

Intervention Area	Current Year (2010)	Planned (within next 5 years)
Case Management		
Diagnosis		
National diagnosis policy (confirmed, clinical)	All suspected cases to be definitively diagnosed with microscopy or RDT; currently 10% of cases in high incidence areas and 50% in low incidence areas receive parasite-based diagnosis (microscopy/RDT)	Ensure access to early, accurate diagnosis, and prompt, effective and safe treatment through public and private sectors; by 2015, 60% of suspected cases in high incidence and 100% in low incidence counties to receive confirmed diagnosis
Tools (microscopy, RDT, PCR, parasite genotype, algorithm for clinical diagnosis)	Microscopy coverage in all hospitals to the township level; rapid diagnostic tests (RDTs) used in remote villages in high incidence counties and for standby use at township hospitals in high and low incidence counties (for emergencies and when microscopy is temporarily unavailable)	
Monitoring/ QA	Expand and strengthen QA reference labs; annual microscopy skills and knowledge competition held to build motivation and camaraderie	All slides of patients with clinical symptoms of malaria to be rechecked at Provincial CDC or with PCR; QA of RDTs at peripheral levels with positive control kits; National reference lab to be established for RDT quality control testing
Treatment		
<i>P. vivax</i> – 1 st line treatment protocol (radical cure, type, unit, dose); contraindicated populations (type, unit dose)	Free provision of chloroquine (CQ) and primaquine (180 mg over 8 days) plus another 180 mg of primaquine (PQ) over 8 days in subsequent pre-transmission season (a type of Spring Treatment, see “MDA” section below) for total dose of 360 mg of primaquine	By 2011, 95% of Pv cases to have received correct treatment; will continue use of higher doses of primaquine; pending results of treatment efficacy studies, will update drug policy of Pv treatment (see “Resistance Monitoring” section below)
<i>P. vivax</i> – 2 nd line treatment protocol		
<i>P. falciparum</i> – National treatment protocol/policy (type, unit dose)	Pf only endemic in Yunnan and Hainan provinces; free provision of 3 days of ACT plus single dose of primaquine per WHO protocol; currently 40% of cases in high incidence and 60% of cases in low incidence categories receive treatment within 24 hrs of fever onset	By 2011, 90% of confirmed Pf cases to have received correct treatment; by 2015, to have 80% of Pf cases in high incidence and 95% in low incidence counties receive treatment within 24 hours of fever onset
<i>P. falciparum</i> – Complicated Malaria	Treatment failure: artemether/artesunate for 7	ACTs and artemisinin-based injectable drugs to be

	<p>days, dihydroartemisinin for 7 days, pyronaridine for 3 days, artemether + pyrimethamine, artemether-lumefantrine (AL) for 3 days, pyronaridine + sulphadoxine/sulphalene-pyrimethamine (SP), artemether + pyrimethamine, dihydroartemisinin/artemether/artesunate + pyronaridine + primaquine for 2 days; Severe malaria: parenteral artemether, artesunate, or pyronaridine</p>	<p>stocked at township level in high and low incidence counties, and at prefecture level in potential transmission and malaria free counties where Pf cases are only due to importation</p>
Mixed infections – National treatment protocol/policy (type, unit dose)		
Directly Observed Therapy (DOT) and Case Follow-up (drug adherence)	<p>40% of cases receive modified DOT program in high and low incidence counties; patients receive daily follow-up by village doctors or other health staff after confirmed diagnosis; daily follow up by village doctors or other health staff.</p>	<p>By 2015, to have 80% of confirmed cases receive modified DOT</p>
G6PD screening		<p>Pending results of G6PD deficiency pilot tests, (see “Operational Research” section below) roll-out G6PD screening to be implemented in all Pv endemic areas with high prevalence of G6PD deficiency</p>
G6PD prevalence survey	<p>Jiang et al. found rates from 4.7-17.4% depending on ethnic group; higher prevalence is geographically correlated with historical patterns of malaria and shows positive selection of resistance to malaria</p>	<p>After successful pilot of G6PD screening test, will scale-up testing in all malaria endemic areas to better characterize prevalence</p>
Mass screening & treatment/Focal screening		
Focused Mass Drug Administration (MDA)	<p>Spring Treatment program provides 180 mg primaquine over 8 days for patients who had Pv in the year prior, close contacts of positive Pv cases in the year prior, and occasionally entire villages; efficacy of this program currently under study</p>	<p>Plan to continue Spring Treatment program</p>
Monitoring/QA		
Chemoprophylaxis		

