Washington — siding with mosquitoes against wo

By Nicholas D Kristof

Humans are better off exposed to DDT than exposed to malaria

IF the US wants to help people in tsunami-hit countries like Sri Lanka and Indonesia — not to mention other poor countries in Africa — there's one step that would cost us nothing and would save hundreds of thousands of lives.

It would be to allow DDT in malaria-ravaged countries.

I'm thrilled that we're pouring hundreds of millions of dollars into the relief effort, but the tsunami was only a blip in third-world mortality. Mosquitoes kill 20 times more people each year than the tsunami did, and in the long war between humans and mosquitoes it looks as if mosquitoes are winning.

One reason is that the US and other rich countries are siding with the mosquitoes against the world's poor — by opposing the use of DDT.

"It's a colossal tragedy," says Donald Roberts, a professor of tropical public health at Uniformed Services University of the Health Sciences. "And it's embroiled in environmental politics and incompetent bureaucracies."

In the 1950's, 60's and early 70's, DDT was used to reduce malaria around the world, even eliminating it in places like Taiwan. But then the growing recognition of the harm DDT can cause in the environment — threatening the extinction of the bald eagle, for example — led DDT to be banned in the West and stigmatised worldwide. Ever since, malaria has been on the rise.

The poor countries that were able to keep malaria in check tend to be the same few that continued to use DDT, like Ecuador. Similarly, in Mexico, malaria rose and fell with the use of DDT. South Africa brought back DDT in 2000, after a switch to other pesticides had led to a surge in malaria, and now the disease is under control again. The evidence is overwhelming: DDT saves lives.

But most Western aid agencies will not pay for anti-malarial programmes that use DDT, and that pretty much ensures that DDT won't be used. Instead, the UN and Western donors encourage use of insecticide-treated bed nets and medicine to cure malaria.

Bed nets and medicines are critical tools in fighting malaria, but they're not enough. The existing anti-malaria strategy is an under-financed failure, with malaria probably killing 2 million or 3 million people each year.

DDT doesn't work everywhere. It wasn't nearly as effective in West African savannah as it was in southern Africa, and it's hard to apply in remote villages. And some countries, like Vietnam, have managed to curb malaria without DDT.

But overall, one of the best ways to protect people is to spray the inside of a hut, about once a year, with DDT. This uses tiny amounts of DDT — 450,000 people can be protected with the same amount that was applied in the 1960's to a single 1,000-acre American cotton farm.

Is it safe? DDT was sprayed in America in the 1950's as children played in the spray, and up to 80,000 tons a year were sprayed on American crops. There is some research suggesting that it could lead to premature births, but humans are far better off exposed to DDT than exposed to malaria.

I called the World Wildlife Fund, thinking I would get a fight. But Richard Liroff, its expert on toxins, said he could accept the use of DDT when necessary in anti-malaria programmes.

"South Africa was right to use DDT," he said. "If the alternatives to DDT aren't working, as they weren't in South Africa, geez, you've got to use it. In South Africa it pre-

> Why do the UN and donor agencies generally avoid financing DDT programmes? The main obstacle seems to be bureaucratic caution and inertia. But it's also tragic that our squeamishness about DDT is killing more people in poor countries, year in and year out, than even a once-in-a-century tsunami

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vented tens of thousands of malaria cases and saved lots of lives."

At Greenpeace, Rick Hind noted reasons to be wary of DDT, but added: "If there's nothing else and it's going to save lives, we're all for it. Nobody's dogmatic about it."

So why do the UN and donor agencies, including the US Agency for International Development, generally avoid financing DDT programmes? The main obstacle seems to be bureaucratic caution and inertia. President Bush should cut through that and lead an effort to fight malaria using all necessary tools — including DDT.

