

WHO Misses the Point on DDT says AMREF

The WHO statement and new stance on DDT announced this week yet again shows how so many in the West throw out opinions without really understanding the context or culture of Africa. The WHO recent statement forcefully endorses wider use of the insecticide DDT across Africa to exterminate and repel the mosquitoes that carry malaria. Currently the disease needlessly kills more than a million people a year, 800,000 of them young children in Africa.

Dr. Arata Kochi, Director of the WHO malaria program, has announced that DDT is the most effective insecticide against malaria. However, those of us here on the ground in Africa, have to think logically and realistically about the socio-economic context in which we work. The first question to answer is whether or not Indoor Residual Spraying (IRS) is a logistically and economically feasible intervention compared to the widespread use of Insecticide Treated Nets. We must bear in mind that at least 80% of all household structures must be covered every 6-12 months by well coordinated spray teams, and it is unlikely that this will be sustainably resourced or coordinated well in Africa. Imagine trying that across the Congo basin! Imagine trying that with an internally displaced population in the Congo Basin! It is not realistic to assume this will happen, leaving the communities vulnerable again. But now imagine every family in Africa has a net. Nets last 4-5 years and can be carried around by everyone, including internally displaced people and other highly mobile or nomadic groups. The distribution of nets, if for example part of a one-off large scale vaccination campaign, is logistically less challenging than trying to reach 80% of all household structures with a veritable army of spray teams every 12 months.

Like the WHO, AMREF supports the continued use of DDT as a means to control malaria, but only in areas where it is cost effective and logistically feasible to conduct IRS on a regular basis. This is one of the reasons IRS has become an intervention primarily suited to unstable transmission areas, for example the Kenyan highlands or the Afar region in Ethiopia. These places are known as unstable transmission areas because malaria only poses a risk to a small group of people for a short time of the year. Hence the malaria is geographically containable and localized, and is therefore it is suitable and manageable to spray every 6-12 months. Compare that with trying to spray a country the size of the Democratic Republic of the Congo, which battles with malaria 365 days a year, has a war raging, is largely a rainforest, and has little infrastructure to get to isolated communities. It is far, far easier to deliver insecticide-treated nets there every 4 or 5 years.

No one with any technical knowledge in this area doubts the value of IRS or DDT. But those with experience of managing IRS campaigns know that it is logistically very difficult, much like a full scale military exercise. The new WHO statement is misleading and operationally unsound, as are some US republican politicians support for it.

South Africa is often cited as a prime example of the benefit of IRS (and DDT), but the SA example is very misleading. The country has very little malaria in the first instance, and transmission is largely seasonal and restricted to a tiny belt in the north east of the country. There is good infrastructure and a reasonably well financed ministry of health. It is relatively easy to control malaria in SA with IRS. It would NOT be easy to control malaria with IRS across the majority of the more tropical countries in sub-Saharan Africa.

The Roll Back Malaria working group on scaleable vector control is currently putting together a new Cochran Review on the relative merits of IRS versus ITN. I can only hope that when it finally becomes available that the politicians and lawyers currently 'leading' this pointless and harmful debate actually read it and learn something.

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