Prophylaxis - travellers		Quarantine bureau will work with employers to provide prophylactic treatment for groups travelling abroad on business
Prophylaxis – high risk populations	See “MDA” section above, and “High Risk Population” section below	
Prophylaxis – pregnant women		
Intermittent Preventive Treatment – infants (IPTi), Children (IPTc) or in Pregnancy (IPTp)	Incidence not high enough to warrant IPTp or IPTi	None planned
PREVENTION		
Vector Control		
IRS Strategy (e.g., spatial or temporal rotation)	Responsive measure to foci and emergency outbreaks through this strategy: <u>Emergency outbreaks</u> : Spraying of entire village in villages with local cases having ≥ 10 cases in one month, or villages with no cases having ≥ 5 cases in one month <u>Foci</u> : Spraying of entire village in high incidence counties with at least two confirmed cases in one month; spraying of all neighbouring houses within a 50 meter radius if a village in a low incidence county has at least one case in a month	100% of foci in lower incidence counties to receive IRS by 2015
Insecticides	Pyrethrin, Deltamethrin, Cyfluthrin, Permethrin	
LLIN	All villages with incidence $\geq 1\%$ in year prior to receive free LLINs with goal of 100% coverage with rate of 1 net per 2 persons; target pregnant women and children in high incidence counties for LLIN coverage	Will provide 51,000 LLINs to forest workers in Hainan province within the next 5 years; by 2015, goal to protect 99% of high risk population with ITNS/LLINs or IRS
Expired LLIN collection & replacement		
ITN (and insecticides used)	Main strategy in higher risk areas where vectors are indoor biting and resting (<i>An. minimus</i> , <i>An. dirus</i> , or <i>An. anthropophagus</i>); all villages with at least one case in year prior to receive free annual retreatment of existing ITNs; currently 80% of high risk populations covered by some method of vector control, in select areas, free retreatment of conventional ITNs offered	

	until people are able to upgrade to LLIN	
Larval control & environmental modification	Environmental management through levelling uneven land, filling ditches and controlling erosion, installing screen doors or windows on houses, and improving the living conditions and habits of local people; biological control using fish and microbes	
QA		QA laboratories to be identified and certified with testing of vector control products to be performed using standard WHO GMP and WHOPES protocols
Other	<i>Anopheles sinensis</i> is the primary vector of Pv in China, and global warming may contribute to improving its efficiency and lifespan by increasing temperatures; main vectors in Northern/Central regions are <i>Anopheles sinensis</i> and <i>An. anthropophagus</i> and in the Southern Region is <i>An. minimus</i> and <i>An. dirus</i>	
Prevention of reintroduction	Lower threshold for outbreak IRS in low-risk counties where elimination is goal; GF R5 grant from 2006-2011 aimed to halt re-emergence of malaria in central provinces via scale-up of prevention, diagnosis and treatment, surveillance, and emergency response	
<u>Advocacy & Education</u>		
Mass media	Over 30 county mass media campaigns are focusing on elimination, including National Malaria Day campaigns and announcements/education during outbreaks	By 2015, over 500 county mass media campaigns to be focused on elimination; will establish CDC Travel Medicine website for Chinese nationals working or travelling to endemic countries abroad
IEC/BCC campaigns	Support for schools, Youth League, Women Union and private health providers to implement BCC activities in 121 target counties; NGOs reach out to mobile Chinese workers at their residential mountain villages with "Total Malaria Control," a program of health education, mobilization, and community-monitored behavior change;	Working to develop IEC materials and BCC strategies based on outcome of field surveys in 24 provinces; 50,000 health education sessions per year for the next 5 years to be delivered to primary and middle school students; IEC/BCC with peer groups to high-risk groups (forest workers in Hainan province and migrant