One of my most exhilarating moments with my children came when we were back-packing together and spotted a bald eagle. It was a tragedy that we nearly allowed DDT to wipe out such magnificent birds, and we should continue to ban DDT in the US. But it's also tragic that our squeamishness about DDT is killing more people in poor countries, year in and year out, than even a once-in-a-century tsunami. COURTESY THE NEW YORK TIMES

An acute AIDS concern

Ahmed Saleem

No disease has inspired an international response equal to the World Health Organisation's mobilisation against the Acquired Immune Deficiency Syndrome (AIDS). None in recent memory has provoked more anxiety, aroused such prejudice against the afflicted, or stimulated so many moral, ethical, and legal debates. And no disease has more pointedly forced societies to confront issues otherwise ignored: drug abuse, sexuality, and the plight of the poor.

The world is rightly alarmed at the potential of AIDS to surpass other killers, if allowed to spread unchecked. Moreover, body counts do not alone reflect what AIDS sets apart. Unlike most diseases, AIDS is almost always fatal; there is no cure and no vaccine. Carriers may go for years without symptoms, evoking the paranoia and fear that accompany uncertainty. And the most common mode of AIDS transmission deals with the most intimate of activities, the most powerful of human emotions.

Significantly, (AIDS) is one of the few diseases that pose a substantial threat to both industrial and developing nations including Pakistan.

Pakistan has more than 2500 reported cases of the human immunodeficiency virus (HIV) and AIDS. But what about those unreported cases, estimated at between 80,000 and 90,000, or 0.1 per cent of the adult population in Pakistan, that are HIV-positive, according to a recent World Bank report released on World Aids Day 2004. Social taboos deter patients from reporting their illness with the result that many cases go unreported, says the report, adding that although the prevalence of HIV in Pakistan is still low, the country is highly vulnerable to an escalating epidemic due to several significant risk factors.

Pakistan's many competing needs (including provision of basic social services and debt servicing and drug control expenditures) make resource mobilisation difficult. This difficulty is compounded by an almost major donor freeze on grant aid after the 1998 nuclear tests.

Political commitment to HIV/AIDS has greatly increased in recent years in this "low prevalence, high-risk AIDS country". The government, together with donor agencies and local social sector organisations, is striving to take curative and precautionary measures as far as the spread of the disease is concerned. There is a national AIDS control programme to combat the virus. UNAIDS is working in Pakistan on awareness and bringing about behavioural changes among the people against this killer epidemic, which has engulfed the African continent and has the potential to become a major health problem in Asia.

These efforts and programmes, though commendable, are missing an important point: creating awareness and making a behavioural change in people about something they don't experience, see, hear or talk about is an uphill task. This country has low literacy, widespread poverty and a unique socio-cultural-religious environment. Innovative approaches are needed before the people will learn to protect themselves from potential health risks and infections. HIV will have to be grouped with other problems such as Hepatitis B and C, which already infect large numbers and have exactly the same mode of transmission.

Estimating the social and economic impact of AIDS in Pakistan is fraught with uncertainty. Scientists have very little data on the prevalence of HIV infection or on the conditions - both behavioural and social - that determine its spread, to confidently project the future course of the epidemic. Even less information is available on translating rising death rates into potential impacts on an overtaxed health system, economic output, or future population growth.

It is in the area of child health that AIDS has the greatest potential to erode hard-won health gains in Pakistan and the rest of the Third World. Over the last three decades, Pakistan has developed a "child survival revolution" through encouraging oral rehyderation therapy for diarrhoea, immunisation, breast-feeding, and birth spacing. Left unchecked, AIDS will undermine these gains as more and more pregnant women become infected and transmit the virus to their children *in utero*.

Unlike other diseases that cull the weakest members of the society AIDS eliminates the most productive segment of population. We in Pakistan have to think about these lethal impacts very seriously where the ranks of people with certain specialised skills and training may be small, the loss of even a handful of engineers, health planners, or agronomists can be debilitating.

Stopping AIDS in Pakistan will take an overriding alliance of professional skills, resources, and experience. Left unaided, we will have to divert scarce resources from other essential development initiatives or accept ever-rising death tolls. Even developed and industrialised countries cannot fight this scourge alone, for the disease respects no national boundaries. Unless all nations work together against AIDS, there will be little success in combating this deadly disease.

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