Epidemiological Analysis of Malaria Outbreak in Ankesha District, Awi Zone, Amhara Region, Ethiopia, 2012: Weaknesses in Control Measures and Risk Factors

Mastewal Worku Lake, Mulugeta Mebratu, Degu Mehari, Kelemu Dessie

1. Background

Malaria is a life threatening parasitic disease transmitted by female anopheles mosquitoes. It is caused by the protozoan parasite plasmodium and transmitted by anopheles [1]. The five plasmodium species that are known to infect humans but
them each differ in many aspects of their biology and geographic distribution [2].

Malaria is a major health problem in the world. 3.4 billion people in the world are at risk of malaria infection, and each year 270 million (Range 135-287) people are infected and 627,000 deaths (range 473,000–789,000) of malaria occurred globally in 2012. About 80% cases and 90% deaths occurred in sub-Saharan Africa and most deaths (77%) were in children under 5 years of age [3]. Malaria is presently endemic in a broad band around the equator, in areas of the Americas, many parts of Asia, and much of Africa; however, it is in sub-Saharan Africa where 85–90% of malaria fatalities occur [4, 5].

Approximately 52 million people (68%) live in malaria risk areas in Ethiopia; primarily at altitudes below 2,000 meters [6]. Malaria is mainly seasonal with unstable transmission in the highland fringe areas and of relatively longer transmission duration in lowland areas, river basins and valleys [7].

In Ethiopia, a devastating malaria epidemic occurred between 1958, involving about three million cases and 150,000 deaths, and covering about 100,000 square miles (259,000 square kilometers) of highland area [8]. Since 1958, major epidemics of malaria have occurred at approximately 5-8 year intervals, though recently there has been a trend towards smaller-scale, more frequent, sporadic epidemics, and seasonal case build-ups. In 1998, a widespread severe malaria epidemic occurred in most highland as well as lowland areas in the country [8, 9].

Amhara region is one of the low land malarious Regions of Ethiopia. The prevalence of malaria in 2011/2012 was 4.3% and the prevalence rate among sex was male (4.8%) greater than female (3.4%). The dominant species of malaria in the region are both P. falciparum and P. vivax [10].

Malaria is a major public health problem in Amhara region. Ankesha district is one malaria endemic districts of the region. There could be epidemics in high transmission areas if there is deterioration of health system, interruption of anti-malarial measures or migration of non-immune individuals, such as population movement in search of labor to these areas [8].

Outbreak investigation was conducted in Azena kebele, Shumata kebele and Ayehu kebele of Ankesha district of Awi zone. The region deployed a team of investigators to undertake possible investigations and intervention measures. The objective of this study is to a) to gather evidence to indicate what might be the underlying causes of this epidemic; b) to better understand the events at that district; c) to verify the epidemic; d) to identify gaps and provide technical support e) to make recommendations about how to better control the epidemic; f) and to help determine whether these local malaria events have implications to other parts of the region.

2. Methods

2.1. Study Area and Population

Ankesha district is one of the districts in Awi zone, Amhara regional state. Ankesha was located at a distance of 139 KM from the regional town (Bahirdar) and 421 Km from Addis Ababa (figure.1). The catchment area of the district is 95,503 hectare with a total population of 217,941 (197,733 Rural and 20,208 Urban). The median annual rain fall is 1500 mm (with range 1000-2000 mm), median temperature of 17°C (with range of 15-20°C), Altitudes with range 1500-2800mm.

![Figure 1. Site of Malaria outbreak investigation, Ankesha district, Amhara, Ethiopia, 2012.](Image)
2.2. Laboratory Method
Malaria parasites were identified by microscopic examination of thick and thin blood films stained with Giemsa at health center levels and detects specific antigen derived from blood stage parasite by Rapid Diagnostic Test (RDT) at health post levels.

2.3. Descriptive Epidemiology
A case of malaria was defined any person with fever or fever with headache with plasmodium parasites by confirmed microscopy or RDT in resident of Ankesha district from March 24 – May 17/2012. We reviewed data from health post records from 2007 to 2011 to determine the baseline incidence of malaria in Ankesha District. Data were collected using filed observation and a structure questionnaire. A structure questionnaire was used to collect demographic and risk factors information. All the quantitative data collected was checked and entered on a computer and analyzed Epi Info version 3.5.1. Data cleaned and checked for inconsistencies and missing values.

2.4. Environmental Assessments
Entomological survey was conducted to identify potential mosquito breeding sites. Selected case patients were interviewed and assessed their bed net utilization by visiting households randomly.

3. Result
3.1. Laboratory
During the study period a total 2,958 cases were tested by blood smear microscope and RDT for malaria resulted 73% (2,061) malaria positivity rate. The species distribution, plasmodium falciparum was accounted 72% (1484), had 19% (392) plasmodium vivax and 9% (185) mixed cases.

