PMI President's Malaria Initiative
Fighting Malaria and Saving Lives

MADAGASCAR

AT A GLANCE

Population (2016): **24.4 million**[1]

Population at risk of malaria (2014): **100%**[2]

Malaria incidence/1,000 population at risk (2013): **83**[3]

Under-five mortality rate (2009): **72/1,000 live births**[4]

1 U.S. Census Bureau, International Data Base 2015
2 World Health Organization (WHO), *World Malaria Report 2015*
3 WHO, *World Health Statistics 2016*
4 Demographic and Health Survey (DHS) 2009

The President's Malaria Initiative (PMI)

Malaria prevention and control is a major U.S. foreign assistance objective, and PMI's strategy fully aligns with the U.S. Government's vision of ending preventable child and maternal deaths and ending extreme poverty. Under the PMI Strategy for 2015–2020, the U.S. Government's goal is to work with PMI-supported countries and partners to further reduce malaria deaths and substantially decrease malaria morbidity, toward the long-term goal of elimination.

Country Context

Madagascar witnessed a decade of health improvements between 1997 and 2008, including a 50 percent decrease in under-five mortality. However, a 2009 coup d'état resulted in the suspension of U.S. Government support to Madagascar as well as a negative impact in access to, and quality of, health services within the country. The inauguration of a new president in 2014 resulted in a lifting of U.S. Government restrictions and was a major step toward ending the country's political and economic crises. Still, national health infrastructure, information, and commodity management systems remain weak, and much remains to be done at central and regional levels to ensure quality services and sustainable health financing.

While malaria cases and deaths reported through the national health management information system declined between 2003 and 2012, malaria remains a major health problem in Madagascar. Severe malaria is among the top five causes of reported overall mortality. Malaria epidemiology varies considerably in different regions of the country; however, the entire population is considered to be at risk for the disease. The revised national strategic plan has organized the country into two malaria operational zones based on changes in transmission dynamics, local epidemiology, and level of coverage of malaria interventions: the high transmission zone, including the East Coast and West Coast, and the low transmission zone including the South and the Central Highlands. The majority of cases are caused by *Plasmodium falciparum*. The cyclone season, extending from December to April, often results in flooding and increased risk of communicable diseases and malaria, compounded by the loss of insecticide-treated nets (ITNs).

Though implementation of PMI funding began in Madagascar with fiscal year (FY) 2008, the 2009 suspension of all activities requiring direct government collaboration impeded full implementation of malaria control activities until 2015, when PMI re-engaged with the Malagasy Ministry of Health from the central level to the primary health facility level.

Progress to Date

The following table provides information on the major indicators used by PMI to measure progress in malaria prevention and treatment activities in Madagascar.

Madagascar Malaria Indicators	PMI Baseline	DHS 2009	MIS 2011*	MIS 2013
All-cause under-five mortality rate	94/1,000 (DHS 2004)	72/1,000	–	–
Proportion of households with at least one ITN	–	73%	94%	79%
Proportion of children under five years old who slept under an ITN the previous night	–	58%	89%	71%
Proportion of pregnant women who slept under an ITN the previous night	–	58%	85%	68%
Proportion of women who received two or more doses of intermittent preventive treatment for pregnant women (IPTp) during their last pregnancy in the last 2 years	–	8%	22%	21%

