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REPORT OF THE
MINISTERIAL CONFERENCE ON MALARIA
Amsterdam, 26-27 October 1992

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Les opinions exprimées dans les documents par des auteurs cités nommément n'engagent que lesdits auteurs.

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THE MINISTERIAL CONFERENCE

1. INTRODUCTION

At the eighty-fifth session of the Executive Board of the World Health Organization in January 1990, in view of the general increasing gravity, complexity and neglect of malaria, it was proposed that a global malaria conference should be convened at the level of ministers of health to raise public awareness of the disease and to stimulate national and international action to curb it.¹ Accordingly, at the invitation of the Government of the Netherlands, the Ministerial Conference on Malaria was held in Amsterdam on 26 and 27 October 1992, the cost of the conference and of the preparatory steps being defrayed by contributions by governments and by intergovernmental and nongovernmental organizations and concerns (see ANNEX 11).

The conference was opened by Dr Hiroshi Nakajima, Director-General of the World Health Organization, who proposed H.E. the President of the People's Republic of the Congo, Professor Pascal Lissouba, for the Presidency. Dr Lissouba was elected President of the conference by acclamation.

The conference unanimously elected as Vice-Presidents:

Dr Eusebio del Cid, Minister of Health, Guatemala;
Dr M. Adhyatma, Minister of Health, Indonesia;
Dr Ali Bin Mohammed Bin Moosa, Minister of Health, Oman; and
Mrs Hilda Lini, Minister of Health, Vanuatu.

The participants (see ANNEX 2) were welcomed by Dr Ed van Thijn, Mayor of Amsterdam, and by Dr Hans J. Simons, State Secretary for Health, Ministry of Welfare, Health and Cultural Affairs, the Netherlands. The Director-General of WHO and the President then addressed the conference. (See ANNEXES 3,4,5,6, and 7).

The conference adopted the agenda (see ANNEX 1) and agreed that, should the need for voting arise, the Rules of Procedure of the World Health Assembly should be applied mutatis mutandis.

2. PREPARATORY MEASURES FOR THE CONFERENCE

To prepare for the conference, three WHO interregional meetings were held, attended by representatives from the 95 countries in which malaria is endemic. At the first of these meetings, held in Brazzaville 21-25 October 1991, more than 130 participants from 53 countries focused on pragmatic approaches to malaria control in the conditions of tropical Africa, where over 80% of the world's malaria occurs. The second meeting, in New Delhi 3-7 February 1992, was attended by some 150 participants from 43 countries, who considered malaria in Asia and the Western Pacific. The meeting concentrated on the application of current epidemiological knowledge to prevention and on diagnosis and treatment of malaria in relationship to the organization and management of health care delivery

¹ WHO Document EB85/1990/REC/2, pp. 63-67.

systems. The third meeting in Brasilia 26-30 April 1992, grouped together nearly 100 participants from 29 countries, who considered malaria in the Americas and in the context of social and economic development, ecological aspects, and intersectoral collaboration for control of the disease.

The deliberations of working groups at the three interregional meetings permitted the preparation of a Global Malaria Control Strategy that was one of the focal points of the discussions at the Amsterdam conference. This document,¹ which was finalized by an international expert review group in June 1992, summarizes the current malaria situation in the world and presents the objectives, bases and means of application of the elements of malaria control, together with an outline of programme organization and international collaboration.

Resulting from these preparatory meetings and the global strategy was a draft World Declaration on the Control of Malaria to be considered by the conference for possible adoption as public recognition of the importance of malaria and formal proclamation by political and health leaders of a global strategy for its control.

3. REVIEW OF NATIONAL EXPERIENCES AND IMPLEMENTATION OF THE GLOBAL STRATEGY

The ministers of health or other senior health leaders of 65 countries in which malaria is endemic addressed the conference, briefly outlining national experiences and expectations. Their addressees were followed by 16 statements by other partners in malaria control - principally providers of bilateral and multilateral assistance.

The reviews of national experience indicated a very wide variety of problems that were particular to or generally encountered in different countries or groups of countries. Beyond these and such serious, widespread problems as the resistance of malaria parasites to chemotherapeutic drugs and of the vector mosquitos to insecticides, it was apparent that many constraints to malaria control are common to the great majority of endemic countries. Significant among these were the following, many of which interact upon one another:

- (a) population growth and low educational levels;
- (b) inadequate development of the peripheral health services (primary health care, district-level services, local health systems);
- (c) a lack of orientation of these and higher-level services to the purposes and means of malaria control, whether or not in combination with the control of other (especially vector-borne) diseases;
- (d) inadequate community participation in health protection and promotion;
- (e) insufficient knowledge about essential antimalarial drugs at the community level, together with their inadequate distribution to that level;
- (f) lack of managerial resources;
- (g) lack of financial resources for the health sector, aggravated by the current severe economic crisis;
- (h) relatively low priority allocated at national level to the health sector in comparison to other sectors;

¹ WHO Document CTD/MCM/92.3

- (i) failure to involve sectors that are not primarily responsible for health but are directly or indirectly capable of influencing health;
- (j) lack of clear guidance as to which persons and services sectors should pursue what activities;
- (k) lack of national determination to cope with malaria using the tools already available, stemming in large measure from doubt and disillusionment created by past setbacks;
- (l) policies of social and economic development that ignore the possibility of abating or - on the contrary, of creating - the ecological and other conditions are conducive to malaria and other diseases; and
- (m) failure, in many countries attempting structural reorganization, to include serious public health problems, including malaria, in the fundamental concepts of restructuring.

There was almost unanimous agreement among the speakers that the proposed Global Malaria Control Strategy provided essential and practical lines of approach to the ultimate control of the disease in a sustainable manner, and that it was appropriately adaptable to local circumstances.

Implementation of the strategy, however, was considered to depend upon the political determination not only of the endemic countries but also of industrialized countries. Although the latter are not directly threatened by transmission of the disease within their borders, they can contribute to the social and economic development of the affected countries by supporting their malaria control programmes. Support from these partners was seen as necessary both for the direct application of the four basic elements of the strategy (early diagnosis and prompt treatment; implementation of preventive measures; prevention or rapid containment of epidemics; and regular assessment of the malaria situation) and also for creating the underlying conditions of sustainable development in which such work becomes practically feasible.