	promotion of early treatment-seeking behaviour and compliance through school-based health education, where primary and middle school students transfer IEC/BCC knowledge to elders	workers in Anhui); Quarantine bureau provides pre-departure IEC for nationals travelling to endemic areas abroad, screening/treatment for nationals who are febrile in airport upon return; text message campaigns during transmission season to people living in or travelling to endemic areas
Community-based interventions	Utilize community organizers to mobilize community involvement and support	Aim for 17,850 villages to have regular health education activities conducted by focus groups from 2010-2015
Surveillance		
Case detection and reporting		
Case reporting system	Mandated and routine reporting of surveillance data and monitoring of malaria program through internet-based China Information System for Disease Control and Prevention (CISDCP); underreporting a challenge in the private sector and in township hospitals that lack computers	Will strengthen malaria surveillance by improving case reporting through 100% access to internet-based disease reporting systems at township level and monetary incentives to encourage reporting at private and public sectors; by 2015, 95% of high incidence and 100% of low incidence counties will provide daily malaria reports through national internet-based reporting system
Active case detection (ACD)	Blood examinations for fever cases carried out in all sentinel sites, with target rates of >5% in unstable sentinel areas, >2% for low endemic areas, and >1% in pre-elimination sites	Will improve case detection by screening villages for fever cases in high incidence counties (and low incidence if poor or no reporting) by village doctors every 10 days to catch cases that may not have presented to the health care system, and testing with microscopy/RDT if appropriate
Passive case detection (PCD)	Strong network of public health facilities and full time staff at township and often village level enables effective delivery of diagnostic and treatment services, however the cost of diagnosis is not covered in some rural areas	Aiming to enhance coverage and reimbursement costs of care in rural areas
Case investigation or “re-active surveillance”	Individual case investigation for reported cases to be carried out by county CDC staff within 10 days, data reported to Provincial CDC monthly and National CDC yearly	By 2015, will aim for rapid follow-up investigations of 97% of confirmed cases in low incidence counties within 2 days of diagnosis; will conduct door-to-door surveys by county CDC staff to classify cases as local or imported with tracing of

		local case origins; blood slides/filter papers from all suspected fever cases in the village will be examined for the next 2 weeks
Other surveillance (e.g., screening, prevalence surveys)	62 sentinel surveillance sites in 18 provinces perform periodic case surveys to assess levels of under-reporting in sentinel counties; serological IFA tests performed on samples from primary school children at all sentinel townships at the end of transmission season	Continue sentinel population level surveillance to complement case detection by collecting samples from selected villages for blood smears in high incidence counties, and blood smears combined with IFA or ELISA in low incidence counties
Outbreak (Epidemic) detection and response		
Outbreak/Epidemic Prediction & Response	See study by Xiao et al. under “Operational Research”	Improvement of epidemic prediction and response through further exploration of model developed by Xiao et al. (under “Operational Research”)
Entomological Surveillance		
Surveillance vector species, behaviour, or densities	Vector population and density surveys conducted once every 10 days in selected sentinel sites from June-October	69 studies per year from 2010-2015 that will include vector species identification, density, and insecticide resistance at 3-6 sentinel sites in provinces with high and low incidence areas
Resistance monitoring		
Insecticide and drug resistance activities	Monitoring in three sentinel sites in each province every year; some reported resistance to DDT, permethrin, and deltamethrin	Goal is to conduct 4 resistance studies per year from 2010-2015; will perform regular <i>in vivo</i> studies in both Pv and Pf for emerging resistance and work to establish <i>in vitro</i> protocols to evaluate Pf sensitivity to artemisinin and Pv to chloroquine
Drug efficacy	Available evidence suggests no drug resistance to current anti-malarial drugs used; no current data on efficacy of Chinese treatment regimen (WHO-recommended), two studies are currently underway in Yunnan and Anhui provinces; currently testing efficacy of Spring Treatment program (see “MDA” section above)	If further studies are indicated, other trials will be designed and conducted in consultation with international experts
Prevention of reintroduction		
High risk populations	Work activities, residence location, and genetic make-up determine high-risk populations; target populations include poor ethnic groups along the Myanmar/Yunnan border, forest workers and	By 2015, will ensure 80% coverage of vulnerable, poor, and marginalized populations in high and low incidence counties with appropriate malaria interventions as follows:

