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Roll Back Malaria

Community involvement in rolling back malaria

World Health Organization

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Contents

Boxes

Illustrations

Background

Historical perspectives

The malaria eradication programmes that were launched in 1955 by the 8th World Health Assembly were initiated in all malarious countries in the Americas and Europe, and in the majority of countries of Asia and Oceania. In Africa, only pilot projects were attempted.

Within 15 years malaria had been eliminated from the developed world, and its elimination seen to have contributed to economic development as well as to a general improvement in health. By 1977, however, malaria was again increasing, even in some of the countries where it had been eliminated. Many reasons have been identified, including the reduction of malaria control activities due to the economic crisis, rising cost of insecticides, development of resistance to DDT and resistance of *Plasmodium falciparum* to chloroquine and other drugs.

Following re-examination of the global strategy of malaria eradication, the 22nd World Health Assembly in 1969 decided that eradication programmes should be continued in areas with good prospects, but in countries where eradication does not appear feasible malaria control operations should form a transitional alternative. Reasons for the decision included the inadequacy of financial and human resources or shortcomings of basic health services.

Further study confirmed the existence of other constraints to malaria control, including social factors like nomadism, refusal to spray dwellings or the extreme simplicity of their construction, replastering of sprayed walls, uncontrolled development of irrigation, deforestation, etc. This led to WHO resolutions on malaria control in line with the Alma-Ata declaration in1978 on Primary Health Care (PHC). In 1992, a global malaria control strategy was endorsed by a ministerial conference on malaria control in Amsterdam.

In Africa, despite the integration of malaria activities into basic health services through the PHC approach, malaria resurgence continued. The Organization of African Unity (OAU) identified malaria as a major impediment to development and called for international support for malaria control in Africa. In response, WHO, UNICEF, UNDP and the World Bank launched the Roll Back Malaria (RBM) movement in 1998. At Abuja, Nigeria, on 25 April 2000 [1] African heads of state committed their governments to halve the malaria mortality for Africa's people by 2010, through implementing the strategies and actions for Roll Back Malaria.

Global trends of malaria

From the 1930s until recently, there has been a steady and significant decline in malaria deaths globally. This is attributable to the elimination of malaria in North America and Europe and highly effective control programmes in other regions, notably Latin America and Asia. However, this overall trend has now reversed and global malaria mortality is steadily rising. This increase is primarily due to the rise in sub-Saharan Africa, but malaria is also re-emerging in areas where it had been eliminated, such as in eastern Europe and central Asia.

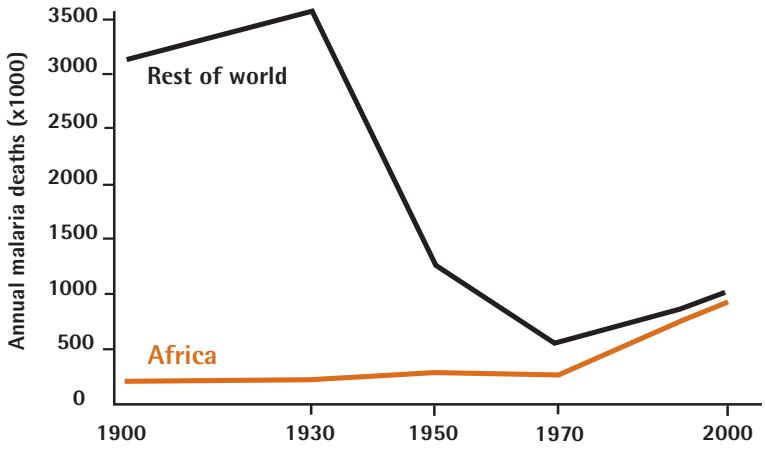


Figure 1. Annual deaths due to malaria during the course of the 20th century in the world and Africa [2]

This re-emergence of malaria is due to many factors, among them declining vigilance and a decrease in resources for malaria control. The situation of malaria in sub-Saharan Africa is further exacerbated by generally poor access to health care, poor health service infrastructure, and limited financial or human resources. The emergence of drug-resistant parasites has also contributed to epidemics. An ever-present economic crisis and the resurgence of war, border conflicts, famine and other complex emergencies are also common in many malaria-endemic African countries. These latter circumstances often lead to the migration of large populations, which in turn lead to a breakdown of basic social services accompanied by epidemics of diseases, including malaria. International factors such as climatic and environmental changes and global warming also contribute to the adverse situation in which sub-Saharan Africa seeks to counter the effects of large-scale epidemics that continue to plague the region.

'Home is the first hospital'

Community-based health initiatives enable the 'home to be the first hospital'. They are the arms of our health systems that directly comfort the afflicted. They are the life-support systems of people who are poor, isolated and living in rural areas.
In building upon the social organizations of communities, and on the informal and private health sectors, community-based health initiatives serve the direct interest of those most affected. The public sector health system, through support and stewardship, maximizes the potential of these partnerships so as to increase the effectiveness of community-based health initiatives. Community-based health initiatives complement the formal public health system, but do not replace it. Each enhances the activities of the other.

Roll Back Malaria, WHO

The burden of malaria

Current morbidity and mortality rates of malaria are simply intolerable. The cost in terms of lives lost and of those whose lives are affected is staggering. There are about 300-500 million episodes of malarial illness globally each year, resulting in over a million deaths. Over 90% of these deaths occur in Africa, and almost 90% of deaths due to malaria occur in children. The consequences of such high rates of malaria go far beyond health to affect the economic circumstances of communities, and, in turn, the development prospects of the countries in which malaria is rife.

Effective interventions against malaria are available, yet the burden persists, largely for three reasons—most people at risk of malaria are unaware of interventions; they are unable to afford them; or the interventions are inaccessible. A lack of education, information and access to effective interventions currently restricts the success of RBM programmes, especially among the poor, and in poorer countries generally.

This document outlines the principles and mechanisms of RBM action at community level and describes the interventions in which the community can play an important role. It also describes some critical aspects of community-based health care programmes and identifies their potential limits in the context of the RBM strategies. It is based upon evidence from community-based projects and on experiences gained in past and present health and non-health programmes.

This document is intended to serve as an introduction to, and a guide for, community-based malaria control interventions. It is particularly relevant to health policy makers in malaria-endemic countries, health officials of provinces and districts, and leaders of NGOs and CBOs as they scale-up interventions at the community level. It may also be of interest to the communities themselves, especially to community leaders.

What is the RBM community movement?

The RBM community movement is both an active participant in malaria programmes and a political force intended to bring pressure upon governments to ensure that the health care needs of those most at risk of malaria are met. Evidence-based actions underpin all RBM operations. RBM has already achieved notable successes in increasing political will, particularly in African countries,

RBM: A societal movement against malaria

RBM is founded on the important principles of:

- A partnership for action at global, regional and country levels;
- Driven by country and community priorities;
- A social movement for health centring on people, particularly women and children;
- A supporter of intersectoral approaches; and
- An initiative that will strengthen the health systems of endemic countries.

