



WHO

REGIONAL OFFICE FOR EUROPE

EUR/00/5021960
ENGLISH ONLY
EDITED
E71537

SECOND INTERREGIONAL MALARIA COORDINATION MEETING

Report on a WHO Coordination Meeting

Baku, Azerbaijan
31 May–1 June 2000

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2000

EUROPEAN HEALTH21 TARGET 7

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REDUCING COMMUNICABLE DISEASES

By the year 2020, the adverse health effects of communicable diseases should be substantially diminished through systematically applied programmes to eradicate, eliminate or control infectious diseases of public health importance

(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

ABSTRACT

The meeting reviewed the malaria situation and progress made in the control of the disease in the WHO European and Eastern Mediterranean Regions. Despite considerable progress, a number of countries in both regions with similar epidemiological conditions still faced high rates of malaria morbidity, outbreaks of the disease, the occurrence and spread of *Plasmodium falciparum*, and the risk of re-establishment of malaria transmission in areas from which the disease had been eradicated many years ago. To address these problems, the meeting identified malaria-related problems and constraints, outlined a strategy and joint action plan for more coordinated and synchronized malaria control operations in border areas, and discussed the practicalities of regular exchange of information on the malaria situation and its control. Participating countries have requested WHO to continue its support for national malaria control programmes, particularly in the fields of training, surveillance, operational research, and the coordination of malaria control in border areas. WHO was also requested to continue brokering financial assistance to countries in order to implement the Roll Back Malaria project plans at country level.

Keywords

MALARIA – prevention and control – epidemiology
PROGRAM EVALUATION
HEALTH PRIORITIES
REGIONAL HEALTH PLANNING
INTERNATIONAL COOPERATION
EUROPE
EASTERN MEDITERRANEAN

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Executive summary

Controlling infectious diseases, including malaria, is one of the highest health priorities for the countries represented at the meeting. As a result of civil wars and the disruption of government functions, and consequently of communities' ability to implement appropriate malaria control measures, massive malaria epidemics have occurred, accompanied by the progressive return of endemicity, in some countries of WHO's European and Eastern Mediterranean Regions. The WHO Regional Offices for Europe (EURO) and the Eastern Mediterranean (EMRO) committed themselves to making an intensive response to the burden of malaria, by developing a Roll Back Malaria (RBM) strategy in 1999. This strategy is now being successfully implemented in these regions.

The RBM strategy focuses on addressing malaria-related issues by encouraging institutional development, expanding partnerships, enhancing the capacity for decision-making, investing in human development, improving capacities for disease management, promoting cost-effective and sustainable vector control, strengthening surveillance mechanisms and local research capabilities, ensuring community mobilization and enhancing intersectoral collaborative actions.

A strong political commitment and will to tackle the disease, intensive support from WHO, a high level of advocacy for action against malaria, and broad partnerships with considerable financial assistance and attention focused on local malaria situations, have brought about a significant reduction in reported malaria incidence. Malaria epidemics have also been successfully contained in several countries in both regions.

Despite RBM's considerable impact on the malaria situation, some countries in these regions (with common epidemiological features in terms of local malaria problems) are still facing high rates of malaria morbidity, extensive malaria outbreaks, the occurrence and spread of *Plasmodium falciparum* malaria, and the risk of re-establishment of malaria transmission in areas where the infection was eradicated many years ago.

To address these problems, the interregional working group reviewed the current malaria situation; identified the malaria-related problems and constraints being encountered; outlined a direction, strategy and joint action plan for more coordinated and synchronized malaria control operations in border areas; and discussed the practical modalities for regular exchange of information on the malaria situation and its control.

The following recommendations were made for WHO:

- to provide technical support for national malaria control programmes and to coordinate malaria control in border areas;
- to organize meetings among neighbouring countries in the two regions on an annual basis;
- to continue to support regional and national training programmes on malaria and its control;
- to strengthen epidemiological surveillance mechanisms, with special reference to border areas;
- to assist Member States in improving national operational research capabilities;

- to continue brokering financial assistance to Member States, in order to implement RBM plans at country level.

Recommendations for Member States are as follows:

- to improve the exchange of information related to malaria and its control, particularly in border areas;
- to develop and implement joint action plans, in order to synchronize malaria control operations in border areas;
- to develop or, where necessary, modify national antimalarial drug and insecticide policies;
- to continue conducting training and refresher training on malaria and its control;
- to carry out operational research on malaria and its control;
- to mobilize community support;
- to enhance intersectoral collaboration.