	<p>ethnic minority groups in southern mountainous areas of Hainan, and highly mobile populations within central provinces; adult males have twice the reported incidence of adult females, because of work context and propensity to sleep outside without a bednet;</p> <p>GF R6 from 2007-2012 funds allocated to improving malaria treatment to migrant workers of Yunnan province who work in Myanmar and local residents at Myanmar border through mobile medical teams</p>	<p><u>Border crossers at Yunnan/Myanmar border:</u> distribute “malaria packs” containing LLINs, prophylactic medications, and IEC/BCC materials</p> <p><u>Hainan Forest Workers:</u> provide IEC/BCC and extra LLINs for them to use if staying overnight in forest</p> <p><u>Anhui Migrant workers:</u> provide IEC/BCC through peer groups</p> <p><u>Ethnic minority groups with higher G6PD deficiency prevalence:</u> modify case management policy as appropriate after screening test piloted</p> <p><u>Pregnant women and Children:</u> distribute LLINs through ANC clinics</p>
Border screening	<p>Malaria control consultation and service posts screen workers returning from Myanmar into Yunnan Province; migrant workers from endemic areas are required to be screened and cleared by the CDC in order to gain employment</p>	<p>Aiming for 30,000 people to be screened per year from 2010-2015, and treated as appropriate; will improve access of border crossers to health services by supporting NGO-run mobile medical teams providing malaria diagnosis and treatment at Yunnan/Myanmar border area</p>
Cross border collaborations	<p>Greater Mekong Subregion partnership consists of China, Vietnam, Lao, Myanmar, and Cambodia, and is supported by the RBM Mekong Initiative; allows neighbouring countries to work together in malaria control by maintaining a regional database of standardized malaria epidemiological data and creating maps of disease distribution</p>	<p>Will strengthen border malaria activities with neighbouring countries and NGOs; establishing cross border malaria surveillance, information exchange, and joint control mechanism to reduce malaria disease burden at China-Myanmar border</p>
Vector-control specific POR activities		
Program Management and health systems		
Program Finance		
National elimination goal (by province, district)	<p>By 2010, all endemic counties to meet malaria control standards, except those at the border areas of Yunnan and mountainous areas of Hainan, (control is incidence <1/1,000) and achieve basic elimination in 70% of all endemic counties, except those at the border areas of Yunnan and mountainous areas of Hainan (basic elimination is incidence <1/10,000)</p>	<p>By the end of 2013, all counties with higher malaria incidence (Type 1) will achieve pre-elimination (incidence < 1/10,000);</p> <p>by the end of 2015, 60% or more of these counties will achieve elimination;</p> <p>by the end of 2015, 95% or more of low incidence counties (Type 2) will achieve elimination (zero locally transmitted malaria cases);</p>

		<p>all Type 3 counties with interrupted malaria transmission will prevent reintroduction of malaria (zero locally transmitted cases); will eliminate <i>P. falciparum</i> malaria from Hainan province; aiming for complete elimination in China by 2025</p> <p>(See “Stratification” section below for definition of county types)</p>
Funding sources and funding budget from each source	<p>65% of total malaria programme costs from National Government; \$136.7 million from GFATM from 2003-2012, \$80,000 from WHO from 2006-2010</p> <p>Global Fund 2009 (\$12,931,971 USD)</p>	<p>In the next 5 years: budget required for implementing Revised National Strategy plan is \$786,437,649 USD; Chinese government expected to contribute \$603,441,243 USD, or 76.73% of total budget; financial gap of \$182,996,406 remains; GF R10 application submitted</p>
Stratification		
Stratification strategies for defining risk areas, to allocate resources & activities (tools may include sampling strategy, population-based statistics, GIS)	<p>Stratification scheme based on malaria endemicity at county level:</p> <p>Type 1: Areas of high incidence, presence of confirmed local case(s) in the last 3 years, with at least one year having an annual incidence $\geq 1/10,000$ (75 counties)</p> <p>Type 2: Areas of low incidence, presence of confirmed local case(s) in the last 3 years, annual incidence $< 1/10,000$ (687 counties)</p> <p>Type 3: Potential transmission areas, no local case for at least 3 years, only imported cases (1,432 counties)</p> <p>Type 4: Malaria-free areas, no history of any local cases, only imported cases (664 counties)</p>	<p>Working to improve mapping capabilities of National GIS system</p>
Program structure and organization management		
Program management	<p>The public health system in China is divided into two parts: medical care services (diagnosis, treatment and case reporting) are separate from disease prevention and control that is conducted by the China CDC at the province, prefecture and</p>	<p>Will establish <i>ling dao xiao zhu</i>, or governmental leadership groups, to lead and facilitate intersectoral coordination on malaria activities; working to ensure high-level political commitment through regular meetings and coordination, and</p>

