



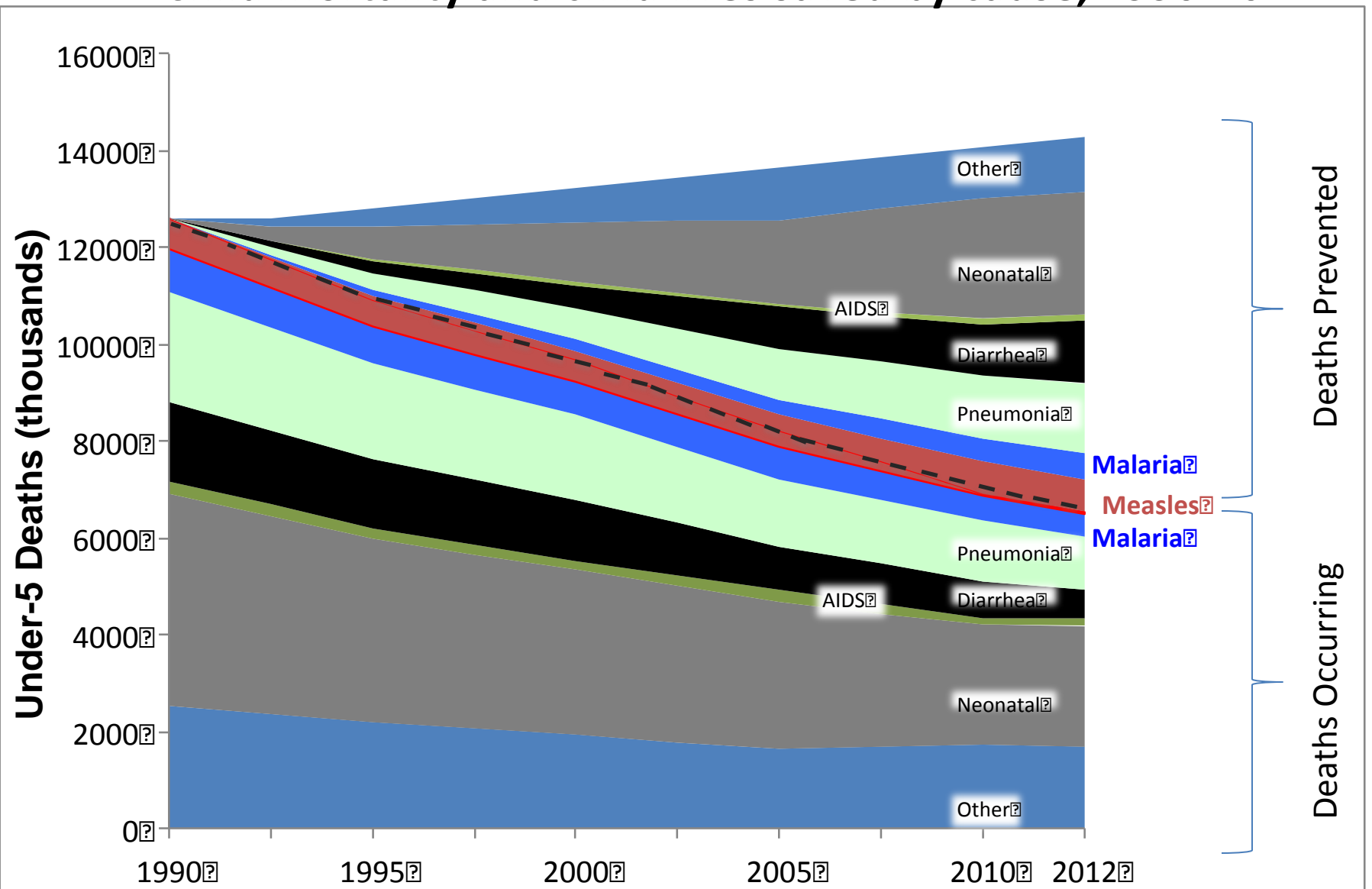
THE SECRETARY GENERAL' S SPECIAL ENVOY FOR FINANCING THE HEALTH MILLENNIUM DEVELOPMENT GOALS AND FOR MALARIA

