Fatal Inaction

There is a silver bullet for Africa's malaria epidemic. Why the Bush administration won't pull the trigger.

By Joshua Kurlantzick

Ndirande, Malawi, is one of the poorest neighborhoods in one of the poorest nations in the world. At a local health clinic, anxious mothers in brightly colored body wraps and head scarves shove their children's health records at the admissions counter. Inside, another 80 women wait for blood tests in a hot, tiny, windowless room, their babies suckling weakly at their breasts. Several babies lie unconscious or shaking on the ground. Others are so thin that their skeletal structures are plainly visible.

Twenty-three year-old Margaret cradles her 11-month-old son in her arms. When he contracted malaria last week, she gave him Fansidar, a commonly prescribed antimalarial drug here. "He's not getting better," she says. Her voice cracks. Next to her, 25-year-old Innocent, a tall woman with long, wiry hair, has bundled her one-year-old in a heavy sweater to quell the chills that shake his small body. He's had malaria twice in the past two months, and also took Fansidar, with little effect. A physician's assistant moves from mother to mother, distributing pills that he knows are essentially worthless. Most of the children in this room have had malaria before, and most will get it again: An African child dies of malaria nearly every 30 seconds.

Stories about Africa frequently hew to a familiar script: narratives of intractable tragedies ignored by the world with no feasible solutions in sight. This isn't one of those stories. Roger Bate, a malaria-policy expert at the American Enterprise Institute, calls malaria probably the most obviously preventable serious disease in Africa. Although the parasite has grown resistant to drugs that once tamed the disease—including the Fansidar distributed in the Ndirande clinic—it's easily treatable with a powerful drug called artemisinin. Nor has malaria escaped political attention. In 1998, Roll Back Malaria (an alliance of international organizations, including the World Bank and the United Nations) launched a campaign to halve global malaria deaths by 2010. Last year, President Bush called for a "broad, aggressive campaign" to cut malaria deaths in Africa by half—an effort which, he declared, "our nation is prepared to lead."

Yet leadership has been noticeably absent from Washington's main aid-givers: the United States Agency for International Development and the World Bank. Both agencies have questioned artemisinin's effectiveness in the past, and squandered large portions of their malaria budgets. Meanwhile, malaria death rates have not decreased. Although some thoughtful conservatives like Sen. Sam Brownback have pushed USAID hard to address this entirely solvable problem, other conservatives have diverted reform energies by turning the issue into a partisan debate about environmental regulations. And the malaria crisis has received little tangible attention from the man who promised that "aggressive campaign" to fight it. After the president reaped considerable public praise for his declaration of support for Africa, he's shown less inclination to actually deliver the help that he promised.

ACT up

Not that long ago, developed countries viscerally understood the connection between malaria and their own national health. Until the mid-20th century, the disease was a scourge of nearly every continent. The parasite, which travels from mosquitoes to humans, then through human blood to the liver, triggers fevers, nausea, and sometimes, deadly comas. Tellingly, major advances in treatment have often been spurred by economic ambitions. Malaria-control efforts were seen as crucial to the development of the American South, and became a linchpin of FDR's Tennessee Valley Authority Project, leading to the almost total

Joshua Kurlantzick is special correspondent for *The New Republic* and a visiting scholar at the Carnegie Endowment for International Peace.

eradication of the disease here by the late 1940s. But the effective disappearance of the disease from the developed world means that malaria, unlike HIV, lacks a vocal or wealthy Western constituency to push for the production of new drugs.

For a while, no new treatments were needed. Beginning in the 1950s, chloroquine halted malaria's march in Africa and Asia. But by the 1980s, the parasite had become resistant to the drug on both continents. The World Health Organization (WHO) termed chloroquine "useless"; other cheap drugs like Fansidar also lost their effectiveness. Now, at least 300 million cases of malaria occur annually. Ninety percent of the resulting deaths occur in Africa where the climate is particularly hospitable to mosquitoes. Severe epidemics are becoming common (almost half of Burundi's population of 6.5 million contracted malaria in 2001), and the number of children killed by the disease is rising. Malaria paralyzes economies too: recurring bouts keep children from school and adults from work. The disease is estimated to cost Africa as much as $12 billion in lost gross domestic product each year.

