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l'Assemblée mondiale de la Santé a adopté une résolution appelant à éliminer la filariose lymphatique.⁴

Haïti

Le paludisme sévit toute l'année en Haïti (population: 8 millions d'habitants) et dans tout le pays (jusqu'à 600 mètres au-dessus du niveau de la mer), mais plus particulièrement dans les zones de plaine et de rizières (Fig. 1). L'ensemble de la population est exposé au paludisme. Les zones urbaines sont autant touchées que les zones rurales. Au total, 19 680 cas ont été officiellement diagnostiqués en 2005 (ce chiffre repose sur des rapports partiels provenant de 7 des 10 départements du pays); ce total comprend les personnes touchées par une flambée en novembre. Tous les cas survenus en Haïti étaient dus à *Plasmodium falciparum*. Le nombre de décès par paludisme à Haïti n'est pas connu, mais l'on sait que la sous-notification est importante en raison du manque d'installations, de personnel et de matériel. Le parasite reste sensible à la chloroquine. Le vecteur concerné est *Anopheles albimanus*.

Depuis une vingtaine d'années, il n'existe pas de programme antipaludique actif en Haïti. Toutefois, un projet de 5 ans financé par le Fonds mondial de lutte pour le SIDA, la tuberculose et le paludisme, d'un montant de US\$ 14,8 millions, a démarré en janvier 2005. Pratiquement tous les crédits destinés à la lutte antipaludique proviennent de l'aide extérieure. Le projet du Fonds mondial est un effort concerté du Ministère de la Santé et de 11 organisations non gouvernementales, bénéficiant de l'assistance et de l'appui techniques de l'Organisation panaméricaine de la Santé (OPS), des *Centers for Disease Control and Prevention* (CDC) des Etats-Unis, de la Coopération française et de l'UNICEF. La première phase du projet, qui vise à renforcer la coordination, la surveillance épidémiologique, la prise en charge clinique, la prévention et la capacité de diagnostic en laboratoire, couvre 3 des 10 départements du pays. Les interventions portent notamment sur le traitement par la chloroquine et l'application de larvicides à un petit nombre de gîtes larvaires. Un renforcement de la lutte antivectorielle est prévu pendant la phase II du projet, mais aucun épandage d'insecticides à effet rémanent à l'intérieur des habitations n'est effectué pendant cette phase. Des moustiquaires imprégnées ont été distribuées au cours de l'épidémie survenue en novembre 2005. Au total, 60 000 moustiquaires imprégnées ont été commandées début 2006; 95 % de celles-ci bénéficient d'un

Dominican Republic

Malaria is transmitted throughout the year in the Dominican Republic (population, 9 million), mostly in certain rural areas in the south-east and west of the country (*Fig. 1*). It is associated with indigenous Dominican and immigrant Haitian agricultural labourers (mostly working in the sugar cane industry) and construction workers. Of the 2354 cases officially reported in 2004, 1547 were reported from only 4 provinces (Azua, Bahoruco, Barahona and La Altagracia); 1670 patients were Dominican nationals and 667 were nationals from Haiti. About two thirds of cases occurred in males. Outbreaks are sometimes associated with hurricanes. About 99% of cases are caused by *P. falciparum* (the remainder being imported cases of *P. vivax*). Resistance to chloroquine has not yet been found. The vector is *Anopheles albimanus*, as in Haiti. Malaria is a serious health problem and also a major economic problem in the Dominican Republic. News of an outbreak in late 2004 that affected a few tourists caused an estimated loss of US\$ 200 million in revenue from the tourist industry. Malaria control is thus a national priority.

Interventions implemented by the national programme include detecting cases by active and passive surveil-

République dominicaine

Le paludisme est transmis toute l'année en République dominicaine (population: 9 millions d'habitants), principalement dans certaines zones rurales du sud-est et de l'ouest du pays (*Fig. 1*). Il touche notamment les travailleurs de l'agriculture dominicains ou haïtiens immigrés (qui travaillent presque tous dans l'indus-

lance, offering laboratory diagnosis, treating cases with chloroquine and primaquine (including offering presumptive treatment), using indoor residual spraying in selected situations (for example, in areas with high incidence or where other vector-control measures cannot be applied), using biological larvicides (including *Bacillus thuringensis* and *B. sphaericus*) and chemical larvicides, and monitoring for resistance of the parasites to chemotherapy and of mosquitoes to insecticides. The CDC is helping to monitor for resistance to insecticides, including dichlorodiphenyltrichloroethane (DDT). The national programme coordinates the involvement of many related agencies and sectors in malaria control. No funding has been provided by the Global Fund, despite a request for funding. The Government of the Dominican Republic funded >96% of the national malaria budget of US\$ 463 930 in 2004; the remaining 4% was provided by external donors.

Lymphatic filariasis is also endemic in sporadic foci, including the 2 provinces at highest risk for malaria in the southern part of the country (*Fig. 1*). As in Haiti, the vector for lymphatic filariasis is *C. quinquefasciatus*.

