

Chairman's Statement
Sen. Tom Coburn (R-OK)
An Assessment of USAID's Anti-Malaria Policy
May 12, 2005

Today's hearing will examine the United States Agency for International Development's efforts to control the spread of malaria throughout Africa. When I learned that funding for USAID's malaria program had increased from \$14 million in 1998 to \$90 million in 2005, I wasn't expecting to find that the number of deaths due to malaria had, in fact, increased by about 10 percent.

Not only have they not achieved the stated goal of reducing malaria by fifty percent, the actual number of deaths have increased. How can this be? That is what we hope to learn during the course of this hearing.

Recently, I have read reports on USAID's anti-malaria program. An author of one such paper, Dr. Bate, is testifying here today. In preparing for this hearing I was struck by the lack of accountability and transparency on the part of USAID in providing a breakdown of how the agency allocates its malaria budget.

For instance, how much money does the agency actually spend on interventions to prevent the further spread of the disease? How much funding goes to contractors? And, more to the point, why hasn't the agency provided this information when it was previously asked to do so? I intend to ask the Government Accountability Office to conduct an audit of USAID's malaria program because I believe the citizens of this country have a right to know how their tax dollars are being spent.

Malaria still claims a million victims annually, with over 90 percent of the deaths occurring in Africa. An even more daunting statistic is that malaria kills a young African child every thirty seconds. USAID can't be proud of this track record.

Representatives of USAID have testified in the past that the agency supports the use of indoor residual spraying and insecticide treated nets to prevent new infections. However, the fact is that USAID has never been a strong proponent of these methods and did not push for the use of indoor residual spraying and insecticide treated nets despite the fact that such interventions have proven to be successful when they were used by the agency in 1950s and 60s. Most recently, such interventions were very successful in reducing malaria in South Africa and Zambia.

Another disturbing issue is the resistance on the part of USAID to stop using ineffective drugs to combat malaria. The American Enterprise Institute's paper entitled: *The Blind Hydra*, provides evidence from a project consultant to the World Relief project, Dr. P. Ernst. Dr. Ernst related that efforts to convince USAID and UNICEF to change the type of drug included in the drug kits distributed to First Aid posts have failed. He went on to say: "Even today, children in Chokwe receive ineffective medicine." That was in 2004.

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This is completely unacceptable since the cost for a full treatment, the smallest pack (young children) costs \$0.90 and the largest pack (adults) costs \$2.40.

This Subcommittee notes that there are important questions about the policy choices USAID has made. However, we are also deeply concerned about the failure of the agency to provide accurate information to the public about its activities. If the Congress and the public do not know what is being spent and for what purpose, how can results be assessed? With that in mind, we will explore these issues with our witnesses.

In conclusion, I would like to explain several charts that are displayed in front of the dais.

Malaria: Preventable, Curable, Controllable – the Inexcusable Failure of Public Health. What this chart points out is that 2.5 billion people in 90 countries around the world are at risk – that is alarming since we are talking about 40 percent of the world's population;

Malaria represents the most life threatening infection in the world; 500 million acute illnesses every year, 90 percent of these are in sub-Saharan Africa;

Malaria claims 3,000 people every day, and up to 90 percent these deaths occur in pregnant women and children under the age of five;

Malaria accounts for as much as 40 percent of public health expenditures, 30-50 percent of inpatient admissions, and up to 50 percent of outpatient visits; Children that survive can suffer brain damage, or experience cognitive learning deficits.

Malaria and Deaths – South Africa 1971 – 2002. This chart shows the dramatic rise in the number of deaths attributable to malaria when the government was pressured into stopping its program of spraying with DDT. South Africa had been successful in controlling malaria for years with DDT – the chart shows the number of new cases and deaths increased dramatically when DDT was no longer being used.

KwaZulu-Natal, South Africa: What can a little DDT and Coartem do? This chart shows that when the government reinstated the use of effective drug therapy with Coartem (ACT drug) and the spraying of DDT that the number of cases fell dramatically.

Number of Houses Sprayed Compared to Number of Cases of Malaria Above the Rate Expected if Spraying Had Continued (data from countries of the Americas) clearly illustrates that the resurgence of malaria is directly linked to DDT spraying (bar graph – as the number of sprayed houses decreased, the excess cases over the amount seen during spraying exponentially increased).