



WORLD MALARIA REPORT 2015 Summary

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The *World malaria report 2015* summarizes progress in malaria control and elimination in a milestone year: 2015 marked the end of the era of Millennium Development Goals (MDGs) and was the target year for the malaria goals set by the World Health Assembly and other global institutions.

The report shows a dramatic decline in the global malaria burden since 2000. The malaria component of Target 6C of the MDGs – to have halted by 2015 and begun to reverse the incidence of malaria and other major diseases – was achieved convincingly. Fifty-seven countries reduced their malaria cases by 75%, in line with the World Health Assembly's target for 2015. For the first time since WHO began keeping track, the WHO European Region reported zero indigenous cases of malaria.

Despite this tremendous progress, much more needs to be done to further reduce the malaria burden. The *Global technical strategy for malaria 2016–2030*, approved by the World Health Assembly in May 2015, set ambitious but achievable targets for 2030, including a reduction of at least 90% in global malaria incidence and mortality.

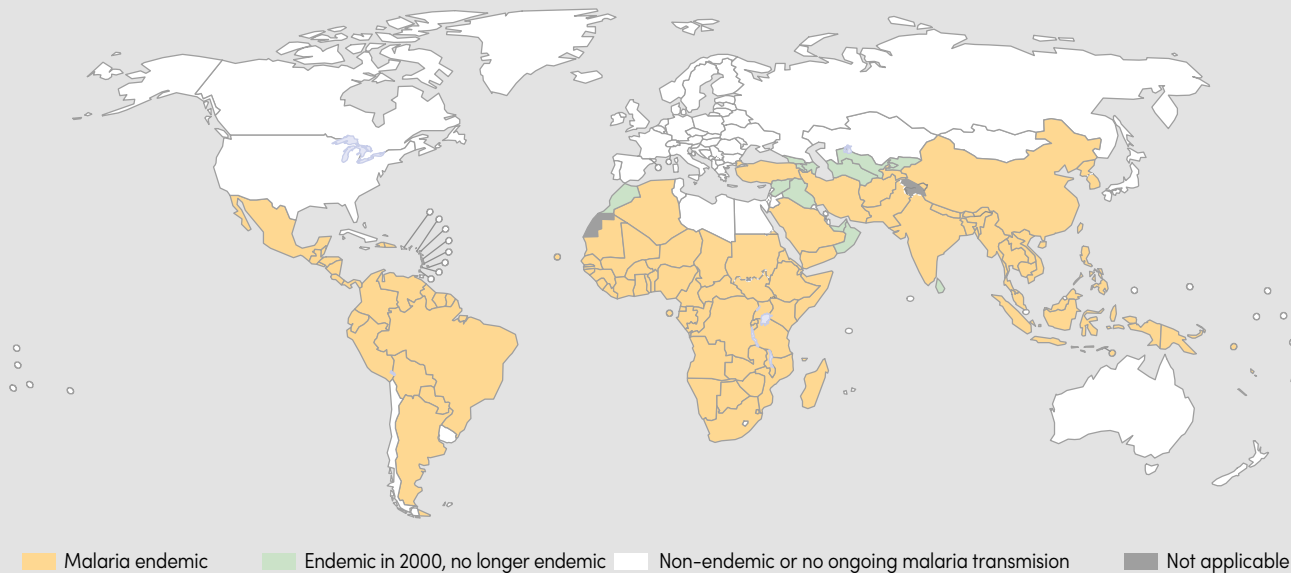
The complete *World malaria report 2015* can be found at:
<http://www.who.int/malaria/publications/world-malaria-report-2015/report/en/>

Distribution of malaria

The number of countries and territories with ongoing malaria transmission has decreased since 2000

In 2000, there were 106 countries and territories with ongoing malaria transmission; by the end of 2015, there were 95. Data were assembled from these 95 countries and territories, and from a further six countries that have recently eliminated malaria, to produce the *World malaria report 2015*.

