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Resurgence of Malaria

The resurgence of malaria in the last decade has become a matter of serious concern for health professionals, policy-makers and planners. The epidemics in Andhra Pradesh, Manipur, Nagaland, Rajasthan and West Bengal in 1994 and in Assam, Maharashtra and West Bengal in 1995, were characterized by high morbidity and mortality and increasing evidence of the spread of *Plasmodium falciparum* infection around the country.

The classical public health approach, even now dominated by biomedical perspectives, had described and studied this resurgence and identified technical, administrative and operational failures within the context of the national malaria eradication programme (NMEP). Resistance to chloroquin and vector resistance to insecticides have been highlighted as major obstacles. The rising cost and shortage of insecticides and antimalarials, inadequate coverage by residual insecticides and inadequate surveillance have been seen as complementary causative factors.¹

However, there is increasing evidence that the malady is deeper. The resurgence is symbolic of a collapse of the 'public health system' and 'primary health care system' in the country. Some factors leading to this collapse have been there for a long time while others are the result of the recent liberal economic policies that have seen a decreasing investment in health and a rolling back of state intervention in public health.

The first of these broader contributing factors is the near absence of a reliable surveillance system, plagued by shortage of laboratory technicians at the primary health centre level and male multipurpose health workers at the field level—who between them would form the surveillance team at the grassroots. While the existing MIS (management information system) has shown a plateau at 2 million cases per year in the last few years, indirect evidence collected by the NMEP/MRC (Malaria Research Centre) suggests a gross underestimate, with the actual numbers being closer to 30 million per year. Therefore, there is an urgent need for 'a district level surveillance system' if response by the public health system has to be prompt and effective to the resurgence of malaria or any other communicable disease.²

The second factor is the continuing irrational management of suspected malaria cases by general practitioners and specialists. A plethora of irrational injections, antibiotics and antipyretics are still being used, even when the NMEP has provided guidelines in 'National Drug Policy on Antimalarials'.³ There is a tendency to exaggerate the prevalence of chloroquin resistance and there are concerted efforts to

promote mefloquin as the new 'wonder drug'. Studies presented recently at a national seminar have highlighted the role of chloroquin in inhibiting haem-dependent protein synthesis in the parasite, the implication of which is that increasing the dose of chloroquin (a cheap, effective, and adequately available remedy) would probably overcome the resistance problem rather than costly alternatives.⁴ The dangers of overuse and misuse of mefloquin have also been highlighted in a recent report.⁵

Similarly, while personal protection measures are important in the short term, the recent efforts by international public health agencies to socially market 'insecticide-treated mosquito nets' (ITMNs) as a 'magic bullet' are likely to be counterproductive. This will divert funds and attention to a top-down, vertical distribution and marketing programme when community-oriented and integrated bio-environmental approaches are perhaps more sustainable. An IDRC/WHO publication⁶ has also cautioned that ITMNs may not be easy to implement and sustain on a large scale in routine health interventions; and this advice needs to be heeded.

A recent independent expert group has taken a broader social-economic-cultural-political approach to epidemiological analysis and identified a host of interesting issues which have contributed to the resurgence of malaria.⁷ These include malariogenic development strategies; the inadequate involvement of voluntary agencies, general practitioners or the community in the national programme; the increasing loss of public health skill and competence at various levels of the health care system; the increasing corruption and political interference in health care decision-making; the confused dialectics of centre-state responsibility in health and the decrease in health care expenditure. Other studies taking broader socio-epidemiological approaches are identifying factors such as migrant labour and agricultural development.⁷⁻⁹ Recognition of the need for this shift is only very recently getting some emphasis in international research reviews.¹⁰

The time has come for health policy planners to move away from narrow biomedical approaches seeking technological fixes to a much broader social and community-oriented paradigm shift in research, problem analysis and action initiatives. In the absence of this, malaria and the re-emerging communicable diseases will continue to represent not only a failure of our public health system but also of our research methods.

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