

and risks for alteplase. It will report its conclusions to the CHM. The membership, terms of reference, and the full minutes of the expert working group will be published in due course.

I am MHRA Chief Executive. I declare no competing interests.

Ian Hudson

info@mhra.gsi.gov.uk

Medicines and Healthcare Products Regulatory Agency (MHRA), London SW1W 9SZ, UK

- 1 The IST-3 collaborative group. The benefits and harms of intravenous thrombolysis with recombinant tissue plasminogen activator within 6 h of acute ischaemic stroke (IST-3): a randomised controlled trial. *Lancet* 2012; **379**: 2352–63.
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- 3 O'Fallon M, Asplund K, Goldfrank LR, et al. Report of the t-PA Review Committee. 2004. <http://stroke.nih.gov/resources/t-pa-review-committee.htm> (accessed July 31, 2014).
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Venezuela's failure in malaria control

In their recent Correspondence (June 7, p 1967),¹ José Félix Oletta and colleagues noted that in the past 15 years the Venezuelan Government has been incapable of implementing a coherent plan to address the health needs of its people, and importantly, failed in the control of vector-borne diseases such as malaria and dengue. Malaria control in Venezuela contrasts with the progress made globally and by neighbouring countries that have substantially decreased the morbidity, mortality, and economic burden associated with malaria. For example, Brazil and Colombia have decreased disease burden due to *Plasmodium falciparum* and *P vivax* by more than 50%: the burden in Brazil

decreased from 606 067 cases in 2005 to 242 758 in 2012; in Colombia it decreased from 125 262 cases in 2007 to 60 179 in 2012.²

Worldwide, between 2000 and 2012, malaria mortality estimates fell by 42% in all age groups and by 48% in children younger than 5 years.² Malaria mortality is projected to decrease by 52% in all age groups, and by 60% in children younger than 5 years by 2015.² This represents substantial progress towards the World Health Assembly's target of reducing malaria burden by 75% by 2015.²

In the Americas, substantial achievements have been reached towards reduction of this endemic disease, with a 58% decrease in malaria cases (from 1·1 million in 2000 to 469 000 in 2012). This reduction was observed in all endemic countries, with the exception of Venezuela, Haiti, and Guyana.² In Venezuela—a country with a Human Development Index (HDI) of 0·748 and gross national income per head of US\$11 475,³ malaria incidence increased between 2000 and 2012. A similar increase in incidence was seen in Guyana and Haiti, but both of these countries have a much lower HDI than Venezuela,³ and a devastating earthquake hit Haiti during that period.

In Venezuela, in 1998, there were 21 815 malaria cases; in 2013, there

were a total of 76 621 reported cases (figure),^{2,4} and estimates suggest that the number of cases will continue to rise.^{2,4} As of May 11–17, data from the Venezuelan Ministry of Health show that for 2014, there have been 29 931 reported cases, thus an alarming average 1 497 cases per week.⁴

Although some public health officials have questioned this increase, the epidemiological data clearly show that the number of cases has increased, and even though most cases are reported from endemic states in the south, these cases are occurring predominantly in suburban areas. Antimalarial drugs are not available in private drug stores nor sold under medical prescription. How can the government expect to lower the rates of malaria if it cannot provide adequate coverage in highly endemic areas? How to control malaria when there is a continuous shortage of antimalarial drugs?

Worryingly, a similar situation is happening with leishmaniasis, where the effectiveness of the national control programme has been hampered and patients have no access to treatment because of shortages in the national stock of antimonial drugs.

There are shortages of supplies for control campaigns, not only for

For the minutes of the Commission on Human Medicines see <http://www.mhra.gov.uk/Committees/Medicinesadvisorybodies/CommissiononHumanMedicines/Minutes/index.htm>

