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Address by Mr Ray Chambers United Nations Secretary-General's Special Envoy for Malaria to the Sixty-third World Health Assembly

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Mr President, Director-General Dr Margaret Chan, Excellencies, ladies and gentlemen.

It is an honour and a privilege to have been invited to speak before you today. Just three years ago, you took the decision to create a World Malaria Day to be celebrated on 25 April each year. The following year, in 2008, the Secretary-General of the United Nations, Mr Ban Ki-moon, appointed his first Special Envoy for Malaria. Soon after, he called for all people at risk of malaria to be provided with preventive, diagnostic and treatment measures by the end of 2010 and an end to deaths from malaria by 2015. At the time many thought this overambitious.

As you know, there has been tremendous progress, as recorded in WHO's most recent *World Malaria Report* presented last December here in Geneva. Thirty-eight countries have recorded declines in cases and deaths by over 50% since 2000; nine of these are in sub-Saharan Africa. The ministers of health who have demonstrated such leadership in this fight are to be congratulated.

Of course, this did not happen just because of activities since the Secretary-General's call. However, that call, and its immediate endorsement by the Chair of the African Union, led to a dramatic increase in funding available for malaria. This was primarily from the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank and the United States President's Malaria Initiative as well as from the United Kingdom and other bilateral partners, the Bill & Melinda Gates Foundation, UNITAID, UNICEF and members of the private sector. These commitments, as well as increases in funding from endemic countries themselves, allowed for the rapid scale-up of WHO-recommended malaria-control interventions, primarily in sub-Saharan Africa. The active work of the Roll Back Malaria Partnership under the leadership of Professor Awa Marie Coll-Seck ensured continued advocacy and the development of the comprehensive Global Malaria Action Plan.

The efforts and resources have largely been focused on sub-Saharan Africa to date. Why this focus? As you all know, 85% of the world's malaria cases are found on the continent as well as 90% of the deaths, most of those among children under five years of age. These tragic deaths are entirely unnecessary as the tools exist to prevent them.

In my role of Special Envoy, I concentrate on advocacy, the mobilization of resources, and helping to remove any obstacle in a country's path to achieving the universal coverage target. In order

to do this well, my own experience from business tells me that communications have to be brief, focused and clear. We, therefore, used the bednet as the symbol of an action that was immediately understandable to the lay person, affordable and doable. In the United States we started a campaign to raise both awareness and funds based on the slogan "US$ 10 buys a net, saves a life." This was picked up in popular television programmes, by many nongovernmental organizations and professional associations and created what the media people call a "buzz" around malaria; particularly that controlling it was achievable. It was extraordinarily successful. By the end of 2009, nearly US$ 4 billion had been committed to the fight against malaria. In 2009 alone, nearly US$ 1.5 billion was disbursed. Much of the funding did indeed go to nets, but by no means all. Much was spent on the life-saving antimalarials – the artemisinin-based combination therapies – as well as on diagnostics and indoor residual spraying. While this increase in funding has been dramatic, we are still far short of the approximately US$ 5 billion per year that is required to scale up these effective tools.

Thirty months ago it was estimated that 700 million people were at risk from malaria in Africa. WHO estimated that one bednet for every two people would be needed to achieve universal coverage. That meant 350 million WHOPES-approved long-lasting insecticide-treated bednets had to be procured and distributed, which would require a tremendous effort from manufacturers, national malaria programmes, and partners involved in distribution and communications. The response has been terrific, and today I can say that over 325 million nets have already been financed, 93% of the originally calculated need. Over 200 million of these have been delivered to countries, and most have either been distributed or are in the process. The remaining nets are either in the production queue or being delivered.