Figure 2. Epidemic weeks in current year above third quartile threshold from Shumata kebele in Shumata HP.

3.2. Descriptive Epidemiology
In all studied kebeles, an outbreak was verified by comparing the current year data with a third quartile method (2nd largest number) during the previous 5 years. It was shown that the current case trend line crossed the threshold levels in all kebeles (figure 2). The screened 50 febrile cases, RDT result comes out with 72% positivity rate. As the national guideline the outbreak threshold is >50% positive, this result confirmed an outbreak.

3.2.1. Socio-Demographic Characteristics
From 24th March to 17th May 2012 we identified a total of 2,061 confirmed malaria cases and one death (CFR=0.05%) from three kebeles (Azena, shumata and Ayelu) of the Ankesha District. The median age of the cases was 17 years with a range of 0.2-83 years old. The sex wise distribution of cases, male accounted 10.1 per 1000(1,098) population. (Table 1).

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Population</th>
<th>Rate/1000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>963</td>
<td>46.7%</td>
<td>113115</td>
<td>8.5</td>
</tr>
<tr>
<td>Male</td>
<td>1098</td>
<td>53.3%</td>
<td>108681</td>
<td>10.1</td>
</tr>
<tr>
<td>Total</td>
<td>2061</td>
<td>100.0%</td>
<td>221796</td>
<td>9.3</td>
</tr>
</tbody>
</table>

The overall attack rate (AR) of the cases was 9.2 per 1000 populations in all ages. Age specific attack rate (ASAR) was highest in children aged five up to fourteen years (17.9 per 1000(642) population) followed by adults aged 15 years or older (8 per 1000(1,172) population) and least in children aged one to four years (4.6 per 1000(38) population) (Table. 2).
Table 2. Distribution of malaria cases by age in Ankesha district, Amhara, Ethiopia, 2012.

<table>
<thead>
<tr>
<th>Age group</th>
<th>Frequency</th>
<th>Percent</th>
<th>Population at risk</th>
<th>Age Specific attack rate/1000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>28</td>
<td>1.4%</td>
<td>6,036</td>
<td>4.6</td>
</tr>
<tr>
<td>1-4</td>
<td>219</td>
<td>10.6%</td>
<td>29,509</td>
<td>7.4</td>
</tr>
<tr>
<td>5-14</td>
<td>642</td>
<td>31.3%</td>
<td>35,960</td>
<td>17.9</td>
</tr>
<tr>
<td>≥15</td>
<td>1172</td>
<td>56.8%</td>
<td>146,436</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>2061</td>
<td>100%</td>
<td>221796</td>
<td>9.2</td>
</tr>
</tbody>
</table>

Table 3. Distribution of malaria cases by Kebele with age group Ankesha district, Amhara, Ethiopia, 2012.

<table>
<thead>
<tr>
<th>Kebele</th>
<th>Popn. at risk</th>
<th>Number of cases</th>
<th>Rate per 1000 pop.</th>
<th>Popn. at risk</th>
<th>Total cases</th>
<th>Rate per 1000 pop.</th>
<th>Popn. at risk</th>
<th>Total cases</th>
<th>Attack Rate per 1000 pop.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azena</td>
<td>6522</td>
<td>891</td>
<td>137</td>
<td>883</td>
<td>146</td>
<td>165</td>
<td>5631</td>
<td>745</td>
<td>132</td>
</tr>
<tr>
<td>Ayehu</td>
<td>8019</td>
<td>586</td>
<td>73</td>
<td>1085</td>
<td>89</td>
<td>83</td>
<td>6934</td>
<td>497</td>
<td>72</td>
</tr>
<tr>
<td>Shumata</td>
<td>8396</td>
<td>584</td>
<td>70</td>
<td>1136</td>
<td>75</td>
<td>67</td>
<td>7260</td>
<td>509</td>
<td>70</td>
</tr>
<tr>
<td>Total</td>
<td>22937</td>
<td>2061</td>
<td>90</td>
<td>3104</td>
<td>310</td>
<td>100</td>
<td>19825</td>
<td>1751</td>
<td>90</td>
</tr>
</tbody>
</table>

The overall AR of the outbreak cases were 90 per 1000(2,061) population. The frequency of the attack rate was differ in those studied kebeles. The highest attack rate was in Azena Kebele which was 165per 1000(883) population in under-fives and 132 per 1000(745) population in>5 years old. (Table 3)

3.2.2. Distribution of Cases by Date of Fever Onset

Weekly malaria reports increased from an average of 70 cases per week to more than 160 per week and a continued elevated malaria case load is being observed between the end of March and May 2012. The weeks when epidemic started was on March 24, 2012. However, the district health department was notified on May 6, 2012. The epi-curve showed the outbreak is a propagated one with multiple peaks with a possibility of person to person transmission (Figure 3). The peak numbers of malaria patients were on 7th-17th May, 2012. The proportion of Plasmodium falciparum infections was higher than plasmodium vivax.