In the 1980s, a British researcher named Nick White helped develop the drug artemisinin, derived from a wormwood plant grown in southern China. White found that when artemisinin is combined with other drugs to form artemisinin-based combination therapy, or ACT, it cleared malaria from the blood in 90 percent of the cases. Clinics on the Thai-Burmese border were among the first in the world to use this remedy. In 2000, I visited one such clinic amid a thick, scrubby forest. Though the woods teemed with mosquitoes, only two women lay in the hut with their feverish children; as they played with their babies, they seemed convinced the kids would get better. They were right. By the end of the day, the children were running around the hut, and by nightfall, their mothers were able to take them home.

Using drugs manufactured in China and India, other Asian nations imitated White's success. Vietnam used ACT to slash infection rates by more than 97 percent in the 1990s. In 1999, prominent infectious disease specialists penned an article in the prestigious British medical journal, *The Lancet*, calling for a rapid rollout of artemisinins in Africa. The following year, South Africa introduced an ACT called Coartem, manufactured by the Swiss pharmaceutical giant Novartis. Twelve months later, the number of cases in the South African province of KwaZulu Natal had plunged by almost 80 percent. In 2001 the World Health Organization recommended that all countries where malaria is resistant to older drugs should switch to ACT.

Most African nations accept that ACT should be their primary weapon in the war on malaria. At the central hospital in Lilongwe, Malawi's capital, Dr. Peter Kazembe's office is crammed with malaria studies and antiquated laptops that run malaria control models; his window overlooks a courtyard where young mothers wait anxiously for news of their sick children. (Virtually the entire population of Malawi is vulnerable to the disease.) As a pediatrician and longtime member of a government advisory committee on malaria control, Kazembe understands ACT's benefits. But Malawi, like most African countries, hasn't adopted ACT, partly because of the expense of the drugs. Kazembe considers his predicament: He knows exactly how to treat his patients, but he still can't help them. He laughs wryly, then excuses himself to leave for a funeral. "We spend so much time going to these things," he says.

Saving lives vs. the Redskins

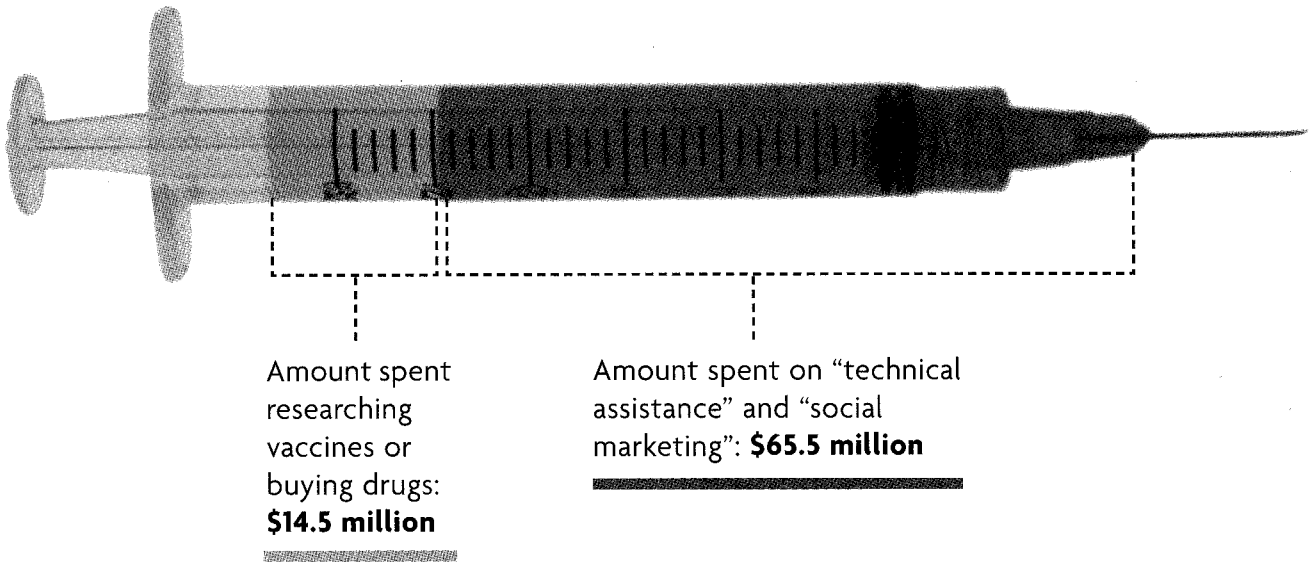
The cost of providing ACTs for the world's malaria sufferers is negligible by the standards of the rich world. For once, big pharma isn't the villain here. Novartis, which controls most of the ACT market, is willing to produce Coartem at cost. However, it won't boost production without guaranteed orders, according to people familiar with its operations. Until recently, donors couldn't purchase generics instead because, according to Médecins Sans Frontières, WHO has been slow to grant ACT produced in places like India the necessary pre-qualification status; under pressure, the WHO has started to step up pre-qualification. Without an increased supply, the price of artemisinin drugs is unlikely to fall. At the moment, the drugs run to about $2.50 per treatment, more than 20 times the cost of chloroquine, and well out of reach of the villagers in Malawi, for instance, where the average income is about 50 cents per day.

