

# 'More people in Asia than in Africa are at risk of malaria, perhaps a billion'

London-based NGO Malaria Consortium has been awarded a £50 million contract by the British government for anti-malaria programme in Nigeria. Sunil Mehra, its New Delhi-born head, tells *Shyam Bhatia* about his priorities and what his teams hope to achieve both in Africa and Asia

**A** *sianAffairs*: Malaria Consortium has recently had reason to celebrate winning a major contract to continue its all-important work. Could you comment and elaborate?

**Sunil Mehra**: We are approaching the fifth anniversary of starting this charity or NGO in England and we have developed way beyond expectations. Primarily, just like business looking for a significant niche in the market, we found a very significant gap of a problem that is worldwide but is receiving very little attention. The good news is that we probably have competitively won the biggest malaria control programme available, and that's Nigeria.

**AA**: Where is the funding coming from?

**SM**: Entirely from the British government. Nigeria in Africa contributes probably one-third of the malaria problem in terms of deaths. So what you have after years of neglect – not just for malaria but health in general – is that development investment in Nigeria is amongst the lowest in Africa. This is partly to redress that balance. Collectively, I think the British government has Nigeria as a focus country.

**AA**: What's involved in implementing such a huge contract?

**SM**: The team will come from Nigeria. The programme is comprehensive in terms of disease control. It includes prevention elements, treatment elements; but in addition it has a very significant emphasis on improving the capacity of the Nigerian health service



delivery systems, not just at the federal or national level, but more importantly in the 12 states of Nigeria.

In addition, it has the contribution towards improving the evidence that is gathered to improve the planning and response to that, possibly engaging between six to eight research institutions.

**AA**: What about prevention?

**SM**: The challenge in Nigeria is similar to the rest of Africa, but the scale is much, much greater. It's similar to some parts of Asia as well, where malaria is much harder to reach and where malaria clusters are greatest among clusters of population that are harder to access. In terms of Nigeria, the team has to deal with, first of all, how to ensure that the right treatment gets to the child, or in some cases the adults, quickly. In malaria you have a very short window to save a life, between 24 and 48 hours. In Asia we don't see the killer because the Asian parasite, *Vivax*, makes you ill but doesn't kill. The *falciparum*, which is increasing in Asia and India too, is the real killer, especially of children. The challenge for the team is to ensure how the treatment gets to the child or the

family or the household, quickly.

Part of that is for the family to quickly recognise the symptoms, which is actually not a big problem because malaria is and has been a very big problem.

**AA**: How many full-time members of the team will you have working out there?

**SM**: We will initially start with eight offices in Nigeria; that means each office will be staffed with the technical management, finance and administrative persons. So that straightaway makes it about 40 persons. In addition, what we have is technical people who are needed for different components. Totally, we will end up with somewhere around 55 people.

To return to some of the challenges we will be facing, it is unlikely that you can deliver the treatment on time and effectively, just working through the public sector. The reach is not there. So we have to come up with a combination of working with the public sector, and in some states where there is much greater presence of society partners of NGOs. We cannot also ignore the private sector, because for malaria many families go to the private sector provider. To achieve the treatment side we would have to have programmes that link very much with that.

**AA**: Where else in Asia is the Malaria Consortium active?

**SM**: Currently, our programmes in Asia are much smaller, just because 80–90 per cent of the deaths are occurring in Africa. Historically, the two senior directors of my organisation have been associated

with programmes in Asia. Until last year we did not have an office there to service the needs. But last year, partly as a result of demand from donors, we opened an office in Thailand at Mahidol University. We were asked to improve the evidence because Malaria in Asia is lost within the larger statistics. The ethnic minorities and those that are in more remote areas are more vulnerable.

In India, it is clustered more in the North East and Orissa. Historically, most of the efforts in India have been along the tribal belts.

Programatically, we don't have good enough evidence to respond adequately to where the problem is.

AA: Isn't the Mekong Valley vulnerable?

SM: Yes, Laos, Cambodia. A lot of the planning hitherto has been linked to the studies that were done 30, 40, 60 years ago. Also, Asia historically has been the epicentre of drug resistance to malaria, nobody quite knows why. All the drug resistance has come from around the borders of Thailand and Cambodia.

How to contain this resistance within the known area, so that it doesn't spread? If we don't act, we will have a situation similar to what we have with Chloroquine and other anti-malarial drugs. The resistance has gone from Asia to Africa, and has spread through Africa. The wonder drug we have for treatment of malaria are the Artemisinin, or ACT drugs. (Mumbai-based) Cipla have set up an anti-malarial factory in Uganda.

AA: The popular perception is that malaria was conquered a long time ago, but you are saying the opposite.

SM: If you look at the literature, some say up to a million die, others say three million die every year. In the last four or five years the Global Fund for AIDS, TB and Malaria (GFATM), has contributed in a massive way. In terms of risk, there are more people at risk in Asia than in Africa – perhaps a billion. In Asia you have much fewer deaths because the type of malaria there makes you ill but doesn't necessarily kill.

But the tide is turning. Asia has been complacent because its malaria does not kill and in South East Asia it affects adults more than kids. Recently, there is evidence that the falciporum malaria is increasing and the potential for concern is there. India and Thailand have good programmes, Cambodia, Vietnam and

Laos have a lot of support. Even southern China has received support from outside.

AA: Where have you received most of your funding and support from?

SM: The British and American governments have been the most continuous supporters over a long time. In terms of innovative financiers by way of new ideas it has been the Irish. We also get funding from UNDP (United Nations Development Programme) because we work in quite a few post-conflict situations like southern Sudan and northern Uganda, for example. In some programmes we have assisted UNICEF (United Nations Children's Fund). In addition our technical side gets support from WHO (World Health Organisation). More recently, we have had some activities with the World Bank. We've also had the first major big donation from an Africa-based network of mobile telephone companies. They made their own assessment in terms of the charity they wanted to support.

AA: How would you compare the anti-malaria programmes in Africa and Asia?

SM: In Africa, you come up with a solution or expertise and you are received with open arms. In Asia, it's quite closed. They have been much more resistant to change their ways of control, although they started and were much better organised than in Africa. Quite a few things we learned from Asia we exported to Africa. But now there are quite a few things in Africa that Asia needs to learn from.

AA: Such as?

SM: One is the formation of regional networks to monitor drug resistance; another is to use a more multiple approach to prevention. Asia has been traditionally more focused on spraying inside households; in Africa that is still used where appropriate, but there is also more emphasis on personal protection methods such as long lasting, treated nets. The validity of the data collected in Africa, the planning around that and the fund raising is huge, compared to Asia.

AA: What is your estimate of how many people are infected by malaria in South Asia?

SM: A very good question. Whose

numbers do you believe? Under-estimation has persisted long enough for us to be cautious. Some say the number of people under-reported is ten times. If you look at the tribal people of Madhya Pradesh who are most affected, the likelihood of them showing up in some statistical analysis is extremely low. There's also sensitivity. Historically, it's also affected tourism, which is why it's taken seriously in countries like Thailand, inward investment, which is why Malaysia takes it seriously. India recognises that it's an important disease to deal with, and can be controlled.