Speakers from endemic and non-endemic countries and from international organizations pointed to the extraordinary difficulty - and in many cases, the impossibility - of achieving control with only the national resources of those most affected, and to the ultimate necessity of attaining that degree of economic and social advancement in which malaria no longer flourishes and its control becomes greatly simplified. The very long haul from the present disastrous malaria situation to that ideal would involve a series of gradual steps, each requiring international cooperation and solidarity, in the enlightened self-interest of all countries.

The current economic situation in the world restricted international funding and made it more necessary than ever to ensure the best use in all spheres of national human and financial resources and of resources from outside collaborators. This would require greater coordination (and might entail revision) both of national public health, social and other structures and of mechanisms of international cooperation; antimalaria services and structures could not escape such changes. Many endemic countries and potential outside partners in malaria control placed particular emphasis on such matters as linking the control of malaria with that of related diseases (whether in the structures of malarious countries

or in those of cooperating institutions), establishing well-managed health and social infrastructures that could become self-reliant and sustainable, the redeployment of resources with greater emphasis on local or district services, and the integration of specific disease-control programmes into those of the general health services while maintaining a core of expertise for such diseases as malaria.

No universally applicable world plan for malaria control could be workable or, indeed, appropriate. Each malarious country must adapt the principles of the global strategy to its own circumstances, and constantly revise that adaptation as the circumstances alter over time or as practice reveals imperfections. That entails sound information on which to base the planning, and realism in the light of the resources available. In a few countries, conditions might encourage aiming at the elimination of transmission. In the great majority, it would be necessary to set a more modest goal and concentrate at the outset on diagnosis, treatment and prevention, backed by national commitment to malaria management and well-designed, practical planning that could attract external investment.

Speakers from non-endemic countries and international institutions made it clear that they were willing, on the basis of well-conceived programme proposals, to collaborate with the endemic countries by providing support for developing more responsive combinations of control tools and strengthening national information and research, for training and the development of essential drugs, and for the development of health systems and structures that would better enable the affected countries to cope with their major health problems, including malaria.

4. CONSIDERATION OF DRAFT WORLD DECLARATION ON THE CONTROL OF MALARIA

The text of the draft World Declaration on the Control of Malaria was discussed in detail on the second day of the conference. A number of amendments to clarify the text of the draft were proposed by the Secretary in response to comments that had been submitted prior to the session; these were accepted without discussion.

Discussions on section VI centered upon the desirability of making the second sentence more affirmative than was the case in the draft (covered by adoption of the version in the definitive text) and on addressing the needs of the least developed countries (covered by the addition of the final sentence).

In section VII, specific mention of vector as a preventive measure (in the second of the technical elements of the Global Strategy) was agreed to be a desirable even though the many other measures were not detailed. The draft wording of the fourth technical element was amended so as to emphasize the importance of strengthening local research capabilities. The subparagraph concerning the crucial role of a core group of national malaria specialists was enlarged to include that group's work in health education. The final sentence of the concluding subparagraph was added to the draft to bring out the importance of science in the social sectors. A proposal to substitute a different text, with a different objective, for the entire section VII did not find favor.

In section VIII, the first subparagraph of the draft was amended to show more clearly the necessity to identify unmet needs for which traditional resources should be mobilized. The Conference also accepted a proposal to add the final clause to the last subparagraph in order to stress the right to have access to diagnosis and treatment.

Sections IX and X, not in the original draft, were included to cover points raised by numerous participants.

5. CLOSURE OF THE CONFERENCE AND ADOPTION OF THE WORLD DECLARATION

Closing addresses were delivered by Dr B. Sangster, Director-General for Health of the Netherlands, on behalf of the host Government; by the Secretary of the conference, Dr R.H. Henderson, on behalf of the World Health Organization; and by the President. These are given in ANNEXES 8, 9 and 10.

The World Declaration on the Control of Malaria, as amended (see PART II), was then read out by Dr Fanny Friedman, Minister of Health of Swaziland, and adopted by acclamation. The President and the four Vice-Presidents appended their signatures to the document, bringing the conference to a close.

PART II

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 are 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 childhood killers in tropical Africa, taking the life of 1 out of 20 children before the age of 5 years. The disease 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 large-scale uncontrolled population movements and ecological disturbances. Non-immune populations entering malaria-endemic zones within the frontiers of economic development are paying an exorbitant price in disease and disability.

IV

Construction and environmental change brought about by development are creating environments favorable 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 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 the appropriate strategies 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 provoked 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.

VII

We, recognizing the above:

- endorse the Global Malaria Control Strategy, acknowledging the need to focus upon 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; 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;
- support decentralized structures of programme management in which those closest to the problem are delegated the responsibilities to employ 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 assure 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 control 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 concerns must be incorporated in such projects if they are to contribute positively to social and economic development for the communities concerned;
- will involve the communities concerned as partners in our efforts, as well as the sectors concerned with education, water resources, sanitation, agriculture and development; and
- 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 actions 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 the United Nations system, bilateral agencies, and nongovernmental organizations to increase their support to malaria control efforts, 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 fulfillment of its constitutional function to act as the coordinating authority on international health work, to exercise leadership in providing support for national implementation of this global strategy.

