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MALARIA AND THE INTERNATIONALLY AGREED-UPON DEVELOPMENT GOALS, INCLUDING THOSE CONTAINED IN THE MILLENNIUM DECLARATION

Malaria transmission was eliminated from a number of territories but is still reported in 21 of the Member States of the Pan American Health Organization (PAHO). It is estimated that 40 million persons live in areas of moderate and high risk, and approximately 1 million cases have been reported annually since 1987.

Having abandoned efforts to eradicate malaria, the World Health Organization introduced the Global Malaria Control Strategy in 1992, which was adopted by PAHO Member States. In 1998, the Roll Back Malaria (RBM) Initiative was launched with the aim of creating a movement at the global, regional, national, and local levels to further strengthen the implementation of the Global Malaria Control Strategy and to reduce the malaria burden by 50% by 2010.

At the 42nd Directing Council of PAHO, Member States in which malaria continued to be a public health problem adopted the RBM Initiative. In 2000, the United Nations General Assembly included "Combat HIV/AIDS, malaria, and other diseases" in the internationally agreed-upon health-related development goals in the U.N. Millennium Declaration.

There has been a reduction in the overall malaria incidence in recent years, but the disease still constitutes a public health problem in the Region with a disparity in the outcome of efforts in different countries related to a number of factors including variations in ecological conditions, diagnostic and treatment coverage, weaknesses in health systems, and technical capacity issues. Operational research is important for evidence-based decision-making.

There is a need for continued commitment to achieving the Roll Back Malaria (RBM) Initiative and the internationally agreed-upon development goals including those on malaria contained in the Millennium Declaration, preserving achievements in malaria control, and focusing on present and new challenges including those related to communication, coordination, and cooperation within the health and other sectors.

The document complements the report to the Fifty-eighth World Health Assembly in May 2005 (Document A58/8), which focused on the malaria situation in Africa. It provides a summary of the malaria situation in the Americas and PAHO's technical cooperation to Member States.

The Directing Council is invited to provide comments and to urge Member States to continue their commitment to the RBM Initiative and the internationally agreed-upon health-related development goals in the U.N. Millennium Declaration.

The Council is also invited to consider the annexed resolution proposed by the Executive Committee.

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Introduction

1. During the early years of the twentieth century, malaria transmission occurred throughout the Americas. It was one of the prevalent infectious diseases that triggered a resolution of the Second International Conference of American States held in Mexico, January 1902, which recommended that "a General Convention of Representatives of the Health Organizations of the different American Republics" be convened. The Convention, held in Washington, D.C., United States of America, in December 1902, was the predecessor of the current Pan American Health Organization (PAHO).[1]

2. Although experience and knowledge in combating malaria was gained by efforts in the United States of America and other countries in the Region, malaria was identified as "the disease that causes most harm to the greater number of nations of the Continent" by the 11th Pan American Sanitary Conference in 1942. It recommended that the Malaria Committee of the Pan American Sanitary Bureau be considered the consulting group for carrying out survey and malaria control programs in the Americas. That role was undertaken, and by 1948, it had shown great success in reducing malaria and even eliminating transmission in large areas of two South American countries, Guyana and Venezuela, a result of efforts led by Drs. George Giglioli and Arnoldo Gabaldon in the respective countries. There was additional information on successes in resolving the malaria problems in Argentina and the United States of America and marked progress in Brazil and Ecuador. These were some examples used in promoting the call for eradication of the disease, and in 1954, the 14th Pan American Sanitary Conference in Chile gave the Pan American Sanitary Bureau the responsibility for support and coordination of malaria eradication from the Americas; a Global campaign to eradicate malaria was subsequently approved at the Eighth World Health Assembly held in Mexico in May 1955. [2]

3. In undertaking the eradication strategy that focused on combating mosquitoes, efforts in the Americas were supported by PAHO until 1992, when the global eradication strategy was abandoned and replaced by the Global Malaria Control Strategy (GMCS). The strategy in the Americas is consistent with the four basic technical elements of the GMCS. The GMCS was designed to provide early diagnosis and prompt treatment of malaria; to plan and implement selective and sustainable preventive measures, including vector control; to detect early, contain, or prevent epidemics; and to strengthen local capacities 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.

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[1] Pan American Health Organization. A History of the Pan American Health Organization. Washington, DC; 1992.

[2] Pampana. E. A Textbook of Malaria Eradication, Second Edition. Oxford University Press; 1969.

4. In 1998, the World Health Organization (WHO) and partner institutions launched the Roll Back Malaria (RBM) Initiative as a response to the recognition of the global burden associated with malaria. The RBM Initiative aims to halve the malaria burden in participating countries by the year 2010 through interventions that are adapted to local needs and by reinforcement of the health sector.[3] Two years later, in 2000, the United Nations released the U.N. Millennium Declaration, which included halting and beginning to reverse the spread of HIV/AIDS, malaria, and other major diseases by 2015.[4]

5. It is in the context of the aforementioned global objectives and efforts that the malaria situation is monitored and analyzed in the Americas. The same framework is used to conceptualize, plan, implement, and monitor malaria projects in the Region, as well as respond to the continuing, emerging, and reemerging challenges that the disease presents. Member States provide PAHO with information on malaria, which is used annually in preparation of a situation report. In the Region, prevention of a reemergence of malaria is an important consideration in North America and the majority of the islands in the Caribbean where elimination has been achieved.