* MIS - Malaria Indicator Survey

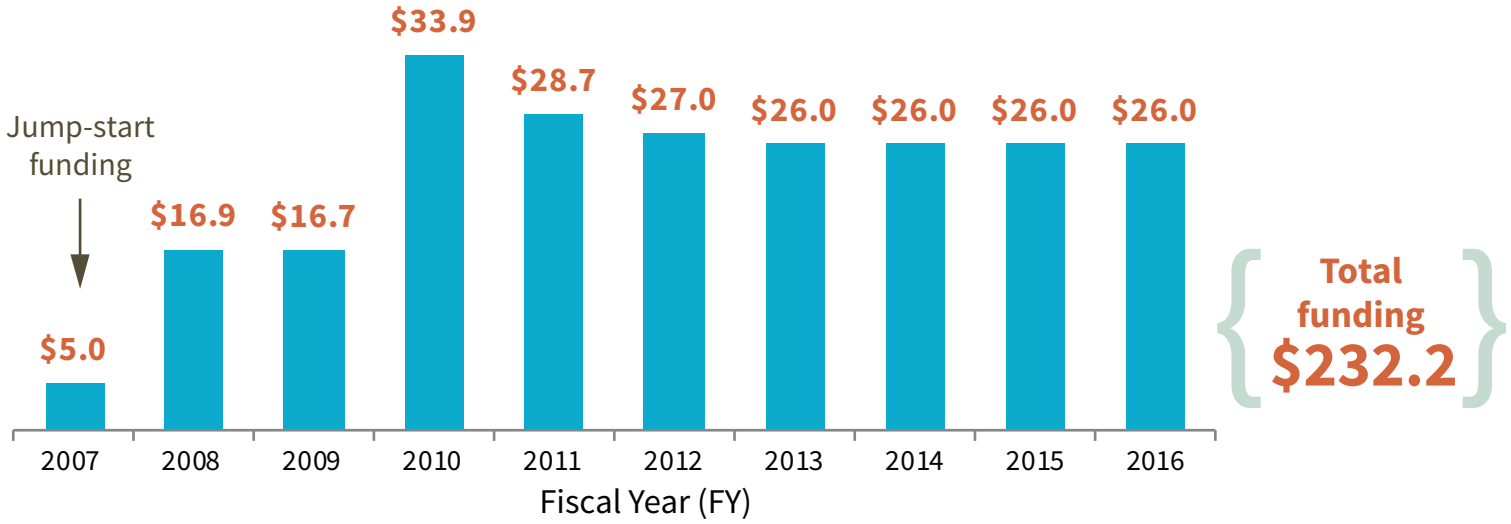
PMI Contributions Summary

Madagascar is in its ninth year as a PMI focus country. With support from PMI and other partners, malaria control interventions are being scaled up, and critical commodities are being distributed to vulnerable populations. The following table shows PMI contributions for fiscal year 2015 and cumulatively across the key intervention areas.

	PMI CONTRIBUTIONS[1]	FY 2015	CUMULATIVE
Insecticide-treated Nets	ITNs procured	3,145,250	15,678,357
	ITNs distributed	154,895	6,254,454
	ITNs procured by other donors and distributed with PMI support	0	3,495,283
Indoor Residual Spraying	Houses sprayed	373,027	n/a[2]
	Residents protected	1,766,806	n/a[2]
Rapid Diagnostic Tests	RDTs procured	2,000,000	8,328,000
	RDTs distributed	2,998,380	7,610,849
Artemisinin-based Combination Therapy	ACTs procured	1,609,900	2,990,925
	ACTs distributed	673,544	1,947,681
	ACTs procured by other donors and distributed with PMI support	0	1,699,579
Sulfadoxine-pyrimethamine	SP treatments procured	0	750,000
	SP treatments distributed	368,083	368,083
Health Workers	Health workers trained in treatment with ACTs	7,139	n/a[3]
	Health workers trained in malaria diagnosis	7,246	n/a[3]

1 The data reported in this table are up-to-date as of September 30, 2015. Please refer to Appendix 2 of the *2016 PMI Annual Report* for year-by-year breakouts of PMI contributions.
2 A cumulative count of the number of houses sprayed and residents protected is not provided since many areas were sprayed on more than one occasion.
3 A cumulative count of individual health workers trained is not provided since some health workers were trained on more than one occasion.

PMI Funding (in millions)



For details on FY 2016 PMI activities in Madagascar, please see the *Madagascar Malaria Operational Plan*.

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