Professor Pascal Lissouba, President of the Republic of the Congo, President of the Ministerial Conference on Malaria

Dr Eusebio del Cid, Minister of Health of Guatemala, Vice-President of the Ministerial Conference on Malaria

Dr M. Adhyatma, Minister of Health of Indonesia, Vice-President of the Ministerial Conference on Malaria

Dr Ali Bin Mohammed Bin Moosa, Minister of Health of Oman, Vice-President of the Ministerial Conference on Malaria

Mrs Hilda Lini, Minister of Health of Vanuatu, Vice-President of the Ministerial Conference on Malaria

ANNEX 1

AGENDA

<u>Monday, 26 October</u>	8.00 - 9.00	REGISTRATION OPENING SESSION - Addresses by representatives of the Host Country - Address by the Director-General - Election of the President (break) - Election of four Vice-Presidents - Procedure formalities - Purpose of the Conference
	10.00 - 10.30	GLOBAL MALARIA CONTROL STRATEGY - Dr R.H. Henderson, Assistant Director-General
	10.30 - 11.15	MALARIA CONTROL FILM
	10.15 - 12.30	MINISTERIAL INTERVENTIONS
Afternoon	14.30 - 18.00	MINISTERIAL INTERVENTIONS (cont'd)
<u>Tuesday, 27 October</u>	9.00 - 11.00	STATEMENTS BY OTHER PARTNERS IN CONTROL
	11.00 - 11.15	UNDP/WORLD BANK/WHO SPECIAL PROGRAMME FO RESEARCH AND TRAINING IN TROPICAL DISEASES: MALARIA RESEARCH - Dr T. Godal, Director ¹
	11.15 - 11.30	WHO's GLOBAL MALARIA CONTROL PLAN: 1993-2000 - Dr P. de Raadt, Director, Division of Control of Tropical Diseases ¹
	11.30 - 12.00	DECLARATION OF THE CONFERENCE
Afternoon	15.00	CLOSING CEREMONIES - Adoption of the Declaration - Closing remarks

¹ Time did not permit these items of the agenda to be taken up.

LIST OF DELEGATES AND OTHER PARTICIPANTS

I. COUNTRY DELEGATES

AFGHANISTAN

Dr S. Sahar, Deputy Minister of Public Health
Dr M.A. Karimzad, President of the Malaria Institute

ALGERIA

Dr A. Chakou, Directeur de la Prévention, Ministère de la Santé et la Population
Dr A. Kabrane, Chef de Service du Paludisme, Institut National de Santé Publique

ANGOLA

Dr F. Fortes, Directeur du Programme national de Lutte antipaludique

AUSTRALIA

Mr W. Weemaes, Ambassador to the Netherlands

BANGLADESH

Mr S. Ahmed, Secretary, Ministry of Health and Family Welfare
Dr M.I. Haq, Deputy Director for Malaria and Parasitic Diseases Control

BENIN

Mme le Docteur Véronique Lawson, Ministre de la Santé
Dr C. Comlanvi, Responsable des Activités de Lutte contre le Paludisme

BHUTAN

Mr P.J. Dorji, Ambassador, Permanent Representative of the Royal Government of
Bhutan to the United Nations, Geneva
Dr P. Namgyal, Deputy Director, Malaria Control Programme

BOLIVIA

Dr G. Cuentas Yañez, Viceministro de Salud

BOTSWANA

Mr B.K. Temane, Minister of Health
Mrs Rosina Diseko, National Malaria Coordinator, Community Health Services
Mr M.I. Ali, Senior Entomologist

BRAZIL

Dr J.C. Pinto Dias, President of the National Health Foundation

BURKINA FASO

M. C. Dabire, Ministre de la Santé, de l'Action sociale et de la Famille
Dr L. Lamizana, Responsable du Programme de Lutte contre le Paludisme

BURUNDI

Dr N. Ngendabanyikwa, Ministre de la Santé publique
Dr H. Ndiokubwayo, Responsable de la Lutte contre le Paludisme

CAMBODIA

Dr S. My, Vice-Ministre de la Santé
Dr S. Lek, Directeur de l'Institut de Malariologie du Ministère de la Santé

CAMEROON

Dr J.L. Mvondo Abane, Responsable du Programme national de Lutte contre le Paludisme

CAPE VERDE

Dr Maria Alice Ribeiro, Inspectrice générale de la Santé
Dr Joana Alvez, Directrice du Programme de Lutte contre le Paludisme

CENTRAL AFRICAN REPUBLIC

Dr J. Limbassa, Inspecteur central des Services de Santé et des Affaires sociales
Dr J -B. Roungou, Directeur de la Médecine préventive et de la Lutte contre les grandes Endémies

CHAD

Dr Julienne Deyo, Secrétaire d'Etat à la Santé publique et aux Affaires sociales
Dr D. Syam, Responsable du Programme national de Lutte contre le Paludisme

CHINA

Dr Jiasheng He, Vice-Minister of Public Health
Dr Zhao Wang, Deputy Director, Department of Health and Epidemic Prevention
Dr Guogao Wu, Programme Officer, Department of Foreign Affairs, Ministry of Public Health
Dr Shuhui Xu, Chief, Division of Parasitic Diseases Control, Department of Health and Epidemic Prevention
Dr Chuanhong Chen, Deputy-Chief, Department of Science and Technology for Social Development, The State Science and Technology Commission
Dr Zhentian Liu, Programme Officer, Department of Foreign Affairs, Ministry of Public Health

COLOMBIA

Dr L.E. Gomez Pimienta, Viceministro de Salud

COMOROS

Dr S.A. Ahmed, Directeur du Cabinet du Ministre de la Santé publique et des Populations
Dr A. Said Ali Petit, Directeur général de la Santé

CONGO

Professeur P. Lissouba, Président de la République du Congo
Professeur J.R. Ekoundzola, Ministre de la Santé, de la Population et
des Affaires sociales
Dr R. Coddy Zitsamele, Directeur de la Médecine préventive

COSTA RICA

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COTE D'IVOIRE

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Professeur K.L. Manlan, Directeur général de la Santé et de la Protection
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Dr J. Niangué, Sous-directeur des Services de Santé primaires et des grandes
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DENMARK

Dr J. Heldrup, Health Adviser, Danish International Development Agency,
Ministry for Foreign Affairs

DJIBOUTI

Dr C. Saad Omar, Directeur technique, Ministère de la Santé
Dr Md. Mahyoub Hatham, Economiste, Ministère de la Santé

DOMINICAN REPUBLIC

Dr G. Gonzalez Garcia, Director Nacional del Servicio de la Erradicación del
Paludismo

ECUADOR

Dr E.M. Gutierrez, Viceministro de Salud

EGYPT

Dr M.H. Harb, Director-General for Malaria, Filariasis and Leishmaniasis

EL SALVADOR

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Mr A. Guerra Sandoval, Jefe del Departamento de Paludismo

