

## Overview of malaria control activities and programme progress

Malaria transmission ranges from unstable and epidemic in Puntland and Somaliland to moderate in central Somalia to high in the south. The groups most severely affected are young children, pregnant women and nomadic populations. At a frequency of 95%, *P. falciparum* is overwhelmingly the predominant parasite species. The major malaria vectors are *A. arabiensis* and *A. funestus*; while both vectors are found in the south, only *A. arabiensis* is found in the north.

The conflict in Somalia has destroyed the entire public health infrastructure, except in Somaliland in the north-west zone of the country and in Puntland in the north-east zone. Priorities for malaria control vary across the country, according to variations in endemicity. In the north, the priorities are to reduce transmission through vector control and to ensure epidemic preparedness; in the more endemic south and central areas, the priorities are to reduce malaria morbidity and to prevent mortality in high-risk groups through early diagnosis and prompt treatment and personal protection through ITNs.

Control activities have continued to develop since the inception of the RBM Partnership, with strong partnerships with WHO, UNICEF and international NGOs. An international staff and national officers were recruited by WHO to implement RBM activities, and an RBM strategic framework was developed. Functional sites for monitoring antimalarial drug efficacy have been established, and studies were conducted in Jamane, Janale and Jowhar for AQ and ASU+SP. The antimalarial drug policy is being updated to include ACTs. Malaria outbreaks in 2003 were promptly responded to as a result of pre-positioning of antimalarial drugs in epidemic zones. Several capacity building and training courses were conducted. Other achievements include the recruitment of an RBM control programme coordinator and operational research on the use of larvivorous fish in selected areas in the north-west zone.

Funding of malaria control activities is supported by international and donor agencies such as WHO and UNICEF. The GFATM funds totalling US\$ 8.9 million have been committed, of which over half were disbursed in 2004.

### National malaria policy and strategy environment

#### National malaria strategy overview for 2003

	Strategy
<b>Treatment and Diagnosis Guidelines</b> Published/updated in	
<b>Monitoring antimalarial drug resistance</b> Number of sites currently active	Yes 4
<b>Home management of malaria</b>	Yes
<b>Vector control using insecticides</b>	Yes
<b>Monitoring insecticide resistance</b> Number of sites currently active	No
<b>Insecticide-treated mosquito nets (ITNs)</b>	Yes
<b>Intermittent preventive treatment (IPT)</b>	Yes
<b>Epidemic preparedness</b>	Yes

#### Current antimalarial drug policy

	Current policy
<b>Uncomplicated malaria</b>	
<i>P. falciparum</i> (unconfirmed)	CQ
<i>P. falciparum</i> (lab confirmed)	CQ
<i>P. vivax</i>	
<b>Treatment failure</b>	SP
<b>Severe malaria</b>	Q
<b>Pregnancy</b>	
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
			3 049						9 055
2000	2001	2002	2003	Date of last report: 25 May 2004					
10 364	10 364	96 922	23 349						

### Reported malaria by type and quality

For most recent year

Reported malaria cases	23 349
Reported malaria deaths	10

#### Probable or clinically diagnosed

Malaria cases	15 778
Severe (inpatient or hospitalized) cases	
Malaria deaths	44
Slides taken	12 578
Rapid diagnostic tests (RDTs) taken	

