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Letters

Global campaign to eradicate malaria

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Meeting showed scope for scaling up campaign

Sylvia Meek, director (sylvia.meek@lshtm.ac.uk), Jane Edmondson, human and institutional development coordinator, Dennis Carroll, senior health adviser

Malaria Consortium (London and Liverpool School of Tropical Medicine), London School of Hygiene and Tropical Medicine, London WC1E 7HT

USAID Global Bureau, Office of Health and Nutrition, Washington, DC 20523, USA

Liverpool School of Tropical Medicine, Liverpool L3 5Q

Mahidol University, Bangkok, Thailand

World Bank, Washington, DC 20433, USA

Cardiff School of Biosciences, University of Cardiff, PO Box 915, Cardiff CF10 3TL

EDITOR—Yamey's editorial summarises some of the key issues raised at the fourth global partners' meeting for Roll Back Malaria.¹ As he says, more and rapid action is desperately needed at country level. Three other messages, however, came across strongly at the meeting.

The first is that partners within countries are not waiting for the outside world to tell them how to start. Several countries have recognised the opportunities to make a real difference as part of Roll Back Malaria. For instance, in Uganda those responsible for malaria and for integrated management of childhood illness are working together to support the campaign's objectives instead of competing over territory.

After developing strategies to reduce poverty Uganda is already benefiting from increased malaria allocations through debt relief and other funds earmarked for poverty sensitive activities. Malawi is implementing a strategy for reducing the burden of malaria in pregnancy. Despite a relatively simple and cheap intervention known to be effective, few countries have gone this far. Tanzania has brought public and private partners together systematically to develop a national strategy for supplying insecticide treated nets and is achieving rapidly growing coverage rates.

These encouraging examples might well have happened without Roll Back Malaria, but they underscore the fact that great progress can be made in rolling back malaria. They also serve as a challenge to the campaign, showing that it has the opportunity to do much more than it has done to date.

The second message from the meeting was that many participants, including those from the world's poorest countries, were impatient at the slow pace of Roll Back Malaria. But countries have limited capacity to scale up quickly. Although more money is necessary to develop the needed capacity, and

partners need to convert their pledges into resources, money is not the only essential ingredient. There also needs to be will to invest in people as the key to future success, by both governments and donors, and to create an environment where people can use their skills effectively.

The third important message from the meeting was that the power of communication can greatly increase the number and type of people willing and able to contribute. Strategies to optimise use of this resource will see Roll Back Malaria reaching those parts of the poorest countries that are always left till last.

References

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Malaria is paradigm of an emergent disease

D H Molyneux, professor, Lymphatic Filariasis Support Centre (fahy@liv.ac.uk), G Barnish, senior lecturer, S Looreesuwan, professor, B Liese, senior adviser, J Hemingway, professor

Malaria Consortium (London and Liverpool School of Tropical Medicine), London School of Hygiene and Tropical Medicine, London WC1E 7HT

USAID Global Bureau, Office of Health and Nutrition, Washington, DC 20523, USA

Liverpool School of Tropical Medicine, Liverpool L3 5Q

Mahidol University, Bangkok, Thailand

World Bank, Washington, DC 20433, USA

Cardiff School of Biosciences, University of Cardiff, PO Box 915, Cardiff CF10 3TL

EDITOR—We believe that fundamental biological principles have been ignored in the debate over malaria and that eradication is not the objective of Roll Back Malaria, a campaign discussed in Yamey's editorial.¹ We have posted a longer version of this letter as a rapid response (www.bmj.com/cgi/eletters/322/7296/1191#EL2). The Roll Back Malaria campaign seeks to halve child and maternal mortality due to malaria by 2010. Any malaria control initiative must learn lessons from the failed eradication programme of the 1950s and 1960s.

One of those lessons is that any chemotherapeutic, prophylactic, or insecticide based tool has a finite duration of efficacy: chloroquine and dicophane (DDT) rapidly induced resistance in *Plasmodium* spp and *Anopheles* spp respectively. These organisms reproduce rapidly and as vector/parasite systems have an unrivalled capacity to change, have coevolved an efficient host-parasite relationship, and are hugely diverse below the species level. *Anopheles* adapts rapidly to ecological, environmental, and climate change; such change is often local and operationally relevant to malaria control. The development of drug and insecticide resistance and ecological and demographic change will outstrip the capacity of any health system to respond even if human resources were available to implement changes in policy on the basis of good evidence.

Resources available to public health services in sub-Saharan Africa have declined greatly over the past two decades; some countries are unstable or in active conflict. The poorest populations have limited access to health care; up to four fifths rely for the provision of malaria “control” on the uncontrolled informal sector. Health reform has ensured that no specific disease control budgets are available at