In 2004, the Institute of Medicine, a U.S. government scientific advisory body, proposed a global ACT subsidy to remedy this problem. The plan would require donor countries and multinational agencies to reserve up to $500 million to buy ACTs from companies like Novartis. (By comparison, $500 million is less than half the value of the Washington Redskins.) That way, Novartis and others could boost production knowing that orders were certain. The Institute noted that the subsidy would make ACTs available to all malaria sufferers for the same price as chloroquine—about 10 cents per treatment—and would actually stem future demand for anti-malarials: Unlike HIV treatments, which require long-term prescriptions of complicated antiretroviral drugs, ACT act rapidly and don't have to be taken indefinitely.

Dr. Francisco Saute is the deputy director of malaria control in Mozambique, which has one of Africa's highest malaria death rates. (One in every hundred Mozambican children dies from the disease.) A short man with a round face and a pug nose, Saute, who trained at elite institutions in Spain and Britain, shifts rapidly from English to Portuguese to Spanish. His cell phones trill constantly; he sweats rivulets out the front of

HOW USAID SPENDS ITS MALARIA MONEY

Total malaria budget for 2004: $80 million



his open-necked shirt. As he rushes between ten-minute meetings in the bowels of Mozambique's dilapidated, water-stained health ministry, he emits a stream of complaints. Some international health agencies, pressured by well-meaning activists, are pushing Mozambique to change its entire malaria infrastructure and buy artemisinins now—but won't provide the money to make the drugs affordable, he says. Mozambique did try to adopt ACT in 2004, with disastrous results when a surge in demand for Novartis caused a global shortage. One infectious disease doctor told me that some rural parts of Mozambique now have no malaria medications at all. "The international community pushed them to go to artemisinins, but with no way to pay for it," he says. Ramanan Laxminarayan, a malaria expert at the nonprofit Resources for the Future, believes that this situation could rapidly be solved if the United States threw its weight behind the subsidy. "African countries try to do what USAID wants them to do," he says. "It wouldn't take much time to get up and running once there is political will."

Africans can tell time, too

USAID was devised in 1961 as a tool in the Cold War. When that conflict ended, the agency faced fierce challenges to its relevance from conservative firebrands like Sen. Jesse Helms. Because of this pressure, in the 1990s, USAID's budget was slashed repeatedly and so was its staff—37 percent of the agency's staffers left or were not replaced. As a result, according to a report by AEI's Roger Bate, USAID became "largely a contracting organization." But by relying on American contractors to fulfill many of its mandates, USAID became far less accountable—as evidenced by its troubled malaria program.