The meeting reaffirmed the objectives of the RBM initiative for the European Region of WHO. These are:

- to halve malaria incidence in the epidemic countries and to eliminate malaria as an infection in countries such as Armenia and Turkmenistan, by 2005;
- to maintain malaria-free status in those countries where malaria has been eradicated;
- to reduce the fatality rate of *P. falciparum* malaria by 50%, by 2005.

The ultimate goal for the European Region and the neighbouring part of the Eastern Mediterranean Region is to strive to achieve the interruption of malaria transmission and to prevent the reintroduction of *P. falciparum* malaria by 2010. It was reiterated that success in reaching these objectives will depend upon political support, mobilization of resources, professional direction, personnel management, capacity-building, community participation and intersectoral collaboration, to ensure that malaria problems in these two regions are tackled in the most cost-effective and sustainable way.

Introduction

The Second Interregional Malaria Coordination Meeting, organized jointly by the WHO Regional Offices for Europe (EURO) and the Eastern Mediterranean (EMRO) was held in Baku, Azerbaijan from 31 May to 1 June 2000. The participants (Annex 3) included representatives from selected countries in the two regions concerned. WHO staff from headquarters, EURO and EMRO, temporary advisers and observers.

Scope and purpose of the meeting

The aims of the meeting were:

- to review the current malaria situation and identify problems and constraints encountered in the participating countries;
- to follow up on actions taken in line with the recommendations from the First Interregional Coordination Meeting, held in Baku in 1999;
- to outline a direction and strategy for increased coordination of malaria control in border areas for the period 2000–2001;
- to develop joint action plans for the synchronization of malaria control operations, particularly in border areas;
- to discuss the practical modalities for regular exchange of information on malaria situation and its control, particularly in border areas.

Inaugural session

The meeting was opened by Professor Ali Insanov, Minister of Health of Azerbaijan. Dr Serguei Litvinov, speaking on behalf of Dr Marc Danzon, WHO Regional Director for Europe, emphasized that malaria continued to be a major public health problem and one of the foremost strategic priorities for WHO in Europe. In 1998 WHO had declared malaria to be a global threat, and on 23 July of that year the Director-General announced “Roll Back Malaria” (RBM) as a priority project for the Organization. The European Region had immediately given its full support to the initiative. Several meetings to establish RBM partnerships had been held at regional, subregional and country levels. The regional RBM coalition, composed of governments, United Nations agencies, international and national nongovernmental organizations, private sector groups, research institutions and the media, had decided to intensify its efforts to reduce the malaria burden in Europe. The regional RBM strategy was designed to help strengthen national systems and enable countries to respond more effectively to the challenges of combating malaria and, more generally, of meeting their peoples’ health requirements. Regional and interregional cooperation were of vital importance for tackling common problems, including border malaria.

Officers of the meeting

The meeting appointed the following officers:

- Chairperson: Professor Ali Insanov, Minister of Health of Azerbaijan;

- Vice-chairpersons: Dr Farid Joseph Shamo, Malaria Control Programme, Ministry of Health of Iraq and Dr Abbas Soltan Ogly Velibekov, Deputy Minister of Health of Azerbaijan;
- Rapporteur: Dr Mikhail Ejov, Roll Back Malaria project, WHO/EURO.

Organization of the meeting

The first day of the two-day meeting was devoted to countries' presentations on various subjects related to the dynamics and trends in their malaria situations and the progress made in RBM actions in the previous year. On the second day, three working groups were formed (see below) to discuss priority problems, constraints and deficiencies encountered, and how countries addressed those. The participating countries shared ideas regarding a direction and strategy for more coordinated malaria control and the development of joint action plans, in order to synchronize malaria control operations in border areas. The practical modalities for regular exchange of malaria-related information in border areas were also discussed.

Working groups

Group I: Afghanistan, Kazakhstan, Kyrgyzstan, Tajikistan, Uzbekistan, Turkmenistan
Group II: Azerbaijan, Armenia, Georgia, Iran, Russian Federation
Group III: Iraq, Iran, Afghanistan, Turkey.

The respective groups discussed the assigned subjects in depth and formulated recommendations. At the end of the second day, the recommendations were presented by each working group and formally adopted in plenary.