EQUATORIAL GUINEA

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Dr M. Nguema Ntutumumu, Director Nacional de Lucha contra el Paludismo

ETHIOPIA

Dr A. Kidane Mariam, Minister of Health
Mr G. Kidane, Head, National Organization for the Control of Malaria and
other Vector Borne Diseases

FRANCE

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M. J.R. Bernard, Ambassadeur aux Pays Bas
M. M. Levallois, Président du Conseil d'Administration de l'ORSTOM, Paris
M. P. Castella, Conseiller technique, Ministère de la Coopération et du
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GABON

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Dr M.O. George, Director of Medical and Health Services

GERMANY

Dr P. Weis, Deutsche Gesellschaft für Technische Zusammenarbeit,
Division of Health, Population and Nutrition

GHANA

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Dr K. Ahmed, Head of Epidemiology Division

GREECE

Dr Méropi Violaki-Paraskeva, Honorary Director-General of Health

GUATEMALA

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Dr R.D. Lechuga Del Cid, Jefe del Programa de lucha contra el Paludismo

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Dr M. Keita, Responsable du Programme national de Lutte contre le Paludisme

GUINEA BISSAU

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Dr J.C. Sa Nogueira, Directeur régional de la Santé

HAITI

Dr C. Jean-François, Ministre de la Santé
Dr M. Alvarez, Professeur à la Faculté de Médecine, Expert en maladies transmissibles

HONDURAS

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Mr J.R. Gomez, Jefe de la División de Enfermedades Transmitidas por Vectores

INDIA

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Mr B. Lamba, Joint Secretary to the Government of India, Ministry of Health and Family Welfare
Dr M.V.V.L. Narasimham, Director, National Malaria Eradication Programme

INDONESIA

Dr M. Adhyatma, Minister of Health
Dr R.P. Arbani, Chief, Sub-Directorate Malaria Control
Mr S. Martokusumo, Embassy of Indonesia to the Netherlands

IRAN (ISLAMIC REP. OF)

Dr R. Malik-Zadeh, Minister of Health and Medical Education
Dr H. Nammaki, Deputy Minister of Health
Dr M. Azmuddih, Director-General, Communicable Diseases, Ministry of Health and Medical Education

IRAQ

Dr A. Al Thamiri, Director-General of Preventive Medicine
Dr A.N. Hasan, Director, Malaria Control Programme

JAPAN

Mr M. Kawai, Deputy Director-General of the United Nations Bureau, Ministry of Foreign Affairs
Dr T. Kobayakawa, Managing Director, Medical Cooperation Department, Japan International Cooperation Agency
Mr Y. Tojo, Planning Division, Medical Cooperation Department, Japan International Cooperation Agency
Professor M. Suzuki, Department of Parasitology, Gunma University, School of Medicine
Mr I. Shuichi, Second Secretary of the Embassy of Japan in the Netherlands

KENYA

Mr T. Ogur-Ochola, Assistant Minister for Health
Dr H.J. Ouma, Director, Division of Vector Borne Diseases Control
Mr A.K. Langat, Senior Public Health Officer

KUWAIT

Dr M. Al-Saleh, Head of Epidemiology and Infectious Disease Control Unit,
Ministry of Public Health

LAO PEOPLE'S DEMOCRATIC REPUBLIC

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Dr K. Pholsena, Directeur de l'Institut de Malariologie, de Parasitologie
et d'Entomologie

LIBERIA

Mr E. Johnson, Acting Minister of Health and Social Welfare

MADAGASCAR

Professeur D. Andriambao, Ministre de la Santé
Dr D. Randriatsimaniry, Directeur de la Lutte contre les Maladies transmissibles

MALAWI

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Professor J.J. Wirima, College of Medicine, Blantyre
Dr J.S. Kure, Controller of Preventive Health Services
Mr B.S. Chawani, Deputy Secretary, Ministry of Health

MALAYSIA

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Dr Sundarajoo Poovaneswari, Deputy Director, Vector Borne Disease Control
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Dr A.S. Maïga, Responsable du Programme national de Lutte contre le Paludisme

MAURITANIA

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Dr I. Kane, Directeur de la Promotion sanitaire

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OPENING REMARKS BY DR ED VAN THIJN, MAYOR OF AMSTERDAM

Excellencies, ladies and gentlemen,

On behalf of the City Government of Amsterdam, I am happy to welcome you in the RAI in Amsterdam. For the second time in a few months the city of Amsterdam and the RAI are hosting a conference addressing a major global health problem. In July we hosted the VII International Conference on AIDS, and we today are host to the Ministerial Conference on Malaria.

Malaria is a devastating tropical disease transmitted by a mosquito. There was a time, not so long ago, when the general thinking was that malaria had been conquered by science. We are here today because we know, we recognise, that this is no longer true. In the past ten years malaria has once again become one of the major public health problems around the world. Malaria kills around 1 million people every year, most of them children, and threatens the health of many millions more.

Malaria is, however, not only a disease transmitted by a mosquito, but a social condition related to economic development. As so often happens, the poor and those living in underdeveloped areas of the world are the ones most affected by the disease. So, addressing malaria is not only a question of research. Neither is it solely a question of gaining vector control. The fight against malaria is also a fight against poverty. It is a fight to create adequate medical infrastructures in the countries affected. It means making available knowledge and information about the prevention of malaria and about the ways of treatment of the disease accessible to all governments and to those most threatened by it: the poor. These measures demand international and national solidarity, and a concerted effort of all concerned to agree on a global malaria strategy. That is the main goal of this Ministerial Conference on Malaria. That is why you are here. I wish you all a great deal of wisdom in the next two days.

Thank you very much.

ADDRESS BY DR HANS J. SIMONS, STATE SECRETARY FOR HEALTH
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THE NETHERLANDS

It is a pleasure for me to welcome you all, on behalf of the Netherlands Government, to Amsterdam. I am speaking especially on behalf of Mr Jan Pronk, our Minister for Development Cooperation, who is currently in Sub-Saharan Africa.

