Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

CORRESPONDENCE

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Extension of US trade embargoes to science editing

Sir—The USA has recently extended its trade embargo on Iran, Libya, Sudan, and Cuba to the editing of scientific articles. Articles submitted from such countries can now only be published subject to specific licensing from the US treasury department,[1] and editing them is a criminal act punishable by fines of up to US$500 000 or jail terms as long as 10 years.[2] Publication of "camera-ready copies" of manuscripts is allowed, but many journals will not be prepared to accept this compromise and some have already stopped considering manuscripts from embargoed countries.

Does an editing embargo make sense? Technical editing of articles submitted by scientists working in embargoed countries is said to be a service to their authors and thus violates the trade embargo. But who really benefits from technical editing of an article? Is it the authors, the editors, the reviewers, or the readers?

Except for a few small journals, no editing is done on submitted articles before peer review. Only after completion of the peer-review process does the paper enter the technical editing process. Technical editing influences the clarity of the message being conveyed, in effect helping readers more than authors or editors. This means that the technical editing of an article—ie, "reordering of paragraphs or sentences, correction of syntax, grammar, spelling and punctuation, replacement of inappropriate words, and preparing the text for printing" is not a service to the authors, but to the readers, and therefore should not be treated as a violation of the trade embargo.

What the rule actually does is to violate editorial freedom, and the basic tenet that acceptance or rejection of an article should be solely based on its scientific contents and quality and not on its country of origin or its author.

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1 Brumfiel G. Publishers split over response to US trade embargo ruling. *Nature* 2004; **427:** 663.

2 Curtius M. U.S. embargoes extended to editing articles. *Los Angeles Times*, Feb 21, 2004: A20 http://pqasb.pqarchiver.com/latimes/548325091.html?did=548325091&FMT=ABS&FMTS=FT&date=Feb+21,+2004&author=Mary+Curtius&desc='The+Nation%3b+U.S.+Embargos+Extended+to+Editing+Articles%3b+Treasury+says+altering+any+works+written+in+the+five+affected+nations+is+illegal.+Academic+publishers+grapple+with+the+implications (accessed Mar 16, 2004).

WHO, the Global Fund, and medical malpractice in malaria treatment

Sir—Amir Attaran and colleagues (Jan 17, p 237)[1] highlight a very serious public-health issue. Provision of ineffective drugs for a life-threatening disease is indefensible. There is no doubt that chloroquine is now ineffective for the treatment of falciparum malaria in nearly all tropical countries, and that its usual successor, sulfadoxine-pyrimethamine, is falling fast to resistance. As a result, malaria mortality in eastern and southern Africa, where hundreds of thousands of children die each year from the infection, has doubled in the past decade.[2] We have failed to roll back malaria, and we in the developed world bear the responsibility for this humanitarian disaster.

Malaria is not an insoluble problem. We already have the tools (insecticides, bednets, highly effective drugs) to reduce substantially the terrible death toll. But we are not providing them to the people who need them desperately, but who cannot pay for them. Only a tiny fraction of the millions with malaria today receive highly effective treatments. The donors must take some responsibility for this failure. Given the choice between receiving donor support for ineffective chloroquine or sulfadoxine-pyrimethamine and receiving nothing, most countries have naturally opted for the former. It is not easy to protest, particularly when the main donors, and the representatives of international organisations, both claim these drugs are still "programmatically effective". It is an uncomfortable but inescapable fact that, despite much anodyne rhetoric, the rich world does not wish to provide the required funds to drive back this eminently treatable killer.

To tackle malaria seriously, we hope that the WHO can recapture the singularity of purpose, scientific rigour, courage, cohesion, and determination that characterised the successful smallpox eradication campaign and more recently its response to the epidemic of severe acute respiratory syndrome (SARS). For this to be achieved, WHO will need to be better supported financially, and regain its independence from the political influence of powerful donors. The Global Fund is a beacon of hope, but it too needs a much greater injection of funds from the wealthier countries, and for malaria it needs better advice and technical review—hopefully led by a revitalised and independent WHO.

Success in controlling malaria is possible, and would provide a tremendous humanitarian and economic benefit to the less developed world, but it will not come if we continue to underinvest in public-health systems in poor countries, and to provide ineffective antimalarial drugs. The international medical and scientific community must do more to present a convincing case to obtain increased appropriate funding. If we could all admit the problems, agree on evidence-based intervention strategies, ban empty and confusing politically driven rhetoric, and show that success can be achieved, then it might be easier to persuade those who control the purse strings that malaria control is both achievable and a humanitarian bargain.

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1 Attaran A, Barnes KI, Curtis C, et al. WHO, the Global Fund, and medical malpractice in malaria research. *Lancet* 2004; **363:** 237–40.

2 Korenromp EL, Williams BG, Gouws E, Dye C, Snow RW. Measurement of trends in childhood malaria mortality in Africa: an assessment of progress toward targets based on verbal autopsy. *Lancet Infect Dis* 2003; **3:** 349–58.