Working papers and background documents

Detailed country reports were submitted by representatives of the Member States, translated into English and/or Russian, as appropriate, and circulated at the meeting. Background documents were also provided. A list of working papers and background documents is contained in Annex 2.

Current malaria situation and trends

Global situation

At present, more than two thousand million people throughout the world are still exposed to the risk of malaria. It is estimated that each year there are 300–500 million new clinical cases of the disease, with 1.5–2.7 million deaths. One of the greatest challenges to malaria control worldwide is the spread and intensification of parasite/vector resistance to antimalarial drugs and insecticides. An increasing number of malaria epidemics, resulting from a variety of reasons, have recently been documented throughout the world. Another disquieting factor is the re-emergence of malaria in areas where it had once been eradicated, or its increase in countries where it was nearly eradicated.

The impact of malaria on countries' social and economic development is enormous. To overcome the challenge of malaria, the new Director-General of WHO committed the Organization in January 1998 to making an intensive response to the global burden imposed by the disease. A global coalition to Roll Back Malaria, characterized by strategic synergy, coordinated efforts and

science-based strategies, was proposed at the World Health Assembly in 1998. Heads of WHO, the United Nations Development Programme (UNDP), the United Nations Children's Fund (UNICEF) and the World Bank, together with representatives of the private sector, nongovernmental bodies and a group of national governments initiated and formally established the Roll Back Malaria (RBM) partnership at the end of 1998. The purpose of the partnership is to sustain international political and institutional backing both for global efforts and for focused action at country level.

The preparatory phase of the RBM initiative was completed at the end of 1999. During this period regional, subregional and country RBM inception meetings were held and country-level RBM partnerships were developed. The Third Meeting of the Global RBM Partnership, held in Geneva on 2 and 3 February 2000, showed that strong partnerships had been built up in many malaria-affected countries. In 2000, the global RBM partnership is to proceed further with consolidating progress and moving to scale with action at country level, including mobilization of additional resources to intensify country actions to roll back malaria.

The next steps in implementing global the RBM initiative are:

- to focus on country partnerships;
- to complete the inception process in all countries, with agreed plans of work;
- to identify and commit resources for country action;
- to make arrangements on financial flows and management;
- to activate a plan for intercountry activity; and
- to bring new synergies between RBM and other priority health programmes.

European Region

Since the early 1990s, the epidemiological situation relating to malaria has deteriorated considerably. Tajikistan, Azerbaijan and Turkey have been affected by large-scale malaria epidemics, while Armenia and Turkmenistan have been faced with small-scale outbreaks. In 1997, a total of 77 985 malaria cases were reported in the Region. Despite a significant reduction in the reported incidence of malaria cases in the Region during 1998–1999, the situation is at present complicated by the spread of *P. falciparum* malaria in Tajikistan (where 335 cases were reported in 1999) and by the re-establishment of malaria transmission in areas of the northern part of Tajikistan where the infection was eradicated many years ago. The constant increase in international travel and population movements has led to the massive importation of malarial diseases into western European countries, associated with high fatality rates. The risk of massive re-establishment of malaria transmission is relatively high in areas of Turkmenistan, Uzbekistan, Kyrgyzstan, Armenia and Georgia bordering Afghanistan, Tajikistan and Azerbaijan, particularly owing to their high receptivity and vulnerability and the frequent introduction of malaria parasites with infected carriers into these areas.

Tajikistan

As a result of civil war and socioeconomic disturbances, the malaria situation in the country has deteriorated since 1992 and assumed epidemic proportions in the mid-1990s. In 1999 a total of 13 493 malaria cases were reported in the country, 50% of which were found in the Khatlon Region. Thanks to intensive malaria control interventions, the reported incidence of malaria fell by 50% between 1997 and 1999, from 29 794 to 13 493 cases. However, the situation was complicated by the occurrence and spread of *P. falciparum* malaria, the lethal form of the disease, in the southern part of the country. During the same period, the reported number of *P. falciparum* cases rose from 196 to 335, with more than 90% of all such cases reported

between August and December. The reintroduction of malaria transmission and a six-fold rise in the reported incidence of *P. vivax* malaria in the northern part of the country are the other aggravating features of the malaria situation in Tajikistan. Despite a significant reduction in reported incidence in 1998–1999, the real magnitude of the disease in the country cannot be reliably assessed on the basis of data available but is thought to be much greater.