MDG4 Progress and Opportunities to Close the Achievement Gap



February 17, 2014
Alliance for Malaria Prevention annual Meeting

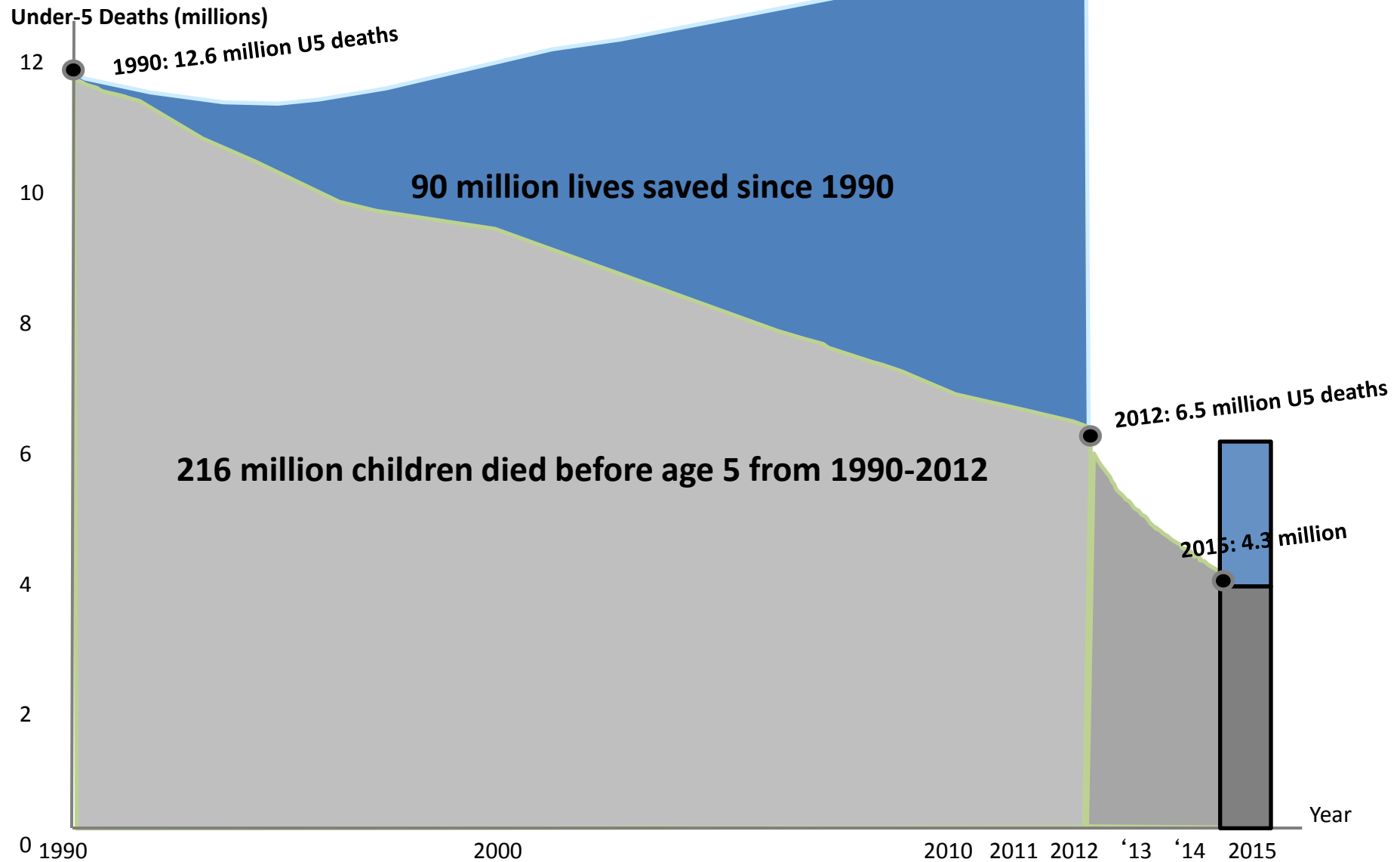
Child mortality and child lives saved by cause, 1990-2012