Malaria - and more in particular its control - is our main theme for the next two days. It is a disease that outsiders often fail to take seriously - until someone close to them is hit by the familiar symptoms such as the fevers, the anaemia, the general lethargy, and even worse. In most of the countries of Sub-Saharan Africa, and in parts of Asia and Latin America, malaria is one of the most prevalent diseases, if not the most prevalent.

Malaria is closely linked to poverty. Most cases occur in poor rural areas, where it also stands in the way of poverty alleviation. The disease is a major cause of productivity loss, and as a result, seriously obstructs socio-economic development. And socio-economic hardship - resulting for instance from structural adjustment programmes - in its turn impedes effective malaria control.

In the past decade, the incidence of malaria had increased. They do not call it the King of Diseases for nothing. It lives up to its name. Fifteen to 20 years ago, optimists thought that the war on this infectious disease was almost won. How wrong they were.

Poverty alleviation - reducing the gap between rich and poor in developing countries as well as the gap between rich and poor countries - is the main goal of Dutch development policy.

Primary health care - with its emphasis on combating the most prevalent diseases and reducing infant mortality - is the most essential component of poverty alleviation. Health is, after all, a precondition for a productive life. It is the poorest who are most often and most seriously ill. They often have no access to adequate treatment.

In developing countries, there are estimated to be over 100 million new cases of malaria - and over one million deaths from it every - year again. The worst hit part of the world is tropical Africa, where malaria is one of the main causes of infant mortality. The rural poor are especially hard hit. But the malaria mosquito has also found its way into the more urban slums, and here too the disease it on the increase.

Malaria has been made worse by the floods of refugees driven from their homes by war and famine, and by the rise in migration to uncultivated lands - the new frontiers. People who are not immune arrive in transmission areas, which gives rise to the risk of epidemics. On top of which, there is often too fragile a medical infrastructure in these areas to ensure a more adequate treatment.

Even development projects have - unwittingly - contributed to the spread of malaria, certainly in the past. For instance, irrigated fields make an ideal breeding ground for the mosquito.

In the 1950s and 1960s, large-scale vertical control programmes were started as part of the World Health Organization's malaria eradication campaigns. A lot of attention was especially focused on vector control. Programmes of this type were conducted in Asia and Latin America, and to lesser extent in tropical Africa. The campaigns met with some success. But in the long run, there were often too costly, and as a result, unsustainable. Additional problems came from the resistance of insects to insecticides and behavioural changes on the part of the vectors. Large-scale eradication turned out not to be sustainable - as we are coming to realize.

During the 1970s and 1980s, in keeping with the general trend in health care, there was a shift of emphasis towards malaria control as part of primary health care. In practice, however, this often amounted to little more than making medication available to be administered by village health workers. Prevention received little attention. Nor was there much evaluation of this type of control. On top of which, the focus gradually shifted away from malaria. Other diseases - such as AIDS - become the focus of attention.

Nevertheless, the scale of the malaria problem had grown much in the past ten years. And its control had been complicated by an increase in the parasite's resistance to medication even to relatively new medicines such as mefloquine. The Netherlands Government hopes that this conference will contribute to the recognition of malaria once again as one of the world's most serious health problems, and give its control fresh impetus. A global strategy is what is needed. And the Netherlands supports the inclusion in the strategy of four technical components:

1. early diagnosis and prompt treatment;
2. selected and sustainable preventive measures;
3. specific measures against epidemics; and
4. operational and strategic research.

We must approach these four components as part and parcel of the same strategy, and avoid devoting an inordinate amount of attention to any one element. Malaria manifests itself in different ways in different countries - and sometimes in different parts of the same country. In addition, the way in which health care is organized varies from country to country. For this reason, flexibility in the implementation of the strategy is an essential question. A rational approach is required, if only because of the often limited resources available in countries where malaria is endemic.

The Netherlands supports the development of sustainable intervention methods and their adaptation to the local eco-epidemiology of the disease. For this purpose, information about the incidence of malaria and parasite's resistance to medication needs to be collected and sharply analyzed. This information will serve as a good basis for guidelines on treatment and prevention.

National, and possibly regional, medication protocols will have to be drawn up. Enough medication will have to be available. It will be necessary to train health workers in the rational use of this specific medication. We will also have to focus on prevention in the form of selective vector control. I am thinking here of impregnated mosquito nets, environmental sanitation, and selective residual insecticide spraying.

Malaria epidemics present a special problem. We must decide on guidelines for their prevention and measures to be taken when they occur. Operational research will be most useful in helping us evaluate and make good

adjustments to the implementation of malaria control. In addition, basic research is necessary for the development of new control methods.

At national level, the national programmes will be the basis for shaping and implementing malaria policy. A special unit within the Ministry of Health will be responsible for the design and implementation of this sort of policy. But at district and peripheral level, it will be preferable to integrate malaria control into basic health care services as far as possible. That is the main thing. In many countries, this will have major consequences: primary health care will have to be strengthened.

Wherever integration is not possible on account of inadequate basic health care services, a vertical approach to malaria control may be preferable.

It is important that local communities always be involved in the implementation of this sort of policy. This will encourage the rational use of anti-malaria medication. In addition, preventive measures such as personal protection and selective vector control will be more successful if communities participate in the design and implementation from the start and from the very beginning.

If our policies are to be effectively implemented, we must be familiar with the attitudes and behaviour of people already with regard to malaria and the methods of treatment and prevention most commonly used. We must be aware, for instance, that self-medication with over-the-counter medicines is the method of treatment used by more than half the world's malaria sufferers.

An additional problem is that malaria often breaks out just before a harvest, when people have little money. As a result, it is often inadequately treated because of insufficient drugs are available, which increases the parasite's resistance to medication. National medication policies must take these aspects into consideration.

Informing the general public - and in particular health workers and others who prescribe medicines - is vital in this respect. Legislation as an element of essential drugs policies is in our view also a priority. This calls for effective coordination with National Essential Drugs Programme.

A good basic health care system is in our opinion crucial for efficient malaria control; it also has a favorable impact on the control of other major diseases. I also believe that adequate health care is a precondition for human development. And socioeconomic growth in its turn contributes to the reduction of morbidity and mortality.