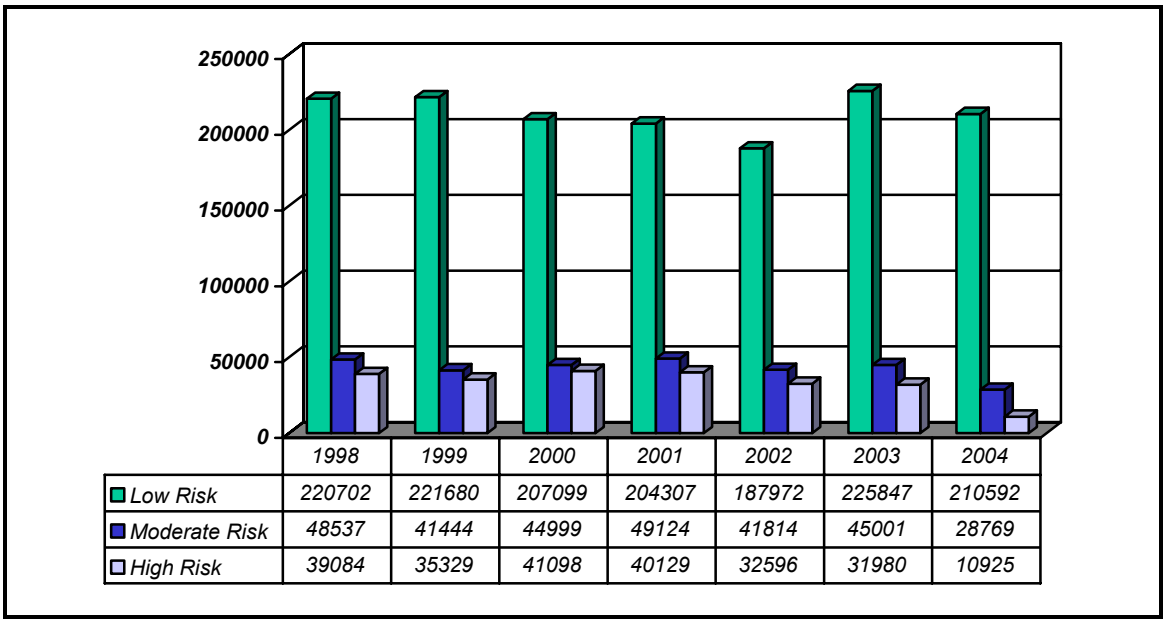
6. The purpose of the report is to provide a summary of the malaria situation in the Americas since the Roll Back Malaria Initiative launched by WHO in 1998 and its official adoption in the Americas in 2000; to highlight achievements and the unfinished agenda; to encourage Member States to continue their commitment to achieving the Roll Back Malaria and the goals on malaria prevention and control in the U.N. Millennium Declaration, taking into account new and contemplated challenges; and to contribute to the implementation in the Americas of resolution WHA58.2.

Current Malaria Situation: An Overview of the Epidemiological Patterns

7. In 2004, PAHO Member States indicated that of the estimated 865 million inhabitants of the Americas, approximately 250 million live in areas at ecological risk of malaria transmission. Of those, approximately 211 million live in areas at low or extremely low levels of risk (<1 case per thousand population), 29 million in areas of moderate risk (1-10/1000), and 11 million at high risk (>10/1000) (Figure 1). These figures represent a 14% decrease in the percentage of the Region's overall population reported at risk of malaria transmission in 2000, when the RBM Initiative was officially adopted in the Region. Malaria remains a public health problem in the Region with transmission reported in 21 of the PAHO Member States.

[3] World Health Organization. Roll Back Malaria. Geneva: WHO; 2000.
[4] United Nations. Millennium Development Goals. New York: UN; 2000.