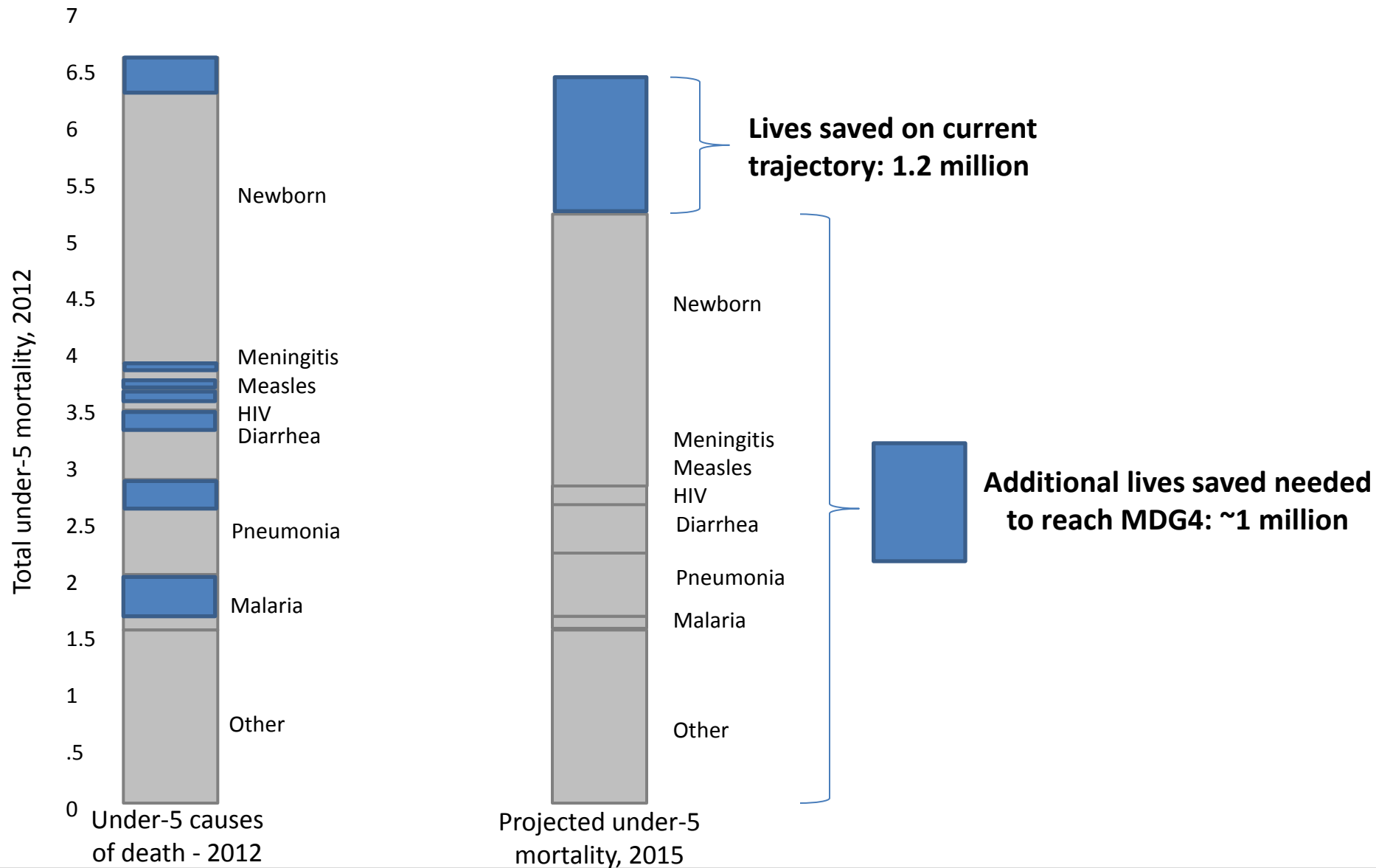
CONTENTS

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 2. Scaling up CHW programs and iCCM
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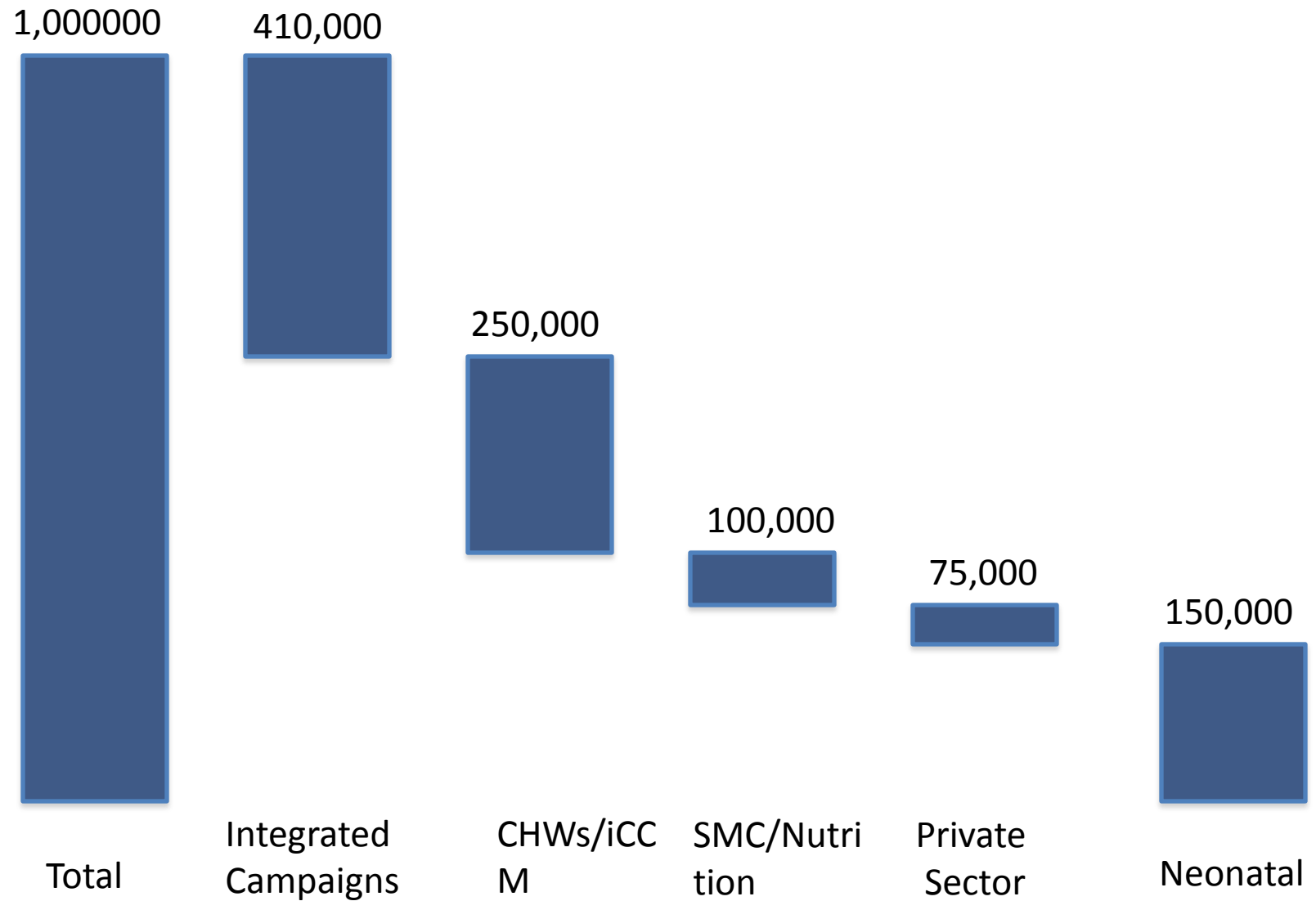
TO REACH MDG 4, NEED TO SAVE AN ADDITIONAL 2.25 MILLION CHILDREN'S LIVES IN 2015



CURRENT TRAJECTORY OF LIVES SAVED AND REMAINING GAP



A SET OF HIGH-IMPACT INTERVENTIONS CAN REACH MDG4



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POTENTIAL FOR 150-250K LIVES SAVED THROUGH CHWS

ESTIMATES

Priority countries (draft)	2015 estimated cost to deliver iCCM (including CHW salary), \$m	Sub-cost for pneumo and diarrhea commodities, \$m	2015 lives saved, (thousands)
Nigeria	57.78 ¹	2.3	33.5 ²
DRC	16.41	1.0	9.7
Kenya	4.12	0.3	4.1
Ethiopia	60.03	3.5	21.5
Angola	4.16 ¹	1.6	2.4 ²
Uganda	29.15	1.9	35.7
Niger	8.94	0.6	7.5
Mozambique	12.75	0.7	4.7
Zambia	1.08	.08	1.3
Malawi	8.69	0.5	7.8
South Sudan	6.05	0.4	9.4
Burkina Faso	6.27	0.4	5.0
Sierra Leone	7.02	0.5	6.1
Senegal	TBD	.01	TBD
Rwanda	2.04	0.1	1.1
Liberia	0.76	.05	0.7
Mali	7.93	0.5	7.2
Total	234m	14.4m	158,000

¹ Estimate based off #of CHWs (no CCM yet through Malaria program)

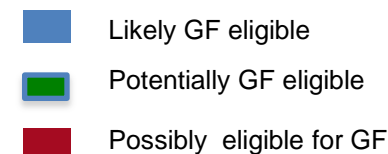
² To be verified if such scale is possible in short period of time