Azerbaijan

Malaria was practically a forgotten disease in Azerbaijan in the 1960s: only three indigenous cases were reported in 1967. The malaria situation started to deteriorate rapidly after 1990, and the number of malaria cases reached 13 135 in 1996. The major reasons for the malaria epidemic were a sharp worsening of socioeconomic conditions and the displacement of nearly one million people from war-stricken zones. Thanks to international assistance, the reported number of malaria cases fell from 9911 in 1997 to 2315 in 1999.

Turkey

A national malaria eradication programme was launched in 1957, and the incidence of malaria dropped drastically by 1968. In 1970, 1293 cases of malaria were reported, mainly from the south-eastern part of Anatolia. However, from 1971 onwards the number of malaria cases in the plains of Cukurova and Amikova continued to increase, reaching alarming proportions in 1976 and 1977, when 30 852 and 115 512 cases were reported, respectively. Through concentrated efforts and at considerable cost, the incidence of the disease began to recede in this area in 1978, and 22 323 cases of malaria were reported in 1979. However, during 1980 the malaria situation deteriorated again and the number of cases reached over 56 000, and this tendency remained unchanged with 66 681 cases in 1983. After 1990, when only 8680 cases were reported, there was another marked deterioration in the malaria situation, with the number of cases peaking at 84 345 in 1994. Between 1995 and 1999 there was a steady decline in malaria incidence, with the number of cases dropping from 82 096 to 20 963. At present, over 15 million people or 23% of the total population of Turkey still live in areas where malaria is endemic. There is also a rather large proportion of the total population (nearly 44%) in unstable non-epidemic areas, where there remains a high risk of the explosive resumption of focal transmission of malaria producing an outbreak situation.

Armenia

Malaria was completely eradicated in Armenia in 1963, and a malaria-free situation was maintained until 1994. After 1991, following the break-up of the Soviet Union, the situation became critical in terms of maintaining this status. In 1994, 196 malaria cases among military personnel were reported in the country. In 1995 the number of imported malaria cases increased to 502. In the next year, out of 347 cases, 149 were reported as indigenous. During 1997–1998, the number of reported cases continued to rise, and a total of 1156 cases were reported in 1998. Although 30 out of 81 districts recorded malaria cases, 89% of the indigenous cases were registered in Masis district, in the Ararat valley bordering Turkey. Owing to extensive international support for malaria control, the situation improved in 1999, when only 616 *P. vivax* cases were reported in Armenia.

Turkmenistan

Malaria was eradicated in Turkmenistan in the 1960s. Between 1965 and 1980, there were only 23 indigenous cases in the country. In the 1980s, most of the cases which occurred in the country were reported among military personnel who had returned from Afghanistan. In 1998, the

epidemiological situation worsened and local transmission of malaria was started again. During 1997–1998 there was a sharp increase in the number of cases, and 137 indigenous cases were reported, particularly in border areas, in 1998. In 1999, only 49 local cases of *P. vivax* infection were reported in Turkmenistan.

Georgia

Following a large-scale eradication campaign, malaria was practically eliminated by 1961 and had completely disappeared from the country by 1970. Between then and 1995, 139 cases of malaria were recorded as imported. In 1996 three cases of *P. vivax* malaria were reported among residents in the region bordering Azerbaijan. The number of indigenous cases has continued to rise since, and 35 local cases were reported in 1999. Conditions favourable for malaria transmission exist in nearly 52% of the whole country, where 93% of the total population lives.

Uzbekistan

As a result of an eradication campaign, malaria was eradicated in Uzbekistan in 1961. However, the country remains highly vulnerable to the resurgence of malaria transmission, particularly in the areas along the border with Tajikistan. At present, the epidemiological situation is being aggravated by increasing migration between the two countries. This is reflected in the number of malaria cases imported into Uzbekistan: 27 in 1995, 51 in 1996, 52 in 1998 and 85 in 1999. Several indigenous cases were also reported in the country in 1999.

Kyrgyzstan

Malaria was eradicated many years ago, but cases started to appear again in Kyrgyzstan from 1995, particularly owing to massive cross-border population movements. Most cases were imported from Tajikistan. During 1995–1999, there were 58 cases of malaria in the country, of which six were indigenous (in Chui *oblast*).

Kazakhstan

The last indigenous case of malaria was reported in 1967, and in 1968 only cases of imported malaria were reported in Kazakhstan. In the 1980s, about 40–80 imported cases were reported annually in the country. Between 1991 and 1996 the number of imported cases rose from 2 to 87, whereas from 1997 to 1999 the number of malaria cases was on the decline – only 47 cases were reported in 1999. The first case due to local transmission occurred in 1992, and there were sporadic cases in the following years in the southern and northwestern parts of the country.