Therefore, despite the doubts of some, the Secretary-General's goal will be met as far as the delivery of nets is concerned. In its 2009 *World Malaria Report*, WHO demonstrated that in countries that have achieved high coverage with nets and other malaria-control interventions, the decline in malaria cases and deaths that follows is dramatic, often exceeding 50%. WHO has also shown that in a number of countries, the benefits go beyond malaria, and extend to sharp reductions in overall child mortality. For many countries, the control of malaria will enable the achievement of the Millennium Development Goal of child survival – MDG 4. These declines have the potential to ease the pressure on medical facilities in endemic countries. I witnessed this myself last August when I travelled to Zanzibar, in the United Republic of Tanzania, along with the WHO Director-General – Dr Chan – and Dr Tachi Yamada of the Bill & Melinda Gates Foundation. The 12-bed paediatric ward of the main hospital was empty! Apparently, up to two years before it had been overflowing, often with two children to a bed. These results were achieved through the widespread availability of effective treatment with artemesinin-based combination therapy, the universal distribution of nets, and universal indoor spraying. I know many of you are thinking about the optimal deployment of nets and indoor spraying with a range of insecticides. Clearly a comprehensive approach to control the malaria vector is required to make further gains as well as sustain our current efforts. We must also take care to deploy these and newly developed insecticides and contain the spread of resistance as we will need a full arsenal of all effective insecticides for years to come.

Beyond prevention with nets and spraying, the scale-up of other malaria-control interventions is accelerating, but still lags far behind. Yet there is good news on this front. With regard to treatment, the number of WHO quality artemisinin-based combination therapies has increased and their price has dropped significantly from what it was a few years ago. Nevertheless, we are still seeing the overuse of oral artemisinin monotherapies, and this is dangerous as it may foster resistance to the best available medicines against malaria.

Resistance to artesunate was reported in 2009 at the Thai–Cambodian border, where artemisinins have been used alone as monotherapies for many years, especially in the private sector.

When treated with an oral artemisinin-based monotherapy, most patients feel well after two to three days and, for this reason, discontinue treatment. Since they do not take the seven days of treatment required with oral artemisinin-based monotherapy, they may remain with persistent parasites in their blood. Without a second drug given as part of a combination (as is done with artemisinin-based combination therapy), these resistant parasites survive and can be passed on quickly to a mosquito and then another person. These monotherapies are therefore the **primary driving force** behind the development of resistance by the malaria parasite to artemisinins.

As Dr Chan and Dr Newman, the Director of the Global Malaria Programme at WHO, have stated, the widespread availability of artemisinin monotherapies is one of the most dangerous threats to our collective efforts.

If resistance to artemisinins develops and spreads to other large geographical areas, as has happened before with chloroquine and sulfadoxine-pyrimethamine, we could have a public health disaster. There are currently no alternatives to these life-saving antimalarial medicines, and there will not be one for the treatment of falciparum malaria in the near future.

It is, therefore, imperative that oral artemisinin-based monotherapies be rapidly removed from the market as was called for in the 2007 Health Assembly resolution on this issue. Progress has been made, but not fast enough. There are at least 37 pharmaceutical companies still involved in the production and marketing of oral artemisinin-based monotherapies, and 29 countries that allow the marketing and use of these compounds. The time has now come for all nations to band together and halt this practice once and for all. Before it is too late.

On the positive side, we have seen a rising use of rapid diagnostic tests which have become increasingly reliable. The increasing availability of quality assured tests allowed WHO to recently recommend that all persons with suspected malaria receive a diagnostic test prior to the treatment of confirmed cases. Through the use of diagnostic tests, health-care workers are able not only to target artemisinin-based combination therapy to those who actually need it, but also determine which patients have other causes for their fevers – such as pneumonia – and to treat them appropriately. The universal use of diagnostics therefore has the potential not only to diminish the unnecessary use of artemisinin-based combination therapy, and, therefore, save money, but also to improve the treatment of febrile illness, and contribute to continued improvements in child survival.

I know that all of you are deeply committed to building health systems in your countries. I also know that many of you have watched, likely with some amusement, the debate within donors and partners on whether or not to focus on health systems, or whether to control disease. I know you have no choice but to do both, but of course the two are inseparable. There is no doubt in my mind that malaria interventions have boosted health systems development. Whether it is in lowering stress on the system as in Zanzibar, providing commodities that lead to a more integrated approach to treating sick children as in Zambia, supporting the development of community health cadres to link communities with health services as in Ethiopia and Rwanda, or delivering malaria-control services through accredited social health activists in India, controlling and reducing malaria has had a remarkably positive and rejuvenating impact on health systems. This can and should go much further. In my visits to malaria-endemic countries, health ministers have always reminded me that malaria is a major cause of poor pregnancy outcomes, including maternal mortality. Many countries have programmes targeted at preventing pregnant women getting malaria. However, this objective should be more assertively pursued. One idea may be to ask local religious leaders to ensure that each couple getting married receives a bednet. Just as WHO has reported a decline in cases and deaths from malaria in many countries, the same tools could be used to reduce the number of complications in pregnancy and child birth in malaria-endemic countries and reduce further the burden on health systems.

