

Malaria's appalling death toll in sub-Saharan Africa

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Malaria kills 3,000 children every day in Africa—that is, a million a year. It is on the increase as war forces people to move out of their homes and the disease becomes resistant to the old drugs. The number of cases in the 1990s was four times higher than in the 1970s.

The medical charity Medecins Sans Frontieres (MSF) recently issued a report calling for the drug artemisinin to be made available. According to MSF, the drug is able to reduce the load of parasites in the blood 10 times faster than quinine.

Artemisinin can be used as part of a combination therapy that reduces or prevents the problem of drug resistance. The technique of utilizing more than one drug, each with a different mechanism and biochemical action, has been used in other infections such as HIV/AIDS to great effect.

Existing therapies are increasingly ineffective. Chloroquine was introduced in the 1950s. When resistance to the drug developed in the 1970s, sulphadoxine-pyrimethamine (SP) was introduced. Resistance to these drugs is now so high in parts of Africa as to render them “virtually useless,” according to MSF.

According to the World Health Organisation (WHO), when the failure rate of drugs begins to register between 5 percent and 15 percent, it should ring warning bells. When rates rise to between 16 percent and 24 percent, a new drug regime needs to be initiated; but when failure rates reach 25 percent and above, the drug regime needs to be changed. Failure rates for the drug chloroquine are above 25 percent in a majority of the malaria-affected countries of Africa, and the failure rate of SP is on the increase.

MSF points out in a recent report, *ACT Now*, that “ineffective drugs continue to be used despite the spectacular levels of resistance, leading to increased treatment failure.”

Chloroquine and SP continue to be used because they cost around 10 US cents per treatment, whilst Artemisinin combination treatment (ACT) costs US\$1.50 per treatment. MSF estimates this to be an annual cost of between US\$100 million and US\$200 million a year.

“Poor people who represent most of the continent’s malaria disease burden cannot afford to pay much more than what they currently pay for the old treatments, so costs must be subsidised by national governments with the help of international donors.”

“What is missing is political will. Unless this changes, people will continue to die needlessly from taking drugs that no longer work,” the report concludes.

Melinda Moree, director of Malaria Vaccine Initiative, says that a third of the world’s population is at risk of catching malaria, and has called for a vaccine programme to be developed. She states, “Unlike many other infectious diseases now being controlled or even eliminated, there is no vaccine to prevent malaria... vaccines are desperately needed as part of an effective malaria control strategy in Africa... Despite its enormous human toll, malaria is still largely neglected. With sufficient financial support and greater international cooperation, a malaria vaccine can become a reality.”

The production of drugs and vaccines is dominated internationally by five corporations. The majority of their research and sales is directed towards the developed world where they reap enormous profits. A proposed relaxing of patent rules to allow underdeveloped countries to be able to import cheap substitutes from generic drug manufacturers was recently scuppered by the actions of the US government, acting on behalf of American pharmaceutical companies. Provision of effective anti-malarial drugs to the population of Africa does not figure in the plans of these companies.

The Global Fund established by the United Nations in 2001 to fight AIDS also had TB and malaria in its remit. It has given money to projects involving ACT treatment in Zambia, Tanzania and Burundi. The fund is failing to meet its targets, as donations from the Western nations have almost dried up. The MSF reports states, “the several millions of dollars that have so far been made available are a fraction of what is needed for effective implementation of ACT in all the African regions that need it today.”

This year, the United Nations Children's Fund (UNICEF) together with the World Health Organisation issued the *Africa Malaria Report 2003* detailing the effects of malaria on sub-Saharan Africa. The disease is endemic throughout most of Africa, from the southern edges of the Saharan desert and as far down as northern parts of South Africa. The disease is caused by a parasite *Plasmodium falciparum* that is carried by the mosquito and injected into the person's blood stream when he or she is bitten.

The statistics associated with the disease are staggering. Of the 300-500 million cases per year in the world, 90 percent of them occur in sub-Saharan Africa. It is responsible for 30 to 50 percent of all hospital admissions in Africa and around 30 percent of outpatient visits. Carol Bellamy, executive director of UNICEF, said, "Malaria kills an African child every 30 seconds and remains one of the most important threats to the health of pregnant women and their newborns."

Of the 1 million children dying every year as a result of malaria, most are under five years of age. Because of the endemic nature of the disease, most people will develop a certain level of resistance to it over time due to constant exposure. However, in young children, this resistance has not developed and so they are most at risk. Pregnant women are also at risk because pregnancy reduces their resistance.

Those children who succumb to the infection but survive are often left damaged. Recurrent infections can leave the child listless and with a poor appetite. It reduces social interaction, leading to poor development. Two percent of children who survive the cerebral form of the disease are left with learning difficulties and conditions such as spasticity and epilepsy.

In the 1950s, a WHO-led programme to eradicate malaria was launched. The programme used recently discovered insecticide chemicals such as DDT to wipe out the mosquitoes that were responsible for transmitting the disease. It resulted in the eradication of the disease in most of the temperate areas of the world and had a big impact in Asia. This did not apply to Africa, however. With its high levels of infection and lack of infrastructure, eradication was deemed impossible.

The WHO began a programme of medication to control the disease in Africa in 1969. There was widespread use of anti-malarial drugs, especially chloroquine and later sulphadoxine-pyrimethamine. This began to have an effect and the number of cases began to fall. This fall continued until the early 1980s.

Since then, according to MSF, the disease has "roared back in Africa, spreading throughout almost all of sub-Saharan Africa."

In 2000, the UN declared that the decade 2000 to 2010

would be the "Decade to Roll Back Malaria." A meeting of African heads of states and ministers met in Abuja, Nigeria, to set targets for the Roll Back Malaria campaign. One of the goals was that 60 percent of malaria sufferers would be able to access appropriate treatment within 24 hours by the year 2005.

The *Africa Malaria Report 2003* shows how little impact the campaign has made to date. It explains how the poorest within Africa are most affected by the disease. In Tanzania, mortality rates amongst under-fives are 39 percent higher in the poorest socio-economic group compared to the richest.

A study undertaken in Ghana showed that 34 percent of the income of poor families was spent on drugs and protection measures against malaria, compared to 1 percent of income of the richest. To try to protect themselves, the poorest were spending a third of their very meagre income.

Another of the goals set at the Abuja conference was that 60 percent of pregnant women would have access to personal and community protective measurements. One of the main protective items is insecticide treated nets (ITNs), for sleeping in at night to keep out mosquitoes. Yet, according to the report, a survey of 28 African countries within the endemic malarial area found that only around 15 percent of children sleep under nets and fewer than 2 percent under the treated nets.

Malaria could be brought under control in Africa as it has been in Europe and America. Instead, it is being allowed to run out of control in sub-Saharan Africa just like the AIDS epidemic because of the indifference of Western governments to the lives of the poorest people on the planet.



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