USAID's malaria budget increased from $22 million in 1998 to $90 million by 2005. Last year, members of Congress held hearings to determine what that

In the 1990s, USAID's budget was slashed repeatedly and so was its staff. By relying on American contractors to fulfill many of its mandates, USAID became far less accountable—as evidenced by its troubled malaria program.

money had produced. The results weren't pretty. After interrogations from Sen. Tom Coburn and others, it emerged that in fiscal year 2004, USAID spent just 5 percent of its malaria budget on antimalarial drugs. The rest of the budget went to various "technical assistance" projects (such as a $65 million program for "social marketing" of mosquito nets to impoverished Africans), as well as salaries of U.S. consultants, travel expenses, training, and other services provided by American contractors. "We spent most of our money telling people how to use the cheap and effective tools to fight malaria," said Coburn at another hearing this January, "and very little money actually providing them those tools and very little money actually saving lives." Coburn has also questioned why the U.S. sinks its malaria cash into USAID, instead of supporting the Global Fund to Fight AIDS, Tuberculosis and Malaria, the major international organization that finances the purchase of malaria drugs. Bate concludes that most of USAID's malaria funds "either never left the United States ... or funded the employment of U.S. citizens." Former USAID head Andrew Natsios admitted in 2003 that the organization has relied on contractors, but lacks the resources to oversee them: "We don't have enough officers to do the work," he told *Government Executive* magazine.

According to USAID's own internal reporting, as much as 80 percent of its total budget goes to American goods and American contractors. Disturbingly, it's almost impossible to know whether these contractors provide value for money, as the agency is notoriously intransigent when it comes to evaluating its effectiveness. In 2000, economist Ruben Berrios found that USAID's bidding procedures were woefully uncompetitive, relying heavily on a small pool of contractors. The agency is also generally reluctant to release information on its work (dealing with the Pentagon is far easier). Bate points out that contractors have little incentive to actually solve the problems they're supposed to address, as successful advice would ultimately render them jobless.

But although USAID's inept response to malaria can partly be blamed on these institutional defects, even more troubling is the agency's apparent ambivalence towards ACT. Internal documents obtained by *The Washington Monthly* suggest that well after leading malaria experts recommended the benefits of ACT in *The Lancet*, USAID was still privately discouraging their use. "Let's not argue for ... artemisinin therapy right now," reads a message from a 2001 email exchange between two of the agency's malaria specialists. Another message from 2003 suggests that the treatment should still be seriously debated—two years after the World Health Organization recommended a switch to artemisinins for countries where resistance had developed to older drugs. A 2004 *Lancet* article by 13 malaria specialists noted that countries that sought to switch to ACT were "forcefully pressured out of it" by the U.S. The resulting outcry forced USAID to declare support for ACT. In a meeting at USAID, agency disease experts told me that the organization had initially harbored concerns that countries would switch to ACT too quickly, before necessary infrastructure was in place. However, they said they recognized the importance of the powerful new treatment.

Some critics believe USAID had shunned artemisinin because of deep-seated doubts that Africans can handle complex treatments. In 2001, Natsios told a House committee hearing on HIV/AIDS that Africans "do not know what watches and clocks are." (Studies have shown that African patients correctly follow HIV drug regimens, which are more complicated than artemisinin combinations.) And although USAID commissioned the Institute of Medicine study that proposed subsidizing ACT, it has

shown little inclination to support the plan. When I asked Peter Bloland of the Centers for Disease Control whether he'd seen the political will from Washington to push for the subsidy, he answered simply, "no."

Green herring

Oddly, malaria has become something of a conservative *cause celebre* in recent years. Sen. Brownback has become a dedicated advocate for combating the disease. At congressional hearings, he and fellow Republican Sen. Coburn display an impressive knowledge of the crisis and the deficiencies of USAID's response. However, apart from a few such thoughtful exceptions, conservative energies have mostly been focused on another supposed solution: the insecticide DDT.

DDT, which helps kill malarial mosquitoes, was sprayed in America to eradicate malaria. But Rachel Carson's vivid portrayal of the horrors wrought by the chemical in her seminal book *Silent Spring* caused DDT to be banned in 1972, and helped launch the modern environmental movement. For some conservatives, malaria policy has now become an unlikely tool in the anti-environmentalist backlash. *The Weekly Standard*, *The Wall Street Journal* editorial page, and *National Review* have dedicated more than 10 editorials in recent years touting the benefits of DDT (although some conservatives like Bate, Brownback, and Coburn do advocate both DDT and ACT). At malaria hearings for the Senate Foreign Relations committee, Republican members have repeatedly asked why the United States doesn't promote DDT in malaria-stricken nations.