I have not yet touched on another issue. The burden malaria puts on the economy. In the past, several figures have been quoted for the annual burden for sub-Saharan Africa. These range from US$ 12 billion to US$ 30 billion. Whichever is more accurate, the economic burden is tremendous. Heads of State and ministers of finance have been keen to see this burden reduced. The recently formed African Leaders Malaria Alliance is currently composed of 27 Heads of State who are particularly concerned about this. They want to see an end to malaria being such a drag on their economies. Three weeks ago, at an event at the World Bank in Washington DC, the Bank's President, Bob Zoellick, and the ministers of finance of Kenya, the Democratic Republic of the Congo and Zambia all spoke to this. They see the fight against malaria as an investment, not a cost. I recognize in the audience today someone you know well, Joy Phumaphi, the former Minister of Health of Botswana, who is the interim Executive-Secretary for the Alliance.

On a personal note, I want to thank Dr Chan and her colleagues, particularly Dr Nakatani, Dr Newman, and staff of the Global Malaria Programme, as well as the Regional Director for Africa, Dr Luis Sambo, for their unwavering support to my mission to help achieve the goals set by the Secretary-General. I know they have been struggling for resources, but I can witness the impact of their work. They deserve your increasing financial support as they systematically improve the tools to track, prevent, diagnose and treat malaria and, with that, make a contribution to global health that goes far beyond the impact on malaria alone. The WHO report I have cited is just one example of the work that is done, much of it away from the glare of publicity. You can be justifiably proud of the way they serve you and your countries.

To conclude, I would like to highlight a number of required actions as we move forward:

Firstly, we cannot let up now. We need to sustain the gains and finish the job. This will mean securing stable financing and diversifying the funding base, including with greater domestic commitments. There needs to be greater dialogue between ministers of health and finance ministers, particularly with evidence on the return on investment. I cited the recent announcement at the World Bank of an additional US$ 200 million investment with the participation of three African ministers of finance. Another recent example is Nigeria's groundbreaking allocation of domestic and debt relief resources to procure and distribute 10 million nets and to invest resources in managing a decentralized malaria programme in the 37 states.

As a businessman, I see why ministers of finance are captivated by their malaria investments. It is a concrete investment that delivers measurable financial and human returns. The more the linkages between the two ministries can be strengthened, the more confident I am, not only in our ability to finance our existing efforts, but also importantly, in our efforts to continue that financing and avoid a catastrophic resurgence.

Secondly, we need to replace nets as they wear out, closing the gap between net ownership and usage (which is already narrowing but needs sustained advocacy and communications).

Thirdly, we must continue to scale up diagnosis, treatment and, importantly, surveillance for malaria.

Finally, it is critical that we insist on the banning of the use of oral artemisinin-based monotherapies, and increase our vigilance regarding parasite resistance to antimalarials and mosquito resistance to insecticides.

There is also the hope of new tools on the horizon. For the first time, a malaria vaccine is in the midst of phase III trials in seven countries. In 2015, there will be sufficient data for WHO to review regarding its safety and efficacy, and to make a recommendation regarding whether it should be added to the armamentarium of existing malaria-control tools. Further research is also needed on new insecticides, diagnostics and antimalarial medicines.

Excellences, progress has been rapid and palpable. We have seen how the Secretary-General's ambitious call is turning into reality. The possibility of having such a positive impact on so many millions of people only comes to us rarely, perhaps once in a lifetime. I am determined to keep the focus so that we will see the impact clearly on reaching the Millennium Development Goals on maternal health, child health, and malaria. If we do that we will also have a major impact on reducing poverty and dramatically improving lives and productivity in malaria-affected countries. The results are within reach but they require determination and constancy to achieve and sustain them. I look to the Health Assembly to monitor this and ensure success.

Thank you once more for this opportunity to address you.

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