RBM technical strategies

The technical strategies of RBM build on the Global Malaria Control Strategy adopted at the Ministerial Conference on Malaria Control in Amsterdam in 1992. They are:

- Early diagnosis of suspected malaria illness and effective treatment within or near the home.
- Multiple prevention:
  - Protection from mosquitoes by using insecticide-treated bednets (ITNs) and other vector control strategies;
  - Intermittent preventive treatment for pregnant women at risk of malaria.
- Early detection of, and rapid response to, epidemics.
- Focused research.

These technical interventions should be conducted with well-coordinated sectoral and intersectoral actions in a dynamic global environment.

including making malaria a priority on the development agenda as well as on the health agenda of affected countries.

RBM aims to generate a dynamic societal movement among those at risk of malaria. In parts of the world where malaria is endemic, the disease is very much a part of people's lives. It recurs many times, often throughout life, leading to acute discomfort, ill health, impoverishment or even death.

The RBM movement is also about encouraging communities at risk to take individual and collective actions to prevent and control malaria. Organized community action against malaria must include empowering the most affected so that they can help themselves. By raising awareness of the disease first and then its cause, the community will be able to incorporate preventive measures into local action. Knowledge also allows communities to be aware of the presence of malaria, access early and effective treatment, improve care and reduce the suffering of those affected. Empowerment leads to both the raising of responsibility and increased expectations. Many societal movements have shown that empowered communities can be powerful instruments of change. They can influence the attitudes and behaviours of people and their leaders, motivate governments, and even inspire international action.

Political commitment to the RBM goal

The political leaderships of many countries around the world are already committed to the RBM goal of reducing the global burden of malaria by half by 2010. In Africa, the Heads of States (or senior representatives) from 44 of the 50 malaria-affected countries signed the Abuja Declaration on RBM in April 2000. They reaffirmed their respective government's commitments to roll back malaria and called upon Member States to undertake health systems reforms which will

include promoting 'community participation in joint ownership and control of RBM actions to enhance their sustainability'[1]. In order to fulfil the aims of the Abuja Declaration and to ensure the accessibility of diagnosis and effective treatment of malaria to affected communities, particularly the poor, innovative approaches are needed to promote community participation.

RBM actions at community level

Malaria is responsible for a large burden of disease in endemic countries [3,4]. Its economic costs are also enormous [5, 6], with evidence strongly suggesting that malaria obstructs overall economic development, particularly in endemic countries.

The coverage of the public health services is currently unacceptably low in many malaria-endemic countries. Many vulnerable communities are widely dispersed across remote geographical areas that are not reached by health services. Since the resources required for the accelerated expansion of health facilities and services to these areas are beyond the financial capacities of most countries, it is necessary that many interventions be undertaken by the communities themselves. This is already happening. A large number (12-82%) of all malaria episodes in sub-Saharan Africa are now managed outside the official health sector [7,8]. The private sector now accounts for 40-60% of all antimalarial drugs distributed, with unofficial sources, such as street sellers and market stalls, accounting for as much as 25%[9].

One of the principles of the RBM movement is that it is driven by community priorities, in particular the protection and care of women and children. Studies have shown that ITN use has a protective efficacy of 17%, saves about six lives each year for every 1000 children protected, and reduces the incidence of mild malaria episodes by 48%[10].

ITNs have substantially reduced clinical episodes of mild and severe malaria and malaria-related anaemia. Intermittent preventive treatment (IPT) using sulfadoxine-pyrimethamine (SP) at pre-defined intervals during pregnancy has proved efficacious in reducing the incidence of malaria, anaemia and low birth weight[11]. However, these measures are all too often not widely known by local communities and not widely available or used (fewer than 5% of children in malaria-endemic communities sleep under ITNs).

Community-based malaria projects have been shown to be both efficacious and feasible. A number of small-scale projects have demonstrated that community-based interventions based on training of caregivers (e.g. mothers) to provide early diagnosis and treatment [12] has great potential. For example:

- A significant decline in overall child mortality has been documented in a situation where a community health nurse and a village health worker deliver primary health care (PHC) for a village[13].
- A reduction as high as 40% in childhood mortality has been shown in a study that used mother coordinators in a randomized controlled community intervention[14]. From every group of 20 mothers a coordinator was selected by the mothers themselves to be trained in early recognition and treatment of malaria. The trained mother coordinator passed on the knowledge and skills to the other mothers who selected her, and this improved the management of malaria at home.

- Other examples, such as the training of shopkeepers to recognize malaria and dispense appropriate drugs, have also been shown to improve compliance with antimalarial treatment[15].

Community-based actions must become an integral part of broad-based malaria control activities to achieve the RBM goal of halving the malaria burden by 2010. However, the public health system, which itself requires strengthening, will have to take on a much larger role of stewardship to ensure that community-based activities are supervised, guided and assured of quality.

Objectives of RBM community-level action

The RBM movement aims to halve the malaria burden by 2010, particularly the malaria mortality among children under five. RBM is helping ensure access to health services to bring about a sustainable impact at community level. It is essential that communities themselves play a central role in this process.

To increase and sustain the effectiveness of RBM interventions it is necessary to develop programmes that directly deal with those who are most affected. By acknowledging the community and supporting them in the implementation of these programmes a significant reduction in malaria incidence will be attained.

Objectives that can be achieved with community participation include:

- To improve recognition of malarial illness and provision of appropriate treatment by caregivers within 24 hours of onset of illness.
- To strengthen the capacity of health systems, particularly at the periphery, so as to support RBM actions at community level, including access to antimalarial drugs and referral mechanisms.
- To improve health-seeking behaviour of caregivers, family and community so they can recognize signs of severe illness and seek appropriate care quickly when referral is indicated.
- To improve access to insecticide-treated nets, and to promote their regular and proper use and re-treatment.
- To promote intermittent preventive treatment for pregnant women, particularly in areas of intense malaria transmission.
- To promote vector control, including environmental management wherever appropriate.

Fundamentals of community-based actions

1. Community participation

Community participation is the process by which communities influence the decisions and resources that directly affect them[16]. The introduction of interventions into communities should take into account all actors, their roles, competence and experience, as well as their environment. Communities should participate at the inception and planning of new interventions whenever possible, although community participation can be introduced at any stage of an ongoing intervention. Continuous monitoring and evaluation of community activities are critical, since adjustments and improvements to interventions can only be made by identifying strengths and weaknesses in their implementation.

Community participation is a continuum[16] as illustrated in Figure 2. The continuum is a lengthy and dynamic process, which helps communities to take greater responsibility for health care, including malaria control. Communities must attempt to move away from the unsustainable position of being mere recipients of services, resources and development interventions towards being active partners, or owners, of the interventions. Achieving long-term self-reliance is not a single action, but an ongoing process that develops through several stages, all requiring time and resources.

The active participation of development partners is needed from the beginning. Though this may create tension between the community's role and those of other partners (e.g. the district health management team), leadership and planning must ensure that the relationship is a cooperative one. The reconciliation of 'top-down' versus 'bottom-up' approaches must be co-ordinated to ensure the best results.

Community participation in Senegal

The idea of managing health through village-based health committees was introduced to Senegal in 1992[17]. Senegal's local health committees are based on the principles of the Bamako Initiative which include the acceleration of primary health care, defining and implementing self-financing mechanisms, encouraging social mobilization for community participation, enabling communities to be principal partners in health care development and ensuring regular supplies of essential drugs.

