

Hopes and fears for malaria



WHO/RBM

Dr Awa Marie Coll-Seck

Dr Awa Marie Coll-Seck earned her degree in medicine in 1978 from Dakar University in Senegal, and served for nearly 20 years as an infectious diseases specialist in leading hospitals there and in France. In 1989, she was appointed professor of medicine at Dakar University and chief of service for infectious diseases at Dakar University Hospital. From 1996 to 2001, Coll-Seck served as Director of Policy, Strategy and Research at the Joint United Nations Programme for HIV/AIDS (UNAIDS) in Geneva, Switzerland, then as Minister of Health of Senegal from 2001 to 2003. In 2004, she was appointed Executive Director of the Roll Back Malaria (RBM) Partnership.

Roll Back Malaria (RBM) was established by the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP) and the World Bank in 1998 with the goal of halving global malaria infections by 2010. Dr Awa Marie Coll-Seck talks about her hopes for a new facility to provide the most effective antimalarials to developing countries at subsidized prices.

Q: Roll Back Malaria's aim is to achieve Millennium Development Goal (MDG) 6 of reducing malaria deaths by 70% by 2015. But how will you know if you have achieved that, as the data from 1990 are poor quality?

A: The data may not be reliable but they exist and can show trends in morbidity and mortality. There are many efforts to improve malaria data quality and measurement, such as the work of the team doing WHO's Global Burden of Disease project. This work is particularly important for MDG 4 to reduce child mortality as malaria accounts for about 20% of these deaths in Africa. Figures for infant and under-five mortality show that in some parts of Africa mortality is declining. WHO has a reference group working on malaria data. There are more and more indicators on malaria, which are incorporated into demographic and health surveys at country level. We already have results from Zambia; a total of eight countries are doing malaria indicators surveys, so in future we will have even more reliable data. In nearly all countries affected there are studies to produce malaria data, but the problem is the quality of data.

Q: Doesn't the proliferation of malaria goals cause confusion?

A: It may seem this way when you read about them, but there are three goals which all partners agree upon. They are the Abuja targets for 2005, and two RBM targets for 2010 and 2015 – the latter correspond to the MDG targets. 2005 was a medium-term goal to measure progress to 2010.

Q: There have been so many initiatives: 1992 Ministerial Conference on Malaria in Amsterdam; Dakar Conference of 1997; Abuja in 2000. Do these top-down efforts have an impact?

A: Nothing can have an impact without community involvement. But these meetings and efforts should not be seen as "top down". For many years malaria disappeared from the international agenda, particularly after the malaria campaigns of the 1950s which failed in African countries though these were successful in other places. These initiatives are a way of ensuring that the international community does not forget malaria and is focused on making treatment and prevention interventions available to all.

Q: Where have efforts to fight malaria been successful?

A: Eritrea was once one of the few good examples, now there are many. For the last couple of years, South Africa, Swaziland and part of Mozambique

have implemented all the strategies to fight malaria and achieved a reduction of 90% in mortality and morbidity. We also have seen reductions in Rwanda and Zambia. In some countries, we have seen a reduction in malaria cases by as much as 60%, because of access to medicines and insecticide-treated nets. However, one study showed that nets distributed for children under five years were not always used properly.

Q: How can you ensure that the RBM partners do not duplicate each others' work?

A: When we started in 1998, there were four partners (WHO, UNICEF, UNDP and World Bank). Today there are hundreds in RBM – nongovernmental organizations, private sector, donor countries, universities and foundations – that's why your question is even more important today. The role of the Partnership is to coordinate efforts. We have working groups that work on consensus and on scaling up malaria control, and we have sub-regional networks in the four regions of Africa, which bring countries and partners together to share best practices and reinforce each others' efforts. We have a strong Board that includes all the major players represented at the highest level. RBM's web site and alerts keep partners updated with latest information. We have reached maturity with these structures helping us to work more effectively.

Q: Huge funds are going into malaria prevention and control, what are you doing to ensure they are not wasted?

A: The recent allocation of 42% of grant money by the Global Fund [to fight AIDS, Tuberculosis and Malaria] in Round 7 was largely due to the huge amount of support provided to countries by RBM to make sure they produced successful proposals. Now we all have to ensure the money is spent properly and in a timely manner. The Global Fund is performance based; if you don't use the money properly in the first phase, you don't get any more. For example, Sierra Leone could not move onto the second phase, Senegal once lost money too. Those are two examples from about 100 countries, which means that on the whole money is spent well.

Q: There has been a lot of criticism of celebrities advocating for health. How have RBM's goodwill ambassadors contributed to the partnership?

