SWAZILAND

Malaria transmission is seasonal in Swaziland and occurs during November to May in all areas except the southeast part of the country. About 28% of the population is at low risk for malaria, with the rest living in malaria-free areas. Almost all cases are due to *P. falciparum*. Confirmed malaria cases have decreased from an annual average of 652 during 2000–2005 to only 106 cases in 2009 (84% decline). In the same period, malaria admissions decreased from 1026 to 230 and malaria deaths fell from 32 to 13 (over 60% reduction for both). Interventions are focalized, targeting the populations at risk. The programme delivered 79 000 LLINs in 2009, enough to cover 48% of the population at risk. Use of ACT as the first-line treatment was adopted as national policy in 2009 but no data were reported on its deployment. Funding for malaria has increased from about US$ 600 000 in 2007 to US$ 3.6 million in 2009, financed by the Global Fund and the government (26%).

I. EPIDEMIOLOGICAL PROFILE

Population and epidemiological profile

<table>
<thead>
<tr>
<th>Population (in thousands)*</th>
<th>2009</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ages</td>
<td>1 185</td>
<td>14</td>
</tr>
<tr>
<td>&lt; 5 years</td>
<td>160</td>
<td>75</td>
</tr>
<tr>
<td>Rural</td>
<td>887</td>
<td>72</td>
</tr>
</tbody>
</table>

Geographical distribution of confirmed malaria cases (per 1000 population)

Vector and parasite species

- Major Anopheles species: *gambiae, arabiensis, funestus*
- Major Plasmodium species: *falciparum*

* UN Population Division estimates

Trends in malaria morbidity and mortality

- Confirmed malaria cases, per 1000 and annual blood examination rate
- Malaria test positivity rate and % of microscopy confirmed cases positive for *P. falciparum*

Note: Reporting completeness of outpatient health facilities (%) in 2009: 81.9%
I. EPIDEMIOLOGICAL PROFILE (continued)

![Graphs showing reported malaria admissions and deaths from 2000 to 2009.](image)

<table>
<thead>
<tr>
<th>Year</th>
<th>All-cause admissions</th>
<th>Malaria admissions</th>
<th>Year</th>
<th>All-cause deaths</th>
<th>Malaria deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>61 258</td>
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<td>2000</td>
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<tr>
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<td>56 231</td>
<td>1 229</td>
<td>2001</td>
<td>2 319</td>
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<td>2002</td>
<td>44 493</td>
<td>949</td>
<td>2002</td>
<td>2 782</td>
<td>30</td>
</tr>
<tr>
<td>2003</td>
<td>36 147</td>
<td>770</td>
<td>2003</td>
<td>2 908</td>
<td>28</td>
</tr>
<tr>
<td>2004</td>
<td>22 562</td>
<td>443</td>
<td>2004</td>
<td>3 083</td>
<td>17</td>
</tr>
<tr>
<td>2005</td>
<td>19 628</td>
<td>543</td>
<td>2005</td>
<td>3 336</td>
<td>27</td>
</tr>
<tr>
<td>2006</td>
<td>61 401</td>
<td>347</td>
<td>2006</td>
<td>7 077</td>
<td>17</td>
</tr>
<tr>
<td>2007</td>
<td>57 610</td>
<td>227</td>
<td>2007</td>
<td>6 280</td>
<td>10</td>
</tr>
<tr>
<td>2008</td>
<td>61 186</td>
<td>230</td>
<td>2008</td>
<td>5 365</td>
<td>13</td>
</tr>
<tr>
<td>2009</td>
<td>7 560</td>
<td>31</td>
<td>2009</td>
<td>1 210</td>
<td>3</td>
</tr>
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<td></td>
<td>7 077</td>
<td>17</td>
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<td>8 030</td>
<td>70</td>
<td></td>
<td>990</td>
<td>2</td>
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</table>