The Netherlands standpoint is that basic health care services need to be strengthened. This is why the Dutch Government is not in favor of further cutbacks in health care as part of structural adjustment programmes. Given the desperate situation in many developing countries, anybody with these countries' middle - and long term - socioeconomic interests at heart can only favor putting more, not less, money into basic health care.

The Netherlands will promote the integration of malaria control into primary health care to the best of its ability. At district level, we intend to continue with direct support to basic health care programmes.

We will also continue to support the development and implementation of national essential drugs programmes. Furthermore, we will support operational research into the implementation of control programmes.

Strategic research into the development of medication and vaccines must be international by coordinated. The Netherlands will work closely in this field with the WHO Tropical Diseases Research Programme.

Particular attention will be paid to applying the results of this specific research. If effective medication - or in the longer term - vaccines are developed, it is essential that they be accessible to people in developing countries. They must be easy to administer and affordable. This means that the WHO and the member states will have to sit down with the research institutes and the private sector and agree on prices.

The WHO must also promote research into potentially effective vaccines and medication which are not profitable in the short term. It would be pointless to leave a good malaria vaccine on the shelf because its potential users cannot afford it. The list of orphan vaccines should not get any longer.

The prevention of malaria also merits attention. Research into sustainable intervention methods, aimed at reducing the transmission of malaria will receive our support. These methods will also have to be integrated into primary health care services. As far as prevention is concerned, it is also very important that steps be taken to avoid making the problem of transmission worse when development projects are planned and implemented.

The Netherlands Government hopes that this conference will give fresh impulse to malaria control. It is now or never. Waiting impassively for some miracle cure could cost millions of human lives. In the years to come, malaria control will have to be conducted on the basis of information exchange between countries. To this end, we will have to develop realistic and effective strategies.

The reward will be improved health and health care, which will in their turn contribute in the best way to socioeconomic development. The costs are low compared to the benefits, at least for anyone who is willing to plan ahead.

Both I and Mr Pronk, our Minister for Development Cooperation, wish to help ensure that the Global Malaria Control Strategy which you are to discuss today and tomorrow receives the attention it deserves and that it is translated into the most concrete action. With this in mind, we have resolved to raise the issue of malaria control and the strategy directed towards achieving it at the next Health Council meeting on 13 November and the Development Cooperation Council on the 18 November. We would thus like to demonstrate once more how health and development are interconnected and how we are pooling our resources in order to tackle the issue at international level.

I wish you all every success, and hope your stay in Amsterdam will be a pleasant one.

Thank you.

OPENING REMARKS BY DR HIROSHI NAKAJIMA
DIRECTOR-GENERAL
WORLD HEALTH ORGANIZATION

Your Excellency, President Lissouba;
State Secretary for Health, Dr Simons
Mayor van Thijn; distinguished ministers of health;
colleagues, ladies and gentlemen

It is with great pleasure that I declare this Ministerial Conference on Malaria open.

As we gather in this lovely and historic city of Amsterdam to discuss how to cope with the crisis caused by the upsurge of malaria in the world, it may come as a surprise, especially to visitors, to learn that, as recently as 1946, the Netherlands experienced a malaria epidemic affecting some 15 000 people.

Many of the measures used by the Dutch authorities to stem that epidemic are still relevant today. The conditions which led to it - social upheaval and ecological disturbances - remain important reasons for the current recrudescence of malaria in some parts of the world. In 1946 these conditions were brought about by a long and destructive war. Today, they are to a large extent the result of inappropriate development.

The lesson we have learned is that there is a need for constant vigilance against the vector and the parasite, and that this can best be achieved if there exists a sound and stable infrastructure.

I know that all who are gathered here will wish me to say how much we appreciate the generosity of our host, the Government of the Netherlands, which has spared no effort in providing the optimum setting for this Ministerial Conference.

The newly elected President of the People's Republic of the Congo, His Excellency President Pascal Lissouba, has done us the very great honor of sparing time from his busy schedule to come to Amsterdam to be with us at this Conference. Professor Dr Lissouba is a scientist of reknown, with extensive experience in international work, having been associated for many years with UNESCO and in various capacities with other organizations such as FAO, ILO and ORSTOM. To his credit he has many scientific works relating to the field of agriculture and health, including studies on the mosquito vector of malaria.

As a political leader, a scientist and a dedicated humanitarian, I can think of no more appropriate person to preside over this historic conference. I propose His Excellency President Lissouba, as our President, and ask you to endorse his election by acclamation.

OPENING REMARKS BY THE PRESIDENT

Ministers, Distinguished Guests, Ladies and Gentlemen, thank you. Thank you Mr Director-General for those kind words on behalf of the participants for choosing me to act as President for the Conference.

I am happy to be here among you all, not in the capacity as President of the Congo, but in a scientific capacity - a discipline that I shall always possess. I am very happy and privileged to have this honor, not simply an honor for the Congo but for the whole of Africa, a continent which pays heavily with regard to this disease, a fatal and dangerous disease, malaria.

I express my gratitude to the World Health Organization and the Government of the Kingdom of the Netherlands for organizing and hosting this Conference in the lovely city of Amsterdam, famous for many features, among others the Royal Tropical Institute, recognized world wide for its contribution towards the fight against malaria.

Again, thank you Director-General.

ADDRESS BY DR HIROSHI NAKAJIMA
DIRECTOR-GENERAL, WORLD HEALTH ORGANIZATION

Your Excellency, President Lissouba;
State Secretary for Health, Dr Simons;
Mayor van Thijn; distinguished ministers of health;
colleagues; ladies and gentlemen,

This meeting is of the utmost importance for the success of global malaria control and I am most encouraged that, by your attendance in such large number, you obviously share our concerns about the malaria problem and the need for urgent coordinated action.

Each year malaria kills over one million people - a death every 30 seconds. One hundred million others fall ill from malaria, often severely. It threatens 40% of the world's population undermining the health and welfare of women and families and the survival of children.

