, and will highlight the areas where joint development is needed.

3. Output

A discussion paper with:

- a) clear descriptions of poverty reduction and debt relief approaches and mechanisms
- b) a brief review of their status and likely future developments
- c) analysis of key issues and lessons learnt, including the following areas:
 - ways in which PRSPs and other debt relief initiatives do or could mobilise budget support for RBM plans in the short and long term
 - ways in which PRSPs and other debt relief initiatives do or could create bottlenecks in the flow of funds for RBM plans in the short or long term, and how these bottlenecks have been or could be resolved
 - the real or potential influence of funds mobilised through PRSPs on patterns of RBM expenditure and priority-setting

- ways in which RBM does or could influence the content and development of PRSPs
- d) outstanding questions and actions for RBM and for wider policy development.
- e) summary of recommended discussion points for the GP4 meeting

It will include a brief review across countries and more detailed analysis in case studies of the following countries: Burkina Faso or Benin, Cameroon, Uganda and Tanzania.

The country case studies should include discussion of:

- status in country of RBM and PRSPs and debt relief mechanisms
- future plans for RBM and PRSPs
- relationship between RBM and PRSPs and debt relief mechanisms showing impact in both directions and covering the issues listed above
- common lessons and issues

4. Tasks

- Identify key informants, stakeholders, and sources of information
- Gather and examine information that can be collected without country visits
- Develop discussion tools for key informants and stakeholders
- Visit countries listed above to discuss the issues identified
- Write draft paper to submit to the Malaria Consortium by 30 March 2001
- Finalise paper by 13 April 2001 following feedback.

5. Management arrangements

Consultants will be contracted by the Malaria Consortium for a total of 30 days between 19 February and 13 April 2001. Country visits of approximately 3 days each will be made to the countries listed above, plus approximately 3 days per visit for travel, preparation and write-up. A team leader will be designated to have overall responsibility for collation of the country reports and other inputs, and production of the overall paper, an additional 3 days (included in the 30 days). A Malaria Consortium Task Manager will have responsibility for briefing and co-ordinating the work, additional technical input and quality control.

Annex 2: HIPC countries – enhanced debt relief status as at end 2000

Country	Decision point under enhanced HIPC	Completion point
Angola	Sustainable case	
Benin	✓ July 2000	Floating
Bolivia	✓ February 2000	Floating
Burkina Faso	✓ July 2000	Floating
Burundi	Post 2000 – conflict affected	
Cameroon	✓ October 2000	Floating
Central African Republic	Post 2000 – conflict affected	
Chad	Post 2000	
Congo Republic	Post 2000 – conflict affected	
Côte d'Ivoire	Post 2000	
DRC	Post 2000 – conflict affected	
Ethiopia	Post 2000	
Gambia	✓ December 2000	Floating
Ghana	No debt relief sought	
Guinea Bissau	✓ December 2000	Floating
Guinea	✓ December 2000	Floating
Guyana	✓ November 2000	Floating
Honduras	✓ June 2000	Floating
Kenya	Sustainable case	
Lao PDR	No debt relief sought	
Liberia	Post 2000 – conflict affected	
Madagascar	✓ December 2000	Floating
Malawi	✓ December 2000	Floating
Mali	✓ September 2000	Floating
Mauritania	✓ February 2000	Floating
Mozambique	✓ April 2000	Floating
Myanmar	Post 2000 – conflict affected	
Nicaragua	✓ December 2000	Floating
Niger	✓ December 2000	Floating
Rwanda	✓ December 2000	Floating
Sao Tomé and Príncipe	✓ December 2000	Floating
Senegal	✓ June 2000	Floating
Sierra Leone	Post 2000 – conflict affected	
Somalia	Post 2000 – conflict affected	
Sudan	Post 2000 – conflict affected	
Tanzania	✓ April 2000	Floating
Togo	Post 2000	
Uganda	✓ February 2000	✓ May 2000
Vietnam	Sustainable case	
Yemen	Sustainable case	
Zambia	✓ December 2000	Floating

Annex 3: Summary of RBM status in countries studied

Cameroon

Malaria is the leading cause of mortality in Cameroon, and among the top five causes of mortality. Malaria represents approximately 45-50% of consultations, and 23% of admissions. There are three main epidemiological zones: an equatorial region where malaria is endemic with year-round transmission, a tropical region where transmission is seasonal for 3-6 months a year, and a sahelian region where the transmission season is less than three months. Resistance of the parasite to chloroquine is an increasing problem.

Recent history of malaria control in Cameroon includes a National Policy declaration in 1997 and, in 1998, the first national plan of action for malaria control. Malaria Control at national level in the Ministry of Public Health (MOPH) is the responsibility of the Directorate of Community Health Services along with other programmes. A part-time National Co-ordinator for malaria control is a professor at the University of Yaoundé. In December 1998 a Working Group for Malaria Control was established which includes the National Co-ordinator, The Director of Pharmacy in the MOPH, representatives of the MOPH Health Education Unit, representatives from WHO, UNICEF, research institutions and paediatricians from the Central Hospital of Yaoundé. The Working Group meets irregularly.

In April 2000 Cameroon signed the Abuja Declaration on Roll Back Malaria. WHO provided technical support in the form of a consultant to assist with first steps towards implementation. RBM was officially launched in Cameroon at a national conference in July 2000 with wide representation from partners. Major partners include WHO and UNICEF (who are seen as leaders), UNDP, the World Bank, the European Union, other ministries, NGOs, private sector clubs, private sector organisations as funders (in particular Exxon Mobil), universities and research institutes, and communities.