Russian Federation

Since 1996, the epidemiological situation has worsened as a result of the importation of malaria from other newly independent states (NIS). In the same year, there were also six indigenous cases of malaria. In 1997–1998, the number of imported and indigenous cases continued to increase and reached levels of 1018 and 63, respectively. Outbreaks of *P. vivax* malaria were reported in Dagestan (25 cases) and Karachaevo-Cherkessia (13 cases) in 1997–1999. In 1999, the number of imported cases dropped by 713, but indigenous cases continued to rise to 76, and malaria was reported in 24 administrative territories of the country.

During the past few years, indigenous cases of malaria originating from imported cases have also been reported in Bulgaria and the Republic of Moldova.

Eastern Mediterranean Region

There are estimated to be 15 million cases of malaria each year in WHO's Eastern Mediterranean Region. About 80% of them (mostly due to *P. falciparum*) occur in the area with afro-tropical malaria (Djibouti, Somalia, Sudan and Yemen). In all these countries the malaria situation is most serious, like in the rest of sub-Saharan Africa. In the area with an oriental ecological and epidemiological type of malaria (which includes Pakistan, Oman, Afghanistan south from Hindukush and the south-eastern part of the Islamic Republic of Iran), both *P. falciparum* and *P. vivax* infection are widespread. However, malaria transmission is successfully controlled in this area wherever the socioeconomic situation is stable. In the rest of the Region, where malaria is of the palaeartic type, malaria control was successful and malaria transmission was interrupted in many countries. However, wars and political instability led to a breakdown of malaria control and the re-emergence of the disease: this happened in Afghanistan at the end of the 1970s and in Iraq in the wake of the Gulf war. *P. falciparum* could be eliminated almost everywhere, and *P. vivax* is the only species still circulating. The only palaeartic area with continuing *P. falciparum* transmission is Afghanistan (north from Hindukush).

During the 1990s there were four main areas of cross-border transmission:

- across the northern border of Afghanistan into Tajikistan and Turkmenistan;
- across the southern borders of Afghanistan into Pakistan and Iran and from Pakistan to Iran;
- from Azerbaijan into Iran across the Aras river and in coastal areas of the Caspian Sea;
- in the border areas between Turkey and Iraq in both directions, and further from Iraq into Iran and Syria, and from Turkey into Syria and Cyprus.

Afghanistan

Malaria is endemic throughout the country at altitudes below 1500 m. Out of a total population of 22 million people, more than 12 million are estimated to be living in malaria endemic areas. There is evidence that Afghanistan is responsible for the re-emergence of malaria in the NIS, as well as for the increase in the number of malaria cases in the eastern part of Iran. Annual incidence is estimated at 2–3 million, although the number of officially reported cases in 1999 was 395 581. *P. falciparum* accounted for 11.2% of all parasitologically confirmed cases. Forty-three per cent of total cases and 71% of the *P. falciparum* cases reported in 1999 were from the three north-eastern provinces neighbouring Tajikistan, i.e. Kunduz, Takhar and Badakhshan. *P. falciparum* is the most prevalent parasite species in these areas and accounts for 16.3% of all malaria species in parasite formula.

As a result of the civil war, Afghanistan has become a country suffering a complex emergency, with a disrupted infrastructure. Given the fact that the health sector is fragmented among different and totally independent stakeholders (the Ministry of Public Health, NGOs, United Nations agencies and the private sector), a voluntary partnership approach to malaria control has been adopted through seven regional “malaria committees”. Over the past five years there has been a remarkable improvement of security in areas south from Hindukush, where most of the NGOs operate, and this has allowed organized malaria control to be restarted. In the north, malaria control is much weaker.

Islamic Republic of Iran

Malaria was widespread in Iran in the past. As a result of the antimalaria campaign started in 1951, malaria transmission was interrupted in many areas. The number of cases has fallen steadily in the 1990s, from a maximum of 98 160 in 1991 to 22 640 in 1999. The problem area is the south-eastern region that includes the provinces of Sistan and Baluchistan, Hormozgan and part of Kerman. This area, where 6% of the population live, generates 79% of total malaria cases in the country. Continuous transmission of *P. falciparum* is nowadays restricted to this area, where the parasite accounts for 25% of cases. There is considerable importation of malaria to this region from Afghanistan and Pakistan. This has been one of the reasons for the spread of chloroquine-resistant *P. falciparum*.