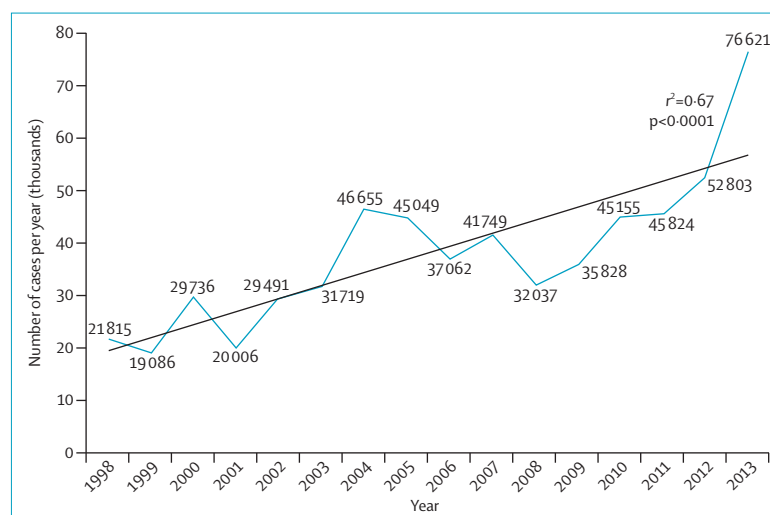


Figure: Malaria in Venezuela, 1998–2013



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malaria control, but also for other vector-borne diseases that rely on indoor residual spraying and outdoor spraying for their prevention. Such a situation is not only affecting malaria transmission, but also the resurgence of yellow fever, dengue, and vector-borne parasitoses such as Chagas disease.⁵

Malaria in Venezuela requires immediate intersectorial action and investment to halt this unnecessary and increasing burden. How Venezuelan authorities will handle this situation remains to be seen.

We declare no competing interests.

***Alfonso J Rodríguez-Morales,
Alberto E Paniz-Mondolfi
arodriguezm@utp.edu.co**

Public Health and Infection Group of Research, Faculty of Health Sciences, Universidad Tecnológica de Pereira, Pereira, Risaralda, Colombia (AJR-M); and Yale University School of Medicine, New Haven, CT, USA (AEP-M)

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Global Governance for Health: what about liberal power?

The Lancet—University of Oslo Commission on Global Governance for Health¹ has identified several power disparities in global governance and their implications for health, and thereby provoked attention to political asymmetries. In their recent Correspondence (June 28, p 2207),² Robert Marten and

colleagues commend the Commission for creating an important discussion and they propose analytical frames to investigate power. We would like to add a perspective to this analytical framework by drawing attention to liberal forms of power characteristic of modern systems of governance.

Power is a changing phenomenon that persistently operates and justifies itself in new ways. The umbrella term New Public Management covers significant changes in the steering systems of public and private sectors in western countries. For the past decade we have taken an interest in the democratic attempts to redistribute power to benefit the weakest and documented how these attempts have paradoxical implications in health care.^{3–5}

Building on the so-called governmentality school, we wish to draw attention to a political determinant of health that seems to be overlooked by Marten and colleagues.⁶ In modern liberal states, people are confronted with a non-negotiable obligation to manage their own freedom. Patients are expected to demonstrate their will to be empowered and to act as user participants. On an organisational level, various systems of self-regulation have been introduced, such as quality assurance systems, self-evaluations, and different documentation practices.

Over the past decades we have been witnessing a close alliance between these liberal forms of power and global governance for health. Systems of self-regulation have to a large degree become a condition for global health initiatives and for development aid more generally.⁷ Those recipients who do not meet these expectations risk being considered unworthy of further assistance. We fear that the obligation for self-regulation risks creating an opposition between a new elite group of worthy needy and those who are too vulnerable

to live up to the expectations of self-regulation. There is a need to explore whether self-regulation and the will to be empowered has become a prerequisite for receiving effective health care and the possible implications of such an ideology.

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***Eivind Engebretsen, Kristin Heggen
eivind.engebretsen@medisin.uio.no**

Faculty of Medicine, University of Oslo, 0316 Oslo, Norway

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Department of Error

Haj-Hassan T, McShane T, Mahmud I, et al. Israel–Gaza conflict. *Lancet* 2014; **384**: 489—In this Correspondence (Aug 9), Imran Mahmud and David Lloyd's affiliations should have read: Thames Valley/Oxford Deanery, Oxford OX4 2SU, UK (IM); and University of Liverpool, Liverpool, UK (DL). These corrections have been made to the online version as of Aug 22, 2014.