

Overview of malaria control activities and programme progress

Malaria is endemic throughout Mozambique, where the climate favours year-round transmission, with peak incidence following the rainy season from December to April. Transmission intensity varies from year to year and region to region, depending on rainfall, altitude and air temperatures. Some of the drier parts of the country are considered to be epidemic-prone. *P. falciparum* is the most prevalent parasite, responsible for about 90% of all malaria infections. *P. malariae* and *ovale* account for 9.1 and 0.9 % respectively of all infection.

Malaria is the primary cause of ill health, accounting for approximately 40% of all outpatient consultations. Up to 60% of inpatients in paediatric wards are admitted as a result of severe malaria illness. Malaria is also the leading cause of death in hospitals, accounting for almost 30% of all deaths recorded. Estimated prevalence in the 2–9 year old age group ranges from 40% to 80%, with as many as 90% of children under 5 years of age infected with malaria parasites in some areas. Access to health care is very low and it is estimated that 50% of the population live more than 20km from the nearest health facility, a situation that effectively equates to no access to health-care services for a large proportion of the population. Malaria is also a major problem affecting pregnant women in rural areas. Approximately 20% of women are parasitaemic, with primigravidae at the highest prevalence (31%). Anaemia, often associated with malaria, is a major problem and 68% of pregnant women have a packed cell volume of less than 33%.

Weekly active case detection of clinical malaria cases suggests that the risk of clinical malaria is highest between the ages of 1 and 3 years old, with children experiencing an average of more than two episodes per annum. Resistance of *P. falciparum* to antimalarial drugs, especially with CQ as the first-line treatment for non-complicated malaria, varies between 15% and 40% depending on location and is increasing. Drug resistance presents a major obstacle to effective case management, particularly at the periphery where capacity for clinical and laboratory diagnosis is weak.

An accurate assessment of the economic losses attributable to malaria in Mozambique is not clear. It is evident that illness as a result of malaria contributes to a loss of industrial productivity, high rates of school absenteeism and poor agricultural productivity, which is the economic mainstay for the majority of the rural population. More detailed description of finances and planned resources for 2004 are available.

National malaria policy and strategy environment

National malaria strategy overview for 2003

	Strategy
Treatment and Diagnosis Guidelines Published/updated in	
Monitoring antimalarial drug resistance Number of sites currently active	Yes 5
Home management of malaria	
Vector control using insecticides	Yes
Monitoring insecticide resistance Number of sites currently active	
Insecticide-treated mosquito nets (ITNs)	Yes
Intermittent preventive treatment (IPT)	Yes
Epidemic preparedness	Yes

Current antimalarial drug policy

	Current policy
Uncomplicated malaria	
<i>P. falciparum</i> (unconfirmed)	AQ+SP
<i>P. falciparum</i> (lab confirmed)	AQ+SP
<i>P. vivax</i>	
Treatment failure	ATM-LUM
Severe malaria	Q(7d)
Pregnancy	
Prevention	SP (IPT)
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
						12 794		194 024	2 336 640
2000	2001	2002	2003	Date of last report: 15 October 2004					
3 278 525	3 978 397	4 458 589	5 087 865						

Reported malaria by type and quality

For most recent year

Reported malaria cases	5 087 865
Reported malaria deaths	3 569

Probable or clinically diagnosed

Malaria cases	5 087 865
Severe (inpatient or hospitalized) cases	
Malaria deaths	3 569

Slides taken
Rapid diagnostic tests (RDTs) taken

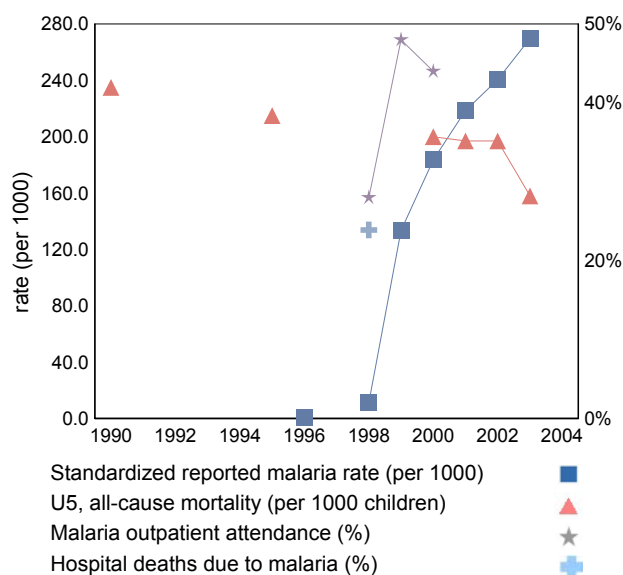
Laboratory confirmed

Malaria cases	
<i>P. falciparum</i> or mixed	
<i>P. vivax</i>	
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	3 278 525	3 978 397	4 458 589	5 087 865	100

Reported malaria cases by selected subnational area

2000	2001	2002	2003	%
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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.