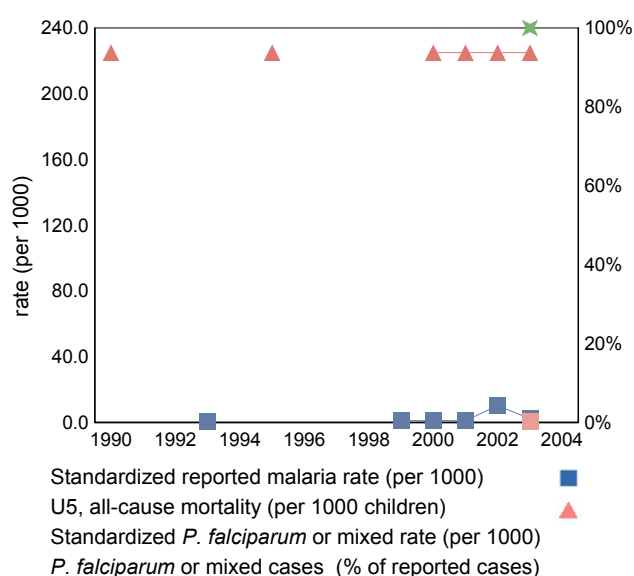
#### Laboratory confirmed

Malaria cases	7 571
<i>P. falciparum</i> or mixed	7 571
<i>P. vivax</i>	
Severe (inpatient or hospitalized) cases	
Malaria deaths	10

#### Investigations

Imported cases

Estimated reporting completeness (%)



### Reported malaria cases by age and gender

Group	Subgroup	2000	2001	2002	2003	%
	Total	10 364	10 364	96 922	23 349	100

### Reported malaria cases by selected subnational area

15 of 15 areas	2000	2001	2002	2003	%
Mogadishu				7 280	31
Las-anod				2 404	10
Berbera				990	4
Hargeisa				766	3
Gabilay				627	3
Burao				492	2
Bossaso				405	2
Borama				358	2
Allay baday				285	1
Baki				213	1
Qardho				203	1
Garowe				157	1
Galkayo				129	1
Ergavo				116	<1
Zeila				50	<1

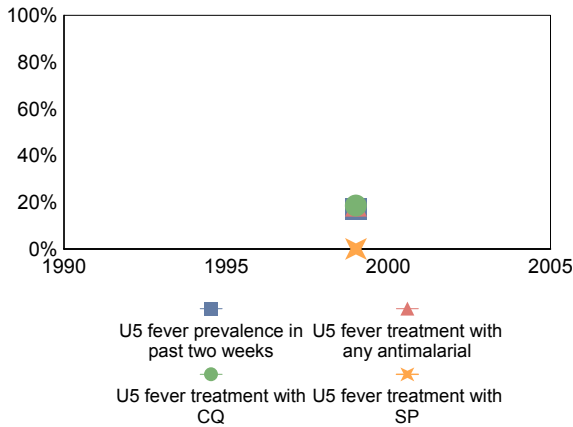
## COVERAGE OF ROLL BACK MALARIA INTERVENTIONS

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.

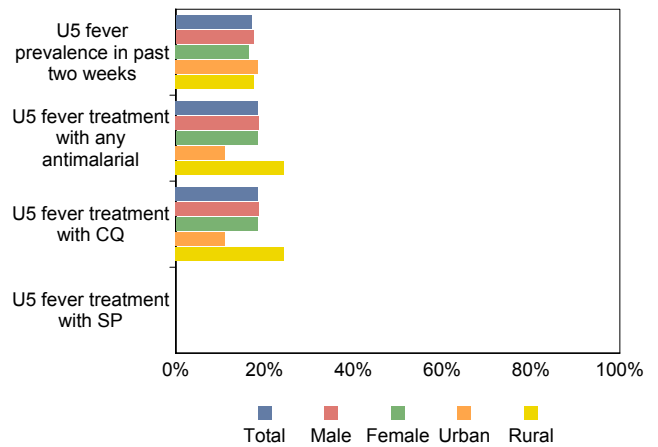
### Fever prevalence and treatment with antimalarials

