

Overview of malaria control activities and programme progress

Malaria is a leading public health problem in Ethiopia where, an estimated 48 million people (68% of the population) live in areas at risk of malaria. In 2002–2003, the disease was the primary cause of reported morbidity and mortality, accounting for 16% of outpatient visits, 20% of hospital admissions and 27% of hospital deaths. Malaria transmission in Ethiopia is unstable and characterized by frequent and often large-scale epidemics. In 2003, large-scale malaria epidemics occurred from April to December resulting in 2 million clinical and confirmed cases and 3000 deaths, affecting 3368 localities in 211 districts. However, as a large number of cases and deaths that occur at community level are not included in health facility reports, the actual number of cases and deaths that occur during epidemics is likely to be much higher.

Prevention and control activities are guided by the national strategic plan (2001–2005) developed in cooperation with the Health Sector Development Programme and in accordance with the objectives of RBM partners. The commitment of the government, participation of communities and donors and other partners' support have created a conducive environment. A Health Extension Package was launched in 2004 to expand basic health services to the rural population at large, where most malaria transmission occurs. RBM partners provide technical and financial support to scale up implementation of malaria prevention and control activities. Strategies include: (i) early diagnosis and prompt treatment with safe and effective drugs; (ii) vector control in selected areas mainly through the use of ITNs and IRS; (iii) epidemic monitoring; (iv) preparedness and response; and (v) cross-cutting strategies that include information, communication and education materials, human resource development and monitoring and evaluation.

Major recent achievements include: (i) an evidence-based change in antimalarial drug policy from SP to ACTs; (ii) development of new malaria treatment guidelines and associated training materials for regional-, district- and health facility-level implementation; (iii) development of a national strategic plan for scaling up the distribution and use of ITNs; and (iv) revision of guidelines on prevention and control of malaria epidemics. Procurement of ACTs and ITNs has been greatly enhanced with funding from the GFATM. Resource limitations for employing and training skilled staff and lack of capital for commodities and operational costs — especially in peripheral health facilities — present ongoing challenges that require coordinated support from partners and donors.

In 2003, Ethiopia reported that almost US\$ 5 million in national funds was available for malaria control efforts. The GAFTM committed US\$ 37.9 million for malaria control in 2003, of which almost half was disbursed by the end of 2003.

National malaria policy and strategy environment

National malaria strategy overview for 2003

	Strategy
Treatment and Diagnosis Guidelines	Yes
Published/updated in	1995
Monitoring antimalarial drug resistance	Yes
Number of sites currently active	
Home management of malaria	Yes
Vector control using insecticides	Yes
Monitoring insecticide resistance	
Number of sites currently active	
Insecticide-treated mosquito nets (ITNs)	Yes
Intermittent preventive treatment (IPT)	No
Epidemic preparedness	Yes

Current antimalarial drug policy

	Current policy
Uncomplicated malaria	
<i>P. falciparum</i> (unconfirmed)	ATM-LUM
<i>P. falciparum</i> (lab confirmed)	ATM-LUM
<i>P. vivax</i>	CQ
Treatment failure	Q(7d)
Severe malaria	Q(7d)
Pregnancy	
Prevention	
Treatment	

EPIDEMIOLOGICAL DATA

Following WHO recommendations, malaria case reporting is carried out in most countries. The data presented below reflect aggregated malaria cases at the national level and are presented by gender, age and subnational level as submitted to WHO. Malaria reporting from national surveillance systems varies in quality and reporting completeness and may have limited value in understanding the actual malaria burden, but may be useful for understanding trends in the relative burden of malaria in the public health sector.

Reported malaria cases (annual)

1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
		206 262	305 616	358 469	412 609	478 411	509 804	604 960	647 919
2000	2001	2002	2003	Date of last report: 15 December 2004					
383 382	400 371	427 831	565 273						

Reported malaria by type and quality

For most recent year

Reported malaria cases	565 273
Reported malaria deaths	

Probable or clinically diagnosed

Malaria cases	
Severe (inpatient or hospitalized) cases	
Malaria deaths	
Slides taken	1 210 868
Rapid diagnostic tests (RDTs) taken	