	county levels; at township level, one or two physicians are based at the township hospital and 1 part-time physician at the village level	advocacy events
Procurement & supply management	Ensure adequate procurement, supply, and distribution of malaria commodities such as diagnostics, drugs, and vector control supplies	Will ensure all hospitals at county and township level in high and low incidence counties have functioning microscopes; by 2015, 99% of township hospitals in endemic counties to have no reported stock-outs in diagnostic and treatment supplies
Financial management	Regular external audits of Global Fund funds through system designed with help of Local Fund Agent	
<u>Program integration</u>		
Level of integration of malaria elimination into public health	Rural Cooperative Medical Scheme of the National Health System is supposed to cover all basic health care needs (including malaria) for remote and rural populations, yet reimbursement is unequal across locales with many persons only receiving 20-30% healthcare paid for by program	Health Sector Reform strategy adopted in 2009 aims to provide basic healthcare services for all citizens by 2020; central government will subsidize a standardized public health package for all citizens but local governments will add public health services to this package depending on local economic situation
<u>Personnel</u>		
Reorientation, retraining, or restaffing & capacity development	GF R6 funds to provide support for 5 CDC staff per year to study for Master’s degrees and for 66 people to attend needs-based study tours; village and township doctors, as well as doctors and pharmacists in the private sector to be trained and retrained in case management, along with monetary incentives for doctors to provide appropriate diagnostic and treatment services; comprehensive training for all microscopists via a “trickle-down approach”	By 2015, all village doctors in low incidence counties to demonstration knowledge about malaria elimination; over 500,000 health providers in low and potential transmission counties to be informed/trained on malaria elimination strategies over the next 5 years; will reorient management on transition from control to elimination; 90% of counties will establish government leading teams to supervise transition from control to elimination by 2015
<u>Legal Framework</u>		
Frameworks/policies/regulation/strategic plans	National Revised Malaria Strategy updated 2010; ensure that necessary resources (financial, human, and commodities) are in place before implementing interventions	Working to update National Guidelines on Malaria Surveillance and Epidemic Response, National Malaria Drug Policy, Urgent Response Plan for Control Malaria Epidemic Outbreak
Standard Operating Procedures (SOP) – list subject	China MOH: Malaria Control and Prevention	

	<p>Manual, 2006; <u>QA testing</u>- standard WHO GMP and WHOPES protocols used for of vector control methods; <u>Treatment</u>-all clinical and suspected cases to be managed according to National Treatment Guidelines; <u>Insecticide resistance</u> surveillance guidelines in China MOH-Malaria Control and Prevention Manual</p>	
Private sector – Providers		
Engagement with formal providers (case management, reporting, other)	80% of cases are diagnosed in the private sector, usually at village level; diagnosis, treatment, and case reporting need to be strengthened	Will target private sector with same interventions as public sector to encourage proper reporting and treatment: trainings, incentives to diagnose and treat, follow-up, and drug quality monitoring
Engagement with informal providers (case management, reporting, other)		
Training	Private sector physicians trained and retrained in case management	No change
Other		Expansion of non-state hospital sector will be encouraged
Monitoring and QA		
Private sector – Companies/Businesses		
Employee or community programs (e.g., medical services, bed net campaigns)	Train health workers for company-sponsored worker teams leaving for Myanmar to be responsible for malaria control services while in Myanmar, clinics to provide follow-up care when workers return	See “IEC/BCC Campaign” section above
Partners		
Funding	The Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM): R1, R5, R6, R9 U.S. Government’s President’s Malaria Initiative (PMI) World Bank International Development Association	Working to increase advocacy on a regional and international level to garner further technical, political, and financial support for China’s malaria programme
Implementation (list partners and type of collaboration)	<u>Asian Development Bank</u> : supports several projects along the endemic southeastern border	Will strengthen regional and global exchange and cooperation; planning to host four meetings per