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

##### MICS 1999

Sample size (U5s): 3 665

Field work: Aug-Dec 1999

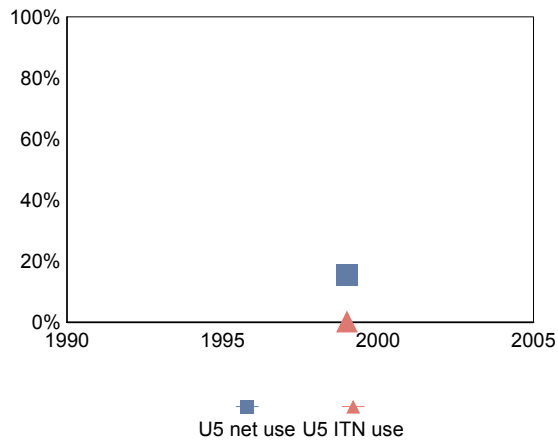
Scale: national

Supporting organization: UNICEF

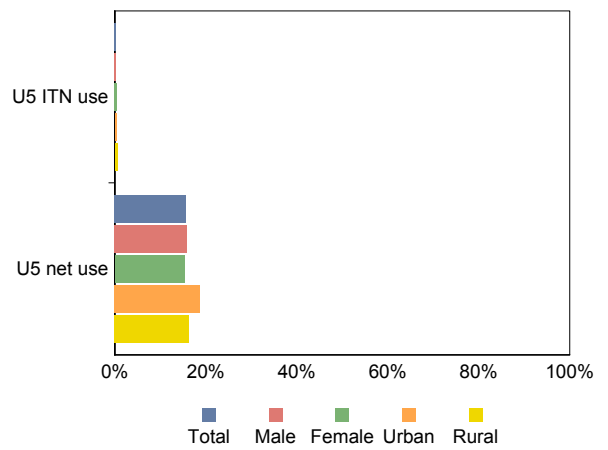
## Insecticide-treated nets

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

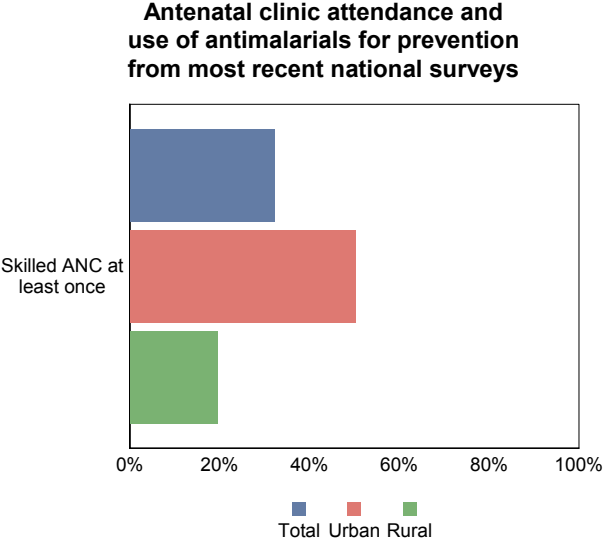
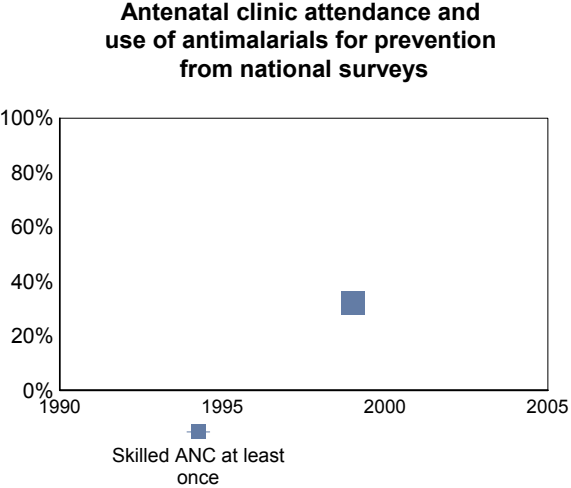
#### MICS 1999