2015 DETAILED COST BREAK DOWN – ASSUMES EACH CHW IS PAID ~\$500 ANNUALLY

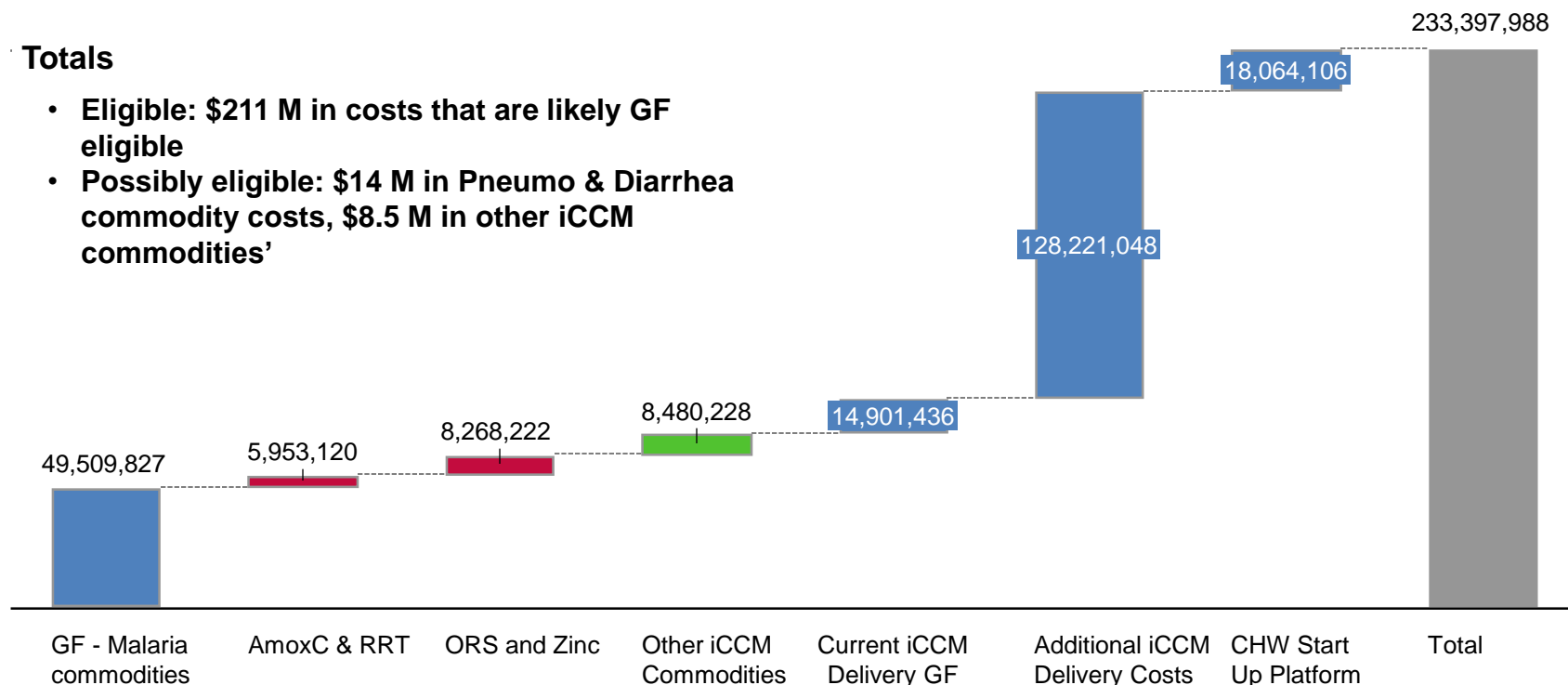
ESTIMATES

Across 17 priority countries - using forecast ACTs



Totals

- **Eligible: \$211 M in costs that are likely GF eligible**
- **Possibly eligible: \$14 M in Pneumo & Diarrhea commodity costs, \$8.5 M in other iCCM commodities¹**



¹Cost estimates assume an average CHW is treating 134 malaria cases annually, 43 pneumo cases, and 63 diarrhea cases – based on observed numbers across actual field trials. Volume estimates based on iCCM Symposium program data analysis. Commodity cost estimates are \$1.50 per malaria case (HWG), \$.52 per pneumo case, \$.50 per diarrhea case (D&P WG). iCCM delivery costs include iCCM training and limited investment in supervision, incentives, BCC, and supply chain. Start up platform costs are for recruitment, basic training, etc. Actual country estimates will vary according to epidemiology, program design, etc.

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SCALING UP MALARIA PROPHYLAXIS & INTEGRATING WITH NUTRITION PROGRAMMING CAN SAVE 48,000-90,000 LIVES

Scale-up Seasonal Malaria Chemoprevention (SMC) and Integrate Nutritional Screening + Food Supplementation

SMC overlaps with the most vulnerable period of the year for nutrition (rainy season / off harvest season). There is an opportunity to link with funding from the GFTAM.

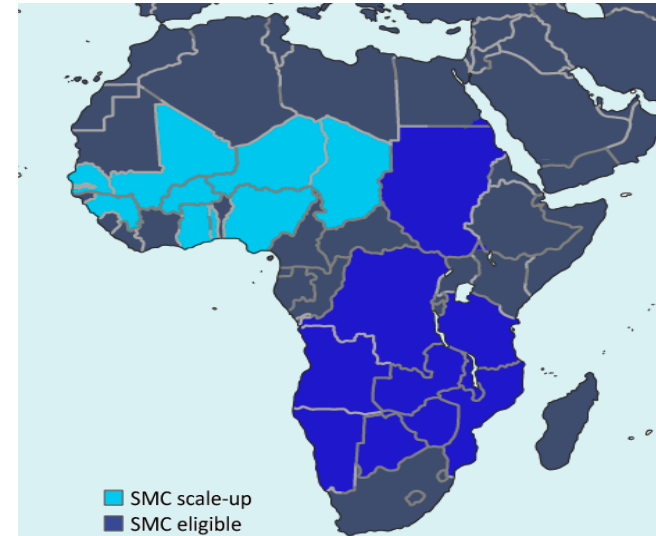
Potential lives saved impact (2014 – 2015)

