Available online at http://www.tjpr.freehosting.net

Editorial

Antimalarial interventions in sub-Saharan Africa: myth or reality?

Several figures have often been quoted to highlight the global burden of malaria, especially as it affects sub-Saharan Africa. Literature reports point to the fact that Africans are in poverty today partly as a result of malaria and other diseases such as HIV/AIDS and tuberculosis. Prior to this time, it was difficult to quantify the global burden of malaria even though it was generally believed that it has enormous socio-economic and medical burden. The most widely quoted figures today to justify this claim are based on estimates, as reliable data are often difficult to obtain in most developing countries. It is estimated that between 300 and 500 million clinical cases of malaria and about a million deaths occur each year, especially among children and pregnant primigravidae in sub-Saharan Africa. *Plasmodium falciparum*, the most lethal malaria parasite, is the predominant species causing malaria in Africa. The rising burden of the disease has been attributed to increasing resistance to insecticides and antimalarial drugs, breakdown in public and health infrastructure, and land-use changes, such as dam-building, irrigation and deforestation.

In recognition of the enormous burden of malaria on the continent, African Heads of State and Governments expressed their political will to fight the disease at the Abuja 2000 Malaria Summit. The target set at the Summit was that by 2005 there would be at least 60% reduction in the burden of the disease in the continent. To achieve this, it was agreed that children and pregnant women (the most vulnerable groups) should benefit from the most suitable combination of personal and community protective measures such as insecticide treated bed nets, intermittent preventive therapy and prompt and adequate case management of clinical conditions. These interventions are in line with World Health Organization's recommendations for malaria endemic regions of the world. While these recommendations and the expressed political will of African leaders are laudable, however, the implementation and applicability of the interventions are of critical concern. Five years after the Summit, a visit to any health care facility in sub-Saharan Africa is all that is needed to convince anyone that not much has been achieved. As a result of this, many African stakeholders have argued that, perhaps, an integrated approach might be the right solution to the malaria situation in the continent.

Many conditions interact to favour malaria in the continent. These conditions have been identified to include: poor, marginalized and largely inaccessible communities; increasing numbers of countries ravaged by conflict without basic social and health infrastructures; environmental changes that facilitate malaria transmission and cause epidemics, and the HIV/AIDS epidemic which is undermining capacity in sub-Saharan Africa. While many of these factors are not within the purview of medical or public health intervention, focusing on measures to eliminate or at least reduce vectors that carry the parasite may have multiplying effects in reducing the burden of the disease. The most often cited example to buttress this submission is the fact that malaria was eliminated in Europe and other developed countries by use of DDT and improvement on environmental sanitation.

With a new target set at the United Nations Millennium Development Goals of reducing malaria and other poverty related diseases in Africa by 2015, antimalarial policy planners and implementers in the continent should begin to refocus on integrated approaches. Focusing on measures to reduce the malaria vectors could be the antimalarial intervention that Africans need.

Professor AO Okhamafe
Editor-in-Chief