In the rest of the country, malaria transmission is limited. Annual parasite incidence was as low as 0.08 per 1000 in 1999, and only a quarter of the cases were due to local transmission. Malaria has been imported mostly from Afghanistan (Iran hosted 1.5 to 2 million Afghan refugees), and internally, from the south-eastern provinces. In 1994 transmission of *P. vivax* restarted in some of the areas bordering Azerbaijan which had been malaria-free since 1977.

Iraq

The antimalaria programme that started in 1951 was successful in interrupting malaria transmission in most of the country and *P. falciparum* was completely eliminated. Since 1991, following the Gulf war, Iraq has been affected by a serious epidemic of *P. vivax* malaria that started in the north-east and spread throughout the country. During the peak of the epidemic, in 1994 and 1995, almost 100 000 cases were reported annually. Owing to a large-scale indoor residual spraying campaign, the epidemic of malaria was contained, and there has been a steady decline in the number of malaria cases (4134 in 1999).

Malariogenic conditions are most favourable in the foothill areas of the north, in Ninawa, Dohuk, Erbil and Sulaimania governorates, that generate about 60% of the total malaria cases in the country. During the epidemic, malaria gained a foothold in a number of areas that were malaria-free in the 1980s, especially in Basrah governorate in the south and Babil in the centre. In the north, there was an exchange of malaria with the neighbouring areas of Turkey affected by a similar epidemic.

Although control of the large epidemic of the 1990s was a success, the future is not assured because of the precarious condition of health services owing to international sanctions.

Syria

Only transmission of *P. vivax* is being recorded, and only in the areas on the northern and north-eastern borders of the governorates of (from west to east) Aleppo, Al Raqa and Hassaka; these have, respectively, 46, 2 and 116 villages at risk, with the total population of about 90 000. In the past, the situation depended to a great extent on the epidemics in the neighbouring areas of Turkey and, later, Iraq. After the retreat of the epidemic in north Iraq that started in 1996, a downward trend could also be seen in Syria: from 584 cases in 1995 to 43 cases in 1999 (only five of them indigenous).

Progress with Roll Back Malaria

European Region

The RBM initiative is being successfully implemented in the Region. During 1999–2000, RBM project proposals were drawn up and partnership meetings were held in Tajikistan and Turkey. The work of the most active partners and donors in the Region is briefly described below.

UNICEF is actively supporting RBM activities in Armenia, Azerbaijan and Tajikistan. Its action is directed towards improving laboratory diagnosis, building capacities, conducting knowledge, attitude and practice (KAP) surveys, promoting information, education and communication (IEC) activities and mobilizing community support.

The International Federation of Red Cross and Red Crescent Societies (IFRC) is providing support to national health services to tackle the malaria problem in the southern districts of Azerbaijan and Armenia. The programme has six main components, including training, strengthening diagnostic services, improving capacities for treatment and prevention, promoting vector control and environmental measures, and health education.

The European Community Humanitarian Office (ECHO) as a funding agency is supporting malaria-related activities in Tajikistan, with particular emphasis on vector control operations. The activities funded by ECHO were evaluated in 2000 and were seen to have had a significant impact on the malaria epidemic in the country.

UNDP activities are oriented towards strengthening sustainable human development on the basis of collaboration and intersectoral action. Owing to close interrelations between environmental conditions and malaria, UNDP included a health component in irrigation programmes, rehabilitation and construction of infrastructures in the Kurak-Arak plain in Azerbaijan.

Medical Emergency Relief International (MERLIN) provides valuable assistance in improving capacities for disease management, in particular by training laboratory technicians, supplying drugs, providing laboratory equipment and setting up a system for quality control in Tajikistan.

The Agence de l'Aide à la Coopération technique et au Développement (ACTED) is focusing on the promotion of community-based approaches to malaria prevention. Thousands of mosquito nets were distributed and impregnated by communities under the supervision of technical personnel from ACTED in Tajikistan. Entomological studies related to the use of mosquito nets and mosquito fauna were carried out in the southern part of the country. Projects aimed at biological control of malaria vectors using *Gambusia* fish are planned by this international NGO in border areas of Tajikistan and Afghanistan in 2000.

