ZNPHI
ZAMBIA NATIONAL PUBLIC HEALTH INSTITUTE

The Health Press

ISSN 2520-4378

VOL 04
ISSUE 1
MARCH 2020

ZAMBIA'S JOURNAL ON PUBLIC HEALTH, DISEASE SURVEILLANCE, PREVENTION AND CONTROL

The Health Press - Zambia is published by Zambia National Public Health Institute, Ministry of Health Zambia SINCE JAN 31, 2017.

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Malaria Trends: An Update

Email: editor.heathpress@znphi.co.zm
Website: http://znphi.co.zm/thehealthpress/
Suggested Citation:
[Author Surname, Initial].[Article title].Health Press Zambia Bull 2020; 04(01):[inclusive page numbers].

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IMPACT OF COVID-19 EPIDEMIC ON MALARIA: LIMITATIONS TO ACHIEVING MALARIA ELIMINATION

EDITORIAL

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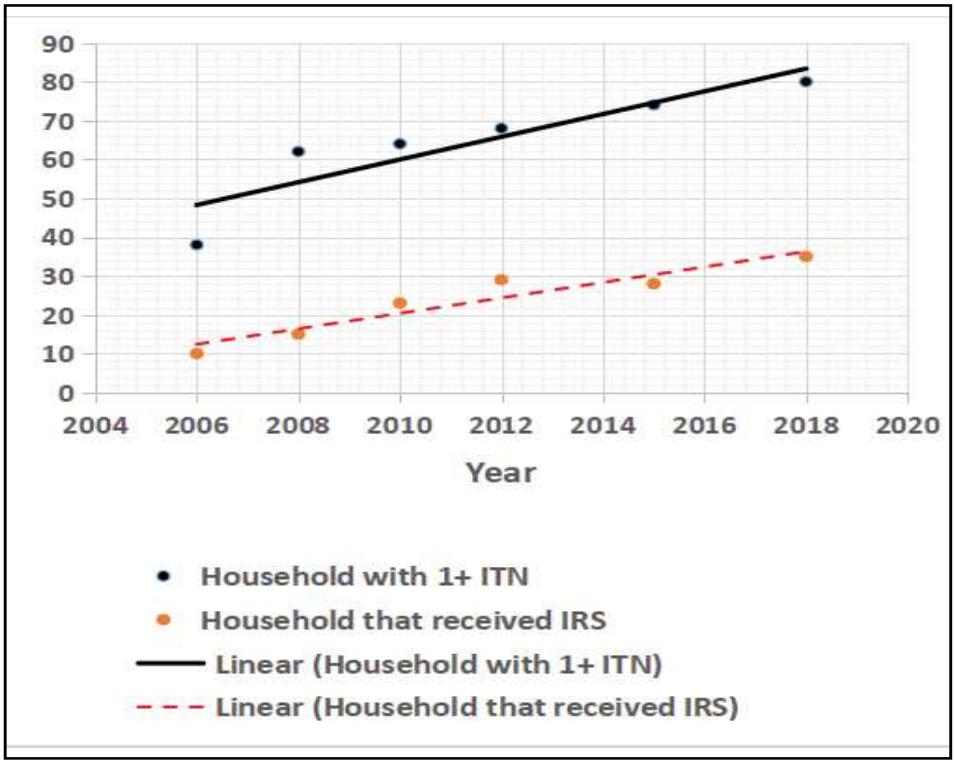
Citation Style For This Article: Siziya S. Impact of COVID-19 epidemic on malaria: limitations to achieving malaria elimination. Health Press Zambia Bull. 2020; 4(01); pp 1-3

Malaria remains a major public health problem in Zambia despite the sustained reduction in the number of cases. Highest prevalence rates for malaria have been reported in northern (Luapula, Northern, North-western and Muchinga provinces) regions of the country (20% or higher), followed by middle (Eastern, Central, Copper-belt and northern parts of Western provinces) regions of the country (10-20%) and least southern (Lusaka, Southern and the southern parts of Western provinces) regions of the country (<10%) [1]. While the impact of malaria interventions might have greater impact in high malaria prevalence regions, elimination of malaria is easier attained in regions of low prevalence rates. Given that the goal of malaria control is to reduce the number of cases to a very low level, then malaria control in Zambia should be targeted to northern and central regions of the country. Meanwhile, malaria elimination efforts should be targeted to southern regions of the country.