-48,000 – 90,000 children's lives

Average cost per beneficiary

-\$1.80 - \$3.50 per child – SMC

-\$10.00 per child – Food Supplementation



Countries w/ SMC Implementation Plans

- Ghana
- Niger
- Burkina Faso
- Senegal
- Mali
- Togo
- Gambia
- Nigeria
- Guinea
- Chad

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Integrated Campaigns: Putting available tools into existing delivery platforms

Strategy

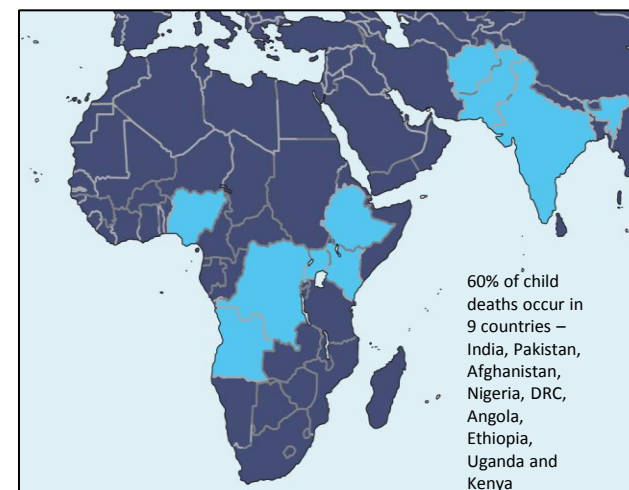
- Target highest risk population (About 40 million <5s in Africa)
- Build on existing polio, measles, child health weeks and other campaigns (bed nets).

Interventions

VACCINATION:
rotavirus, pneumococcal, TT
TREATMENT:
ORS/Zinc, antibiotics
NUTRITION:
vitamin A, RUSF, breastfeeding promotion
MALARIA:
Seasonal Malaria Chemoprevention

Cost per beneficiary

PW/new mothers: \$6.00
Child < 6 months: \$29.00
Child > 6 months: \$18.00



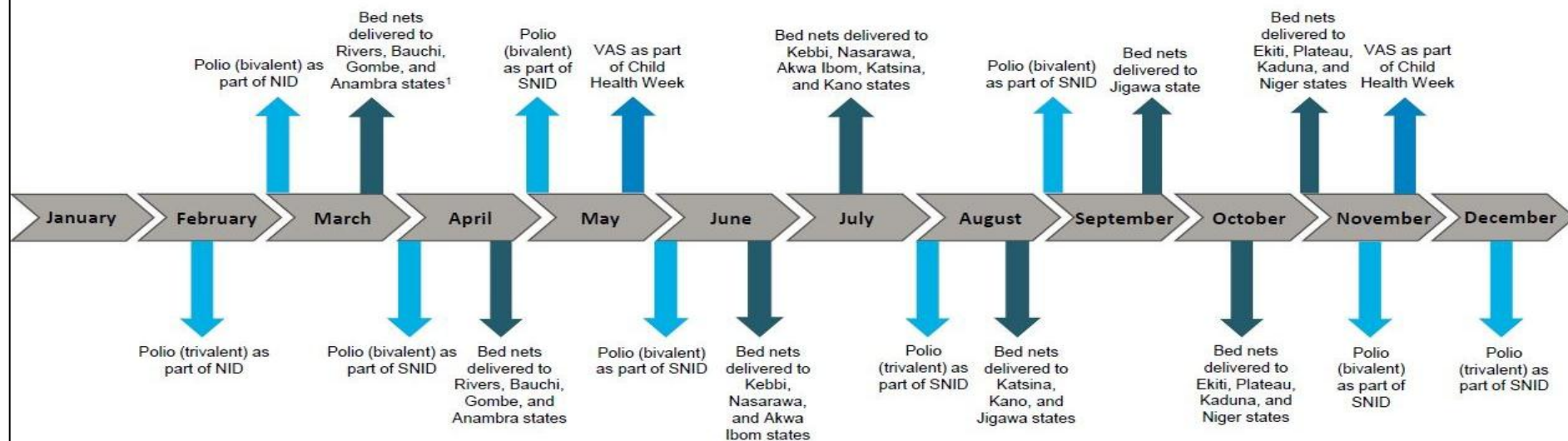
*estimate generated by the Lives Saved Tool (LiST)