Available sub-national surveys

HDS 2003

Sample size (U5s):

Field work:

Scale: sub-national

Supporting organization: Ministry of Health

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.

Available sub-national surveys

NetMark 2000

Sample size (HHs or U5s): 1 388

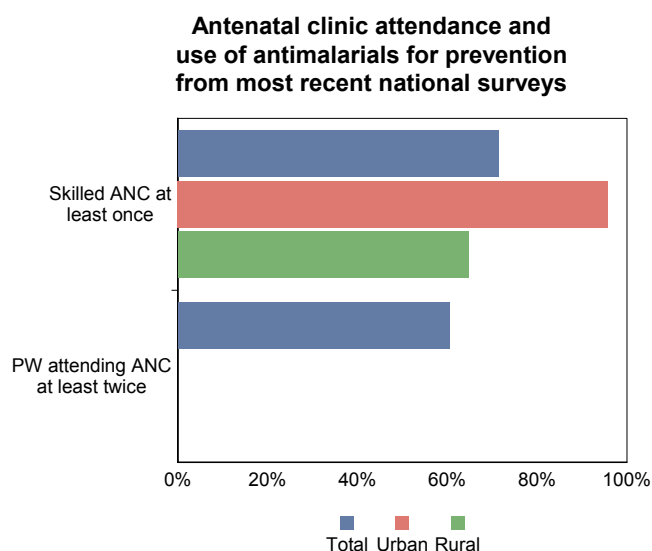
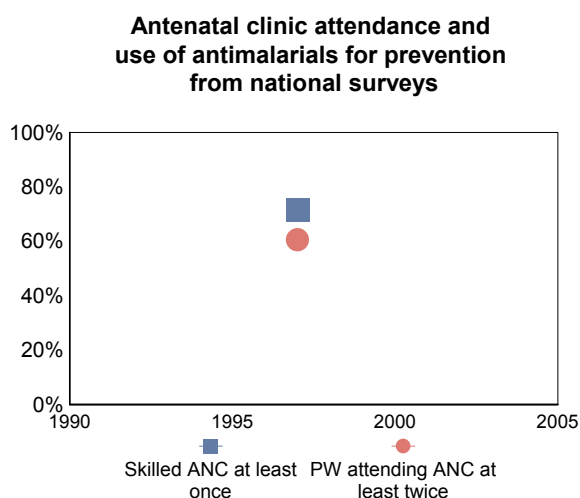
Field work: Nov 2000

Scale: 5 areas: Maputo, Beira, Quelimane, Tete, Nampula

Supporting Organization: NetMark

Intermittent preventive treatment during pregnancy

RBM promotes IPT with SP in countries with areas of stable malaria transmission as one of its key prevention strategies for pregnant women (PW). However, few surveys have assessed the coverage of IPT among pregnant women. Data below represent available household survey results in which indicators related to monitoring IPT have been assessed. The level of skilled antenatal attendance and the percentage of women attending antenatal clinics (ANC) at least twice are presented as a background for which improvements in IPT can be achieved.