	<p>provinces</p> <p><u>Health Unlimited</u>: Community health education in Yunnan and 4 special regions of Myanmar, malaria control of migrant workers along border area</p> <p><u>Humana People to People</u>: Support IEC/BCC activities</p> <p><u>Ministry of Commerce</u>: Facilitate targeting of Chinese nationals at risk for malaria when they travel to malaria endemic areas such as Africa for work</p> <p><u>Ministry of Education</u>: Provide malaria health education for students</p> <p><u>NIPD/China CDC</u>: Technical, management, and implementation support on provincial level</p> <p><u>RBM Mekong Initiative, Greater Mekong Subregion partnership</u>: China, Vietnam, Lao, Myanmar, Cambodia work together on malaria control via regional database of standardized malaria epidemiological data and disease distribution maps</p> <p><u>Red Cross Society of China</u>: Distribute LLINs, provide BCC, monitoring</p> <p><u>State Food and Drug Administration</u>: Anti-malarial drug QA</p> <p><u>Society of Medical Parasitology</u>: Review microscopy QA system, develop training materials to train village doctors, microscopists, and provincial microscopy quality control staff</p> <p><u>State Quality Supervision Bureau</u>: Implement IEC/BCC activities at border crossing spots along Yunnan/Myanmar border</p> <p><u>WHO/WPRO</u>: Technical assistance, monitoring</p> <p><u>Women's Union (Fu Nu Lian He Hui)</u>: IEC/BCC and LLIN distribution to women and children in ANC clinics</p> <p><u>Youth League</u>: Provide malaria education to</p>	<p>year with partners</p>
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	students	
M&E		
M&E Elimination Plan, indicator development	CDC will conduct periodic surveys to assess prevalence, level of under-reporting, and measurement of other indicators; M&E visit frequency goals are 2 visits/year in provinces, 4 visits/yr in counties, at least 6 visits/year in townships, and at least 6 visits during transmission season in villages	Continue M&E of all targets of the malaria programme; regular supervisory visits in 30% of health facilities per year (2010-2015)
QA/QC (diagnosis, supply chain, etc)	State Federal and Drug Administration to perform routine drug quality testing and QA from manufacturing to distribution and storage; as well as testing in sampled private and public sector outlets to reduce marketing and sale of fake anti-malarial drugs	Will improve quality control of insecticide resistance testing with uniform testing methods, training, and supervision
Other		

Operational Research	Research in past 5-10 years	Present research projects	Planned research projects
Parasitological research projects, in particular for <i>P. vivax</i> ; list major outcomes and please cite publications when relevant		Efficacy of the Spring Treatment program currently under study	Plan for molecular studies to better understand epidemiology of relapse versus re-infection; one to two G6PD tests to be selected for pilot studies; establish <i>in vitro</i> Pf and Pv sensitivity studies; explore molecular epidemiology techniques in concert with spatiotemporal data to identify parasite origin for focal targeting of interventions; ELISA vs. IFA tests to be compared for tracking transmission intensity in low endemic areas; further exploration of model developed by Xiao et al. to improve epidemic prediction and

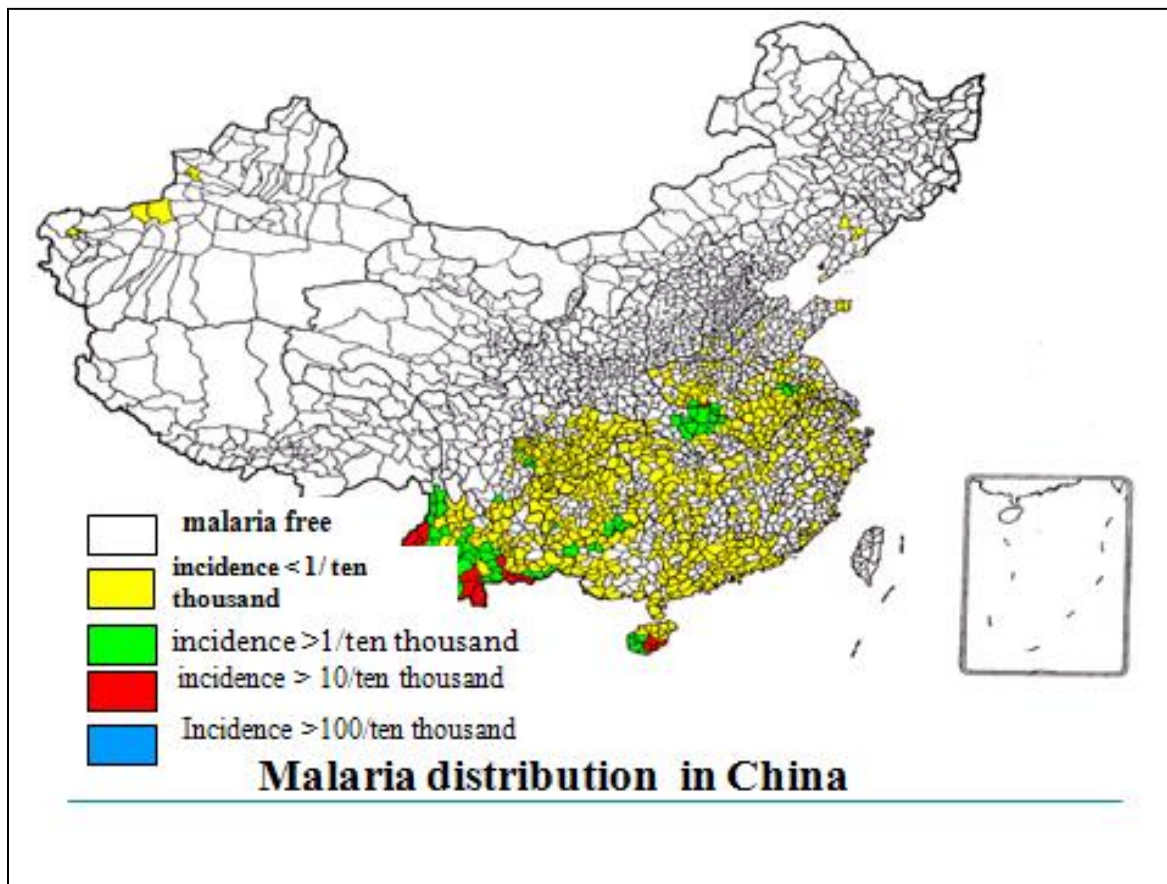
			response strategies
Entomological research projects; list major outcomes and please cite publications when relevant			Needs-based operational research on vector control methods, repellents
Behavioural research projects; list major outcomes and please cite publications when relevant			Plan for evaluation of methods to improve drug adherence; needs-based research on IEC/BCC program evaluation and development
Other research projects; list major outcomes and please cite publications when relevant	Study by Xiao, et al. described a multivariate time series model that can be used to fit and predict malaria epidemics in Hainan province using the number of malaria cases in the previous month and mean temperatures of the previous two months		
Research Partners (national, regional and international) in operational research projects		State Federal and Drug Administration does anti-malarial drug QA	