This preoccupation with DDT, however, is largely a distraction. Environmental leaders now agree that the pesticide should be used to combat malaria; few nations in Africa ban it; and USAID has agreed to spray DDT in countries like Ethiopia and Mozambique. What's more, DDT is no silver bullet. Malaria experts agree that it reduces transmission, but emphasize that it must be combined with other interventions, including ACT. The furor over DDT has undoubtedly hampered efforts to provide better access to antimalarial drugs. When another malaria expert met with Senate staffers to discuss malaria in 2004 and 2005, they badgered him about DDT. "I tried to explain the reality," he says, "and people in the U.S. say 'That's not what I was told.'" "DDT has become a fetish," adds Allan Schapira of WHO. "You have people advocating DDT as if it's the only insecticide that works against malaria, as if DDT would solve all problems, which is obviously absolutely unrealistic."

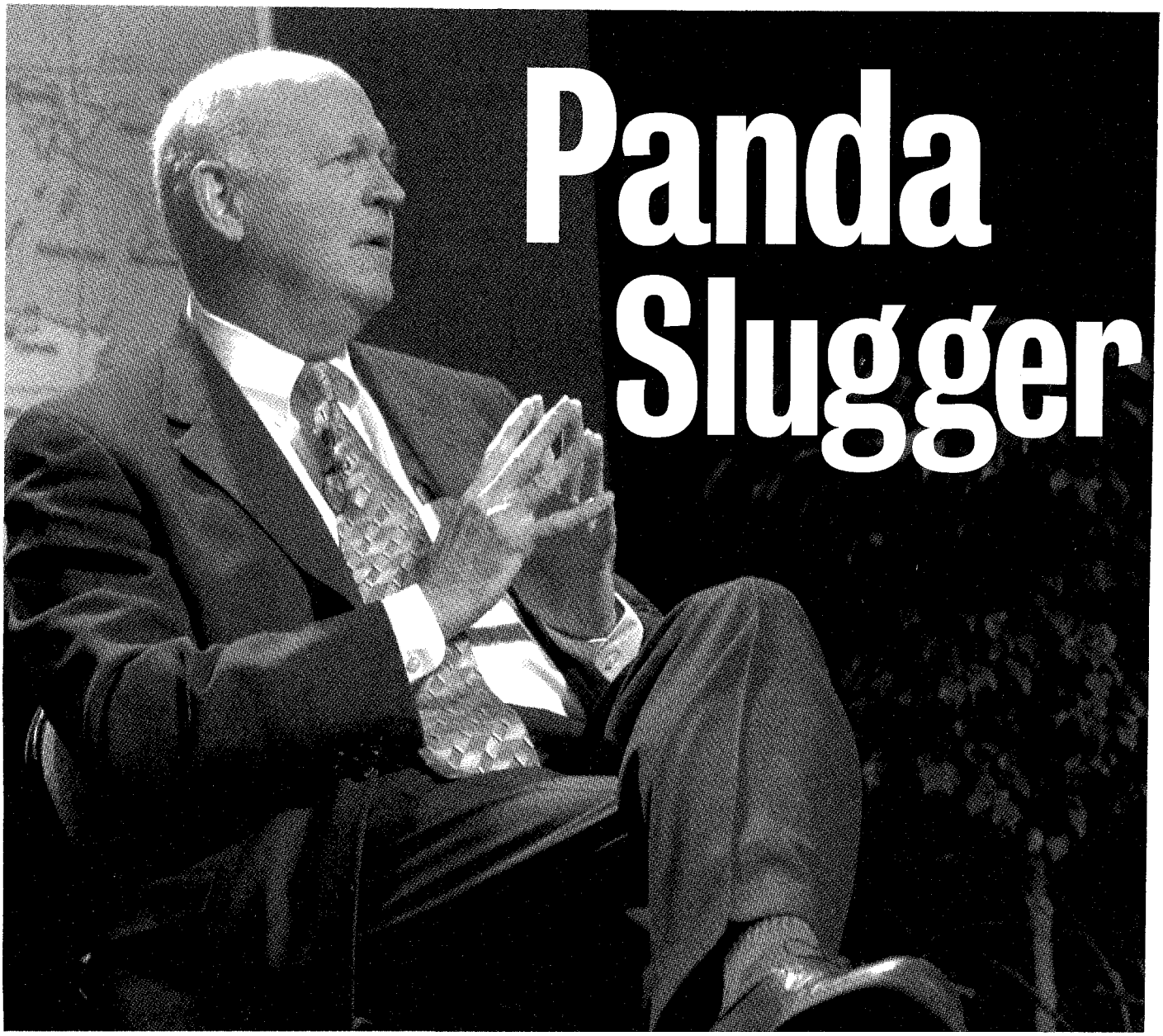
Ultimately, despite the efforts of lawmakers like Brownback, meaningful action on malaria needs White House support. President Bush has certainly been generous with his rhetoric. Last year, he pledged $1.2 billion to the cause, challenging the world to move past "empty symbolism and discredited policies." However, Rep. Tom Lantos pointed out that for the first year, this sum didn't actually include any new money—it simply reallocated previously budgeted funds.