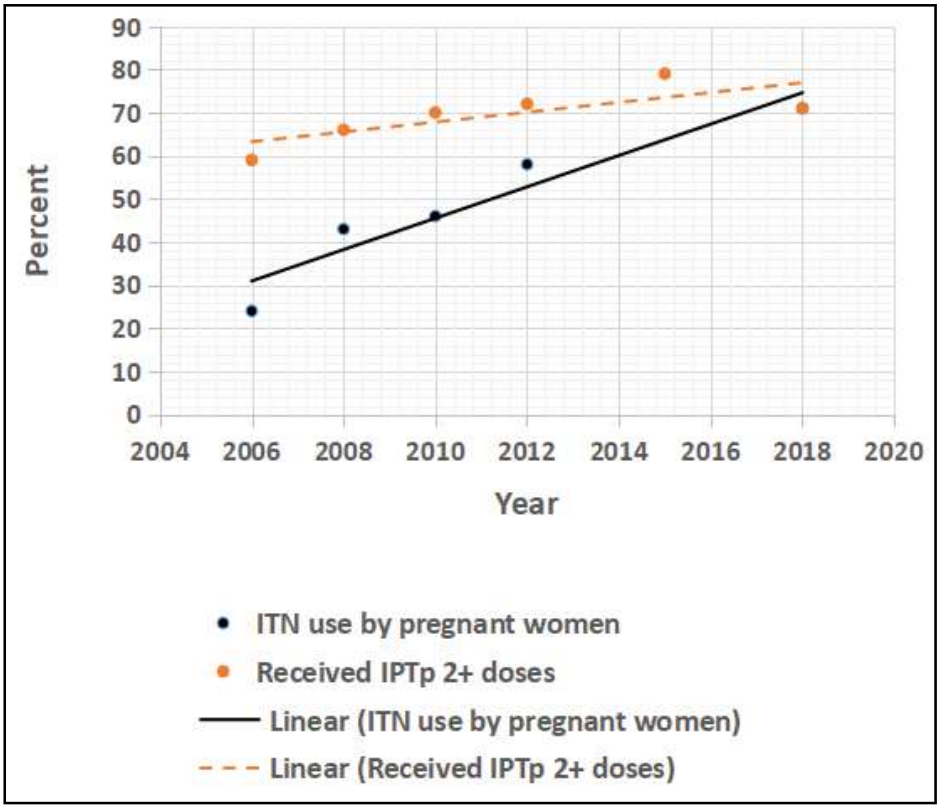
In its National malaria elimination strategic plan of 2017-2021, Zambia opted to eliminate local malaria infection and disease in Zambia by 2021 with the following elimination interventions: Vector control (Indoor residual spraying (IRS), Long Lasting Insecticide-treated mosquito nets (LLINs) and Larval source management); Case management (Diagnosis, Treatment and Integrated community case management); Malaria in pregnancy (Intermittent preventive treatment during pregnancy (IPTp)); Parasite clearance (Mass drug administration (MDA), Reactive case investigation and Focal drug administration); Health promotion (Advocacy with key policy and decision-makers on malaria elimination, Community engagement and SBCC for mobile and migrant populations including cross-border collaboration); Enhanced surveillance, monitoring, evaluation, and research for informed decision-making (Quality and timely facility/community reporting); Incorporation of emerging tools as they become available and are epidemiologically relevant; Health systems capacity (Staffing and Decentralisation); and Financing (Domestic, Donor and Non-traditional/innovative sources (such as private, religious and community) [2]. Clearly, the elimination goal for the entire country will not be attained by the end of next year, 2021.

Although Zambia has made progress in increasing the intervention coverages (Figures 1and 2), these have been below 80% coverage and not ensuring head immunity.