The programme is now fully functional throughout Senegal, from the level of national hospitals and health centres down to dispensaries. Local health committees have been formed to manage the procurement of, and expenditure on, essential drugs including antimalarials at affordable prices. A dispensary, the closest formal public health facility to the community, services several villages and acts as the base for a government-appointed community health nurse. The community health nurse is responsible for maintaining links between the villages and the public health system.

In some areas, the local health committees recruit an additional community health nurse to strengthen services. In each village, there is a 'health house' built by the villagers. A community health worker (CHW) and a traditional birth attendant (TBA), who attends to normal deliveries, work in the health house. Both are trained to treat simple cases of malaria and to refer severe illness to the dispensary. The CHW and the TBA also provide health education activities to communities. At the level of the dispensary and the health house the village health committee is responsible for all services including procurement of essential drugs. The health committees are answerable to the community who can change their membership every two years.

The lessons learned from the Senegalese experience of the Bamako Initiative include:

1. Community participation strengthens the delivery of health services.
2. Use of health services increases with improved availability and accessibility.
3. Community ownership, in terms of managing health facilities and employing health workers, is strengthened.
4. Access to drugs is improved.

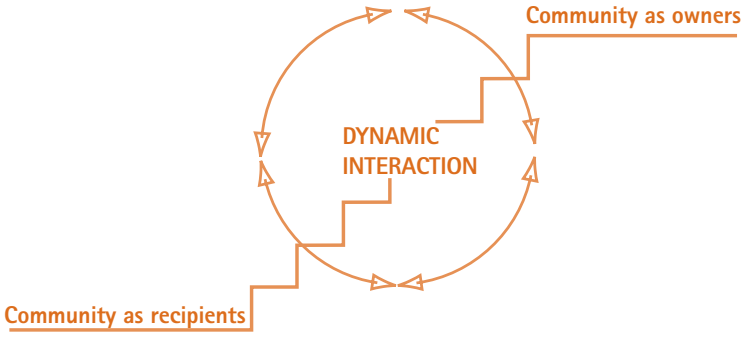


Figure 2. Community participation in health care

As communities are empowered they become capable of demanding and paying for goods and services from both public and private sectors. As the community becomes stronger, interaction with other partners must build towards sustainable systems, decentralized authority and resources, while at the same time strengthening local institutions. Participation promotes self-awareness and confidence, causes people to examine their problems and to think positively about solutions. It increases their sense of control over issues that affect their lives.

In order to help communities develop this control, partners will contribute their knowledge and experience to improving local skills and abilities so that the community itself can make decisions and take the actions that they believe are essential for their own development. Participation thereby leads to ownership, the ultimate goal of such partnership efforts.

Community participation in India

In the 1980s malaria was present in epidemic proportions in India[18]. *P. falciparum* was resistant to chloroquine, while spraying DDT and malathion failed to interrupt transmission. The Malaria Research Centre then introduced biological and environmental management methods in an attempt to control mosquito breeding and contain the further spread of malaria. Initial results were encouraging and the programme was gradually expanded to many parts of the country.

Health education and community participation helped raise awareness of the project. In order to achieve, and then sustain, community participation, it was important to introduce developmental schemes linked to incentives. Schemes such as carp culture and other larvivorous fish production allowed the community to control mosquito breeding and also sell the fish. Public promotion of environment-friendly projects such as smokeless chulhas, solar cookers, bio-gas plants, soak-away pits, road construction, repair of school buildings and others also benefited the community. These examples, primarily used in rural areas, reduced mosquito numbers, which in turn reduced the chances of malaria infection. Some of these methods were also used in urban areas, when community participation was secured through group meetings, public discussions and awareness camps.

2. Broadening partnerships

Partners working with communities for health development may be conveniently divided into three groups [19] as illustrated in Figure 3. In order to achieve sustainable impact upon the malaria burden, communities and other stakeholders need to be brought together. This bottom-up approach will consolidate the community's role in the overall partnership[20] and ensure sustainable impact. Local participants should then be linked together with all the other partners (e.g. civil society, private for-profit sector, NGOs and government agencies) to actively promote community interventions. with the overall objective of linking together a broad base of interested parties in order to improve effectiveness. The initiative for establishing the links in the earliest stages may be taken by the national RBM partnership, district health management or NGOs, depending on local circumstances.

Partnership is a forum for participants to exchange resources, combine competencies and coordinate activities in a productive manner. Partnership includes the sharing of information, and the identification of common objectives and goals. Participatory approaches must therefore build partnerships into the decision-making process at the earliest stages to bring about effective and sustainable change.

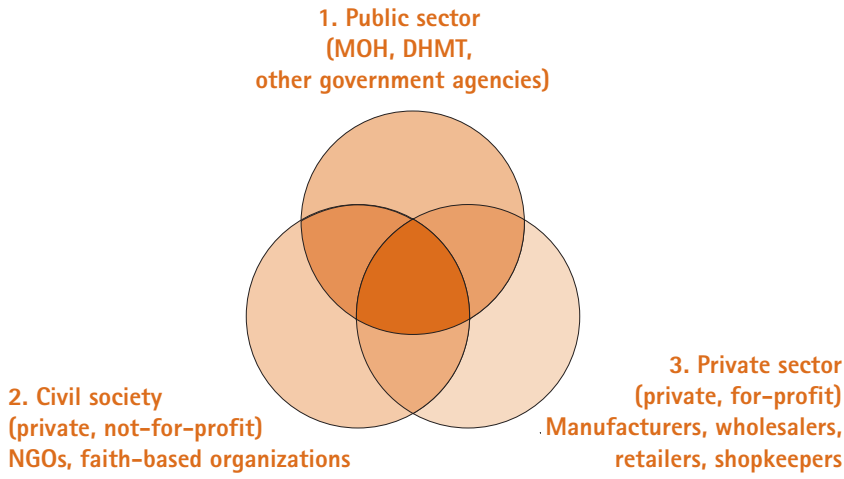


Figure 3. Partners in community health development

According to the *World Bank Sourcebook*, 'Partnership is a collaborative relationship between entities to work toward shared objectives through a mutually agreed division of labour'[16]. The basic strength of partnerships comes from their participatory, complementary and multi-stakeholder nature, which helps reach goals efficiently and effectively. Partnerships are now growing where communities identify and support their own community health workers, with the

Experience with non-health community actions

The experiences of other community actions may prove relevant to the health sector. Much has already been learned about ways of working with communities from community development programmes, in which agricultural extension workers who have regular contacts with remote farming communities pass on information. In such programmes, a 'training and visits' system—in which training periods for agricultural extension workers are interspersed with fieldwork—is practised. A similar system could be applied to the health sector [21-24].

Since the 1980s, the WHO Regional Office for the Eastern Mediterranean (EMRO) has been promoting poverty alleviation as the most potent strategy for equitable development towards health-related goals. EMRO has actively supported and advocated the Basic Development Needs (BDN) approach among the countries of the region (EMRO, personal communication). By collectively addressing all the determinants of health, the BDN approach implements strategies that facilitate access to essential social services, appropriate technologies and financial credit with the aim of promoting fair distribution of resources to achieve equity at the grass-roots level.