In rural Africa, malaria kills 1 out of every 20 children before they reach the age of 5 years. It is eroding economies and development by debilitating the active population, and straining the resources of both countries and individuals. It is the most common disease among young adults in Africa, where it tends to strike during harvest time, affecting productivity. The poor and the underprivileged suffer most, since the disease's greatest impact is felt in areas where the health and social services are weakest.

In 1987 the direct and indirect costs of malaria in Africa south of the Saharan were estimated to be US\$800 million. This figure is expected to rise to US\$1.8 billion by 1995. Countries outside Africa are spending amounts of the same order of magnitude in maintaining current malaria control activities.

In many parts of the world environmental changes, resulting from development projects, have led to conditions which favor the transmission of the disease. The Amazonian basin is one of the places where this is occurring. The migration of populations, rapid urbanization, war and civil disturbances have compounded the situation. In Afghanistan, new cases have risen from 10 000 to 300 000 in the past seven years. In Cambodia, where the parasite is resistant to most antimalarial drugs, cases increased from about 200 000 annually to 500 000 in a few years. And there are many other examples.

Some 500 million people live in areas, mostly in tropical Africa, which lack a sustained antimalaria programme. To name but a few, serious epidemics have occurred in recent years in Burundi, Madagascar and Namibia. It was time, therefore, to strengthen our global commitment to malaria control by organizing this Conference, and to prepare ourselves for action.

The World Health Assembly and the WHO Executive Board have specifically expressed their deep concern for malaria's deleterious impact on the health and socioeconomic development of the endemic countries. Over recent decades, the control of malaria in Member States where it is a public health, social and economic problem has been overshadowed by other pressing priorities. In many, development of the basic health services that are essential to malaria control has not both been as rapid as is necessary. In others, programmes continue with eradication practices that are outmoded, and neither cost effective nor sustainable.

The malaria problem is not homogenous. It shows considerable variation under different social, economic and ecological conditions. The three interregional meetings held in preparation for this Conference were important in providing in-depth reviews and critical analyses of why the situation is deteriorating in many parts of the world. These reviews and analyses were essential for the development of the draft Global Malaria Control Strategy which is before you today.

Malaria is a curable and preventable disease which can be controlled but not by the health sector alone. It is everybody's business and everyone should contribute. There is no "quick fix" - the process will be long-term. It will require sustained political commitment on the part of us all. Since many of the underlying causes, and the means of mitigating them, lie outside the purview of the health sector, all sectors need to be involved at every level. An essential part of the proposed strategy is to ensure that there is a full partnership of the health and other sectors. The strategy requires not only that malaria control should become an integral part of each country's general health programme but, at the same time, that its activities should be coordinated with those of the concerned development programmes in the non-health sectors, for the benefit of both health and development.

At the local level, the proposed strategy requires that communities should be motivated to contribute, each in its appropriate way, to the prevention and control of malaria. All stand to gain from such contributions. Conversely, all stand to lose if action is not taken.

This global malaria control initiative will be a major challenge requiring the mobilization of adequate human and financial resources. While some countries will be able to provide such resources themselves, by establishing priorities and reallocating existing resources, in many cases technical and financial external assistance will be required. Such support must be coordinated in order to ensure that there is continuity in action and unity of purpose, and also accountability, to avoid duplication and wastage. WHO is committed to supporting countries in providing such coordination and ensuring accountability.

The response to this global initiative is already encouraging. In line with the recommendations of the interregional conferences held in preparation for this Conference, 54 malaria endemic countries have already developed proposals for control programmes or for the reorientation of current programmes.

Also before you today is a draft World Declaration on the Control of Malaria. I hope you are willing to adopt such a Declaration, committing us all, even more closely, as partners in the control of man's most devastating parasitic disease. The World Health Organization is ready to join in such a partnership, which will serve the health, social and economic interests of malarious and malaria-free countries alike as we work together towards a brighter and healthier future.

The solidarity shown up to now by the partners in control who have contributed to the preparations for this Conference is, indeed, an auspicious beginning. I would particularly like to thank Member States, governmental organizations, other United Nations organizations and bodies, and industry, who have contributed so generously. I look forward to the outcome of your deliberations and wish you a most successful meeting.

Thank you for your attention.

CLOSING ADDRESS BY DR BERNARD SANGSTER
DIRECTOR-GENERAL OF HEALTH OF THE NETHERLANDS

Thank you, Mr President, Ministers, ladies and gentlemen. I will speak on behalf of the Netherlands' Government, in particular Mr Jan Pronk, Minister for Development Cooperation, and Dr Hans Simons, State Secretary for Welfare, Health and Cultural Affairs.

I congratulate you all and WHO with the outcome of this Conference. The Netherlands fully subscribes to the Global Malaria Control Strategy. In the implementation of the strategy, attention should be paid to each element, or to quote our State Secretary: "we should avoid devoting an inordinate amount of attention to any one element".

Development affects people, so does malaria. Therefore the Netherlands considers the participation of the local population in the implementation of the control strategy of the utmost importance. To this end knowledge of people's attitudes and behaviour is essential. Only when these aspects are taken into account, community based health care programmes will be effective. Preferably malaria control should be integrated in these programmes.

Malaria has always been considered a problem of rural areas. However, it should be realized that malaria also increasingly affects urban slum areas. For this reason we think that more attention should be paid to this problem than in the past.

Poverty and malaria are closely linked, this has also been pointed out repeatedly yesterday and today. Obviously there is a strong relation between inequities in health, which exist all over the world, and differences in the socioeconomic situation between and within countries. Being aware of the seriousness of the socioeconomic problems in large parts of the Third World, we should recognize the urgency of poverty-alleviation and the improvement of health, including malaria control. It is now or never!

Let us all - developing countries, International organizations and donor countries rise to the challenge and translate the global strategy into concrete action.

As a first and small step the Netherlands' Government will put the issue of malaria control and the global strategy on the agendas of the European Council for Health on November 13 and of the European Development Council on November 18.

Furthermore, we will continue to support malaria control in the framework of bilateral and multilateral development cooperation.

Ladies and gentlemen, it has been a great honor for the Netherlands to host this Conference. Let me thank you, in closing, on behalf of the Netherlands Government for coming to our country. I wish you a safe journey home.

