4.9. Venezuela

During the 1930s, malaria morbidity reached 109,334 cases and in 1936 there was the creation of the Ministry of Health and Welfare with a special Division of Malaria which aimed to fight the disease mainly through sanitary engineering. In 1945 DDT spraying inside the home was initiated at a national level, reaching the goal of malaria eradication in 407,975 square km of the Venezuelan territory and thereby restricting the disease to remote wilderness areas.

From the 1980s, the economic situation caused a mass population displacement to mining zones deep inside the jungle, making it difficult to apply control measures, resulting in the re-infection in areas where the disease had been previously eradicated.

Malaria in Venezuela (1999): Epidemiological Map by Risk Levels, is presented in Annex 1, Figure 8.

During the year 2000, malaria was reported in 20 federal entities of the country with an increase in incidence during the first five months of the year. The situation was complicated due to the existence of malaria foci in jungle zones bordering Colombia, Brazil and Guyana, where it is difficult to properly apply control measures. The transmission of the disease in the country mainly affects nine federal states (Bolívar, Sucre, Amazonas, Delta Amacuro, Apure, Táchira, Barinas, Portuguesa, and Zulia) with vulnerable and receptive areas showing controllable outbreaks.

The malaria trend from the last six months of 1999 to the epidemiological week No. 20 of the year 2000 shows an increase of 50.0% (from the end of December) from the number of cases officially reported for the previous year. The increase of 8,046 cases would implicate the transfer of malaria morbidity toward the epidemic zone of the endemic channel during the year 2000. This channel is made up by the following states: Amazonas, Bolívar, and Sucre. These comprise 97.0% of the total number of cases reported in the country. Malaria is a seasonal disease, focal in nature, and is linked to population movements. The future of the epidemiological situation will depend on countries' efforts to prevent an control it.

In accordance with present health policies, Venezuela ratifies the worldwide strategy for Rolling Back Malaria, announced by the WHO in 1998 by proposing as a final objective to reduce morbidity, mortality and economic losses. This would be done in the following ways: through the progressive improvement and strengthening of the total capacity based on the strategy of early diagnosis and prompt treatment, the development of adequate preventive measures, vector control adapted to local epidemiological conditions, epidemiological monitoring supported by the health centers network, basic research of ecological, social, and economic determinants of the disease and through follow-up and evaluation of applied measures.

The following issues were highlighted by the Venezuelan delegation:

- The Ministry of Health is taking actions for the implementation of the RBM Initiative. However, it is still too early to evaluate its impact;
- In 1998 the Minister of Health went to WHO/Geneva to present information about the malaria problem in the country, and as a political decision, the present administration has assigned high priority to malaria and Chagas.
- In April, 2000 a coordination meeting was held in Maracay with the participation of WHO/PAHO PWRs, after which the Minister met with the Health Directors and issued a decree calling all people to come together in the fight against malaria.
- In Venezuela the Malaria Program has always been vertical but in 2000 it was integrated into the Communicable Disease Program. In April, 2000 the first meeting between malariologists and epidemiologists was held.
- The Regional Directors of Health organized a committee of malariologists and epidemiologists.
- These actions broadened the scope of responsibilities that before were restricted to the technical unit responsible for malaria.
- Workshops on stratification and coordination are currently being held.
- The states of Sucre and Bolivar have been prioritized due to the high incidence of malaria. Bolivar State occupies the third part of the country and is mainly settled by indigenous populations.
- Private industries were incorporated in the Bolívar State in the southern region, facilitating training. An increase in activities was expected in this area because of the gold mining.
- Training in diagnosis and treatment involving program staff, members of the community, army and teachers has also begun. The time elapsed between the taking of a blood sample and treatment is less than 48 hours.
- Educational actions have included the elaboration of posters and the training of 30 indigenous people in simple treatment schemes throughout 30 communities in remote areas bordering Brazil. Each person received a set called a "Happy Box" which included microscopes, supplies and medicines for the treatment of diagnosed cases.
- The last malaria epidemic was detected by those trained personnel.
- New microscopes are being purchased to expand the diagnosis network.
- A NGO is supervising these community workers in relation to assure quality control.
- There are some limitations regarding sustainability. Recently, the Health Directors were changed and a meeting with the new directors is pending.
- The coordination workshops will be maintained.
- Financial support of one million dollars is currently available for insecticides.
- A program of bed-net impregnation will be implemented.