Specific BDN interventions include the use of appropriate technologies and economic development programmes such as livelihood cooperatives. BDN interventions also apply resource availability for health infrastructure, training, community organization, health promotion (e.g. anti-smoking), and treatments such as DOTS, bednets and ORT. Other social sectors such as education, environment, nutrition, water and sanitation and women's development are brought into consideration by BDN.

Fourteen countries in EMRO are currently implementing BDN. Preliminary evaluation of these ongoing programmes has demonstrated significant improvement in quality of life indices pertaining to a wide range of fields including health, nutrition and other social sectors, as well as economic development through the promotion of self-management and self-reliance.

In the World Bank-supported Albania Rural Poverty Alleviation Project [16], rural farmers were asked to collaborate in testing the suitability of methods for rehabilitating the infrastructure and providing credit to their communities. Government officials had always believed that involving rural farmers in designing such a project was a waste of time because villagers 'knew nothing' about complex issues such as credit delivery mechanisms. The World Bank and the villagers designed a pre-pilot project, set criteria, and created implementation arrangements. The resulting social fund mechanism, which incorporated village credit committees and community-generated proposals for infrastructure funding, proved effective in reaching communities and building local capacity for participatory decision-making.

Government officials were convinced and pushed the World Bank for a larger project. This shows how pilot projects can be used to demonstrate the effectiveness of participatory planning among villagers and so improve acceptance by other partners (government officials in this case).

Community-managed health care centres in Mali

In Mali, a community-initiated and financed health care system, Centre de Santé Communautaire (Cscom), has been operating since 1989[25]. Cscom started in one community in Banhoni, a peri-urban area of Bamako, when a university-based research group approached the community (including physicians and other unemployed health staff) who agreed to participate in the project. The successful relationship that resulted led to further developments and the communities took the initiative of building more Cscom centres in other areas. The fact that there were jobless doctors who were willing to take jobs in these rural areas was also a major factor in the success of Cscom.

The activities of Cscom centres in Mali are now widely accepted, with increased use of health services and client satisfaction illustrating their success. Cscom is continuing to build new centres and has now outgrown the public health sector. The government of Mali now includes Cscom centres in the national health policy and has plans to build more centres every year.

Partnership is a major factor in the success of these Cscom projects. A community-initiated health centre was established because of the partnership between the communities, a research team and the French Cooperation, who assisted in the initial resource mobilization. Communities were engaged because they saw that the initiative provided potential solutions to their health problems. Cscom has been sustained and expanded, not only because of the availability of financial, material and human resources, but also because the communities have maintained interest, changed behaviour and developed a positive attitude to the concept of self-reliance. Maintaining financial viability with wider geographical access remains a challenge.

public health system providing technical expertise and financial support in training, educating and supervising activities to maintain optimum quality of service. In an ideal partnership of this type the private sector's cooperation would also be engaged to ensure the availability of pre-packaged quality antimalarial drugs in the communities.

Creating partnerships requires building structures, skills, and processes that can use the differences between stakeholders to encourage an exchange of ideas and creativity[20]. Although differences can be sources of strength to a partnership, they can also present particular challenges. Partnerships must be constantly vigilant to ensure that when bringing together partners with diverse goals, values and perspectives, they minimize the ground for disputes and maximize the benefits of cooperation.

3. Building upon experience

In harnessing community participation it is important to know what a 'community' represents within a particular country or district, as the structure of communities will vary from region to region. In many African countries, villages usually have community development or health committees with the leader of the village serving as chairman.

The status of these committees and their potential for participation has to be established. It must also be asked what are the current structures and functions of

the various parts of a community? Are there groups or committees that deal with social development, social welfare, or more specifically, health problems? What can be learned from past activities that can be used for future health actions?

There are often one or more community development activities going on in a community at any one time. New interventions should therefore identify the successes of previous projects and build on them. (See also pages 8-11.) For example, if control of diarrhoeal diseases (CDD) is already established in communities, depots for oral rehydration solutions (ORS) will already be established. These depots could be expanded for ITN and insecticide distribution.

There are many other examples. If a district has been successful with door-to-door programmes for polio vaccination of children, then that programme's information and mechanisms could also be used for malaria services. Should a community-based group, such as a faith-based organization, be responsible for local irrigation schemes, negotiations could be conducted so that malaria services are able to use their information resources, staff or technical knowledge. Similarly, if NGOs are operational in local communities, their experiences, services and cooperation could be useful at many levels of an RBM programme.

4. Developing community-level intervention channels

The initial phase in community health intervention involves identifying community leaders and other key persons in communities in order to establish a community development committee. Sometimes it may be possible to strengthen

Partnerships in Kenya and the United Republic of Tanzania

The principle of partnership in strengthening the health system was also demonstrated in several other countries. In Morogoro, United Republic of Tanzania, the District Health Management Team (DHMT), in collaboration with Tanzania Essential Health Interventions Programme (TEHIP), has been working to strengthen the health system with community participation[26].

Village health committees and partners drew up plans that could be developed with resources from the MOH and partners active in the district. This led to a significant improvement in equipment in all health facilities. The district has now agreed to continue support by providing qualified health personnel and drug supplies to the health facilities. With health facilities reorganization almost complete, all that remains is the smooth transfer of management responsibility to the village health committees, who will work under national guidance.

Direct community participation can exist at many levels of malaria projects. In the Kirinyaga and Mbere districts of Kenya, Cry for the World (CW) foundation is combining micro-enterprise and franchise principles to allow the community's own resource persons (CORPs/CHWs) to open and operate micro-pharmacies in underserved areas.
In one example, CHWs who have been trained and approved as qualified and responsible by CW have formed small partnerships and established franchises to supply drugs in CW shops[27]. This shows how the community's involvement can be enhanced when empowered to manage resources, rather than merely absorbing information or providing labour.

Learning from, and building on, the experiences of other disease programmes

The Onchocerciasis Control Programme in West Africa (OCP) initiated large-scale, effective campaigns for the control of onchocerciasis, and in particular for its complication, blindness. The success of these campaigns [28-30] shows how effective well-organized programmes can be. Fundamental components included:

- OCP was a community-directed intervention that developed a plan, identified the target population, and selected and supervised appropriate ivermectin distributors.
- The mobilization of resources, tools and expertise, which in many cases included the free provision and distribution of the drug directly to communities.
- Active participation in the campaign by ministries of health, NGOs and other partner organizations.

Although OCP's interventions are quite different to those required for malaria (ivermectin is distributed in mass, only once a year, and is provided free), the structure of the programme may serve as a model. Common components do exist and the possibility of integrating certain elements should be examined (e.g. ivermectin distributors may be used as outlets for ITN sales). The OCP also illustrates the success that can be accomplished by giving significant roles to communities in cooperation with partners. The success of such partnerships should be consolidated in the establishment of other control programmes, including malaria.

an existing village health committee or other community group for this purpose. The community development committee will act as the link between the district and communities, and will equitably resolve issues such as recruitment, remuneration and accountability.

Community health committees should decide on appropriate selection criteria for the community's own resource persons (CORPs). They should also participate in needs assessment and analysis, as well as in prioritizing interventions. They should contribute to the mobilization of resources, which may include the training of CORPs and community leaders, as well as the preparation of health education materials relevant to their community. Further responsibilities for such a committee should be decided in cooperation with development partners.