Médecins sans Frontières Belgium (MSF-B), which is active in three regions of Azerbaijan (Saatly, Imishli and Fizuli), is helping the Ministry of Health to improve the quality of health services for local communities, by strengthening laboratory capacities and training different categories of health staff in disease management and prevention.

The Italian oil and natural gas company Eni is collaborating with WHO in helping the Ministry of Health of Azerbaijan to combat the disease by supporting its activities with training in malaria control and the supply of antimalarial drugs and equipment, as well as insecticides for indoor residual spraying.

The World Bank is supporting health sector reforms in Azerbaijan. This support has a direct bearing on improving the malaria situation in the country in the medium and long terms.

The World Food Programme (WFP) is supplying food to spraying personnel and other categories of malaria field workers in Tajikistan, to stimulate them to improve their performance.

The Government of Italy is providing funds to improve malaria surveillance, facilitate communications and recruit WHO experts in Tajikistan.

It is expected that the United States Agency for International Development and the Asian Development Bank will support RBM activities in Tajikistan and Georgia, while UNDP, UNICEF, the European Union, Japan International Cooperation Agency (JICA) and the administration of the South-eastern Anatolia Project (GAP) will provide some assistance for malaria control in Turkey.

Eastern Mediterranean Region

To begin implementation of the RBM initiative, two consensus-building meetings were convened, one for African countries (Nairobi, 20–22 April 1999) and another mostly for Asian countries (Cairo, 14–16 September 1999). Fourteen countries of the Region were involved (all those with malaria transmission at present or in the very recent past). The only exception was Iraq, whose representatives were participating in an RBM activity for the first time at the present meeting.

With regard to the status of RBM projects in the countries invited to the meeting, Iran and Syria had submitted statements of intent to start national RBM projects, but their RBM plans needed to be revised, while statements of intent were still awaited from Afghanistan and Iraq.

Although RBM support is concentrated on those countries with very serious malaria problems (countries with afro-tropical malaria and/or experiencing complex emergencies), RBM is also giving support to countries in which malaria is well under control. Particular attention is being paid to countries that are progressing towards the elimination of malaria transmission. It is believed that a small additional input in such countries as Morocco, Egypt or Syria might make a difference and allow them to achieve a sustainable malaria-free status, in other words, to reach the maintenance phase of malaria eradication. In other countries such as Iran or Iraq, this status may be achieved in the foreseeable future in large parts of their national territories. In this connection, it is essential to update the strategy for eliminating residual transmission and preventing its reintroduction. That is one of the important forthcoming tasks for both EMRO and EURO. Certification of eradication may be needed in the near future for a number of the countries of the Region, and an updated procedure is needed.

Development of partnership is a trademark of RBM. Most of the partners are operating in countries with afro-tropical malaria, particularly Somalia, Yemen and Sudan. Among the countries participating in the present meeting, partners are most active in Afghanistan, where an RBM task force has been formed, comprising the four founding members (WHO, UNICEF, UNDP and the World Bank), HealthNet International, the Swedish Committee for Afghanistan and the Ministry of Public Health. The task force held its first inception meeting in Peshawar, Pakistan on 16 May 2000. This process has been somewhat delayed in Iran, Iraq and Syria, and one of the immediate tasks of RBM in these countries is to attract new partners.

Follow-up of recommendations made by the First Interregional Malaria Coordination Meeting

The recommendations made by the First Interregional Meeting (Baku, 1999) have been implemented to varying extent. The following weak points should be drawn to Member States' attention:

- There has been no exchange of malaria-related information between countries on a regular basis, and no cross-notification of malaria outbreaks.
- Annual statistical data requested by EURO have not been provided by some Member States.
- Joint action plans for border areas have not been developed, and malaria control activities have not been synchronized.
- Adequate epidemic warning and reporting systems have not yet been widely developed and used in many Member States.
- Many Member States still do not have a comprehensive insecticide policy.

Recommendations

Recommendations for Member States

Improving the exchange of information

Develop an appropriate mechanism for the exchange of information in border areas.

Provide routine malaria information to WHO on a regular basis via the Internet if possible/appropriate.

In case of emergency epidemiological situations, WHO should be notified as soon as possible.

Malaria control in border areas

Develop and implement joint action plans, in order to synchronize malaria control operations in border areas.

Developing/modifying antimalarial drug and insecticide policies

Under the guidance of WHO, develop/modify comprehensive malaria treatment and insecticide policies, in order to regulate the use of drugs and insecticides and to standardize malaria treatment.