NIGERIA: POTENTIAL FOR 75,000 LIVES SAVED



Intervention Package Modeled	2014 Lives Saved	2015 Lives Saved	Total Lives Saved
<i>Pneumococcal and rotavirus vaccines</i>	8,000	14,000	22,000
<i>ORS & zinc treatment</i>	8,000	14,000	22,000
<i>Antibiotics for pneumonia case management</i>	2,000	4,000	6,000
<i>RUSF for moderately acutely malnourished children</i>	4,000	7,000	11,000
<i>Tetanus toxoid vaccine and breastfeeding promotion</i>	2,000	4,500	6,500
<i>Seasonal malaria chemoprevention</i>	N/A	7,000	7,000
Total Lives Saved	24,000	50,500	74,500

Timeline of Child Health Interventions in Nigeria



¹ Delivery of bed nets to Rivers, Bauchi, Gombe, and Anambra states from March through April 2014 is contingent upon the World Bank Booster project procurement of an additional 3.4 million LLINs over the initial commitments of 6.4 million.

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The Campaign Integration Decision Game

Rules of the game:

If no-one wants to integrate then each campaign proceed as a stand alone campaign.

If both integrate, each pays own costs, gets own benefits and gains 25% of other's benefit.

If discordant, the investing partner pays all costs and both get all benefits.

	Cost	Benefit	Value
AMP	-3	+4	+1
Potential Partner	-1	+2	+1

Value of co-investing (and refusing to co-invest) in an integrated campaign

		Potential Partner	
		<i>Co-Invest</i>	<i>Refuse</i>
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	Refuse		+1

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	Refuse	-1 +4.5	+1 +1

Some Observations on the Game:

- There is an equilibrium at mutual refusal. (A Nash Equilibrium: each one is making the best decision that he or she can, taking into account the decisions of the other.)
- Clarifying the situation further doesn't help. It is the clarity that causes the problem.
- Modest changes in costs and benefits do not result in changes in the direction of the outcomes.
- Direct financial incentives to the partner to integrate won't create additional value as they will exceed the value gained from integration.

How to get out of a stable equilibrium?

1. Add non-economic value.



How to get out of a stable equilibrium?

2. Increase cooperation and trust. Help the other player believe that their choice to do the right thing will influence your decision to do the right thing.



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	Refuse	<div> <div>-1</div> <div>+1</div> </div>	<div> <div>+1</div> </div>

How to get out of a stable equilibrium?

3. Appeal to a greater good or an alternative decider of good.

“Equity”

“Country ownership”

“Sustainability”

How to get out of a stable equilibrium?

4. Emphasize the partner's needs to integrate to get value.

You need to reach geographic areas and population sub-groups at high levels that only AMP can.



THE



Health Alliance

How to get out of a stable equilibrium?

5. Create additional value for co-investing (e.g., an investment bonus to increase value or lower costs).



THE



Health Alliance

The Campaign Integration Decision Game

Rules of the game:

Increase value of investing (preferred pricing for integration commodities)

Lower value of refusing (loss of preferred pricingn)

	Cost	Benefit	Value
AMP	-3	+4	+1
Potential Partner	-1	+2	+1

Value of co-investing (and refusing to co-invest) in an integrated campaign

		Potential Partner	
		Co-Invest	Refuse
AMP	Co-Invest	+2.5 (2) +3 (1.5)	+2 (3) -1.5 (0.5)
	Refuse	+1 (-1) +4 (4.5)	+0.5 (1) -0.5 (1)

The Campaign Integration Decision Game

Rules of the game:

Commodity costs reduced if given during integration.

Commodity costs increase (no preferential pricing) if not integrated.

If discordant, no value to non-investing partner

	Cost	Benefit	Value
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	Refuse	+4 +1	-0.5 +0.5

How to get out of a stable equilibrium?

6. Create polices and standards that require integration.

If men were angels, no government would be needed.

James Madison



Summary of Integration Game:

The usual costs and benefits do not typically align to favor integration. Achieving integration will likely require additional inputs, including alternative rationale, incentives or policies. Those additional inputs are familiar to and manageable by AMP.

There are choices available now that can achieve MDG4 using proven strategies in existing systems with available financing. AMP is well situated to take advantage of this unique opportunity.