5. Improving linkage between communities and the district health system

Communities must be linked to district health system facilities which will serve as referral centres, as well as sources of technical expertise, correct information and supplies (e.g. ITNs and drugs).

For administration and resource mobilization, communities are usually linked to health facilities through their village health committees. For health intervention delivery, CORPs are the counterparts of the health workers from the health facilities (Figure 4). CORPs are community residents who have trained as CHWs, TBAs, VHWs, etc. In order to function effectively, they require input from

the district health management team (DHMT) for supervision, technical support, referral, supply and information systems. It is therefore essential to strengthen DHMT capacity and ability to provide this support.

Health facilities should provide easy access to effective treatment of suspected malaria cases that have failed to improve with treatment at home or at lower level health centres. They should also participate in training, monitoring and evaluation activities, and also support supervision of CORPs and community projects. Health facilities should also act as model examples for ITN and insecticide promotion, and serve as distribution and sales outlets.

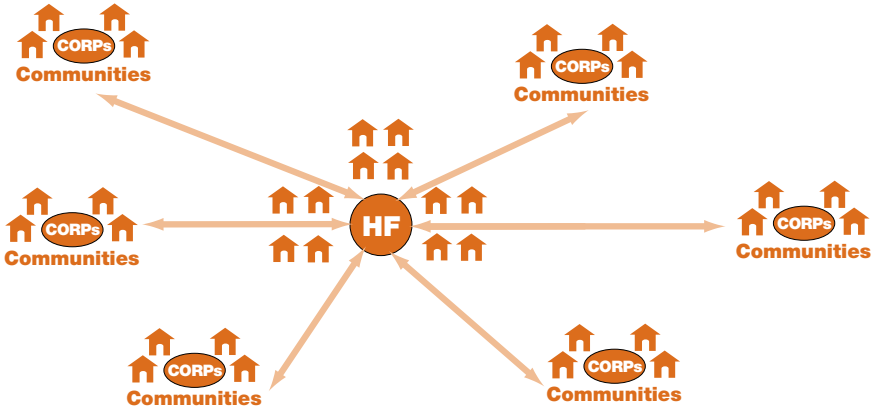


Figure 4: Role of CORPs linking health facilities (HF) with communities.

Community participation in development or health initiatives does not progress at the same rate through a country, or indeed through a district. In many developing countries, the referral system between communities and district health centres requires improvement. Areas such as communication, management, financial resources and transport between the referring HC or dispensary and the referral care hospital, require attention. Once the referral system has been strengthened and links with the district health system are consolidated, the community will be able to cater for many of its own needs and RBM objectives will be more achievable.

6. Strengthening district capacity for RBM community actions

At the beginning of a programme the district health system plays an essential role in guiding inexperienced communities. The DHMT should facilitate cooperation between the partnerships working in the district. The potential for strong collaborative efforts for RBM actions at district level can be further expanded by forming a district working group involving all partners, including NGOs, private sector and community representatives. Some district health facility staff should also be coopted as members.

The district working group can begin district planning activities by reviewing:

- The availability and quality of health care in public and private sectors.
- Information provided by previous studies on key family health practices from district health service data, including demographic health surveys, knowledge, attitude and practice studies, ethnographic studies, etc.
- Any existing community-oriented communication materials from IEC units, NGOs, etc.
- The support systems for supervision, transport, distribution of drugs and ITNs.
- Community-level resources such as village health committees, women's groups, religious groups, community financing schemes, etc.
- The sources of funding, costs and budget implications.

In order to develop a sound plan for actions at community level, a situation analysis should be performed using the tool already developed by RBM[31]. An additional tool may be needed to gather specific information that is relevant to a particular district. When this review is completed, the key partners at district level can then develop an implementation plan.

The DHMT should ensure that the correct technical guidance is followed in the use of tools and services for malaria prevention and treatment at community level, and that correct messages are being given to communities in a consistent manner. Adequate personnel and resources for such duties should be made available.

7. Strengthening community self-monitoring and decision-making

As communities take more responsibility for malaria control it is necessary that they are able to measure the success of their actions. By regularly monitoring key indicators in the community they will obtain evidence-based information upon which to make decisions. This will also allow the community to evaluate the effectiveness of their programmes and improve their capacity.

Key indicators include: the number of households with ITNs, the number of malaria cases treated within 24 hours of symptoms, the overall reduction of incidence and mortality of malaria, cooperation with district management and other partners, personnel and the use of funds. Communities also need to monitor their own resources, including materials and finance, and the performance of the health workers in the community.

Continuous monitoring and appropriate feedback is necessary to maintain high-quality services. Partners can be called to help with supervision, which can be made both effective and practical by using a 'cascade' system that relies on professionals at established health facilities contributing to the expansion of other health services in a form of horizontal supervision.

In Morogoro in the United Republic of Tanzania, for example, the DHMT supervises developments in a limited number of established health centres which in turn use their experience to supervise the progression of other similar health centres. These community health centres are referred to as 'dispensaries' in Tanzania although they are known as 'health posts' in other countries. Health workers in the more established dispensaries have been trained in horizontal 'cascade' supervision of less developed dispensaries. Staff work hand-in hand with VHWs and regularly accompany them on home visits. Their supervision is designed

Why have some community programmes failed to achieve what they set out to do?

1. A major setback to the sustainability of community-based interventions has been the fact that they were generally designed as projects, and when project funding was completed, the mechanisms to sustain activities were not in place.

2. Another common occurrence in many parts of malaria-endemic countries is that individuals become interested in assisting communities and mobilizing funds for a single element of a project. Even when the project is complete it may not function because linking components have not been put in place (e.g. a building may be constructed but equipment and personnel have yet to be allocated to make it operational).

3. Many CHW programmes were established following the declaration of Alma-Ata in 1978, which stipulated the Primary Health Care (PHC) approach and targeting Health for All by the Year 2000. Evaluation of these programmes by a study group [20, 21-24, 30] indicated that they were in crisis in many countries. The failures of CHW programmes were attributed to inadequacies in their planning, lack of support, lack of clear national policies or strategies, lack of community participation in the whole process and lack of intersectoral collaboration. The evaluation also pointed out weaknesses in the selection, training and supervision of CHWs.

These three examples all show inadequate planning for programme implementation. The allocation of human and financial resources appears to have been ill-advised —certainly not advised well enough to sustain activities.

to be supportive with feedback—both administrative and technical skill reinforcement—provided to health worker or VHW. This project is a fine example of successful collaboration between individual persons and partners working to the same ends in the same field. In many countries this supervision system includes checklists for malaria, and is integrated into similar health programmes.

Communities need to engage in a series of partnerships throughout the spectrum of malaria activities. They will gain from the experiences passed on to them from district and national levels and they can then pass on their experiences to other communities as they begin developing malaria projects.

8. Effective communications strategy

Communication is crucial to community actions to combat malaria. It is critical in bringing about behavioural change. Communication provides the community with appropriate information for malaria prevention and treatment. Even when services are available, accessible and affordable, communications are needed to make people aware of them and their usefulness.