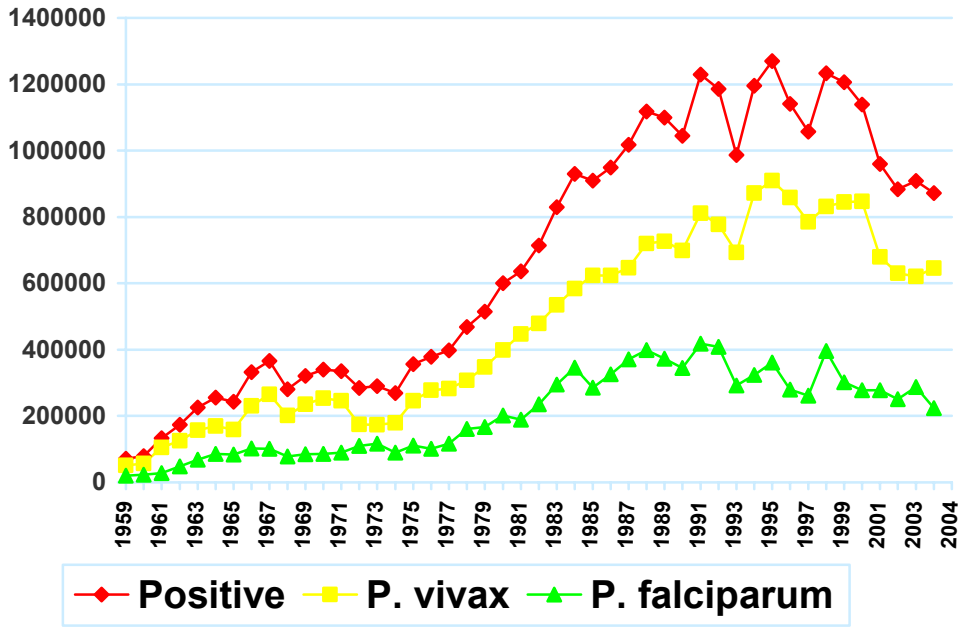
Figure 1. Population of the Americas According to Level of Transmission Risk, 1998-2004 (in thousands)



	1998	1999	2000	2001	2002	2003	2004
Low Risk	220702	221680	207099	204307	187972	225847	210592
Moderate Risk	48537	41444	44999	49124	41814	45001	28769
High Risk	39084	35329	41098	40129	32596	31980	10925

8. Weaknesses in health information systems make underreporting of events likely. Since 1959, information on the annual number of cases by malaria parasite has been reported by Member States to the Secretariat. By 1963, over 200,000 cases were reported; that number quadrupled by 1983 and continued increasing to over 1 million cases in 1987. When the official decade to Roll Back Malaria began in 2000, there were 1.1 million cases reported. Since then, Member States have reported reduced incidence and improvement in epidemiological trends (Figure 2).

Figure 2. Malaria in the Americas by Parasite Species, 1959-2004
Number of Cases



9. *Plasmodium vivax* is the leading cause of malaria in the Region, accounting for 74% of all cases; *P. falciparum* was the cause of 25.6%; and *P. malariae*, less than 0.4% of all cases. In the countries sharing the Amazon rain forest, similar proportions are observed at the country level with the exception of those in the Guyana Shield. In Mesoamerica (Mexico, Central America, and Hispaniola), overall, *P. vivax* accounts for 93.6% of the cases, but in the Dominican Republic and Haiti almost 100% of the cases are due to *P. falciparum.*

10. The burden of malaria reported in the Americas by Member States in 2004 revealed that there were 871,965 cases (Figure 3) and 95 deaths (Figure 4). This reflects a 23.5% reduction in the absolute number of cases in the entire Region and a 21% reduction in the high and moderate risk areas since 2000; there was a 78% decrease in the overall number of malaria-attributed deaths since 2000.

Figure 3. Malaria Morbidity in the Americas, 1998-2004
Number of Positive Blood Slides

