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MINISTERIAL CONFERENCE ON MALARIA

Report by the Director-General

As requested by the Executive Board in January 1990, the Ministerial Conference on Malaria was held from 26 to 27 October 1992 in Amsterdam, the host being the Government of the Netherlands. There were 450 participants including 225 delegates from 100 countries - 90 of the 95 malaria endemic countries were represented, 44 by their minister of health. The Conference, which adopted the World Declaration for the Control of Malaria, was the culmination of three interregional meetings on malaria control held during the past year.

1. The WHO Executive Board and the World Health Assembly in 1989 adopted resolutions EB83.R16 and WHA42.30, respectively, asserting that malaria control must be a global priority, essential for the achievement of health for all and the objectives of child survival programmes. The following year the suggestion was made in the Executive Board that a global malaria conference should be convened at ministerial level to focus on the worsening malaria problem, to adopt a global strategy for malaria control, and to intensify commitment to malaria control by political and health leaders and among donor agencies.

2. A two-day Ministerial Conference on Malaria was held on 26 and 27 October 1992 in Amsterdam, Netherlands, with the objectives of: (1) achieving formal recognition of malaria as a major public health problem and an obstacle to social and economic development; (2) strengthening commitment to malaria control by political and health leaders; and, (3) making a formal declaration of approach and support for a global strategy for malaria control.

3. Three interregional preparatory meetings set the stage for the Conference, involving all 95 countries in which malaria is endemic. The first interregional meeting on malaria control, for Africa, was held in Brazzaville in October 1991 and was attended by over 130 participants from 53 countries. It focused on the pragmatic approach to disease control of tropical-forest, savanna, urban, desert-fringe and highland-fringe malaria, and it called on all countries in the African Region, donor countries, regional and international organizations and agencies and the private sector to commit themselves to a global initiative for malaria control. The meeting concluded that malaria control should be an integral part of health care services and disease control programmes and that the strengthening of these services is crucial. Member States from the African Region are, indeed, now well advanced in initiating, strengthening, or revising national malaria control programmes in accordance with the strategies recommended.

4. The second interregional meeting on malaria, for Asia and the Western Pacific, was held in New Delhi in February 1992 and was attended by more than 150 participants from 34 countries. It considered particularly the application of current epidemiological knowledge for the prevention, diagnosis and treatment of malaria, related to the organization and management of health care delivery systems. The meeting put forward a number of recommendations for the development and implementation of a malaria control strategy, based on four broad elements: prompt diagnosis and treatment of cases; development or strengthening of information systems to guide programme management; vector control; and the prevention and control of epidemics.

5. The third interregional meeting was that for the Americas, held in Brasilia in April 1992. It was attended by 100 participants from 29 countries. Its principal focus was malaria in the context of social and economic development and intersectoral collaboration. The meeting emphasized that, in the planning and evaluation of social and economic development projects appropriate attention should be given to health effects, including the risk of malaria; and that policies which promote migration to social and economic projects or natural environments where malaria epidemics are likely must be reconsidered in order to ensure a more economic, humane and environmentally balanced development.

6. Detailed deliberations by the working groups of all the interregional meetings permitted the preparation of a generally accepted and well-defined global malaria control strategy that was the focal point of discussions in Amsterdam. This document, as finally edited by an expert review group in June 1992, presents the objectives, bases, and means of application of the elements of malaria control together with an outline of programme organization and international collaboration and outlines a more pragmatic WHO Action Plan for the remainder of the decade.

7. There were 225 delegates from 100 countries among the 450 participants in the Ministerial Conference on Malaria, held at the RAI Congress Centre on 26 and 27 October 1992, the host being the Government of the Netherlands. Ninety of the 95 countries in which malaria is endemic were represented, 44 of them by their minister of health.

8. His Excellency President Pascal Lissouba, of the Congo, was elected President of the Conference by acclamation. Dr Eusebio del Cid, Minister of Health of Guatemala, Dr M. Adhyatma, Minister of Health of Indonesia, Dr Ali Bin Mohamed Bin Moosa, Minister of Health of Oman and Mrs Hilda Lini, Minister of Health of Vanuatu, were elected Vice-Presidents.

9. There were interventions by the ministers of 65 endemic countries and 13 statements by other partners in malaria control efforts. A draft World Declaration on the Control of Malaria that had been prepared during the interregional meetings was extensively discussed and reviewed during plenary sessions. The final version of the draft which was endorsed reflected not only the commitment made by Member States to malaria control, but also the commitment made by organizations and bodies of the United Nations system, bilateral development organizations, and other international nongovernmental and commercial organizations. This was signed on behalf of the participants by the President and Vice-Presidents of the Conference (Annex), thus fulfilling the threefold global mandate for recognition, action and commitment to malaria control in response to the suggestion first put forward by the WHO Executive Board in January 1990.