Community initiatives should therefore include a strong communication component. The skills to define the information to be delivered, elaboration of that information, options for its delivery and implementation using participatory methods such as PLA or PRA are needed [32-33]. It is important that key messages are articulated jointly by all partners responsible for programmes and that these

Proposed roles and responsibilities of

1. Communities

- Identify and support CORPs and community-based workers (CHWs, TBAs, volunteers, etc.).
- Identify priorities for intervention.
- Implement action at community level.
- Monitor, evaluate and modify programmes.
- Contribute to resources.

2. CORPs (CHW, VHW, TBA, women's groups, others)

- Coordinate community health promotion activities.
- Train mothers in the recognition of malaria illness and its treatment.
- Provide treatment themselves.
- Conduct home visits to follow-up cases and for interpersonal communication education.
- Report and monitor activities.

3. Health facilities/health workers

- Provide regular feedback to communities.
- Conduct outreach services.
- Conduct home visits.
- Organize social mobilization events.
- Conduct training of CORPs.
- Improve interpersonal communications.
- Participate in training students and teachers in schools.
- Manage referred cases.

4. District (zone, region depending on local structures)

- Maintain links with CORPs and communities.
- Provide technical support to CORPs and communities.
- Mobilize communities for RBM actions.
- Advocate for RBM actions.
- Coordinate partnerships at district level.
- Support planning and guide the implementation.
- Conduct community health education.
- Mobilize resources.
- Monitor and supervise.

partners for RBM community actions

5. National (MOH, National Task Force or working group)

- Create an enabling environment for RBM actions at community level.
- Develop policies and guidelines as necessary.
- Coordinate stakeholders.
- Mobilize resources.
- Develop management capacity, and technical skills at all levels.
- Conduct operational research to address implementation problems.
- Ensure quality.
- Ensure equity.
- Monitor and evaluate progress.

6. WHO and UNICEF (country, regional or HQ)

- Coordinate partnerships at global, national and regional levels.
- Provide technical guidelines.
- Create forums for sharing experiences from different countries (e.g. websites, newsletters, annual workshops, etc.)
- Provide financial and logistics support.
- Support operational research.

7. Bilaterals, multilaterals, NGOs and other stakeholders

- Provide technical support.
- Provide financial and other logistics support.
- Support implementation at local level.
- Support operational research.
- Contribute to supervision, monitoring and evaluation.

8. Civil society (CBOs, faith-based organizations, traditional leaders/professional associations)

- Advocate for community actions.
- Mobilize communities.
- Contribute to identifying priority actions and implementation at local level.
- Mobilize resources.
- Contribute to supervision, monitoring and evaluation.

messages are both consistent and correct. Health workers, CORPs, district health management and community leaders should all be involved in their development.

A communications strategy must be developed once the partners have established the campaign objectives. In order to best succeed in interacting with the community, communications activities should, whenever possible, use the services of professionals or persons experienced in media. The communicators should be aware of any previous campaigns that have been conducted as part of other national or regional projects in case their materials or strategies can be adapted for local use.

Communication agents, the actual messengers who carry information, include community elders, spiritual leaders or other opinion leaders. They should be identified by methods such as participatory rural assessment techniques.

Alongside local, regional, district and national mass media there are other ways to transmit messages. These include community networks (e.g. women's associations and youth clubs) and local traditional media. The most successful carrier of a message will often be someone who has recently been converted to the issue and wishes to advocate to any audience, receptive or reluctant. Such individuals are known as 'satisfied acceptors'.

Advocacy, information and social mobilization are all important aspects of communications and communication strategies should therefore include the following elements:

- Improving communication at health facilities.
- Disseminating messages in the community.
- Developing materials and tools.

Policy framework to enable community actions

1. Advocacy and resource mobilization

National governments have an important role in advocacy and resource mobilization since they have vital links both with the district health system and with major international and national partners. They will be the major force in summoning the resources for nationwide projects, often through their MOH. This may occur either through their own budgets or through the leverage of funds from partners. National governments can ensure resource flow in decentralized systems and use cost-recovery mechanisms to contribute to RBM actions at community level (e.g. the Bamako Initiative, launched during a meeting organized by WHO in Bamako, Mali, in 1987 and attended by African ministers of health, which promoted user-financing under community control, in particular the use of revolving drug funds and community mobilization).

National governments will also be fundamental in defining the roles and cooperation of different partners and in brokering, providing and utilizing financial and technical resources. They can also develop a system of resource management and monitoring for malaria projects throughout the country to ensure the efficient use of resources and optimize the chance of success for community programmes.

Potential roles of non-health sector channels at community level

Non-health sector channels can play a vital role in expanding actions being undertaken by groups associated with the RBM programme. Schools are a good example of the type of places where numbers of people gather at one time, creating an appropriate audience for RBM information. Schools have a high population coverage at country or district level, often higher than the health sector, and can act as couriers of new information to families at home. Other examples of non-health sector channels include rural development projects, or the networks of women animators located in most large villages.

Channels	Potential roles in RBM actions at community level
1. Private, for-profit (manufacturers, shopkeepers, wholesale)	• Finance community activities, via NGOs, public sector or in partnership. • Participate in manufacturing ITNs, re-treatment kits and antimalarials. • Participate in the distribution and dispensing of RBM branded drugs and ITNs. • Train shopkeepers to treat malaria.
2. Private, not-for-profit (NGOs, faith-based and other organizations)	• Participate in behavioural change messages. • Participate in distribution and dispensing of drugs and ITNs. • Mobilize communities.
3. Education (schools public, private, NGO, MOE—national or district)	• Influence parent behavioural change through schoolchildren to enhance ITN demand, regular use and re–treatment. • Influence parent behavioural change through schoolchildren for rapid response to fevers, early treatment, and use of RBM branded drugs. • Encourage teachers to teach malaria treatment, urgent referral, promotion of ITN use and ITN re-treatment.
4. Agriculture (extension workers)	• Participate in mobilizing communities. • Become model examples to communities by using nets and participating in promoting ITN use. • Assist with the distribution of nets.
5. Women-centred rural development	• Women animators in villages may participate in income-generating activities (access to credit, small business promotion) to promote ITNs, their re-treatment and drug sales points. • Schemes improving women's access to credit could develop a credit/prepayment facility for ITN purchases. • Adult literacy programmes have the potential to target often-marginalized populations by incorporating RBM behavioural change messages to such groups.

Bridging the gap between ma

RBM can build on existing community-based programmes and initiatives to maximize RBM actions at community level. Since RBM is itself a partnership with a country's government as well as NGOs, it is well situated to collaborate with other programmes operating from the MOH. Several examples are listed below:

- In communities where IMCI is being implemented, RBM may use the mechanisms established as a platform for implementation.
- Where delivery mechanisms for ORS (ORS depots) are operative, they can be used to deliver malaria-related materials.
- Where CHWs are already trained to identify chronic coughers, and follow up with DOTS treatment for tuberculosis [34-37], or ivermectin distribution for control of onchocerciasis or filariasis, they may also be trained to identify malaria symptoms, give treatment and promote the use of ITNs.
- Networks for condom distribution for HIV prevention could be used to reach communities with ITNs or antimalarial drugs.

Similarly, communities with ongoing malaria intervention mechanisms may be able to provide assistance to other priority developmental or health actions.