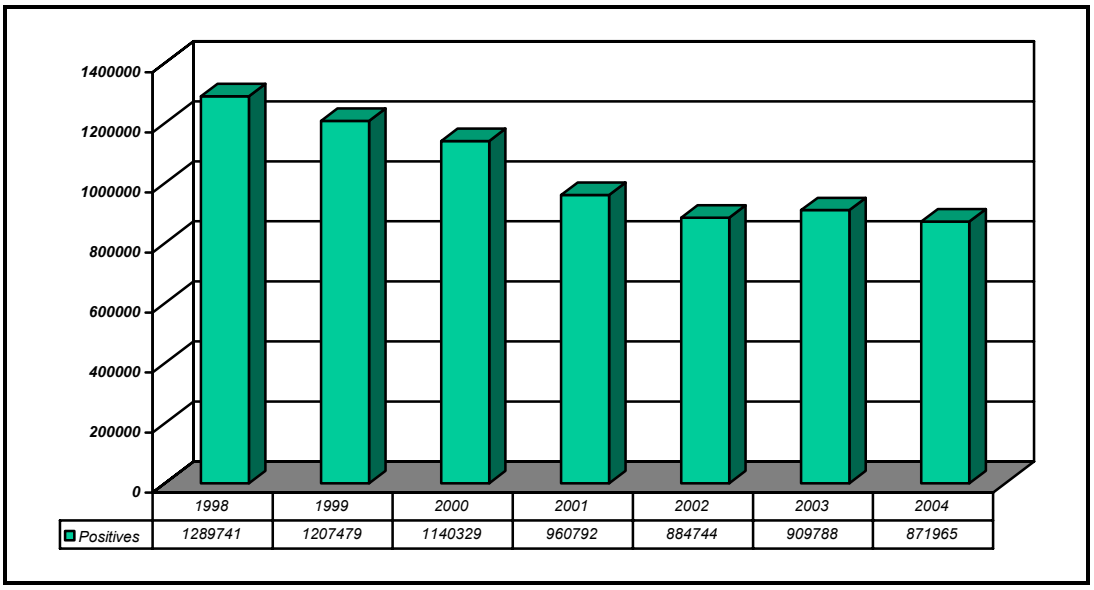
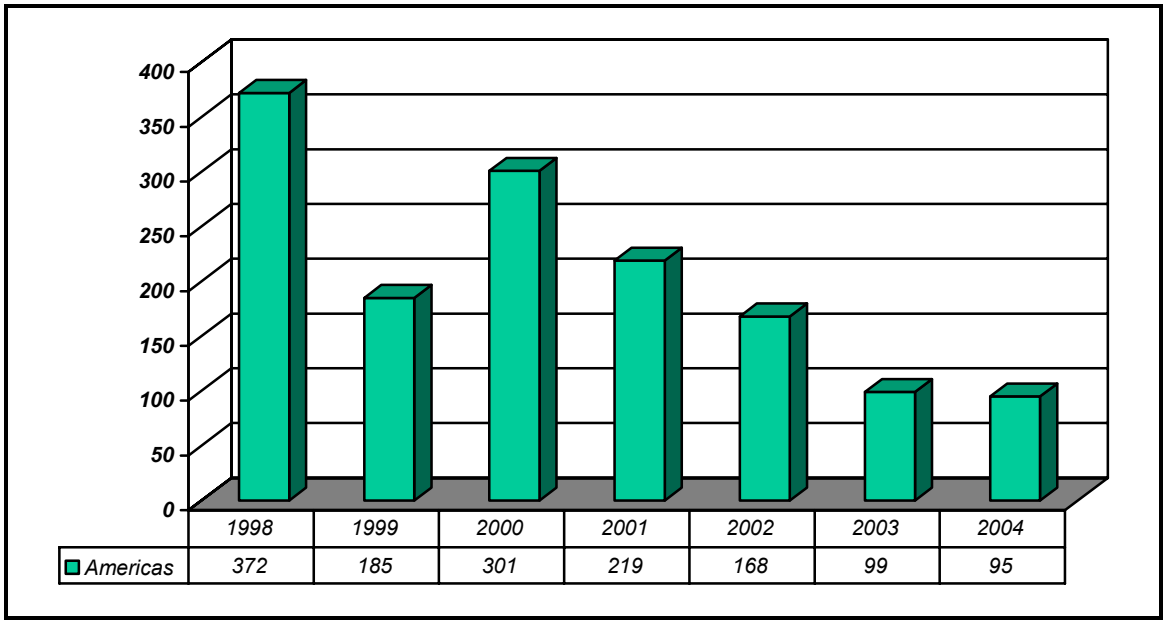


Figure 4. Malaria Mortality in the Americas, 1998-2004
Number of Deaths



11. The countries which share the Amazon rain forest comprising those in the Andean Region (Bolivia, Colombia, Ecuador, Peru, and Venezuela); Brazil; and the Guyana Shield (French Guiana, Guyana, and Suriname) have borne the brunt of the problem, with 91% of all malaria cases and 79% of all malaria-attributed deaths reported in 2004 (Tables 1 and 2).

Table 1. Malaria Morbidity in the Americas by Subregion, 1998-2004
Number of Positive Blood Slides

Subregion	Year						
	1998	1999	2000	2001	2002	2003	2004
Mexico	14,451	6,402	7,390	4,831	4,289	4,289	3,406
CAPB	134,554	138,528	117,593	74,079	64,539	54,292	60,327
HAI-DOR	36,455	4,785	18,112	10,875	11,133	11,366	13,157
GUY-FGU-SUR	57,074	46,529	40,858	48,019	38,647	46,123	39,924
Brazil	471,892	609,594	610,878	388,658	349,873	379,340	459,333
Andean Area	571,930	390,167	337,144	430,342	411,985	411,703	293,774
Southern Cone	2,430	10,169	7,293	2,925	2,993	1,514	809

Table 2. Malaria Mortality in the Americas by Subregion, 1998-2004
Number of Deaths

Subregion	Year						
	1998	1999	2000	2001	2002	2003	2004
Mexico	0	0	0	0	0	0	0
CAPB	30	11	4	2	10	3	4
HAI-DOR	39	13	6	32	27	28	16
GUY-FGU-SUR	43	5	10	4	…	…	8
Brazil	110	75	192	98	75	30	30
Andean Area	150	80	89	83	56	38	37
Southern Cone	0	1	…	0	0	0	0

12. Of the 21 Member States where malaria is endemic, 15 reported decreases in the absolute number of cases, eight of them decreases over 50%, but six countries reported increases (Table 3). There was no reintroduction of transmission in Member States where it has been interrupted.

