

Position Statement of Concerned NGOs on the Malaria Epidemic

DRAFT

Introduction

Recently a number of NGOs took the initiative of meeting to discuss the current epidemic of malaria in Ethiopia and have agreed upon the following analysis of the current situation and recognition of the challenges, which remain to be addressed.

Ethiopia's health care structure & the malaria epidemic

"Health and Health Related Indicators" (2001/2002) report of the Ministry of Health documents health care coverage in Ethiopia, to be 61 percent. Thus about 40 percent of the population has hardly any access to any modern health service facility. Reviews of the health care delivery system have repeatedly revealed that most of the existing health care facilities, even when physically "accessible" to the people, suffer from chronic shortages of health workers as well as medical equipments and supplies. Poor access to routine health care services and poor quality of health care delivery at facilities limits the country's ability to prevent and control malaria epidemics. Inadequate data on overall morbidity and mortality associated with recent epidemics of malaria or the efficacy of the measures taken also handicaps the health care system's ability to respond.

The "Health and Health Related Indicators" (2000/2001) report of the Ministry of Health indicated that Malaria is the leading cause of outpatient visits, the leading cause of inpatient admissions and the third leading cause of reported deaths in Ethiopia. The most recent report (2001/2002) does not provide information on the "top ten" causes of morbidity or mortality or of admissions. It only indicates that the total number of malaria cases was 1,062,444 of which 427,831 were confirmed by laboratory tests and of these 55.85 percent (238,950) were positive for plasmodium falciparum and 36.96 percent being plasmodium vivax. [This latter report cautions that data were incomplete for Amhara and Gambella Regions and not available for Addis Ababa].

Scale of current epidemic and the national response

Country level data for the period 2002/2003 on the number of cases or deaths caused by the recent and current malaria epidemics are unavailable. However NGOs working in the field continue to observe a sharp rise in consultations for malaria symptoms. For example, data collected by MSF from Buge clinic shows an increase from less than 100 people in September to more than 800 within the first two weeks of November. A MoH assessment team found that in Damot Gale woreda, among patients presenting with fever, 60% had malaria (microscopy confirmed) and of these 90% had plasmodium falciparum.

However there are field observations/trip reports which describe the seriousness of the epidemic against a generally weak situation of logistics, preparedness and response capacity to address the epidemic. One reliable source recently reported the following:

- "It was clear that the zonal authorities lacked both the material and human resources sufficient to organise and manage the woredas within their zones, especially during the emergency. Further there seemed to be an overall lack of urgency in response to the current malaria situation."
- "All health facilities visited had no stock of IV quinine available...obviously this is causing high levels of morbidity and mortality..."
- "Some personnel reported serious problems with SP (Fansidar) resistance/treatment failure. One facility had even started using quinine as a first line treatment contrary to the national protocol"

NGOs implementing have also observed apparent treatment failure. MSF has undertaken retrospective mortality assessments in Damot Gale Woreda.

Médecins sans Frontières (MSF) Mortality data:

Retrospective mortality assessments, conducted in Damot Gale woreda from the end of October through the end of November have shown high mortality rates in some villages and kebeles. Below are some Crude Mortality Rates (CMR) and information about main symptoms and treatment prior to death in four villages. A CMR of more than 1/10,000 people/day is considered unacceptable. Deaths were cross-checked by an MSF team and community leaders, and in some cases numbers were also verified by community malaria workers. When reported deaths could not be crosschecked, they were not included in the analysis. Therefore, in three out of the four villages, reported deaths were higher than numbers indicated below.

Ulbo village (Wasedo kebele), population 927

25 deaths were reported during a period of four weeks. CMR: 11/10,000/day.

In all cases family members reported symptoms of malaria (fever, shivering and/or vomiting) prior to death. Of the overall reported deaths five people (20%) had received fansidar treatment, and 15 received no treatment.

Chare Tomtom village (Tomtom Menta kebele), population 768

20 deaths were reported during a period of four weeks. CMR: 8.7/10,000/day. According to family members, seven of the deceased had symptoms of malaria prior to death. Four of the seven received treatment.

Busha village (Busha kebele), population 668

5 deaths were reported during a period of 15 days. CMR: 5/10,000/day. According to family members all of the deceased had symptoms of malaria prior to death. Four of the five received chloroquine+fansidar and one received quinine tablets.

Korke village (Busha kebele), population 782

4 deaths were reported within a period of 15 days. CMR: 3.4/10,000/day. According to family members all of the deceased had symptoms of malaria and have received chloroquine + fansidar prior to death.

Although resistance studies are still ongoing and data is not yet available, these deaths appear to indicate some level of treatment failure.

NGO Concerns and the Way Forward to Address the Epidemic

Based on the discussions, some field observations and current malaria related knowledge and information the NGO group would like to highlight the following concerns/suggestions for the attention of all parties and partners involved in the endeavour to save lives and bring the epidemic under control:

1. There is an urgent need to ensure that all persons residing in the epidemic areas have access to effective treatment against the disease.
 - Anti-malaria drugs donated or purchased for combating the epidemic need to be delivered to the points of end use, the health facilities in affected kebeles, without delay at customs or Federal, Regional, Zonal or Woreda stores.
 - Given the concerns of possible treatment failure, implementers in the current emergency need to undertake structured monitoring of the effectiveness of current malaria treatments in order to inform potential revision of National protocol.
 - The MoH and DACCA should encourage interested NGOs to pilot use of Artemisinin based combination therapy (ACT), e.g. Artemisinin plus SP, to reduce mortality in the hardest hit areas.
2. Woreda Health Offices and their partner NGOs or private health care providers should emulate best anti-malaria initiatives/practices applied in some parts of Ethiopia (the CBHW's in Tigray and the Woreda and Kebele Anti-Malaria Committees in some districts of the Amhara Region).
3. NGOs need to be operationally cognizant of the fact the health care system of Ethiopia is decentralised, adjusting their current strategies of cooperation to be more effective in addressing health emergencies and epidemics at local level.

Dec. 2, 2003/draft