RBM actions at community level: potential areas of collaboration with other programmes

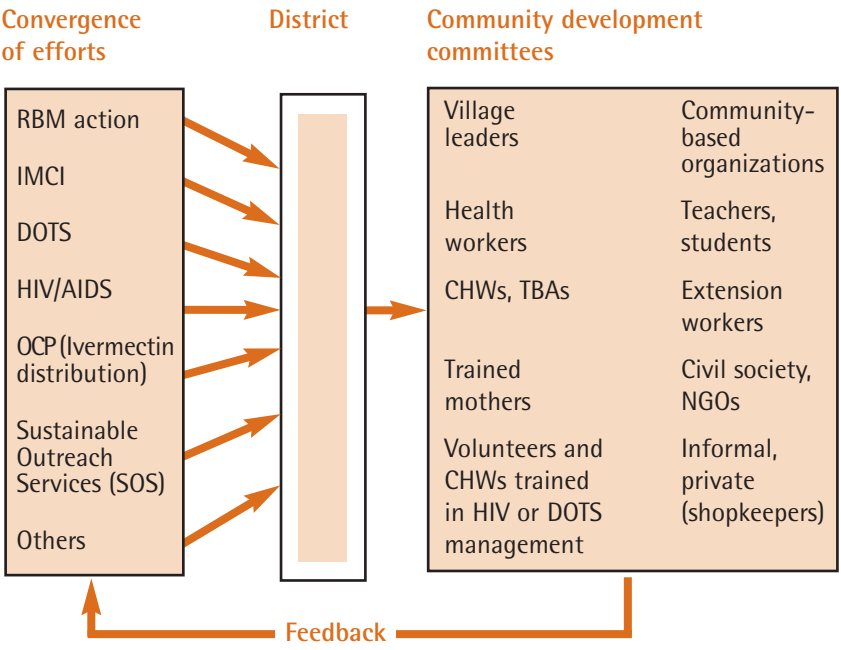
IMCI	Safe motherhood
Recognition of malaria by mothers. Treatment of children under 5 with antimalarials.	Preventive intermittent treatment of pregnant women with antimalarials. ITN distribution.
Stop TB programme	HIV/AIDS
CHWs trained for DOTS also deliver antimalarials and ITNs. Ivermectin distributors also supply antimalarials and ITNs.	Volunteers trained for HIV/AIDS can also treat malaria and distribute ITNs.
Onchocerciasis control	Essential drugs and medicines
Ivermectin distributors also supply antimalarials and ITNs.	Supply of essential drugs – First-line antimalarial drugs.

alaria and other programmes

Community's own resource persons (CORPs) are trained to effect a limited number of health interventions. There is very little experience of, for example, malaria and onchocerciasis or tuberculosis activities being implemented and monitored in the same communities by the same CORP. If a CORP is to be trained in several interventions, careful planning of the curricula is required (e.g. how long the training should be, what should be included, who should be involved in which aspect of training, etc.).

However, a convergence of efforts of several health interventions is, in principle, expected to reduce costs and produce a synergistic impact, provided that the roles and responsibilities are properly shared among the members of community health committees.

The figure below depicts the potential for convergence of all efforts of various programmes (national and global) that could be consolidated at district level. These will then reach communities via a local body such as a community development or health committee. A community development committee has been shown to be a useful entry point to the community, as well as being a body able to facilitate division of work where there may be multiple community actions.



2. Government stewardship

Partners in the RBM movement can contribute in many different ways to strengthening country health systems in a way that should make a sustainable impact on communities. National governments should exercise their stewardship to ensure that goods and services are of standard quality and create an enabling environment through:

- Policies on malaria treatment at the level of community and home.
- National drug policy for health facility and community level.
- Rapid registration procedures, reduction of taxation and import duties on commodities for malaria control.
- Promoting the effective use of multiple channels for delivering interventions and communication for behavioural change.

National health policies should support and facilitate RBM activities at district and community levels. Communities should participate as responsible partners, but expect governments to vouch for technical standards and quality of interventions by both public and private providers.

The quality of tools, services and information available through the private and voluntary sectors can vary widely. There is therefore an urgent need to establish standards that will assure quality. If attempts are made to deliberately harness or expand the capacity of private and voluntary groups it will also be necessary to assist governments with the capacity to legitimize the delivery of service by these agents, as well as to monitor and assure the quality of services.

3. Social marketing

Malaria control interventions can also be made available to communities through nongovernmental channels such as social marketing and franchising. For example, the culture of ITN use is particularly undeveloped in Africa. ITN use, a major part of malaria control activities, suffers from populations either being unaware of the potential benefits of regular use, or deterred from purchasing ITNs by high prices.

The benefits of ITNs need to be extensively promoted among communities. Widespread marketing campaigns, designed to influence attitudes and behaviours, will stimulate demand for the goods and services required. Such marketing campaigns can:

- Build awareness of, and support for, Roll Back Malaria.
- Educate communities about malaria prevention and treatment.
- Tell people where to obtain quality goods and services.
- Build awareness and stimulate demand for ITNs. This will encourage increased production and improved distribution of nets, insecticide treatment kits and other services.

Since demand creation is the objective of marketing campaigns, it is crucial that campaigns be linked to projects that enhance the supply of quality goods and services at affordable costs. Local stores or institutions must have stocks available at all times (especially of bednets and insecticides for their treatment), and be aware of their significance to the community. Demand must be met with supply to result in increased use and make a major

contribution against malaria. When this impact is evident and visible, it will in turn increase the demand for ITNs by communities; thus developing a self-perpetuating cycle to the further benefit of the community.

The main challenges to scaling up net use through the private sector are associated with perceptions of limited profitability (insufficient incentive to stock items), regulatory problems, high taxes and tariffs, inadequate distribution systems and competition from subsidized products or cheaper imports. Strategies to address these challenges include improving communication (for example, an increased market will follow active campaigning for ITN use), maximizing public-private collaboration and tax and tariff rationalization by governments.

4. Franchising and other mechanisms

In many malaria-endemic countries, the public health system is unable to reach a significant proportion of the population at risk. New mechanisms should therefore be put in place to provide access to health services for these people.

Franchising essential services (e.g. distribution of ITNs, diagnostics and pre-packaged drugs) is one way. Franchising will strengthen the capacity of private, voluntary and commercial agents; allow rapid expansion of health services, including malaria interventions; provide incentives to franchisees; and enhance access to quality prevention and treatment services. If franchising can be done at reasonable cost it will bring services closer to the homes most affected.

Other examples include encouraging private companies to set up a credit system for workers to purchase ITNs with affordable payments deducted from their salaries.

The mechanisms of both bilateral and multilateral financial institutions (through programmes such as development assistance and public debt relief) will also help to strengthen public health channels and facilitate the delivery of RBM interventions. These contributions will also form the bulk of health sector development through sector-wide approaches.

5. Ensuring equity

Malaria affects those most unable to protect themselves. It hurts poor people most. Health education may inform the community of the need for protection, and social marketing and commercial advertising may encourage ITN purchase, but the ultimate determining factor will often be the price of ITNs.

In order to bring about a significant impact on malaria morbidity and mortality, the very poor and the most vulnerable groups must not be neglected. Basic prevention methods can be made affordable to the poorest through subsidies and innovative funding mechanisms.