Table 3. Percent of change in number of cases reported, 2000 vs. 2004
By Country

COUNTRY	PERCENTAGE CHANGE
Argentina	- 74%
Belize	- 29%
Bolivia	- 53%
Brazil	- 25%
Colombia	+ 9%
Costa Rica	- 31%
Dominican Republic	+ 94% -
Ecuador	- 70%
El Salvador	- 89%
French Guiana	- 18%
Guatemala	- 42%
Guyana	+ 20%
Haiti	- 40%
Honduras	- 58%
Mexico	- 54%
Nicaragua	- 71%
Panama	+ 392%
Paraguay	- 90%
Peru	+ 23%
Suriname	- 39%
Venezuela	+ 57%

13. *Plasmodium falciparum* is the most pathogenic of the malaria parasites. This is the only parasite for which resistance to antimalarials, first reported in Colombia in 1958, is now reported worldwide. In the Americas, resistance has only been suspected and/or confirmed in the countries that share the Amazon rain forest.

Malaria Strategy in the Region: Implementation and Resource Mobilization

14. In keeping with the resolutions of the governing bodies of WHO and PAHO, specifically Resolution WHA52.11 of the Fifty-second World Health Assembly, and Resolution CD42.R15 of the 42nd Directing Council, PAHO Member States adopted and supported the Roll Back Malaria Initiative and the attainment of the internationally agreed-upon health-related development goals in the U.N. Millennium Declaration.

15. A number of significant global events, initiatives, and other factors have influenced the present malaria strategy in the Americas. These include: (a) the Global Malaria Control Strategy (GMCS), which was adopted by the Ministerial Conference of 1992; (b) the Roll Back Malaria (RBM) Initiative launched in 1998; (c) the promulgation of the internationally agreed-upon health-related development goals in the U.N. Millennium Declaration; (d) resolutions made in recent World Health Assemblies and conferences of WHO and PAHO; (e) the emerging global problem of antimalarial drug resistance and its impact in the Americas; and (f) the status of PAHO and Member States institutional, human, and financial resources.

16. Within the framework of the current malaria strategy for the Americas, efforts focus on support of health ministries' functions related to malaria prevention and control; promotion of synergies with related health programs, especially those for environmental health, pharmaceuticals, and maternal and child health, HIV/AIDS, and tuberculosis; promotion of the participation of communities and civil society; engagement of the private sector in delivery of prevention and treatment; identification of best practices, partnership, and finance mechanisms for extending interventions; preparation of tools and support measures for management; capacity building; and the promotion of collaboration among countries.

17. Protecting achievements made in the reduction of incidence and in preventing reintroduction of transmission where it has been interrupted depends on the continued commitment by Member States to monitor progress; and by PAHO to continue supporting mechanisms for monitoring progress of prevention and control measures as well as those aimed at mobilizing resources in conformity with PAHO Resolution CD42.R15 adopted by the 42nd Directing Council.

18. Member States utilize national resources to combat malaria. The Roll Back Malaria Initiative provides financial support for malaria prevention and control activities. PAHO's assistance in additional resource mobilization in the Region includes: (a) the Amazon Network for the Surveillance of Antimalarial Drug Resistance (RAVREDA)/ Amazon Malaria Initiative (AMI); (b) the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM); and (c) the Global Environment Facility/U.N. Environmental Program Project for the prevention of the reintroduction of DDT use in malaria vector control in Mexico and Central America.

19. In the Americas, the RBM Initiative funds two subregional advisors who provide technical assistance to the countries which share the Amazon and the Mesoamerican countries, respectively. Through this technical assistance, successful proposals were developed and approved by the GFATM for seven countries, including PAHO's five Key Countries. The RBM partnership also provided support to Hispaniola through the presence of a technical officer in Haiti. Within the context of the RBM Initiative, evidence-based decision-making and the development of new tools have been supported by the Amazon Malaria Initiative. The RBM Initiative is also supporting efforts by the Amazon Cooperation Treaty Organization, promoting the development of surveillance and malaria control activities in the countries which share the Amazon basin, with emphasis on border areas and indigenous populations.

20. The Amazon Network for the Surveillance of Antimalarial Drug Resistance/ Amazon Malaria Initiative is a response to the global phenomenon of increasing antimalarial drug resistance by *Plasmodium falciparum*. The network, established at the third meeting of the Surveillance Network for Emerging Infectious Diseases in the Amazon Countries, in Bahia, Brazil, in March 2001, has its funding of approximately $1.5 million annually available through the Amazon Malaria Initiative of the United States Agency for International Development (USAID). The partnership includes Bolivia, Brazil, Colombia, Ecuador, Guyana, Peru, Suriname, and Venezuela. It is coordinated by PAHO and USAID; technical cooperation is provided by PAHO, the United States Centers for Disease Control and Prevention (CDC), Rational Pharmaceutical Management Plus, and United States Pharmacopoeia.[5] Based on evidence from efficacy trials undertaken, six of the abovementioned participating countries have changed treatment policy and are using combination antimalarial therapy, recommended by WHO since 2001 and referred to in the Report of the World Health Secretariat (Document A58/8, 2005) and the resolution adopted by the World Health Assembly (WHA58.2, 2005).