Capacity-building

With the assistance and under the guidance of WHO, continue to develop and produce learning/training materials related to malaria and its control.

Continue conducting training/refresher training on malaria and its control for various categories of general and specialized health personnel.

With the assistance of WHO, support national training of trainers in different malaria-related fields.

Improving science-based knowledge of malaria and its control

Carry out applied field research on drug efficacy (wherever required), update knowledge of malaria vector distribution/bionomics and susceptibility to insecticides.

Mobilizing community support

Continue making efforts to raise community awareness of malaria and people's participation in malaria prevention activities through community skill-building, IEC campaigns and use of mass media.

Enhancing intersectoral collaboration

Identify situations and areas where such collaboration is needed.

Mobilize additional support for malaria control from sectors other than health.

Recommendations for WHO

Malaria control in border areas

Provide technical support and back-up, facilitate the exchange of information and coordinate malaria control activities, including the organization of border meetings among countries in the European and Eastern Mediterranean Regions on a six-monthly basis.

Support for regional and national training programmes

Assist Member States in setting up institutional malaria training networks, using existing training facilities at country, subregional and regional levels.

Support the exchange of senior-level professional malaria staff among Member States.

Support the exchange of trainees and trainers between the regions.

Continue to support the production of regional/country learning/training materials on disease management and prevention, epidemic control and community mobilization in national languages.

Strengthening epidemiological surveillance

Help improve surveillance mechanisms with special reference to border areas by providing assistance with development of a Web site (with access restricted by password, such as Computerised Information Systems for Infectious Diseases (CISID)) used within the European Region, in order to facilitate the exchange of malaria-related information on a regular basis.

Improving national operational research capabilities

Assist and coordinate Member States in carrying out operational research related to drug sensitivity (wherever required), efficacy of the use of antimalarial drugs in mass campaigns, updating malaria vector distribution/bionomics and susceptibility to insecticides, operational stratification, and the socioeconomic determinants of malaria and their impact on the malaria situation. EMRO's experience with the Small Grants Scheme operated by the Organization's Special Programme for Research and Training in Tropical Diseases could be applied in countries of the European Region.

Assistance to regional/national RBM programmes

Continue brokering financial assistance on behalf of Member States, in order to effectively implement Roll Back Malaria actions.

Annex 1

PROGRAMME

Wednesday, 31 May 2000

- 10.00–10.30 Opening session:
Ministry of Health of Azerbaijan
WHO/EURO
WHO/EMRO
- 10.30–11.00 Situation analysis/Progress and acceleration:
The global effort, WHO headquarters
Monitoring malaria progress, WHO headquarters
- 11.00–11.30 Coffee break*
- 11.30–12.00 Situation analysis/Progress and acceleration:
Eastern Mediterranean Region, WHO/EMRO
European Region, WHO/EURO
- 12.00–13.00 Country presentations*:
Afghanistan, MOH/Afghanistan
Tajikistan, MOH/Tajikistan
Turkmenistan, MOH/Turkmenistan
Uzbekistan, MOH/Uzbekistan
- 13.00–14.00 Lunch break*
- 14.00–15.30 Country presentations*:
Azerbaijan, MOH/Azerbaijan
Armenia, MOH/Armenia
Georgia, MOH/Georgia
Iran, MOH/Iran
Iraq, MOH/Iraq
- 15.30–16.00 Coffee break*
- 16.00–17.00 Country presentations*:
Russian Federation, MOH/Russian Federation
Turkey, MOH/Turkey
Discussion

** 10 minutes each, followed by 5 minutes for clarifications*

Thursday, 1 June 2000

- 09.00–09.20 Country presentations:
Kazakhstan, MOH/Kazakhstan
Kyrgyzstan, MOH/Kyrgyzstan
- 09.20–09.45 Working groups:
Formation of working groups
Guidelines for group discussion
- 09.45–11.00 Working groups:
Afghanistan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan
Azerbaijan, Armenia, Georgia, Iran, Iraq, Russian Federation and Turkey
- 11.00–11.30 Coffee break*
- 11.30–13.00 Continuation of working groups
- 13.00–14.00 Lunch break*
- 14.00–15.00 Drafting of recommendations
- 15.00–15.30 Coffee break*
- 15.30–16.30 Presentations from working groups
- 16.30–17.00 Conclusions and closure

Annex 2

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