A malaria situation analysis began in August 2000 has not yet been completed. Recent activities by the MOPH and partners include: establishment of three provincial centres for mosquito net treatment, piloting of ITNs in selected Districts, importation of nets, near completion of national treatment guidelines, studies on antimalarial drug resistance and other research, media promotions (TV, radio, posters, brochures), tax relief on nets and insecticides. Activities for the future include preparation for African Malaria Day, completion of a malaria mapping exercise, and preparation of a series of documents on policy and procedures for malaria control following a model established by Reproductive Health, and developing a pricing policy for ITNs.

Tanzania

Malaria is endemic in the majority of Tanzania. Endemicity varies from stable perennial malaria, through stable malaria with seasonal transmission patterns, to unstable seasonal malaria in areas prone to epidemics. Malaria accounts for approximately 305 of the burden of disease, approximately 35% of outpatient cases, an estimated 14-18 million cases and 100,000 to 125,000 deaths per year (70,000 to 80,000 in children under five). Tanzania made a decision to change its antimalarial

drug policy from chloroquine as first line to sulphadoxine-pyrimethamine but has been slow in implementing the change. Meanwhile resistance to SP is growing.

Malaria Control in the Ministry of Health is the responsibility of the National Malaria Control Programme (NMCP) within the Department of Epidemiology in the Directorate of Preventive Services.

The Head of State committed Tanzania to RBM in writing to the Director General of the WHO in January 1999 and Tanzania signed the Abuja Declaration in April 2000. National partners include: other ministries, WHO, UNICEF, JICA, DFID, DANIDA, the Netherlands, the World Bank, and NGOs including Save the Children, PSI, AMREF, and Care International.

With support from the MoH, the NMCP has produced a one year plan of action for implementing RBM in Tanzania, including the following targets:

- ✓ To reduce by 30% the 1999 Malaria Case Fatality Rate in health facilities in 70 districts implementing health reforms by the end of one year
- ✓ To reduce by 20% the 1999 incidence of severe malaria in children aged less than 5 years in 70 districts implementing health reforms by the end of one year
- ✓ To reduce by 10% the 1999 incidence of malaria in children aged less than 5 years in 70 Districts implementing health reforms by the end of one year
- ✓ To reduce incidence of malaria by 30% should epidemic malaria occur
- ✓ To reduce malaria-related mortality by 80% should epidemic malaria occur

A national level Situation Analysis was conducted in 2000, which reviewed how malaria control fits into national health policy, and a district situation analysis is underway. The District analysis will be essential to establishing the feasibility of the specific target percentages set. The current staffing of the NMCP is felt to be inadequate to support RBM at District level within a reforming health sector.

The MoH has set up a special Task force with key donors and NGOs to scale up ITN coverage in Tanzania. The Task Force has appointed a Management Co-ordinator and an technical group to develop a national strategy. Funding has not been secured.

Uganda

Malaria is highly endemic in 90% of the country with epidemic prone areas in the highlands of the South West and East. A 1995 Burden of Disease in Uganda study indicated that 15.4% of life years lost to premature death were due to malaria. A recent MoH information update on malaria in Uganda (2000) reported that malaria accounted for 25-40% of outpatient visits in 1992/3, 27-51% in 1998 and 29-50% in 1999. A household survey conducted by the Uganda Bureau of Statistics in 1999/2000 showed that Ugandans were reporting more illness than they were in 1992 and particularly more malaria - 28% reported illness in the 30 days preceding the survey; 56% of those stated malaria/fever as the cause of that illness. Reasons for the worsening situation have been attributed to epidemiological shifts due to climate change, increasing resistance to antimalarial drugs, as well as to cost and quality of treatment in the formal and informal sectors. A decision in June 2000 to change the antimalarial drug policy in the light of rising levels of resistance to chloroquine and sulphadoxine-pyrimethamine has not yet been implemented and meanwhile resistance continues to rise.

The Malaria Control Programme (MCP) was established in 1995. Following Ministry restructuring in 1998 it now lies within Department of National Disease Control, within

the Directorate of Clinical and Community Health Services. The MCP first produced a policy and action plan in 1997 and these have continued to evolve. Uganda took part in an RBM inception meeting in Nairobi in 1999 and followed this with a statement of intent committing itself to support the RBM movement and advocate for it at all levels. In April 2000 Uganda signed up to the Abuja Declaration. This was closely followed by legislation to waive taxes and tariffs on ITNs.

Regular meetings between the Ministry and main donors for malaria began in 1999 and, in 2000, an Interagency Co-ordinating Committee for Malaria was established representing all key stakeholders at national level. Partners include other Ministries, other programmes within the Ministry (including IMCI, Reproductive Health, Vector Control, Health Promotion), development partners (including WHO, UNICEF, DFID, USAID, JICA) and NGOs (including AMREF and Commercial Market Strategies who run a social marketing ITN programme).

Malaria is the first named element of the minimum health care package under the control of communicable diseases.

The malaria objective in the Health Sector Strategic Plan is to prevent and control malaria morbidity and mortality. One of the 20 core indicators for monitoring the HSSP nationally is malaria-specific mortality in the under-five population, with a target of a 50% reduction from 37/1000 by 2005; the same target applies to individual districts. National targets for 2005 are:

- Increase from 30% to 60% the proportion of the population that receive effective treatment for malaria within 24 hours of the onset of symptoms
- 60% of pregnant women receive protection against malaria through intermittent presumptive treatment with SP
- Increase from 5% to 50% the proportion of children under 5 protected by ITMs
- Reduce malaria case fatality at hospital level from 5% to 3%

The MCP plan of action covers the following priority interventions: case management, intermittent presumptive treatment with SP in pregnancy, vector control especially ITNs and epidemic preparedness and responsive, with supportive cross-cutting strategies including advocacy, IEC, operational research, training, support supervision and monitoring and evaluation.

A situation analysis was conducted jointly with IMCI in 2000 but analysis is not yet complete. The MCP works closely with IMCI.