[5] Amazon Network for the Surveillance of Antimalarial Drug Resistance/Amazon Malaria Initiative. RAVREDA/AMI Newsletter. 2004.

21. The Global Fund to Fight AIDS, Tuberculosis, and Malaria approved individual country proposals to finance efforts to combat malaria in Bolivia, Guyana, Haiti, Honduras, Nicaragua, and Suriname and is finalizing agreements with Guatemala as well as with the *Organismo Andino de Salud* (ORAS) on a proposal to combat the disease in the border areas of Colombia, Ecuador, Peru, and Venezuela. The total funding for malaria from these proposals is approximately US$ 54 million. PAHO's technical staff at country and regional levels provided technical cooperation in design and development of the proposals, and PAHO is a member of the Country Coordinating Mechanisms.

22. The Global Environmental Facility/United Nations Environmental Program approved a Regional Action and Demonstration Program on sustainable alternatives to control malaria vectors without the use of DDT in Mexico and Central America with participation of PAHO's technical areas of Sustainable Development and Environment, Health Analysis and Information Systems, and Disease Prevention and Control.

23. Research efforts to develop more effective tools for the prevention and control of malaria have been spearheaded by the World Bank/United Nations Development Program/WHO Special Program for Research and Training in Tropical Diseases (TDR), and, in collaboration with PAHO, have supported malaria research projects in the Region. Among others, TDR-funded small grant projects have included operational research in the areas of entomology, vector control, and disease prevention. Additionally, training courses in ethics and surveillance have also been supported.

Current Malaria Challenge, Scaling-up Strategies, and the Role of PAHO

24. The World Health Assembly, in Resolution WHA52.11, encouraged Member States "to reduce malaria-related suffering and promote national development in a sustained way by rolling back malaria;" in 2000, the United Nations General Assembly included the halting or beginning of the reversal of the spread of HIV/AIDS, malaria, and other major diseases by 2015, in the internationally agreed-upon health-related development goals in the U.N. Millennium Declaration. Also in 2000, PAHO's Directing Council urged Member States to adopt the RBM Initiative in territories where malaria still constitutes a public health problem and to make a commitment to perform an annual evaluation of progress in the different areas of the initiative, until malaria is eliminated as a public health problem in the Region. As a review of the data between 2000 and 2004 revealed, this is an unfinished agenda in the Americas as malaria continues to be a public health problem and also increased in some Member States.

25. Challenges in the Americas are directly related to the evolving epidemiologic trends in the Region and disparity in the outcome of the malaria strategy in different countries and subregions are related to a number of factors.

26. Issues to be addressed include information on mosquito vectors in different sub-regions, their distribution, biting and behavioral patterns, operational research to identify and utilize new and innovative vector control methods as well as the use of appropriate insecticides and impregnated mosquito nets. *P.vivax* is the most prevalent parasite in the Region, and given the characteristics of its life cycle, specific efforts will be necessary to ensure reduction in transmission.

27. With respect to diagnosis of the disease, there is a need for expansion of the laboratory network where feasible and expansion of the use of rapid diagnostic tests by community workers and volunteers in areas with difficult access to health services. Another issue which has to be addressed is the higher cost of combination therapy for drug resistant *P. falciparum,* as well as availability and adherence to treatment regimens including the standard 14-day treatment for *P. vivax* malaria.

28. Poorer and itinerant population groups with deficient housing conditions and inaccessibility to adequate prevention and control interventions are subjected to even greater poverty as a result of the disease. Decentralization and health sector reform in several countries with redefinition of delivery and financing of services are issues which impact on the management of health services. Changes in health systems have resulted in the loss of malaria-trained personnel, and this, together with shortage in nursing staff, should be taken into account in determining training needs.

29. The deficiency in the systematic flow of information is another issue which should be addressed through the formation of communication networks between various technical units of ministries of health and other institutions. Countries successful in mobilizing financial resources for malaria prevention and control through mechanisms such as the Global Fund to Fight against AIDS, Tuberculosis, and Malaria will need technical cooperation in implementation, monitoring, and evaluation of planned activities.

30. PAHO can provide technical cooperation, coordinate, and collaborate with other organizations in the effective utilization of resources. PAHO's Regional Revolving Fund for Strategic Public Health Supplies is a potential mechanism for acquisition of appropriate antimalarial drugs.

31. Ecological conditions weigh heavily in addressing the challenge of malaria, because it is a vector-borne disease. Transmission is dependent on the presence of malaria-infected persons and mosquito characteristics, affected by environmental conditions such as temperature, humidity, and vegetation. The general Amazon environment predisposes the countries of the area to greater risk of transmission. As part of the unfinished agenda, entomologic research needs to be intensified in order to define and apply the most appropriate and feasible vector control options.