Stiffed by the World Bank

American inaction on ACT has fed a deeper malaise among both international and private institutions and private institutions that deal with malaria—and which tend to be heavily influenced by U.S policy and funding. Last year, the Global Fund to Fight AIDS, Tuberculosis and Malaria found itself $300 million short of the money it had planned to spend on drugs. President Bush had only requested $200 million for the Global Fund, less than half of what Congress had provided the previous year. But perhaps the most alarming example is the World Bank, which, according to a report in *The Lancet* this year, has failed to fulfill a 2000 promise to boost funding for malaria control. Instead, *The Lancet* found that the Bank funded obsolete drugs, downsized its malaria staff, and faked its financial accounts, possibly to mask mistakes. "No commercial high-street bank could keep such imprecise accounts for its clients, without running a serious risk of civil or criminal illegality," *The Lancet* concluded.

Some of the few hopeful signs are emerging from the private sector. In May 2005, the Bill & Melinda Gates Foundation pledged $35 million to a comprehensive anti-malaria pilot project in Zambia. The project combines all the possible antimalarial weapon—insecticides, bed nets, and ACT. The foundation also appears willing to fund a study to consider exactly how to deliver the global ACT subsidy; several major donor agencies including UNICEF and WHO are discussing how to make the subsidy work. Stung by congressional criticism, USAID also vowed in January to mend its ways (this year it intends to spend half of its malaria budget on drugs, nets and spraying). It has also said that it is rebuilding its staff to become less reliant on contractors. Whether these initiatives will bear fruit, or simply go the way of numerous other lofty goals, remains to be seen.

At Ndirande, a new crowd of children and mothers sits on the floor outside the doctor's office. The room echoes with the wails of skeletal babies. More worrisomely, some of the children are eerily silent. Meria cradles her baby daughter, who's been coughing up blood and vomiting repeatedly. Next to her, Agnes, a 46-year-old with a heavily-creased face who wears a headscarf decorated with brightly-colored mangoes, stares at her three-year-old son. He's not moving at all. "That boy has had malaria every month, and today he's having the same symptoms as before," Agnes says. "I'm worried he'll have this problem every month, forever." ♦



Panda Slugger

The dubious scholarship of Michael Pillsbury, the China hawk with Rumsfeld's ear.

By Soyoung Ho

In May 2002, ten months before he became president of China, Hu Jintao visited Donald Rumsfeld at the Pentagon. The meeting, as then-Vice President Hu saw it, had gone well. Routine U.S.-Chinese military-to-military contacts, which had been suspended since 2001 after a tense standoff over a damaged U.S. spy plane, were to be renewed. China's Xinhua news agency quickly put out a headline announcing the thaw: "Chinese vice-president, U.S. defense secretary agree to resume military exchanges."

But there was a problem. According to the Pentagon, no such consensus had been reached. Instead, the two sides had merely agreed that the possibility of such exchanges would be "revisited."

The mix-up, as it turned out, had a likely explanation. According to *The Far Eastern Economic Review*, Rumsfeld, in a characteristic interdepartmental snub, had barred the State Department's interpreter from the meeting. The man on whose language skills Rumsfeld had instead relied was not a professional interpreter but a Pentagon advisor and longtime Washington operator named Michael Pillsbury. With a proficiency (up to a

is a *Washington Monthly* assistant editor.