

Rolling back malaria—the next 10 years

The Roll Back Malaria (RBM) partnership is 10 years old this month. What started out in 1998 as an alliance of four UN agencies, to facilitate and coordinate implementation of malaria control, has grown exponentially to become a coalition of more than 500 partners. In the early years, RBM faced several problems: uncertainty around its role, four leadership changes in 5 years, and a catalogue of missed opportunities and failures to make any substantial headway to tackle malaria. But last week, the partnership launched their Global Malaria Action Plan to a huge fanfare at the high-level UN Millennium Development Goal meeting in New York. The promise of US\$3 billion, new technologies, increased awareness, and political will to fight this ancient scourge signals a new era of confidence and support for the previously beleaguered partnership.

The plan lays out three goals to reduce malaria: in the short-term, to reduce mortality and morbidity by half from 2000 levels by scaling up the available methods of prevention and treatment for all those in need by 2010; in the medium term, to reduce the number of malaria deaths to near zero by 2015 through sustained coverage of these tools; and in the long-term, to maintain near zero deaths worldwide, while eliminating malaria transmission in feasible countries and moving towards eradication of malaria with new tools and approaches.

The plan is far more comprehensive than previous versions. It provides an evidence-informed approach to deliver effective prevention and treatment to those at risk. It also estimates the annual funding needed to achieve the goals of the partnership, with at least US\$62 billion being required by 2020. Having been sent for wide consultation to countries, experts, and institutions, it is perhaps the closest the malaria community has got to a consensus-based plan. RBM estimates that if the plan is successfully implemented, 4.2 million lives could be saved by 2015 in the 20 highest-burden African countries alone. What makes the plan ambitious is the focus on elimination and ultimately eradication. These terms are attractive and hold much political weight, but one only has to look at the poliomyelitis eradication programme to know in reality that such ambition can turn out to be a great deal more complex. There are dangers in setting the bar too high.

To date the actual burden of malaria has been difficult to be sure of. The second WHO Malaria Report 2008 (containing data up to 2006) estimates a substantial

decrease in the number of cases and deaths compared with previous years. But these numbers are disputed by experts. Without proper baseline assessments of what the current burden was in 2000, it is unclear how exactly the partnership will know when it has reached its 50% target. Furthermore, changes in malaria epidemiology and transmission make it vital that success is measured properly in terms of health outcomes, infection rates, and intervention coverage. Monitoring, evaluation, and surveillance must be prioritised, funded properly, and put in place at the country level. Progress in achieving these goals should be reviewed regularly and independently.

A major challenge in countries with high malaria mortality is the lack of human capacity and health systems to deliver interventions. It is encouraging to see capacity building and health system strengthening being included in the plan, but these commitments, so often given before, need to translate into practice. Too frequently, donors tend to be commodity-driven and would rather invest in bednets and medicines. The returns on health-system strengthening are enormous and provide the opportunity of integration with broader global-health initiatives.

One threat to progress is the commitment to long-term funding. Just to reach the 2010 coverage targets will require four times the funds currently available. Alongside continued donor contributions, increased funding by malaria-endemic countries, monitoring financial commitments against actual needs, and a formal external evaluation of impact and progress of the plan over time are imperative. Partners, donors, and country leaders should all be held to account; here an independent and transparent scientific evaluation would be most useful.

RBM has raised the profile of malaria, taking the disease from being grossly under funded and largely neglected to being widely recognised as an exemplary investment opportunity in the development agenda. It has achieved this through stronger leadership, better cooperation between its partners, and responding to country needs by improved coordination around their national strategic and implementation plans. During the next decade, RBM has huge challenges. But for the first time, we sense these challenges might be met. The decisions taken in New York last week have created an unprecedented opportunity, one that must be grasped firmly by all parties. ■ *The Lancet*



For more on the **Global Malaria Action Plan** see <http://www.rbm.who.int/gmap/index.html>

For the **Lancet Editorials** see *Lancet* 2000; **356**: 521 and *Lancet* 2005; **365**: 1439

For the **PLoS article, International funding for malaria control in relation to populations at risk of plasmodium falciparum transmission** see *PLoS* 2008; **5**: e142 1-11.