32. Drug resistance to *P. falciparum* exists in the Region. Diagnosis and treatment-related factors are also issues of concern. The situation is worse in areas where accessibility and adherence to treatment either among patients or health service providers remain a problem. Effectiveness of treatment decreases, even in the presence of efficacious drugs, if coverage is not sufficient. Coverage can also be affected by duration of treatment, cost of more expensive combination therapy, and education of those affected. Rapid diagnostic tests are available and recommended for use in specific settings, but these tests still need to be improved. As part of the unfinished agenda, treatment evaluation, specifically in terms of resistance and effectiveness, are necessary components to be addressed. In addition, there is still a need for greater efforts in education on malaria, community involvement, and participation of all sectors in ensuring prompt diagnosis, and appropriate, available, and affordable treatment.

33. Weak health systems and inadequate service delivery and quality of care impede the potential for epidemiologic improvements. Political and administrative decentralization and health sector reform in several countries are changing the management, organization, delivery, and financing of services. With the redefinition of functions of central, regional, and local governments in the management of both individual- and population-based health care services, the need for strengthening managerial capacity at all levels is imperative. Poorer population groups and itinerant occupational groups in areas with increased ecological risk of transmission, with deficiencies in housing conditions, prevention interventions, and health service provision, are both predisposed to the consequences of the disease and further poverty as a result of less productivity and loss of income. As part of the unfinished agenda, health systems need to be reinforced in order to address challenges in specific situations. Specific areas may show a need for the establishment of health outposts, reinforcement of efforts through integration of health program delivery, strengthening the health information system, improving logistical capacities, drug procurement and distribution policies, quality improvement, community participation including establishment of a network of voluntary collaborators, and private-public partnerships.

34. Directly related to the problem of weak health systems is the diminishing number of personnel with technical capabilities to address malaria-specific problems within the existing health systems. Changes in the health systems of many of the countries have resulted in the loss of malaria-trained personnel without adequate replacement. As part of the unfinished agenda, efforts must be made to assess the need for malaria-trained staff and ensure recruitment and retention of health personnel as well as training in both the technical and management aspects of malaria control, including the use of epidemiologic stratification to identify priority areas for interventions.

35. Problems of communication, coordination, and cooperation undermine the potential for better results of malaria control efforts and also lower effectiveness in the

use of available resources. A new challenge is to promote the formation of communication networks between various technical units of ministries of health and other institutions, including nongovernmental organizations and the private sector, to facilitate a systematic flow of information and reduce difficulties in pursuing effective courses of action to address malaria prevention and control.

36. PAHO's strength in providing leadership and technical cooperation through the country offices in Member States and coordination of technical support from WHO and collaborating centers, such as the United States Centers for Disease Control and Prevention, keep the institution's role vital in orienting and supporting the implementation of effective malaria control measures in the Americas.

37. Technical cooperation efforts must aim at preserving achievements and focus on present and new challenges in capacity building, horizontal cooperation, dissemination of information and knowledge, development of norms, plans and policies, research promotion, training and resource mobilization, and collaboration mechanisms to strengthen intercountry collaboration to reduce the burden and prevent the spread of malaria across borders.

38. There is a need for continued allocation of domestic resources by Member States to ensure surveillance to detect and prevent resurgence after achievements in reduction. An important challenge for PAHO is to provide Member States the necessary technical coordination and cooperation to mobilize and effectively and efficiently utilize increased financial resources, such as those available from the Global Fund, in continuing to pursue the RBM Initiative and the internationally agreed-upon health-related development goals in the U.N. Millennium Declaration.

39. There is a need for continued commitment to the RBM Initiative and the establishment of national policies and operational plans to ensure increased accessibility by those at risk or affected by malaria to prevention and control interventions and a commitment to an annual evaluation of the Initiative.

40. The following actions are important in order to achieve the internationally agreed-upon health-related development goals in the U.N. Millennium Declaration and reduce the burden of malaria in the Region:

(a) For countries and regions where malaria transmission has been interrupted, surveillance of imported cases and rapid response to detected cases must be strengthened.

(b) The Global Malaria Control Strategy and Roll Back Malaria Initiative should be strengthened and expanded in all endemic countries by:

- Adapting plans, norms, and policies to meet changing conditions;
- Expanding the implementation of integrated vector control management activities based on epidemiologic stratification;
- Integrating the vertical malaria surveillance systems into general health surveillance systems;
- Assessing the degree and quality of implementation of malaria prevention and control strategies;
- Collecting data on a timely basis and evaluating the malaria situation annually;
- Adopting malaria treatment policies based on surveillance and resistance data.

(c) The infrastructure of national programs should be strengthened by:

- Recruiting and developing human resource technical capacity in malaria prevention and control;
- Integrating malaria prevention and control programs within the health system;
- Mobilizing financial resources through the private sector, the Global Fund to Fight AIDS, Tuberculosis, and Malaria or other sources;
- Utilizing technical assistance for implementation of Global Fund projects.