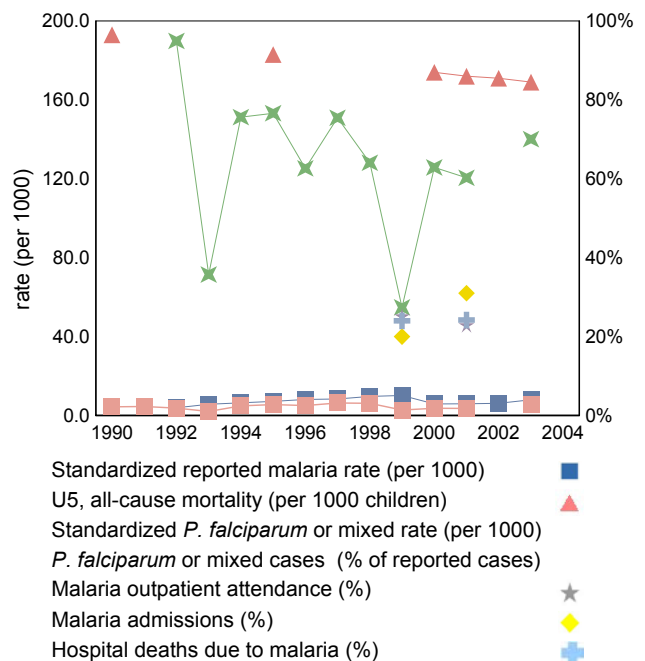
Laboratory confirmed

Malaria cases	565 273
<i>P. falciparum</i> or mixed	395 964
<i>P. vivax</i>	158 115
Severe (inpatient or hospitalized) cases	
Malaria deaths	

Investigations

Imported cases

Estimated reporting completeness (%)



Reported malaria cases by age and gender

Group	Subgroup	2000	2001	2002	2003	%
	Total	383 382	400 371	427 831	565 273	100

Reported malaria cases by selected subnational area

	2000	2001	2002	2003	%

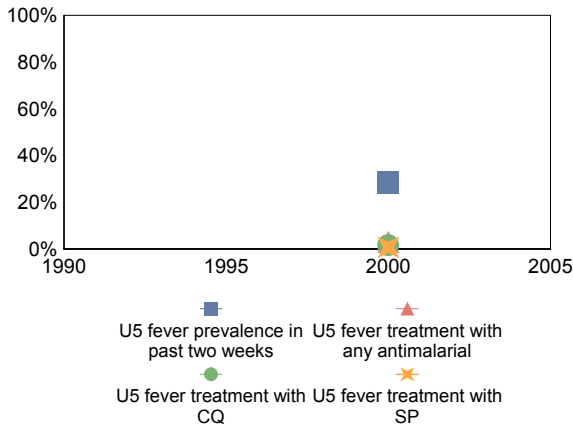
COVERAGE OF ROLL BACK MALARIA INTERVENTIONS

Information related to the coverage of RBM key interventions is presented here. This includes coverage of antimalarial treatment, possession and use of insecticide-treated nets (ITNs), and use of intermittent preventive treatment (IPT) among pregnant women (PW) where national policy indicates.

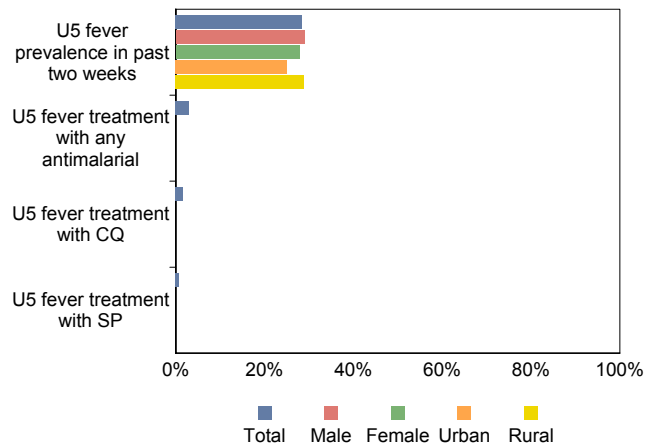
Fever prevalence and treatment with antimalarials

Prompt access to effective treatment is one of the key interventions promoted by RBM. Information presented below is from household surveys on fever prevalence and reported treatment of fever with antimalarials among children under 5 years of age (U5) within the previous 2 weeks.

Trend in fever prevalence and antimalarial coverage estimates from national surveys



Estimate of fever prevalence and treatment with antimalarials from most recent national survey



Available national surveys

DHS 2000

Sample size (U5s): 10 753

Field work: Feb-May 2000

Scale: national

Supporting organization: Macro DHS

Available sub-national surveys

RBM 2001

Sample size (U5s): 3 861

Field work:

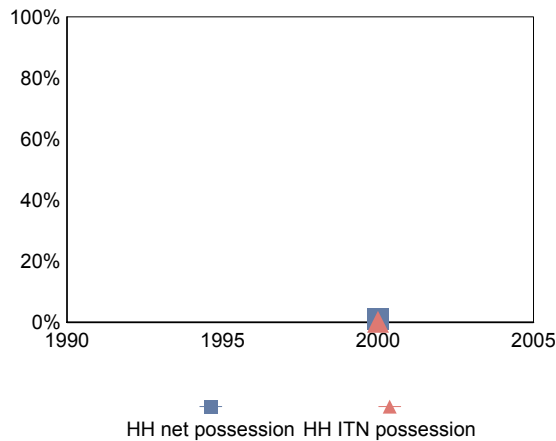
Scale: 14 districts: Dubti, Jabitenam, Bahir dar, Gubalafto, Asossa, Gambella, Hagermariam,

Fentale, Keresa, Erer, Awassa, Arbaminch, Tahatay, Alamata

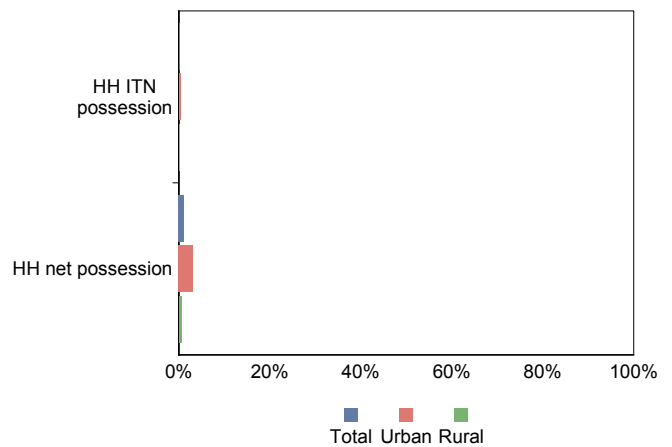
Insecticide-treated nets

ITNs are one of the key interventions promoted by RBM. Coverage of ITNs is best assessed through household (HH) surveys which ask questions on possession and use of nets, as well as insecticide treatment status, among the target populations of children under 5 years of age (U5) and pregnant women. Data below represent available household survey results in which household possession and use of nets and ITNs have been assessed.

Trend in mosquito net coverage estimates from national surveys



Estimates of ITN coverage from most recent national survey



Available national surveys

DHS 2000

Sample size (HHs or U5s): 14 072
Field work: Feb-May 2000
Scale: national

Supporting Organization: Macro DHS

Available sub-national surveys

RBM 2001

Sample size (HHs or U5s): 8 299
Field work:

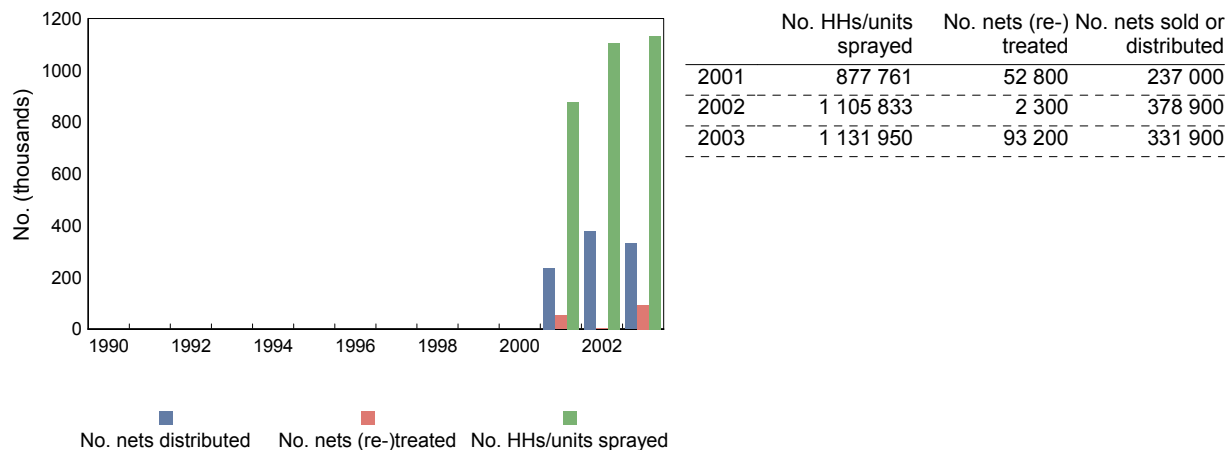
Supporting Organization: WHO/AFRO

Scale: 14 districts: Dubti, Jabitenam, Bahir dar, Gubalafto, Asossa, Gambella, Hagermariam, Fentale, Keresa, Erer, Awassa, Arbaminch, Tahatay, Alamata