Quantitative Data			
Variable	Data	Source	Notes (include year if not 2010)
Total population	1,353,311,033	World Health Organization, World Malaria Report 2010	2009
Population at risk (PAR): Low Medium High	676,655,517 NA 13,533,110	World Health Organization, World Malaria Report 2010	2009

Total malaria deaths	12	World Health Organization, World Malaria Report 2010	2009
Total malaria cases	14,491	World Health Organization, World Malaria Report 2010	2009
Total positive slides – <i>P. vivax</i>	8,214	World Health Organization, World Malaria Report 2010	2009
Total positive slides – <i>P. falciparum</i>	948	World Health Organization, World Malaria Report 2010	2009
Total suspected cases	4,642,372	World Health Organization, World Malaria Report 2010	2009
G6PD deficiency % population	4.7-17.4%, depending on ethnicity	Jiang, et al. <i>Structure and function of glucose-6-phosphate dehydrogenase deficient variants in Chinese population</i> , Malaria Journal: 2010	2006
# imported malaria cases (national)			
Slide positivity rate (SPR)	0.39%	Revised National Malaria Strategy 2010-2015	2008
Annual blood examination rate (ABER)	1-5%	Qi, G. "From Passive to Active Malaria Surveillance in China."	2010
Annual parasite index (API)	0.2/10,0000	Revised National Malaria Strategy 2010-2015	2008
Parasite prevalence rate			

Main Sources (list up to five main sources):

1. Global Fund to Fight AIDS, Tuberculosis, and Malaria, Round 6 Proposal (2007). "Malaria Control Across China-Myanmar Border Areas."
2. Hsiang, M. Global Health Group Malaria Elimination Initiative. "China Malaria Report." [unpublished document]; April 2008.
3. Ling-Hua, T. National Institute of Parasitic Diseases, China CDC. "Update on Malaria Elimination in China." Asia-Pacific Malaria Elimination Network Meeting Presentation, February 9, 2009.
4. People's Republic of China Ministry of Health (2010). "From Malaria Control to Elimination: A Revised National Malaria Strategy 2010-2015."
5. World Health Organization (2010). World Malaria Report 2010.
6. Qi, G. Jiangsu Institute of Parasitic Diseases. "From Passive to Active Malaria Surveillance in China." Asia Pacific Malaria Elimination Network Meeting, Presentation, 2010.



Malaria distribution in China – API (per 10,000) in 2006