countries, not to mention the tourists and other travellers who visit them.

Thirty-year offensive proposed

Faced with this situation, Ebrahim Samba, African regional director of WHO and Richard Feachem, director for health, nutrition and population at the World Bank — and former dean of the London School of Hygiene and Tropical Medicine — last year began exploring the idea of creating a multi-agency, 30-year programme to control malaria.

Discussions have since been broadened to include the US Agency for International Development (USAID), US Centers for Disease Control, European Commission, the Organization of African Unity and other agencies. "There should be no delusion that this is a five- or ten-year programme," says Feachem. "We are thinking of a 30-year effort, and everyone would need to buy in for durations of that order."

Over the past decade, countless international and national strategies to "end malaria" have been devised. But many have gathered dust in government drawers, and few have been properly or fully implemented. "The problem is what people are doing in the field, which is not a lot and not very effectively," complains Feachem.

The thrust of the new initiative is on building the infrastructure needed for malaria control in Africa. Back this with a coordinated and adequately funded international effort, and you have the makings of a situation where existing control and therapeutic tools could be used more effectively, says Feachem.

But research would also be an essential component, and the world's major research bodies would therefore need to be "formal partners". Harold Varmus, director of the US National Institutes of Health, says that joining forces would be "very, very healthy for malaria research in Africa".

Feachem: backs 30-year effort.

The possibility that the programme would fund research directly has not been excluded, says Feachem. "Everything is on the drawing board. The initiative will be an umbrella for many things, and one will need to be a well-directed, adequately funded programme of research; it could be inside or outside, but strongly linked."

None of the agencies discussing the proposed African Malaria Initiative is yet talking dollars. But many of those involved are convinced that the programme will provide a vehicle for better use of existing funds, and act as a magnet to attract new money from the international community.

The initiative has only become possible because of a recent shift in policy at the World Bank. Its support for health projects has leapt from negligible levels in the 1980s to $2 billion annually — about 10 per cent of the bank's current spending — and is growing. There is said to be consensus within the bank that, among the problems that Africa faces, malaria is near the top.

Political commitment crucial

A decision on whether to launch the African Malaria Initiative is expected later this year, although it would probably not begin until around 2000. "We are in no hurry, we want to get it right," says Feachem.

Political and financial commitment from African leaders is acknowledged to be a prequisite for the success of the initiative. Its supporters argue that there is no point in external agencies putting money into a sector to which the government of the country is not giving priority.

In practice, health, and malaria in particular, comes near the bottom of the spending priorities of most African countries, and far behind items such as arms, which often eat as much as half of state spending. But change is in the air. When the Organization of African Unity (OAU), meets for its annual summit later this year, malaria will be on the agenda of the 53 heads of state for the first time.

Political commitment is also needed to reverse widespread 'fatalism' about malaria in Africa. "Countries seem to accept that living with malaria is inevitable, that there will always be dead children," says Déogratias Barakamfityé, director of malaria control at the African regional office of WHO. Infant mortality from malaria is so high that in some cultures parents wait a few years before christening their children.

Robert Mshana, executive secretary of the OAU, sats that the aim of the summit is to persuade African heads of state to "accept that the [success of the] fight against malaria will be largely dependent on African countries themselves". He adds: "African leaders need to say: 'Malaria is killing our children, we must be determined to do something about it'."

Winning a political commitment would strengthen the hands of health ministers in negotiations with their finance ministries. "We want them to persuade politicians that there are tools which could reduce mortality, that there are considerable economic losses, and that they must allocate the human and financial resources needed," says Barakamfityé.

But Mshana also warns that political will is by itself insufficient. "We have had these slogans for the last 50 years and nothing has moved." Governments could help immediately simply by reducing taxes on products used in research, control or therapy, he says: "In some places the import taxes on mosquito nets are so high that nobody can afford them." □

India plans $200 million attack on malaria

When India launched a major malaria eradication programme in the early 1950s, 75 million people in the country were catching the disease annually, and 800,000 were dying. Twelve years, and much DDT, later, malaria had gone from 90 per cent of the territory, new cases had dropped to 100,000 annually, and nobody died.

But at the end of the 1970s new cases climbed to 6.5 million annually, and over the past two decades the government has spent up to a quarter of its health budget on malaria control. In the past three years, there have been four major epidemics. Last year 2.85 million cases were reported, and the official — and under-reported — death toll was around 3,000.

Shiv Lal, director of the National Malaria Eradication Programme, accepts that the early successes led to "complacency" in later years. The national malaria control programme was shut down, only to be restarted in 1981 as the NMEP. But today's efforts are being hampered by increasing resistance to chloroquine, the diminishing efficacy and increasing cost of pesticides, and the spread of mosquitoes in urban areas. In addition, *Plasmodium vivax*, which was prevalent in India in the past, has been succeeded by its more deadly relative *P. falciparum*, which has been less susceptible to chloroquine.

The situation is "bad," admits Vulimiri Ramalingaswami, former chief of the Indian Council of Medical Research, who partly attributes the resurgence of the disease to poorly planned irrigation and urbanization programmes.

India will spend US$40 million on malaria control this year — up 60 per cent on last year. It is also planning a five-year programme targeting 210 million people in 100 high-risk districts that account for 80 per cent of all *P. falciparum* cases in the country, says Lal. The programme will introduce new tools such as pesticide-impregnated bednets. This initiative will be funded by a loan from the World Bank. The sum has yet to be agreed, but will probably be around $200 million, says Prabhat Jha, an official at the bank.

Some argue that bureaucracy and not money is the main obstacle to control. Operations are run by the states which have jurisdiction over health matters, and this has relegated the national programme to being a supplier of drugs and pesticides, claims one observer. The national programme "looks good on paper but does not function at the grass roots," he says.

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