Conclusions and recommendations

☐ The logic of using a subregional approach to eliminate malaria in the Region of the Americas, beginning with the island of Hispaniola, is compelling. *P. falciparum* malaria is an important health problem and a significant economic burden in the Dominican Republic and Haiti; the main vector (*A. albimanus*) is relatively inefficient; and chloroquine is still effective in both countries. Hispaniola is the only remaining focus of endemic malaria in the Caribbean and it accounts for 95% of lymphatic filariasis cases occurring in the region. (Lymphatic filariasis is a disease that is also vulnerable to vector control measures.) Like malaria, lymphatic filariasis causes significant medical and economic burdens in Haiti. E-10.1(n).i.2824 8-10.3(n 1 Tf0.2824 0 TD-0.0004 Tc0.2843 9-6(ling)-16lo)0(l meas)9(ur)3rderi,o

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- free of charge as quickly as possible to the entire population of Haiti, which is the poorest country in the Americas and suffers substantially from falciparum malaria. If the average household consists of 5 people and 2 long-lasting impregnated bednets are needed per household, then Haiti requires approximately 3.2 million of these bednets to protect the population that is at risk.
- ☒ For maximum effectiveness, the use of insecticide-treated bednets should be complemented by the implementation of other vector-control measures, such as focal residual insecticide spraying, the use of larvicide and source reduction.
- ☒ The Dominican Republic, Haiti and their external partners, including PAHO, should weigh the potential benefits and costs of using artemisinin-based combination therapies (ACTs) because these drugs are highly effective in stopping transmission. Because no chloroquine resistance has been found in the subregion, the Dominican Republic and Haiti continue to follow WHO and PAHO guidelines and use chloroquine as a first-line treatment. A combined regimen of chloroquine and primaquine (as used in the Dominican Republic) would provide the transmission-blocking capacity also found in ACTs and would allow the Dominican Republic and Haiti to keep ACTs in reserve until their use is justified.
- ☒ Regional leadership is needed on this issue, and PAHO and WHO are the the best placed to fulfil this role. Among the potential initiatives to be explored are the role of advocacy (perhaps by using the effective programme in El Salvador as an example), the promotion of operational research (for example, to examine the impact of migratory workers, the epidemiology of the diseases, the best strategy for malaria elimination and the costs of epidemic preparedness and control), the presentation of a joint Tfo.3r fi

try remain receptive to resumption of transmission and are vulnerable because of the high influx of temporary immigrant workers. It has been estimated that foreigners, including nationals from malaria-endemic countries, account for 75% of the population of the United Arab Emirates. In 2005, the number of imported malaria cases was 1544, mainly originating from the Indian subcontinent.³ Receptivity in the last 7 previously active foci in the country is closely monitored and controlled mainly through larviciding of natural and man-made mosquito breeding sites.

Current strategies for maintaining the malaria-free status include: active surveillance involving both the public and private sectors; full case investigations; entomological investigations; and an annual average of 150 000 visits to potential breeding sites by personnel from municipalities and the elimination programme, to carry out larviciding operations with temephos and to restock larvivorous fish.

The United Arab Emirates is the first country to be certified by WHO as malaria-free since Australia and Singapore were added to *The official register of areas where malaria eradication has been achieved* in May 1981 and November 1982 respectively.⁴

Worldwide, 107 countries and territories are currently listed as having areas with malaria risk. Of these, Algeria, Armenia, Egypt, Mauritius, Morocco, Oman and the Syrian Arab Republic have reported no indigenous cases recently.⁵

elle pourrait reprendre dans certaines régions, par ailleurs vulnérables en raison de l'afflux important de travailleurs migrants temporaires. On estime que les étrangers, y compris les ressortissants des pays où le paludisme est endémique, représentent 75% de la population totale aux Émirats arabes unis. En 2005, le nombre de cas de paludisme importés était de 1544, provenant pour la plupart du sous-continent indien.³

Malaria elimination is the interruption of local mosquito-borne malaria transmission.

Certification of malaria elimination requires proving beyond reasonable doubt that the chain of local human malaria transmission by *Anopheles* mosquitoes has been fully interrupted in the entire country.

Malaria elimination does not necessarily imply the complete elimination of disease vectors. It also does not imply a complete absence of reported malaria cases in the country: imported malaria cases will continue to be detected due to international travel, and may on occasion lead to the occurrence of "introduced" cases in which it can be proved that the infection is a first generation of local transmission subsequent to a proved imported case (i.e. the mosquito was infected from an imported case).

Because of the ongoing presence of vectors and imported parasites, the following criterion for achieving elimination has been set: the absence of clusters of 3 or more epidemiologically-linked autochthonous malaria cases due to local mosquito-borne transmission, nationwide for 3 consecutive years.⁶

³ Source: <http://www.emro.who.int/rbm/CountryProfiles-uae.htm>

⁴ WHO, *World Health Statistics Quarterly*, vol. 39, No. 2, 1986, pp. 171–205.

⁵ *International Travel and Health 2006*, at <http://www.who.int/ith>

⁶ See <http://www.who.int/malaria/docs/malariaeliminationagenda.pdf>

Certification of malaria elimination is based on the situation at present and the likelihood that elimination can be maintained.

Countries are requested to continue reporting on an annual basis to WHO on the maintenance of their

INTERNATIONAL HEALTH REGULATIONS / RÈGLEMENT SANITAIRE INTERNATIONAL

Notifications of diseases received from 19 to 25 January 2007 / Notifications de maladies reçues du 19 au 25 janvier 2007

Cholera / Choléra	Cases / Deaths Cas / Décès	
Africa / Afrique		
Angola	01-14.I	
.....	2191	52
Zambia/Zambie.....	01-19.I	
	113	2

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