ANNEX

WORLD DECLARATION ON THE CONTROL OF MALARIA

The Ministerial Conference on Malaria, meeting in Amsterdam this twenty-seventh day of October in the year nineteen-hundred-and-ninety-two,

Expressing the urgent need for commitment to malaria control by all governments, all health and development workers, and the world community,

Hereby makes the following declaration:

I

The Conference recognizes that malaria constitutes a major threat to health and blocks the path to economic development for individuals, communities and nations. Almost half the world's population is at risk from this disease, which causes 100 million clinical cases and over one million deaths each year.

II

While over 80% of malaria cases and deaths occur in Africa, malaria is a problem in every region of the world. It affects young and old. Children are particularly at risk, malaria being one of the major causes of death among children in tropical Africa, taking the life of one in 20 children under the age of five years. The disease also causes anaemia in children and pregnant women and increases their vulnerability to other diseases. It afflicts the poor and underprivileged most severely, sapping productivity and causing chronic ill health. The social and economic impact is staggering.

III

Social, political and economic changes all contribute to the worsening malaria problem, particularly through the large-scale uncontrolled population movements and ecological disturbances they cause. Nonimmune populations entering malaria-endemic zones within the frontiers of economic development are paying an exorbitant price because they suffer disease and disability.

IV

Construction and environmental change brought about by development are creating environments favourable for malaria transmission, exacerbating existing problems and opening the way for devastating epidemics in areas which were previously malaria-free, leading to many deaths and profound impoverishment of communities.

V

The spread of drug resistance is making malaria treatment more complicated, often requiring newer drugs that may be more expensive or more toxic than chloroquine. These characteristics place higher priority on personal and community action to protect people against mosquito bites and actually reduce the efficacy of malaria drug prophylaxis.

VI

Despite these problems, the situation can and must be controlled with the tools now available. We have learnt that the key to success is to apply the right strategies in the right place at the right time, and to apply them on a sustained basis. In most endemic countries, the goal will be to prevent malaria mortality and to reduce morbidity and the social and economic losses caused by this disease through the progressive improvement and strengthening of local and national capabilities. The challenge will be especially great in the least developed countries, where international solidarity will be required for sustained support.

Annex

VII

We, recognizing the above:

- endorse the Global Malaria Control Strategy, acknowledging the need to focus on strengthening local and national capabilities and to adapt it to specific country circumstances;

- support the four technical elements of this strategy:

  - to provide early diagnosis and prompt treatment;

  - to plan and implement selective and sustainable preventive measures, including vector control;

  - to detect early, contain or prevent epidemics;

  - to strengthen local capabilities in basic and applied research to permit and promote the regular assessment of a country's malaria situation, in particular the ecological, social and economic determinants of the disease;

- support decentralized structures of programme management in which those closest to the problem are delegated responsibility for employing available resources most appropriately;

- accept the crucial role of a core group of national specialists in defining and evolving national strategies and in implementing effective systems of training and supervision and of health education which incorporate them. These systems are needed to ensure that new knowledge, especially that derived from operational research and from routine monitoring and evaluation, is continuously made available to those in the best position to utilize it;

- know that the problem of malaria will continue to evolve, and know that malaria control strategies must, too, evolve. We support the need for continuous research and development, including basic research to develop better tools for malaria control and applied research to permit the optimal use of existing resources under the widely varying conditions in which malaria flourishes. We recognize that there is need for far more extensive support for science in the service of the social sectors, to ensure that it is put to work for all mankind.

VIII

We commit ourselves and our countries to controlling malaria, and

- will review our current efforts, acknowledging that better use of existing resources is possible, and will identify the unmet needs in order to mobilize any additional resources required to expand current activities:

- will plan for malaria control as an essential component of health development and will incorporate health development as an essential component of national development. We know that the potential for development projects to spread malaria and other tropical diseases can far exceed the ability of the health and social sectors to take remedial action. Health measures must be incorporated in such projects if they are to contribute positively to social and economic development for the communities concerned;

- will involve communities as partners in our efforts, as well as the sectors concerned with education, water resources, sanitation, agriculture and development;

- will implement malaria control in the context of primary health care, seeing it as an opportunity to strengthen health and social infrastructures and to promote the fundamental right of all populations affected by malaria to have access to early diagnosis and appropriate treatment.

IX

While recognizing the primary responsibility of affected countries to take the action essential for malaria control, we draw attention to the fact that the problem is often greatest in the very countries or areas which can least afford to take action. Recognizing also that external support will inevitably be limited in time and directed at building up self-reliance within a reasonable period, we call upon international development partners, including organizations and bodies of the United Nations system, bilateral agencies, and nongovernmental organizations to increase their support to malaria control, contributing their resources so as to strengthen sustainable national malaria control plans in accordance with the global strategy, and to increase support to research that will lead to new malaria control tools, including vaccines. We base this call on grounds of social justice and equity as well as on the conviction that such support will contribute specifically to social and economic development and to alleviating world poverty.

X

We call on the World Health Organization, in fulfilment of its constitutional function as the directing and coordinating authority on international health work, to exercise leadership in providing support for national implementation of this global strategy.

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