

Brief report

The Roll Back Malaria Initiative with special emphasis on the proposed Sri Lankan effort

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Roll Back Malaria (RBM) is a renewed effort on the part of Governments of malaria endemic countries, to bring about a significant reduction of the morbidity and mortality of malaria. This is being undertaken with a greater goal in view of alleviating poverty and promoting health and human development.

Responding to the need to effectively reduce the large burden of malaria, the Director General of World Health Organisation (WHO) has in collaboration with other United Nations (UN) agencies, United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP) and the World Bank, launched Roll Back Malaria as a major new global initiative to help countries achieve their goals (1).

The initiative was originally aimed at the African region, which has no effective country control programmes. It was extended to the Asian region at the request of the countries of this region, at the World Health Assembly held in 1998 (2).

Many countries in Asia have been able in the past 50 years to greatly reduce deaths due to malaria. However malaria morbidity remains considerable, in spite of the initial successes achieved in the fifties with the malaria eradication programmes. Roll Back Malaria in the Asian context does not commence from a zero background. It does however entail doing things differently.

The conceptual background to rolling back malaria contains a few key elements (Table-1), such as: -

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Table 1: Key elements of RBM

1. It should focus on the local situation
2. It should have broad ownership by all stake holders
3. It needs high level national advocacy for action against malaria
4. Action against malaria should be fully integrated into the health system
5. Strategies and approaches should be based on scientific evidence and sound technical guidance
6. It requires quality control and standard setting

• Focus on the local situation

Malaria is a local problem, which requires local solutions tailor-made to that situation. Emphasis should be placed at the district and community levels. National plans to Roll Back Malaria should reflect diverse opportunities and approach (3).

• Broad ownership by all stake holders

There are many partners and many sectors other than the health sector, who are currently engaged in delivering, or more importantly, have the potential to deliver actions against malaria at both national and district levels. The malaria problem should not be the sole concern of the public health sector or the National Malaria Control programme. Roll Back Malaria should therefore engage all potential stake-holders, other concerned government ministries, the community, non-government organisations (NGOs), the private sector, the research community, media personnel, international agencies such as World Bank, other UN agencies and the bilateral donor community. Their activities should be in concert and conform to an agreed plan. The community should be used to create a social movement to roll back malaria (4).

• High level national advocacy for action against malaria

It requires a strong national advocacy policy to recruit commitment from the highest government level, to help Roll Back Malaria

to reduce inequity and promote human development. Sri Lanka has already made this commitment. The Honourable President has sent a letter to the Director General WHO in 1998, affirming Sri Lanka's commitment to the RBM initiative. The Honourable Minister of Health has led the Asian initiative and the Sri Lankan commitment to RBM in 1998 and 1999.

- **Action against malaria should be fully integrated into the health system**
Roll Back Malaria aims to cohesively integrate actions against malaria within the health system as opposed to a narrow disease-specific approach (3).

- **Strategies and approaches to RBM will be based on scientific evidence and sound technical guidance**

Resource Support Networks are being developed by WHO (5), such as:-

1. The health sector development network
 - 1.1. Access and quality for anti-malarials at local level
 - 1.2. Implementation of impregnated bed-net programmes including bed-net supply and insecticides.
2. District and community based action
 - 2.1. Needs assessment and intervention at district and sub-district level.
 - 2.2. Improving quality of care at the home and family level.
 - 2.3. Geographic mapping of malaria control and health care at district and sub-district levels.
3. Regional and epidemiological approaches
 - 3.1. Prevention and control of epidemics.

- 3.2. Monitoring of drug and insecticide resistance.

4. Shareholder collaboration

- 4.1. Integrated sector wide approaches and financing

- 4.2. Malaria control in war-torn zones.

▪ **Quality control and standard setting**

Quality control and standard setting to be an important component of Government responsibility. RBM requires standard setting and quality control over diagnostics, drugs and insecticides.

Current malarial situation in Sri Lanka

Distribution of cases

In spite of continued efforts by the Government of Sri Lanka for containment of the problem of malaria in Sri Lanka, the disease still remains a major public health problem. The morbidity is very high. Although the mortality remained almost negligible until about five years ago, it is disturbing that there has been a rising trend especially during the last three years, in the conflict-affected districts. The morbidity and mortality pattern during the last five years is shown in Table 2.

The epidemiology of malaria in Sri Lanka has undergone significant changes in recent years due to the prevailing conflict-situation in the Northern and Eastern Provinces. During 1998 approximately 53% of the total number of cases detected were reported from the Northern Districts Jaffna, Kilinochchi and Mullativu, the conflict-affected areas. Anuradhapura District

Table 2: Microscopically confirmed malaria cases detected by the surveillance mechanism of the Anti-Malaria Campaign and the reported deaths due to malaria.