Thank you, Mr. President

CLOSING ADDRESS BY THE SECRETARY
DR R.H. HENDERSON, ASSISTANT DIRECTOR-GENERAL, WHO

Mr President
Professor Sangster, Representative of the host country
Honourable Ministers
Honourable delegates
Ladies and Gentlemen

In the name of Dr Hiroshi Nakajima, Director-General of the World Health Organization, who unfortunately had to leave early, and in my own name as Secretary of this Ministerial Conference on Malaria, I wish to express my gratitude and that of the whole secretariat of the Conference to you Mr President, to the vice-presidents, to the authorities of the host country and to all participants for enabling this conference to come to this successful conclusion.

For me this has been an exciting and uplifting conference. WHO as well as the many other participants here, however, do not take our work as having ended. Rather, it is just beginning. For now we must turn words into actions; ideas into sustainable and effective programmes; dreams into realities. On behalf of WHO, I thank the Netherlands for hosting this Conference, I thank the many other countries and organizations who have help support it and I thank you, Mr President, for giving it such special prestige and special symbolic flavor. It is, indeed, for the first time in its history that the World Health Organization has had the privilege of having one of its meetings chaired by a Head of State. The fact that you are also a most distinguished scientist has made this an even greater privilege for us.

But most of all, I salute you, the Ministers and other representatives from malaria endemic countries, for your contributions and commitment. Together bringing to bear political commitment, financial resources and fruits of applied and basic research, we shall overcome malaria. As a hymn from my country repeats, WE SHALL OVERCOME.

CLOSING ADDRESS BY THE PRESIDENT
PROFESSOR PASCAL LISSOUBA, PRESIDENT OF THE REPUBLIC OF THE CONGO

Thank you Dr Henderson. Thank you especially for the words that go straight to my heart. I would not have wished to reply to them, to have to make a speech - and in any case, this will not be one.

Yes, Dr Henderson you are right it is a symbol. I wanted to join you. I did not want to latch on to what I regard as mere appearances. What is a President of a Republic? A title that can be taken by force! Something unstable! It is nothing at all in the face of the challenges confronting our world. The challenge is on an infinitely small scale. We have been shown, by the malaria parasite, that we are of no account, fragile in the extreme. Look: there is Plasmodium falciparum, a few microns across. It has no brain, yet it affects two thousand million individuals that are four thousand times bigger than itself. Its mutability is its only defence against an entire organized planet. It would even survive a nuclear attack. We may destroy ourselves one day, but Plasmodium falciparum will survive us.

That is the challenge. As I said, it has nothing to do with mere appearances. It is a global challenge to our creativity, to scientific and technical skills, and to human technology. Just as we put the Cold War behind us, we can put an end to malaria. This can only be done together, using the creativity of those who are suffering because of this microorganism. It requires us to be modest but perserving, modest but committed and detemined to live, just like the microorganism itself. For Plasmodium falciparum wants to live, and it fights to stay alive. We must get organized; there are not, as the Minister of Benin suggested, people who are strong enough today to turn their backs consiciously or unconsciously on the misery of others. That is unacceptable. Falciparum shows the way: modesty, generosity and solidarity. This is what your conference called for and this is why I, for one, came; but I am speaking as a scientist and researcher like yourselves, sharing your anxiety. This has to be remembered.

Director-General for Health of the Netherlands, Dr Henderson, Assistant Director-General of WHO, Regional Directors of WHO, Ministers, ladies and gentlemen, and of course the interpreters up there, now at the end of the meeting whom we should not forget. My thanks to all of you. well done! I thank the authorities of this country for the friendly welcome, and for your generosity. I congratulate all you participants for the work you have done, for the zeal and skill with which you have tackled a thorny problem. I thank the interpreters for patiently putting up with us; you did not complain when it began to drag on. Thank you also for the example.

Ladies and gentlemen, your conference is coming to an end. It has reviewed the situation with regard to the disease, noting in particular recent factors that have aggravated the problem in a way that could, as you have realized, lead or open the way to devastating epidemics. You have also noted that existing tools could and should be better used to control this disease. You have identified four elements that should form the basis of a modern malaria control strategy, elements that we regard as effective and promising. I will not go over them again, since you know them better than I do. Yet there is one thing that I should speak of once again: WHO, the World Health Organization. As the central agency of this system, WHO shall, as you asked, and as the Member States have decided, support its traditional partners in putting these resolutions into practice. WHO will also be responsible for helping with the exchanges that will bring local officials and researchers into the international scientific movement. Our heartfelt thanks to the Director-General of WHO and his assistants.

The official Declaration that confirms all this will be read to you and initialled in front of you by the office. Thank you very much, thank you for everything.

I invite Mrs Fanny Friedman, Minister of Health of Swaziland, to come and give a solemn reading of the final version of our Declaration.

CONTRIBUTORS TOWARDS THE COST
OF THE CONFERENCE AND ITS PREPARATION

Australian International Development Assistance Bureau

Brunei Darussalam: Ministry of Health

Carnegie Corporation of New York

Commonwealth Secretariat

Denmark: Ministry of Foreign Affairs

France: Ministère des Affaires étrangères
Ministère de la Coopération et du Développement

International Group of National Associations of Agrochemicals Manufacturers
Bayer AG, Animal Health Division
Roussel Uclaf

International Federation of Pharmaceutical Manufacturers Associations
Hoffmann-La Roche Ltd

Japan, Government of

Japan Pharmaceutical Manufacturers Association

The Netherlands: Ministry for Foreign Affairs

Norway: Royal Ministry of Foreign Affairs

Pharmaceutical Manufacturers Association (America's Pharmaceutical Research
Companies)

Spain: Ministerio de Sanidad y Consumo

Swedish International Development Authority

Switzerland: Direction de la Coopération au Développement et de l'Aide
Humanitaire

United Kingdom: Overseas Development Administration

United Nations Children's Fund

United Nations Development Programme

United States of America:
Agency for International Development
Department of Health and Human Services, Public Health Service:
Office of International Health
National Institutes of Health

The Wellcome Foundation

The World Bank