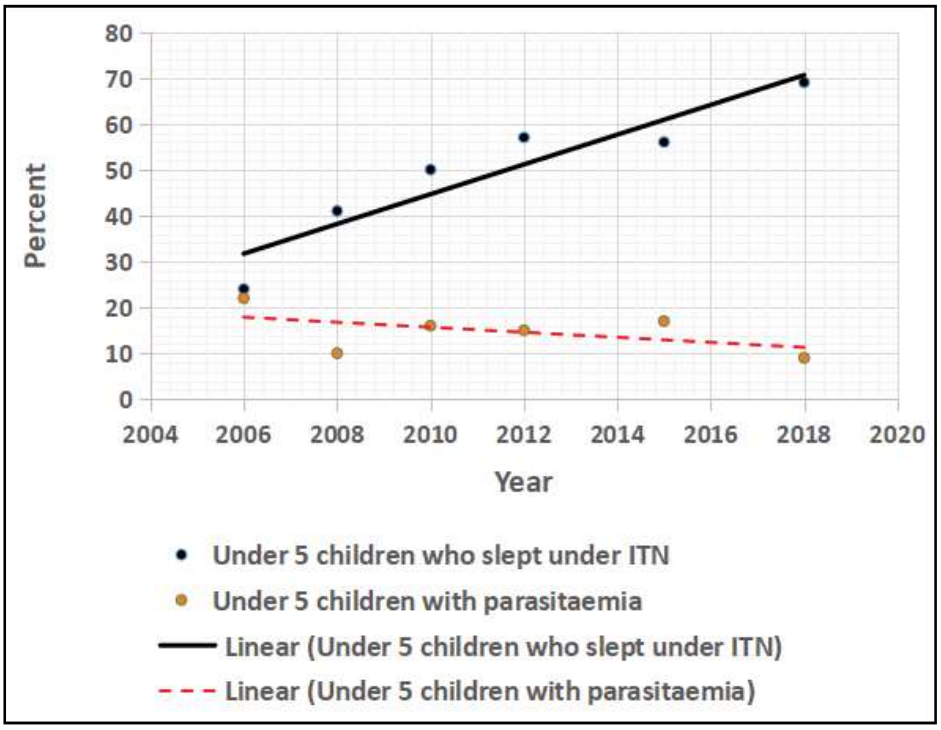
Subsequently, malaria parasitaemia rate among children aged below 5 years has not significantly ($F=1.41$, $p=0.301$) changed between 2006 and 2018 (Figure 3)



Source: Zambia Ministry of Health, 2018. Zambia National Malaria Indicator Survey 2018 [3].
Figure 1: Percent of households with at least one insecticide treated net (ITN) and received insecticide residual spray (IRS).



Source: Zambia Ministry of Health, 2018. Zambia National Malaria Indicator Survey 2018 [3].
Figure 2: Percent of pregnant women who slept under an insecticide treated net (ITN) and received 2+ doses of intermittent preventive treatment in pregnancy (IPTp).



Source: Zambia Ministry of Health, 2018. Zambia National Malaria Indicator Survey 2018 [3].
Figure 3: Percent of under 5 children who slept under an insecticide treated net (ITN) and those who had parasitaemia

Figure 3: Percent of Under 5 children who slept under an insecticide treated net (ITN) and had malaria parasitaemia.

Health coverages of routine health services are affected by outbreaks of epidemics. The model on the Ebola outbreak of 2014-2016 to predict the Ebola epidemic impact on malaria morbidity reported that a 50% reduction in treatment coverage during the Ebola outbreak led to increased malaria-attributable mortality rates by 48.0% in Guinea, 53.6% in Liberia and 50.0% in Sierra Leone [4].

Concerning malaria control, the delivery of ITN and IRS require movement of community health workers and their health facility supervisors to travel to communities. In active case finding at community level, CHW tests everyone living within 140 m radius of the sick person and observes the patient taking the malarial drug [5]. World Health Organization [6] has guided to ensure safety of both the health worker and client/patient from COVID-19 in health facilities and communities in their interaction to deliver malaria interventions.

The reductions in malaria burden have been variable over time in Zambia due to unstable financing and flows of critical antimalarial commodities, such as LLINs, IRS chemicals, antimalarial medicines, and RDT [7]. The major focus has been on containing the COVID-19 epidemic and as result, the malaria elimination program may be negatively affected. However, the Zambia End Malaria Council recommitted

to keep malaria-funding high on the political agenda during the COVID-19 fight. As we strive to control and possible eliminate COVID-19, we should not lose sight of controlling and possibly eliminating malaria.

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