It is the responsibility of governments, together with their development or resource partners, to ensure that equity-enhancing mechanisms provide poor or marginalized populations with the means to protect themselves. There is also an increasing recognition by the international community that they can make a contribution to these interventions, particularly in very-low-income countries. However, care must be taken not to disturb commercial markets with free-distribution schemes.

Malaria 'priority interventions' for community action

With the cooperation of partners and the DHMT, communities can be kept informed of the best possible malaria interventions. This information, along with the results of an RBM situation analysis, allows communities to make decisions best suited to their local circumstances. Priority interventions should be decided through participatory methods such as participatory rural assessment (PRS) techniques [31-32, 34-35].

In deciding which priority interventions take precedence, the community takes responsibility for acting on its own decisions. However, the introduction of such interventions will still be determined by capacity, which will in turn be influenced by factors such as the community's resource limitations and ability to absorb new skills. Ensuring that a 'minimum package' of community-identified interventions may be delivered depends on practical issues.

Once communities have begun to implement activities it is important to document their experiences for use in further interventions, or when projects are expanded to other communities.

Summary

The persistent high burden of malaria significantly affects both communities and countries. Evidence illustrates the significant damage that malaria does, in economic terms alone, by retarding national development. In personal terms, the effects on families and communities are devastating.

Significant progress in the reduction of malaria cannot be made without giving first consideration to those most affected by the disease. Community participation in malaria interventions is essential and the community must be empowered to make changes for its own welfare.

Changes must be made, and they must be made with the cooperation of many partners. National governments, together with bilateral and multinational development partners, NGOs and other interested partners, have a fundamental role in supplying effective interventions. Information, technical and financial resources supplied by these partners will have a major effect in helping communities help themselves.

National commitment to RBM programmes is essential. With strong political support health systems can be strengthened to ensure that services are within reach of all communities. District health services can assist the community in developing local programmes through training and supplies.

National governments (through a national RBM task force or a national community working group) should also assist districts by providing information on key family health practices, by developing community-based communication materials, and by advocating with all partners. National government leadership, together with partner contribution, can help plan and support the district's RBM community activities. The stewardship role of governments in providing

regulatory standards and quality assurance is key to the success of community-based programmes.

By building links with communities, governments will also learn the specific needs of that community. Community-based programmes can be designed to complement current health programmes so that each maximizes the benefits to many communities, especially where a majority of the population lives in widely dispersed areas. In sub-Saharan Africa, for example, anywhere between 12-82% of malaria episodes may be managed outside the formal health sector.

Community-based programmes bring health care directly to the homes of those most affected. They help prevent suffering and death by providing timely care and support. These programmes directly contribute to reducing the incidence of malaria, through the dissemination of information, the provision of appropriate drugs from local drug vendors and by the creation of financial mechanisms to provide interventions. New methods and technologies enable health care and preventive methods (e.g. IMCI protocols, pre-packaged drugs) to be delivered directly to the community with an efficiency and effectiveness not previously available.

Evidence shows that RBM community-based health programmes are already very effective. The objectives of making significant reductions in malaria levels can only be met by concerted actions built upon well-designed and thorough programmes. However, there is still a need for support and cooperation in the development of these programmes, and partnerships must be strongly committed in order to ensure that goals are achieved. Community participation and empowerment are central to the success of RBM programmes and the fulfilment of its objectives.

Glossary

Abbreviations

ARI	Acute respiratory illnesses
BDN	Basic Development Needs
CBO	Community-based organizations*
CDD	Control of diarrhoeal diseases
CHW	Community health worker
CORPs	Community's own resource persons*
Cscom	Centre de la santé communautaire de Mali (Community health centre of Mali)
DHMT	District health management team
DOTS	The internationally recommended strategy for TB
EDM	Essential Drugs and Medicines
EPI	Expanded Programme on Vaccination
ITN	Insecticide-treated net
IMCI	Integrated Management of Childhood Illness
HIV/AIDS	Human immunodeficiency virus/ acquired immunodeficiency syndrome
MOH	Ministry of Health
NGO	Nongovernmental organizations
PHC	Primary health care
IPT	Intermittent preventive treatment
PLA	Participatory learning and action*
PRA	Participatory rural appraisal*
RBM	Roll Back Malaria
SOS	Sustainable Outreach Services (includes EPI)
VHW	Volunteer health worker
WHO	World Health Organization

** See terms and concepts*

Terms and concepts [38-40]

Advocacy—A continuous and adaptive process of gathering, organizing and formulating information into argument, with a view to raising resources or gaining the acceptance and commitment of political and social leadership to a development programme, thereby preparing a society for its acceptance.

Community—A group of people with common interests and fellowship living in the same local area (i.e. more intimately involved than at either district or regional areas).

Community participation—The active involvement of people living together in

some form of social organization and cohesion in the planning, operations and evaluation of a programme using local, national and other resources. It is a process through which communities ultimately influence and share control over the development, local initiatives, decisions and resources of projects (e.g. malaria control) that directly affect them.

Community ownership—Community participation that has been developed to increase people's sense of control over issues that affect their lives.

Community's own resource persons (CHW, TBA, VHW)—Trained health workers who are members of the community where they work, selected by the community, answerable to the community for their activities, supported by the community as well as the health system, and having a shorter training than professional health workers.

Community-based organizations—Local organizations functioning at grassroots level.

Communication strategy—A plan to communicate health messages using methods (e.g. pamphlets, presentations, posters, workshops, film, videotape or slide shows, drama, radio spots, newspapers) that are appropriate to the target population.

Key informants—Persons carefully selected to inform the programme because of their special knowledge of specific relevant aspects of the target population or their in-depth understanding of the key issues.

Participatory learning and action (PLA)—A community development approach whereby facilitators work with communities to help them analyse their needs, identify solutions to fill those needs, and develop and implement a plan of action. PLA is based on many different participatory approaches, including participatory rural appraisal (PRA), rapid rural appraisal (RRA), and applied anthropology.

Participatory rural appraisal (PRA)—A way of learning from and with community members while investigating, analysing and evaluating locally-based development projects. It is a method by which a trained team can quickly and systematically collect information for the general analysis of a specific development intervention (e.g. needs assessments, feasibility studies) in non-literate rural communities.

Social marketing—An approach using marketing techniques to promote and distribute socially beneficial interventions rather than commercial products.

Social mobilization—A process of bringing together all interested intersectoral partners and allies to determine felt needs and raise awareness of and demand for a particular development objective. It involves enlisting the support of all stakeholders, including institutions, groups and communities, in identifying, raising and managing human and material resources, thereby increasing and strengthening participation for self-reliance and sustainability of achievements.

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Roll Back Malaria is a global partnership founded by the governments of malaria-afflicted countries, the World Health Organization, the United Nations Development Programme, the United Nations Children's Fund and the World Bank. Its objective is to halve the burden of malaria for the world's people by the year 2010 by saving lives, reducing poverty, boosting school attendance and making life better for millions of people living in poor countries, especially in Africa.

If you are interested in becoming part of the Roll Back Malaria movement and becoming part of the global success story in reducing malaria, please write to:

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Roll Back Malaria

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