SERVICE DELIVERY AND MALARIA-RELATED COMMODITIES

General malaria-related services delivered

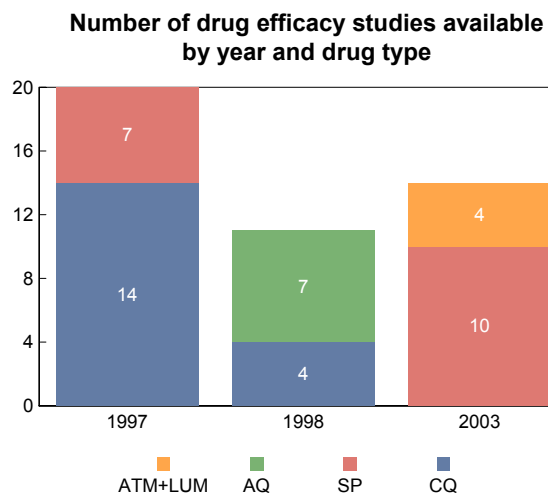
Services delivered for malaria control include numbers of nets and insecticides delivered or sold, numbers of nets (re-)treated with insecticide and numbers of households (HHs)/units sprayed during IRS campaigns. These services and service-related commodities mostly reflect core malaria control activities of national malaria control programmes. The information reflects annual, country-reported data.



MONITORING ANTIMALARIAL DRUG EFFICACY

Monitoring antimalarial drug efficacy is important for understanding the impact of antimalarial treatment being delivered and the need for drug policy change, essential for ensuring prompt access to effective treatment. Median, range and quartiles are based on percentage clinical failure for uncomplicated *P. falciparum* malaria for countries in Africa south of the Sahara, and percentage total failure for all other areas. Included are studies that used WHO protocol among selected drugs.

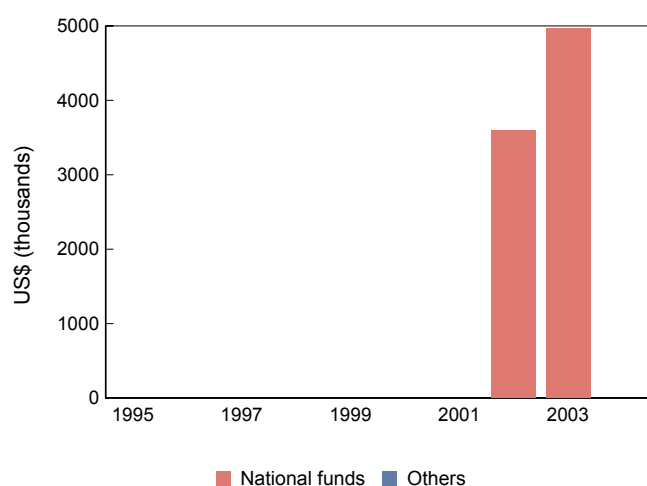
Study years	Number of studies	Median	Range		Percentile	
			Low	High	25th	75th
CQ						
1996-1998	18	70.0	5.0	97.8	55.8	85.2
SP						
1997-2003	17	10.3	0.0	44.9	2.0	26.1
AQ						
1998	7	18.9	6.2	66.7	6.5	45.8
ATM+LUM						
2003	4	0.0	0.0	0.0	0.0	0.0



FINANCING FOR MALARIA

Annual funding for malaria control

This information represents country-reported national and other resources budgeted or spent for national malaria control programme efforts. If information was reported in a different currency than US\$, the annual average of the official exchange rate from the World Development Index was used for conversion. Currency is presented in US\$ (thousands).



	National funds	Others
1995	-	-
1996	-	-
1997	-	-
1998	-	-
1999	-	-
2000	-	-
2001	-	-
2002	3 597	-
2003	4 971	-
2004	-	-

Malaria funds from the Global Fund to Fight HIV, Tuberculosis, and Malaria

Information on additional resources provided to countries through GFATM from 2-year committed funds for malaria from successful proposals through the first four rounds is presented. The details on approved proposals, grant agreements and disbursements to date are provided. Figures are presented in US\$. These data are maintained and updated by GFATM.

Approved proposals			Grant agreements and disbursements (as of 13 January 2005)							
Source	Round	Total year 1-2 budgets	Principal recipient	Signed	Signature date	Grant amount	No. of disbursements	Total disbursed	% disbursed	
CCM	2	37 915 011	MoH	Yes	01-Aug-03	37 915 011	1	17 891 589	47.2%	

General notes and remarks

See explanatory notes at the beginning of the section.

Reporting in Ethiopia is based on roughly a July to June annual cycle. Reported malaria for 2003 presented here are for the July 2003 - June 2004 cycle and so on.