I. Epidemiological profile

<table>
<thead>
<tr>
<th>Population</th>
<th>2014</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>High transmission (&gt;1 case per 1000 population)</td>
<td>6570000</td>
<td>25</td>
</tr>
<tr>
<td>Low transmission (≤1 cases per 1000 population)</td>
<td>13880000</td>
<td>53</td>
</tr>
<tr>
<td>Total</td>
<td>26760000</td>
<td>100</td>
</tr>
</tbody>
</table>

II. Intervention policies and strategies

- ITN: ITN/LLINs distributed free of charge
- IRS: IRS is recommended
- Larval control: Use of larval control recommended
- IPT: IPT used to prevent malaria during pregnancy
- Diagnosis: Patients of all ages should receive diagnostic test
- Treatment: ACT is free for all ages in public sector

III. Financing

- Sources of financing: Government, Global Fund, World Bank, USAID/PMI, WHO/UNICEF, Others

IV. Coverage

- ITN and IRS coverage

V. Impact

- Confirmed malaria cases per 1000 and ABER

- Malaria admissions and deaths

Parasites and vectors

- Major plasmodium species: P. falciparum (99%), P. vivax (1%)

Antimalaria treatment policy

- First-line treatment of unconfirmed malaria: A5+SP
- Treatment failure of P. falciparum: AL
- Treatment failure of P. vivax: CQ+PR(14d)

Insecticide susceptibility bioassays (reported resistance to at least one insecticide for any vector at any locality)

- P. vivax: An. culicifacies

Funding source(s): Government, Global Fund, WHO/UNICEF, Other bilateral, Other (all types)

Per chart includes 63% of total contributions

Cases tested and treated in public sector

Test positivity

Malaria admissions and deaths

Impact: Insufficiently consistent data to assess trends