

Overcoming obstacles to WHO's laboratory programme

Sir— In his article on WHO's laboratory programme (*World health forum*, 19: 68–70), Heuck refers to the fiscal difficulties of implementing the International External Quality Assessment Scheme (IEQAS) in some areas of laboratory medicine. Certainly, health resources are being reallocated to problems such as AIDS, tuberculosis and hepatitis control, and because of this, funds for laboratories are becoming scarce in many countries. However, this shortage could be mitigated by integrating the laboratory component of various vertical programmes aimed at diseases of local public health importance.

For example, many countries have agreed to use the directly observed treatment short course (DOTS) for tuberculosis control in the community. Sputum examination for acid-fast bacilli is an integral part of this programme, and funds are allocated to equip laboratories, train personnel and ensure the quality of specimen analyses. Likewise, serological screening for anti-HIV antibodies is a key component of efforts to tackle the rising incidence of AIDS in developing countries, and funds have been made available for this worldwide.

An integrated plan to include laboratories serving vertical programmes of this kind with those serving horizontal programmes requiring laboratory work for routine investigations would make far better use of available resources. Such a plan could be coordinated by WHO through its regional offices so that optimal use could be made of all available funds for laboratory work.

Heuck also refers to the prolific growth of simple, rapid, sensitive tests that do not require costly equipment or highly trained laboratory personnel. Such tests can enable clinicians to make a diagnosis while the patient waits. IEQAS would be failing in its duty if it did not turn its attention to these activities as well, to ensure that clinicians make the safest and most effective use possible of these rapidly emerging laboratory tests. One would hope that

by involving the users of rapid laboratory diagnostics in standardization procedures it would be possible to ensure good laboratory practices even in countries with small budgets for health. ■

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Community-based malaria control in Zimbabwe

Sir— Zimbabwe has a long history of malaria control, including a national residual house spraying programme which dates back to 1949. Though the malaria programme remains strong there have been severe outbreaks in recent years, many of them in high-altitude areas which were formerly malaria-free. In 1996 alone, more than 1500 people died in Zimbabwe of malaria.

Global warming may have contributed to malaria appearing at higher altitudes, but a number of other factors have reduced national capacity to prevent and control this disease:

- decreasing funds for malaria control;
- loss of malaria specialists at managerial level;
- late treatment due to distance of health centres from malarial areas;
- late treatment and lack of personal protection due to lack of knowledge about this disease in malarial areas;
- few affordable antimalarials available in remote areas;
- inadequate (though improving) surveillance system, often resulting in late response to malaria outbreaks.

Although attempts to diversify control strategies have led to great improvements in surveillance, health education, case management and the introduction of alternative vector control methods (such as the use of larvicides and treated bednets), these initiatives have been carried out on a “one-off” basis and are hampered by ever-decreasing budgets.

To tackle some of these problems, Save the Children Fund (UK) has been involved in community-based malaria control programmes in two districts, Binga and Kariba, along the shores of Lake Kariba, one of the worst areas for malaria in the country. The programmes work with the Ministry of Health and Child Welfare at district level on low-cost activities aimed at community mobilization and involvement in all aspects of malaria management and control at the district level. The activities include:

- community-based environmental and larviciding control, including during the winter and rainy seasons;
- use of volunteers to provide chloroquine treatment in remote areas where other health services are not available (continuing a practice started with village and farm health workers by the Ministry of Health and Child Welfare in 1985);
- improvement of malaria surveillance, particularly through active and passive parasite surveys;
- improvement of health education, especially in schools through the participation of schoolchildren in vector control;
- improvement of access to antimalarials such as repellents and bednets in remote areas;
- improvement of malaria management by training local health staff.

In both districts, health staff have been happy with this approach, and the projects have demonstrated that communities are able and willing to participate in malaria treatment and vector control. Community involvement has been particularly successful where there are strong relationships with the local health staff, most notably with Environmental Health Technicians. Schoolchildren have gone on weekly outings to destroy mosquito larvae, and where this has been done properly, mosquito populations have been drastically reduced. Chloroquine treatment volunteers in remote areas have also done extremely well. In both districts deaths due to malaria have been fewer than in previous years.

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In 1997 four out of the 10 clinics in the Binga district recorded the lowest number of clinical malaria cases in five years, in spite of major malaria outbreaks in surrounding districts and other parts of the country.

The most important feature of these projects is their sustainability. By empowering local health staff and the community and making use of all available local resources, malaria control is optimized, and little outside assistance is needed. However, this approach requires long-term commitment. To help achieve this, the methods used have been written into district malaria policies, which now require staff to use them wherever possible. At the very least, integrated community control of malaria offers an affordable option where resources are scarce. ■

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