(d) Subregional actions should be coordinated for greater impact by:

- Maintaining a multicountry and multiinstitutional network for monitoring antimalarial drug resistance in the Amazon countries;
- Developing a similar multicultural, multiinstitutional surveillance network in the Mesoamerican subregion.

41. PAHO will continue to provide technical cooperation to Member States to support these actions which are in accord with the Report of the WHO Secretariat (Document A58/8, 2005); and the resolution adopted by the World Health Assembly in May 2005 (WHA58/2, 2005).

42. The following table reflects the estimated resources in U.S. dollars required for the biennium 2006-2007.

	Requirements	Available	Deficit
Country	5,700,000	2,560,000	3,140,000
Regional and Subregional	2,800,000	1,700,000	1,100,000
Total	**8,500,000**	**4,260,000**	**4,240,000**

Action by the Directing Council

43. The Directing Council is invited to consider the annexed resolution proposed by the Executive Committee.

Annex

PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

136th SESSION OF THE EXECUTIVE COMMITTEE

Buenos Aires, Argentina, 20-24 June 2005

CD46/17 (Eng.)
Annex

RESOLUTION

CE136.R5

MALARIA AND THE INTERNATIONALLY AGREED DEVELOPMENT GOALS, INCLUDING THOSE CONTAINED IN THE MILLENIUM DECLARATION

THE 136th SESSION OF THE EXECUTIVE COMMITTEE,

Having considered Document CE136/16 on the Roll Back Malaria Initiative in the Americas and the internationally agreed development goal related to malaria contained in the United Nations Millennium Declaration.

RESOLVES:

To recommend to the Directing Council the adoption of a resolution along the following lines:

THE 46th DIRECTING COUNCIL,

Having considered Document CD46/___ on malaria, which proposes that the Member States continue efforts to combat malaria through strengthening national capacity at all service levels to preserve achievements and further reduce the burden of the disease where it continues to be a public health problem;

Taking into account that the 42nd Directing Council urged Member States to adopt the Roll Back Malaria Initiative in territories where malaria still constitutes a public health problem and to make a commitment to perform an annual evaluation on progress in the different areas of the initiative until malaria is eliminated as a public health problem in the Region;

Concerned that the disease continues to be a public health problem in a number of territories and that there is need for sustained efforts to attain the Roll Back Malaria Initiative and the Millennium Declaration Goals of 2010 and 2015, respectively;

Recognizing the potential for increased financial support to countries for malaria control from the Global Fund to Fight AIDS, Tuberculosis and Malaria; and concerned that the eligibility criteria of the Fund exclude many countries in the Region from the possibility of having access to future grants; and

Noting the Malaria Report of the WHO Secretariat to the Fifty-eighth World Health Assembly and Resolution WHA58.2 on "Malaria Control",

RESOLVES:

1. To urge Member States to:

(a) establish national policies and operational plans to ensure accessibility to prevention and control interventions for those at risk or affected by malaria in order to achieve a reduction of the malaria burden by at least 50% by 2010 and 75% by 2015;

(b) perform annual evaluations on the national progress of the Roll Back Malaria Initiative;

(c) allocate domestic resources, mobilize additional resources, and effectively utilize them in the implementation of appropriate malaria prevention and control interventions, and commit to perform regular assessments on their progress;

(d) take into account the need to include those trained in malaria, when assessing the staffing needs of the health systems, and take measures to ensure the recruitment, training, and retention of health personnel;

(e) encourage communication, coordination, and collaboration between malaria control units and other technical units and institutions, including nongovernmental organizations, the private sector, and universities; and to strengthen intercountry collaboration to reduce the burden and prevent the spread of malaria across borders;

(f) implement integrated approaches to malaria prevention and control through multisectoral collaboration and community participation;

(g) aim at reducing transmission risk factors through integrated vector management; promote improvement of local and environmental conditions and healthy settings; and increase access to health services in order to reduce disease burden.

(h) advocate in a coordinated fashion through their representatives on the board of Directors of the Global Fund to fight AIDS, Tuberculosis and Malaria and through other high-level diplomatic channels, including the Summit of the Americas, for equity of countries and partners from the Region in accessing Global Fund resources.

2. To request the Director to:

(a) continue providing technical cooperation and coordinating efforts to reduce malaria in endemic countries and to prevent reintroduction of transmission where this has been achieved;

(b) develop and support mechanisms for monitoring the progress of malaria prevention and control and report on a regular basis;

(c) assist Member States, as appropriate, to develop and implement effective and efficient mechanisms for resource mobilization and utilization;

(d) initiate and support subregional and intercountry initiatives aimed at prevention and control of malaria among mobile populations, as well as in areas of common epidemiologic interest, particularly those in border areas.

(e) assist Member States, as appropriate, in the implementation of projects financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

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