3.3. Entomological Survey

Entomological survey was conducted in Ayehu kebele of Ayehu river dam where the first rumor and majority of cases were coming. There was multiple site of breakage water bodies for increase in vector breeding of anopheles larvae. The river was vast and difficult to drain and fill within a short period of time (Figure. 4).
3.4. Environmental Assessment

Fifty-three households (HH) from each affected kebeles were arbitrarily selected and visited to search new malaria cases and observe the status of LLINs utilization. All households had at least one LLINs in their house but only 32.1% (17) of the HHs hanged the LLIN’s in their ceiling directly to the bedding while the rest were puts underneath of the beds and other places in the house. However, 13% of visited household nets were damaged by rodent. In this study, about 21% do not use their nets at all while of those who reportedly use their nets, about 56% use their nets irregularly. And also clients were responds on indoor residual sprayed was performed for the last one year in all outbreak affected kebeles.

3.5. Interventions Taken

- Case management
- Active case searching from House to house
- Enhancing the community awareness program on bed net utilization, early diagnosis and treatment, environmental control management and indoor residual spray.
- Eradicating or reduced the malaria breeding sites through community participation
- Conducted focal spray on the affected kebeles and neighboring “gores”
- Opening the dam on the river Ayehu though the water pressure is weak to remove the larvae

4. Discussion

These findings provided confirmation of the existence of malaria epidemic based upon credible five years or last one year of epidemiological records including laboratory diagnosed malaria data. Malaria epidemic existed at the end of March, 2012 when it started to cross epidemic threshold. Since Ethiopia has a recent history of severe malaria epidemics, continued vigilance, and prompt investigations of smaller focal epidemics with rapid effective responses are needed to control and contain them.

Malaria epidemic started date in the district was related to the national data, actually the epidemic occurred at different times depending on the region, but overall it is believed to have started in April, and lasted until the end of December, many areas of Ethiopia began reporting an abnormal number of malaria cases [11].

Ayehu river dam was the major precipitating factor for breeding anopheline mosquitoes. This might be due to a change climate pattern; deficit rainfall for breakage of water bodies for an increase vector breeding population. Thus, most of the affected population were lived around and near the irrigation sites. Moreover this the vector control measures such as LLINs utilization, IRS performance and environmental control management was not properly done.

Health posts which was found in the affected kebeles, the weekly monitoring chart was not used properly and updated for detect increased malaria cases at an early stage that would indicate emerging epidemics. Also there were gaps on data recording and reporting to monitor the diseases trend in morbidity and mortality, data analysis and interpretation not done weekly base and not have epidemic management committee those might be the aggravating factor of the outbreak and not detect early to respond the outbreak.

Started in May 7-18 /2012, there was high no of Malaria case reported. This is due to active case searching house to house in the community was done.

Most of cases affected male than female under sex distribution might be male enrolled the irrigation program of Ayehu River.

The high proportion of Plasmodium falciparum cases shows difference as compared to the nationally registered proportion of Plasmodium falciparum and plasmodium Vivax which is 60% and 40% respectively [8].

Factors may have contributed to the high case positive rate of this outbreak might be the high sensitivity of the Malaria rapid diagnostic test (RDT). Since clients who get cured from malaria have also the chance to be positive for malaria if tested by the RDT within14 days of treatment, this may increase the positivity rate falsely when clients visit health posts within 14 days of treatment.

The observed household level of LLIN’s bed net were placed wrongly and poor utilized in the majority of HHs but in the Study of in Prion, Mali, utilization of LLIN significantly reduces the burden of malaria. [12]. Also in the district there was a weak performance on early warning surveillance, environmental management and delayed IRS spray may resulted in seasonal peaks increasing to levels that surpass the epidemic threshold.

5. Conclusion

An epidemic starts when the number of cases in a given week is higher than the threshold number (either the third quartile or double the number in previous year). Being high Larva density, dam of river, deficient rainfall and improper usage of LLIN bed net, impendiment IRS operation had contributed to the outbreak. All kebeles of the district have Suitable areas for malaria spelling site due to adjacent to the breakage river of presences of high Larva density. Vector control interventions were not carried timely in the district. There is no district-based epidemic early warning, prevention and response team.

Recommendations

- Keep weekly malaria data and used it for early detection of malaria epidemics and take action.
- Improving the completeness/quality of data collection, analysis and interpretation
- Use and updated malaria monitoring chart
- Functional and permanent epidemic management committee should be established
LLINs should be used regularly and replaced timely.
District health department must be allocate budget for timely spray of IRS based of the transmission seasons before cases increasing / peak transmission so as to prevent epidemic before malaria flare up.
Irrigation sites should be monitored for prevent malaria outbreak.
It need further study to evaluate the quality of rapid diagnostic tests to avoid false positivity rate.

Acknowledgments
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References