Available national surveys

DHS 1997

Sample size (PW): 4 207

Field work: Mar-Jun 1997

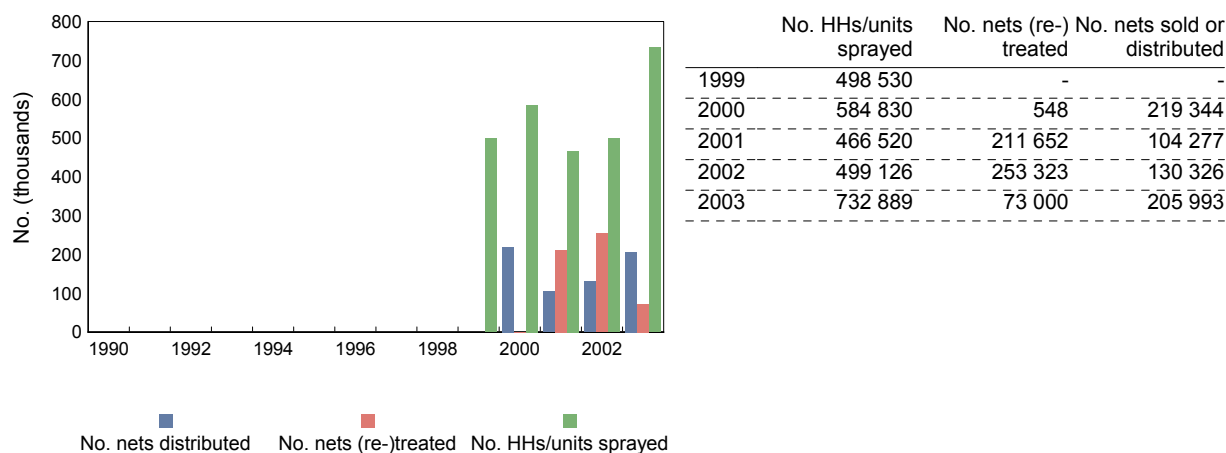
Scale: national

Supporting organization: Macro DHS

SERVICE DELIVERY AND MALARIA-RELATED COMMODITIES

General malaria-related services delivered

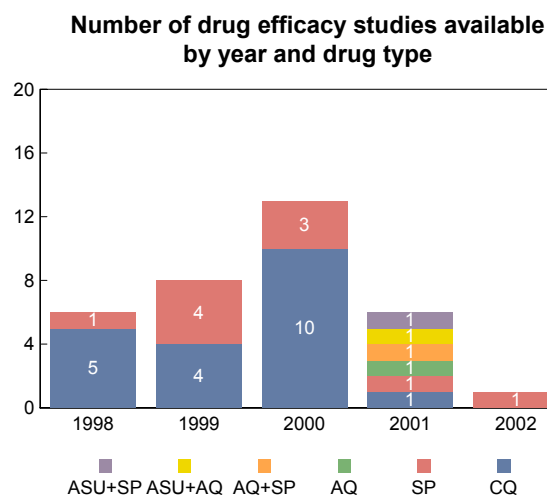
Services delivered for malaria control include numbers of nets and insecticides delivered or sold, numbers of nets (re-)treated with insecticide and numbers of households (HHs)/units sprayed during IRS campaigns. These services and service-related commodities mostly reflect core malaria control activities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

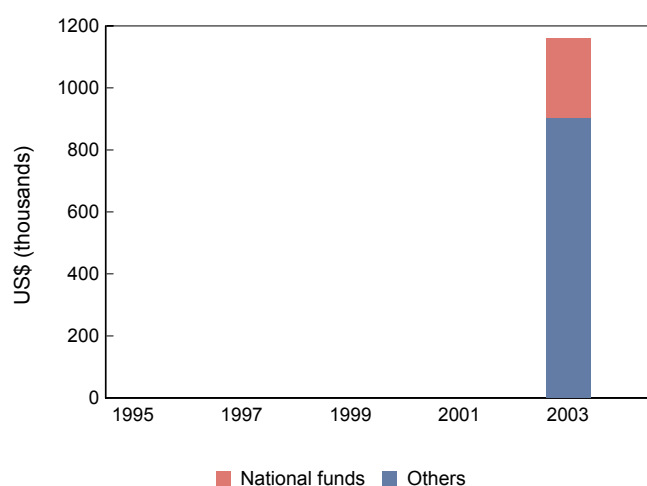
Study years	Number of studies	Median	Range		Percentile	
			Low	High	25th	75th
CQ						
1998-2001	20	35.9	13.0	53.0	22.1	42.9
SP						
1998-2002	10	5.4	0.2	17.3	2.7	13.7
AQ						
2001	1	8.4				
AQ+SP						
2001	1	0.0				
ASU+AQ						
2001	1	0.0				
ASU+SP						
2001	1	0.0				



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	-	-
2003	256	903
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
Reg.Org.	2	7 090 318	Medical Research Council	Yes	18-Jun-03	7 090 318	5	4 997 501	70.5%
			MoH	Yes	02-Apr-04	12 217 393	1	6 653 718	54.5%

General notes and remarks

See explanatory notes at the beginning of the section.