Sample size (HHs or U5s): 3 513  
 Field work: Aug-Dec 1999  
 Scale: national

Supporting Organization: UNICEF

**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.



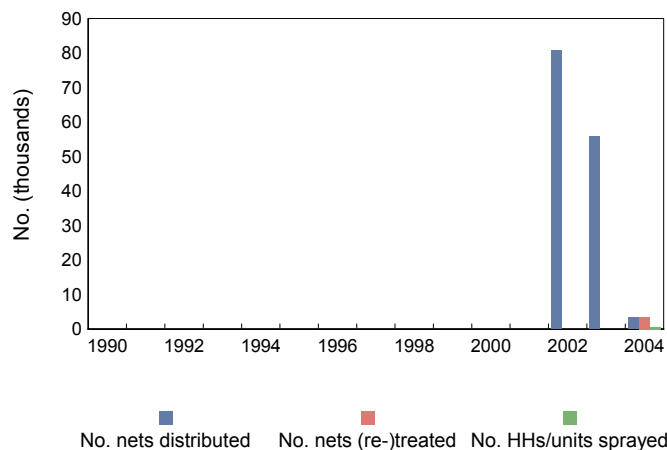
**Available national surveys**

**MICS 1999**  
 Sample size (PW): 1 115  
 Field work: Aug-Dec 1999  
 Scale: national  
 Supporting organization: UNICEF

## 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.

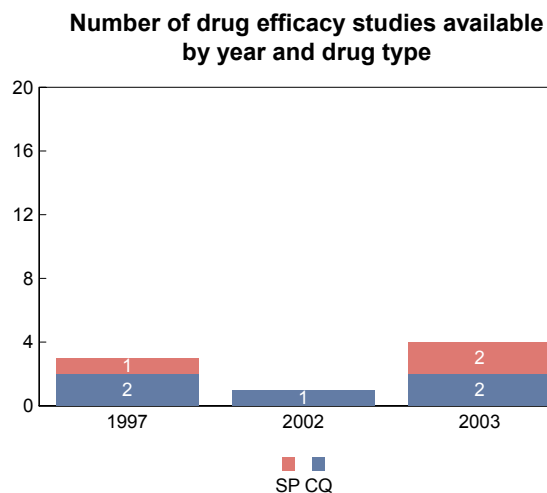


	No. HHs/units sprayed	No. nets (re-) treated	No. nets sold or distributed
2002	-	-	80 839
2003	-	-	55 839
2004	567	3 500	3 338

## 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.

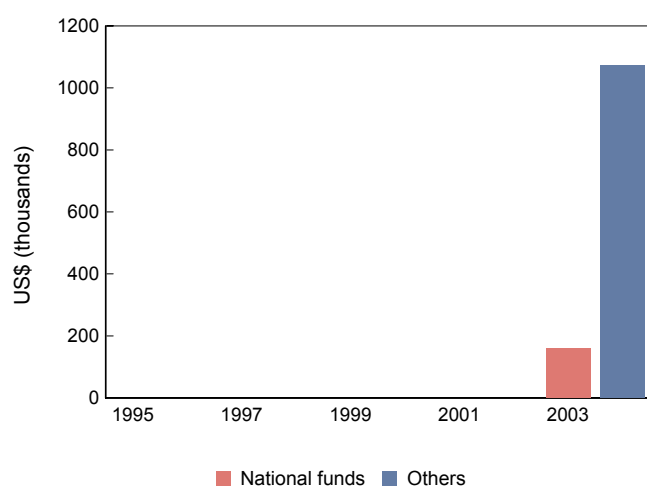
Study years	Number of studies	Median	Range		Percentile	
			Low	High	25th	75th
<b>CQ</b>						
1997-2003	5	51.0	27.5	78.0	30.4	74.0
<b>SP</b>						
1997-2003	3	4.0	2.0	5.9	2.0	5.9



## 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	160	-
2004	-	1 072

### 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	8 890 497	UNICEF	Yes	23-Jun-04	8 890 497	1	4 682 032	52.7%

### General notes and remarks

See explanatory notes at the beginning of the section.

\* IPT is for hyperendemic areas only.