II. INTERVENTION POLICIES AND STRATEGIES

<table>
<thead>
<tr>
<th>Intervention</th>
<th>WHO-RECOMMENDED POLICIES / STRATEGIES</th>
<th>OTHER POLICY / STRATEGY</th>
<th>Year adopted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaria admissions, all ages</td>
<td>Malaria admissions, &lt;5 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>All-cause admissions</td>
<td>Malaria admissions</td>
<td>Year</td>
</tr>
<tr>
<td>2000</td>
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</tr>
<tr>
<td></td>
<td>8 030</td>
<td>70</td>
<td></td>
</tr>
</tbody>
</table>

Antimalarial policy | Type of medicine | Year adopted |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>First-line treatment of P. falciparum (unconfirmed)</td>
<td>AL</td>
<td>2009</td>
</tr>
<tr>
<td>First-line treatment of P. falciparum (confirmed)</td>
<td>QN</td>
<td>2009</td>
</tr>
<tr>
<td>Treatment failure of P. falciparum</td>
<td>QN</td>
<td>–</td>
</tr>
<tr>
<td>Treatment of severe malaria</td>
<td>QN</td>
<td>–</td>
</tr>
<tr>
<td>Treatment of P. vivax</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

Therapeutic efficacy studies (percentage of clinical and parasitological failure)

<table>
<thead>
<tr>
<th>Name of first-line antimalarial medicine</th>
<th>Study year</th>
<th>No. of studies</th>
<th>Failure rate (Minimum, Median, Maximum)</th>
<th>Follow-up</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
III. IMPLEMENTING MALARIA CONTROL

Coverage with ITNs from survey or model data

- Households with at least one ITN (%)
- Children <5 years who slept under an ITN (%)
- Percentage of households with at least one ITN

Source of treatment for febrile children and antimalarial received from survey data

- ACT
- Other antimalarial
- No antimalarial

Coverage with IRS and ITNs from programme data

- Population at high risk protected with IRS
- Population at high risk protected with ITN (1 LLIN or ITN per 2 persons, durability of LLIN: 3 years)

Access to effective treatment from programme data: percentage of cases tested and number of ACT courses delivered relative to cases

- % of suspected cases examined by either microscopy or RDT
- % of reported falciparum cases receiving antimalarials in the public sector
- % of reported malaria cases receiving antimalarials in the public sector

Preventive interventions: programme and survey data

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of ITNs and/or LLINs delivered</th>
<th>No. of people protected by IRS</th>
<th>Pregnant women who slept under any net (%)</th>
<th>Pregnant women who slept under an ITN (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
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<td>0</td>
</tr>
<tr>
<td>2005</td>
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<td>0</td>
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<tr>
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<tr>
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<td>2009</td>
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<td>95</td>
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</tr>
</tbody>
</table>


Diagnostics and treatment courses: programme and survey data

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of RDIs delivered</th>
<th>No. of first-line treatment courses delivered</th>
<th>No. of ACT treatment courses delivered</th>
<th>Febrile children &lt; 5 years treated in public health facility (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>2009</td>
<td>25,000</td>
<td>95</td>
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<td>0</td>
</tr>
</tbody>
</table>

IV. FINANCING MALARIA CONTROL

Governmental and external financing

Breakdowns of expenditure by intervention in 2009

- Insecticide and spraying materials
- ITNs
- Diagnostics
- Antimalarial medicines
- Monitoring and evaluation
- Human resources and technical assistance

Insecticide and spraying materials
- USAID/PMI
- UNICEF
- Global Fund
- Government**

Diagnostics
- USAID/PMI
- UNICEF
- Global Fund
- Government**

ITNs
- USAID/PMI
- UNICEF
- Global Fund
- Government**

Antimalarial medicines
- USAID/PMI
- UNICEF
- Global Fund
- Government**

Monitoring and evaluation
- USAID/PMI
- UNICEF
- Global Fund
- Government**

Human resources and technical assistance
- USAID/PMI
- UNICEF
- Global Fund
- Government**

* Bilaterals: DFID, JICA; and EU, UN agencies, etc.
** Governmental expenditure may not include costs at sub-national level and care related to health systems, human resources, etc.