Thank you



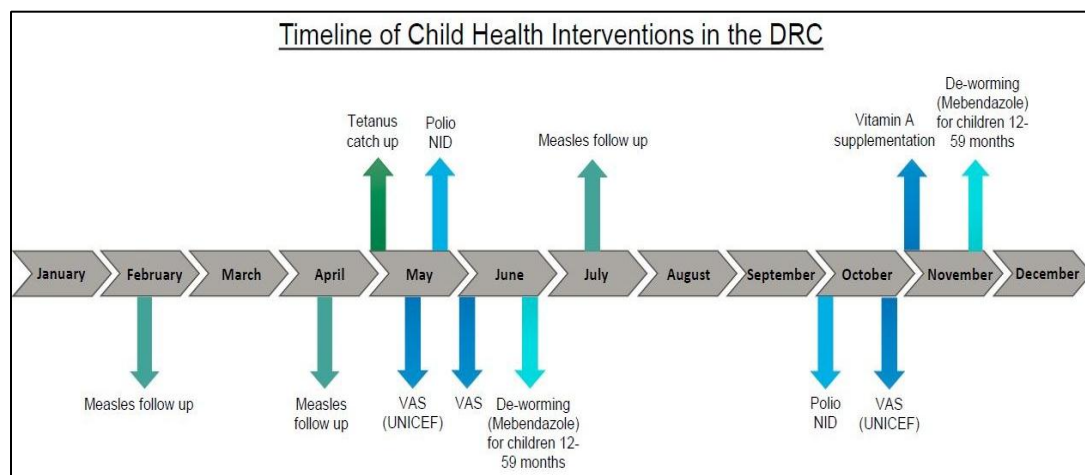
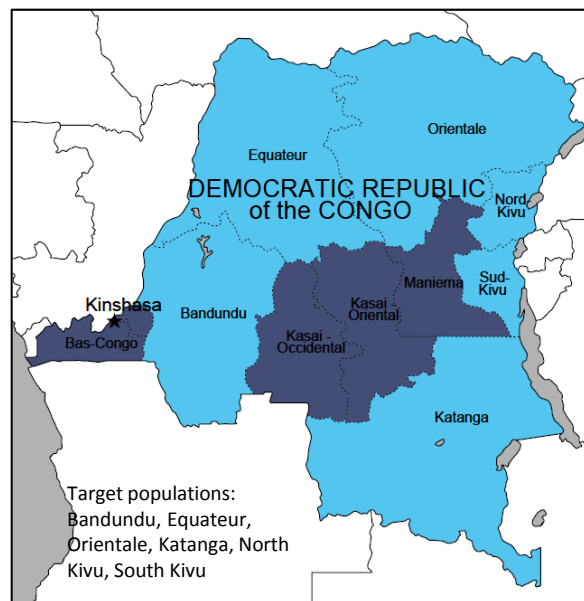
THE



Health Alliance

DEMOCRATIC REPUBLIC OF CONGO: POTENTIAL FOR 69,000 LIVES SAVED

Intervention Package Modeled	2014 Lives Saved	2015 Lives Saved	Total Lives Saved
<i>Pneumococcal and rotavirus vaccines</i>	6,000	15,000	21,000
<i>ORS & zinc treatment</i>	8,000	14,200	22,200
<i>Antibiotics for pneumonia case management</i>	2,600	4,400	7,000
<i>RUSF for moderately acutely malnourished children</i>	4,000	8,300	12,300
<i>Tetanus toxoid vaccine and breastfeeding promotion</i>	2,300	4,200	6,500
Total Lives Saved	23,000	46,000	69,000



Destiny and her newborn, Goma, 2012

ESTIMATED CHILD DEATHS PREVENTED, BY LOCATION AND INTERVENTION

ESTIMATES

Location	Pneumo- coccal and Rotavirus Vaccines	Vitamin A	ORS and Zinc	Pneumo- nia Case Manageme nt	Ready-to-use- supplementary foods	Breast- feeding Promotion	Tetanus Toxoid Vaccine	Malaria Chemopre vention	Total Child Deaths Prevented (Total Package)	% National MDG4 Achievement Gap Closed
India	30,000	8,000	42,500	11,000	28,500	5,000	5,000		130,000	53
Pakistan	16,000	NA	9,500	6,000	10,500	3,500	3,500		50,000	20
Afghanistan	4,000	NA	2,000	2,000	3,000	500	500		12,000	76
Nigeria	22,000	NA	22,000	6,000	11,000	3,250	3,250	7,000	75,000	20
DRC	21,000	NA	22,200	7,000	12,300	3,250	3,250		70,000	26
Angola	4,100	1,500	3,000	1,500	2,200	300	300		13,000	10
Ethiopia	15,000	NA	12,000	3,500	8,000	700	700		40,000	<i>Will contribute to global MDG4 achievement</i>
Kenya	2,300	400	3,000	1,700	3,000	300	300		11,000	17
Uganda	4,000	300	2,000	1,300	2,000	250	250		10,000	<i>Will ensure Uganda achieves MDG4</i>
GRAND TOTAL	120,000	10,000	120,000	40,000	80,000	17,000	17,000	7,000	410,000	