Year	Positive cases		Reported deaths	
	<i>P. vivax</i> No.	<i>P. falciparum</i> No.	Total No.	No.
1994	225864	47638	273502	50
1995	119056	23238	142294	05
1996	139362	44957	184319	26
1997	163856	54694	218550	62
1998	169295	42396	211691	115

(North Central Province) which borders several conflict-affected districts too reported 7% of total number of cases. The district of Moneragala (Uva Province) although not affected by the conflict-situation reported 11% of the total number of cases during the last year.

The five districts mentioned have been selected for the initial implementation of the Roll Back Malaria Initiative (RBMI) Programme in Sri Lanka and collectively contributed 71% of the total case load of the country in 1998

Current malaria control activities

Since 1989, malaria control activities in Sri Lanka are implemented through a decentralised Anti-Malaria Campaign. The line ministry is responsible for the formulation of the National Policy for malaria control (in consultation with the provincial health authorities), technical guidance to the provincial programmes, monitoring and evaluation of the country side programme, co-ordinating training and research, and provision of certain critical supplies to the provincial programmes. The Provincial Anti-Malaria Campaign is responsible for the implementation of the programme within the respective province.

Present problems in malaria control

Technical

Since 1984, the spread of chloroquine-resistant *P.falciparum* strains has been observed and consequently the proportion of *P.falciparum* patients reported from many districts has risen. In many districts vector resistance has been observed against some of the insecticides being used for indoor residual spraying of houses (6).

Operational

The main obstacle for effective malaria control in the Northern and Eastern provinces is the present conflict-situation, which is associated with several factors detrimental to the malaria control programme. There are several areas in which the personnel of the Anti-Malaria Campaign cannot gain access

for control activities, due to the security risk. The presence of a large number of refugee populations and temporary settlements in villages bordering conflict-affected localities have contributed towards an increase of the malariogenic potential in these affected districts. The lack of adequate staff in many categories of health department personnel is also a major constraint towards malaria control in these districts.

Some of the other operational problems to be noted are the lack of information or lack of utilisation on meteorological variables such as floods, excessive rainfall and droughts. These factors are responsible for the increase in mosquito breeding sites and vector density and its effect on malaria epidemics (7).

Entomological support is inadequate for predicting unusual increases in vector density, which may lead to epidemics.

We also need to have a better understanding of the effects of socio-economic variables such as development projects and population movements into the malarious areas (8).

The integrated disease surveillance system should be reinforced to develop methodologies for rapid analysis of epidemiological information e.g. morbidity (fever) and mortality measurements, entomological data and unusual increases in the demand for anti-malarials and other risk indicators at district and sub-district levels.

RBMI in Sri Lanka

RBMI should be used to address (9):

1. Drug supplies, quality and access,
2. Diagnostic services,
3. Human resource inadequacies,
4. Rational use of insecticides,
5. Equipment.

There is also a need to streamline and strengthen the training of the community, health and other sectoral workers, the NGOs, private sector and women's organizations in integrated malaria control activities.

Operational research is essential to develop new tools to control malaria. Special work needs to be done in Sri Lanka on drug combinations due to the spread and increase of drug resistance to the common anti-malarials. Recent work has shown that new drug combinations delay the development of resistance to individual drugs. There has been a drop in in-vivo and in-vitro testing of drug resistance. This has to be re-established. Environmental manipulation and biological control are still very much in its infancy in Sri Lanka. Adequate funds and sufficient trained personnel are essential to strengthen these alternate methods of control, which should be used in areas, where they are cost-effective. The impregnated bed-net programme has to be reviewed, strengthened and extended in the malarious areas.

Plans are to be developed to carry out needs assessment and situation analyses in the selected malarious districts in 1999. Inter-sectoral core groups will be developed at national and provincial levels for the selected districts to develop the needs assessment reports.

A two day top level meeting will be held to discuss the national needs assessment report and formulate recommendations to develop a five year strategic plan for RBMI. The national level core group will then complete the five-year strategic plan.

At the Provincial levels, the inter-sectoral groups will develop the annual plan of action for AD 2000 setting out objectives, goals, targets and the implementation mechanism which includes monitoring and supervision procedures.

Expected outcome

The RBMI emphasises the need for coordinated efforts towards malaria control by all sectors, besides the malaria control authorities, during every stage i.e. planning and implementation, monitoring and provision of supplies and transport facilities. In the conflict areas RBMI envisages using the international UN Agencies, the Red Cross, International and national NGOs working in these areas to assist the

government in carrying out malaria control activities.

It is envisaged that at the end of the five years of RMB initiatives, malaria morbidity and mortality will be reduced by 50%.

After the five year RBMI effort, the reinforced health sector and its allies will be able to effectively control malaria with newly set goals and targets.

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