A: We thought hard about whether to have goodwill ambassadors for malaria for two years before taking them on. Youssou N'Dour's live concert in Dakar in Senegal was relayed around the whole world by national and international television networks. He did not just play music. He also explained what malaria is, so, in terms of advocacy, it was an immense achievement in one day. Yvonne Chaka Chaka is focused on Africa. She doesn't just do a show but also promotes the fight against malaria. We have another goodwill ambassador, our special envoy Princess Astrid of Belgium. When a celebrity says something, the message is much more powerful than when one of us says something.

Q: Most malaria deaths are those of children aged five or under, but why are there no medicines specifically for children?

A: There has been a dearth of paediatric formulations of antimalarial medicines, but this is about to change. Sanofi-aventis and the Drugs for Neglected Diseases initiative, have produced a combination medicine for children. It's available in several countries in Africa, and prequalification will make it more widely available. Also, the Medicines for Malaria Venture is working with Novartis on a paediatric formulation that will be ready to go on the market in the next few months.

Q: ACTs (artemisinin-based combination therapies) are now available at low prices in developing countries, but why do so few people in Africa have access to these subsidized drugs in the public sector?

A: Between 60% and 70% of people buy these drugs in the private or nonofficial sector while the rest go to public hospitals. In the private sector, nearly everyone is buying less expensive but ineffective drugs, such as chloroquine or artemisinin monotherapies, and only 2% are buying ACTs. It's a disaster. That's why we have been working on Nobel prize winner Kenneth Arrow's proposal for an international subsidy for ACTs and later this year a global drug facility, like the one for tuberculosis, will be established. The idea is to make the price of ACTs the same as or less than the chloroquine medicines, so people will buy the ACTs. The Global Fund is well placed to host and manage this facility – this is currently under discussion.

Q: The more that ACTs are dispensed, the greater the risk that resistance will develop or has this happened already?

A: Resistance is always a risk, that's why WHO has banned monotherapy [treatment with one drug]. WHO has been key in setting the norms for dispensing treatment to prevent resistance. This includes use of combination medicines as these make resistance less likely. Recently, a laboratory found evidence of the beginning of resistance to ACTs in Cambodia. Research and development continues and new medicines are in the pipeline.

Q: In Africa, strong voices are calling for a non-curative and non-prophylactic approach that focuses on vector control, such as spraying with DDT (dichloro-diphenyl-trichloroethane). Is this a viable option?

A: Most want both treatment and prevention including vector control. Some people push the idea of prevention alone because they think that is what rid the northern countries of malaria. Today, there are about 12 insecticides, but some countries prefer DDT because it's cheaper, lasts longest and is slightly more effective. The problem is that we must not release it into the environment. Insecticides should only be used inside homes by people who are trained following all the recommendations of the Stockholm Convention on use of DDT for public health.

Q: One USA presidential candidate pledged to invest US\$ 1 billion a year in treatment and prevention to end malaria deaths in Africa after eight years. Is that all it would take?

A: We welcomed this and hope all the candidates promise the same. The idea of wiping out all deaths in this time frame may seem ambitious, but eradication of malaria is considered as a long-term goal. I don't think we will eradicate it in the next 10 years, we may need new tools: medicines, insecticides, nets and a vaccine. At the moment we have US\$ 1 billion a year but need US\$ 3 billion to eliminate malaria as a public health threat. ■

Recent news from WHO

- A national household survey – conducted by the Iraqi government and WHO – estimates that **151 000 Iraqis died from violence in the three years since the 2003 invasion**. The study, produced after a national survey of 9345 households, was published in the *New England Journal of Medicine* on 9 January. The data were collected as part of a wider survey of family health in Iraq.
- **Treating children with severe pneumonia at home is just as effective as treating them in hospitals**, according to a study conducted by researchers from the ARI Research Cell, Children's Hospital, Pakistan, and supported by Boston University School of Public Health, WHO and the US Agency for International Development (USAID). The research, published in the *Lancet* on 5 December, could significantly change the way the illness is managed in developing countries.
- **Aggressive tuberculosis (TB) control can yield big economic gains**, according to a World Bank study commissioned on behalf of WHO's Stop TB department. The study finds that 22 countries with the world's highest numbers of cases could earn significantly more than they spend on treatment if they signed onto a global plan to sharply reduce the numbers of TB-related deaths. The study, published on 12 December, also calls for action to tackle the growing problem of multidrug-resistant TB and extensively drug-resistant TB.
- WHO Member States across west Africa and their partners are launching the first **preventive pan-west-African yellow fever vaccination campaign** in 40 years, it was announced on 3 December. The campaign aims to vaccinate at least 48 million children and adults in west Africa over three years.

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