Countries with ongoing transmission of malaria, 2000 and 2015



There have been large reductions in the number of malaria cases and deaths since 2000

The number of malaria cases fell from an estimated 262 million globally in 2000 (range: 205–316 million), to 214 million in 2015 (range: 149–303 million), a decline of 18%. The number of malaria deaths globally fell from an estimated 839 000 in 2000 (range: 653 000–1.1 million), to 438 000 in 2015 (range: 236 000–635 000), a decline of 48%. Most cases and deaths in 2015 are estimated to have occurred in the WHO African Region (88%), followed by the WHO South-East Asia Region.

Estimated malaria cases and deaths, by WHO region, 2000–2015

WHO region	Estimated number of malaria cases (000's)				Change	Estimated number of malaria deaths				Change
	2000	2005	2010	2015	2000–2015	2000	2005	2010	2015	2000–2015
African	214 000	217 000	209 000	188 000	-12%	764 000	670 000	499 000	395 000	-48%
Americas	2 500	1 800	1 100	660	-74%	1 600	1 200	1 100	500	-69%
Eastern Mediterranean	9 100	8 600	4 000	3 900	-57%	15 000	15 000	7 000	7 000	-51%
European*	36	5.6	0.2	0	-100%	0	0	0	0	
South-East Asia	33 000	34 000	28 000	20 000	-39%	51 000	48 000	44 000	32 000	-37%
Western Pacific	3 700	2 300	1 700	1 500	-59%	8 100	4 200	3 500	3 200	-60%
World	262 000	264 000	243 000	214 000	-18%	839 000	738 000	554 000	438 000	-48%
Lower bound	205 000	203 000	190 000	149 000		653 000	522 000	362 000	236 000	
Upper bound	316 000	313 000	285 000	303 000		1 099 000	961 000	741 000	635 000	

* There were no recorded deaths among indigenous cases in the WHO European Region for the years shown.

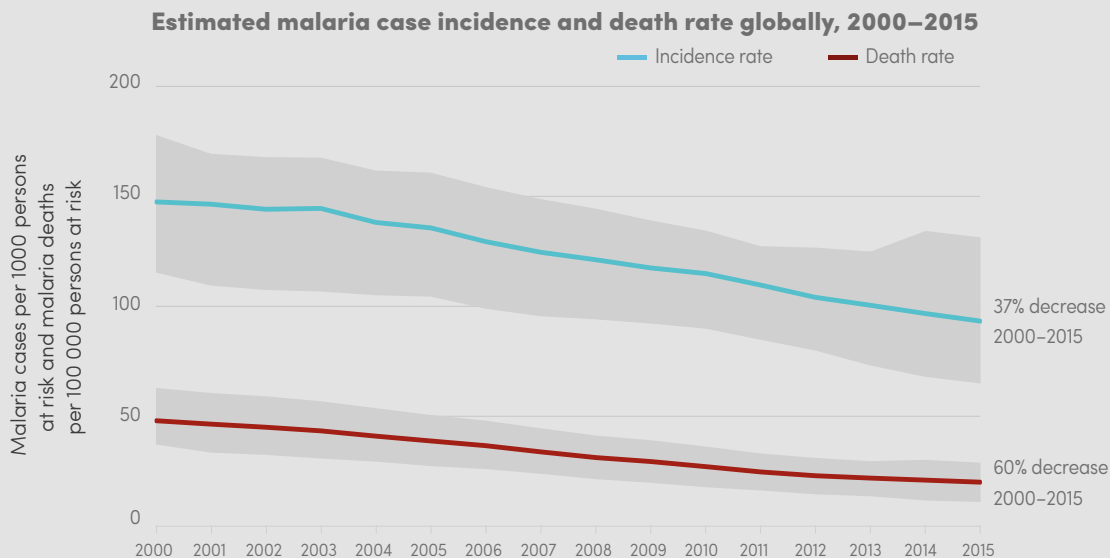
Source: WHO estimates



Changes in case incidence and mortality rates

MDG Target 6C “to have halted by 2015 and begun to reverse the incidence of malaria...” has been met

The incidence of malaria, which takes into account population growth, is estimated to have decreased by 37% globally between 2000 and 2015. Malaria death rates also decreased by 60%. Hence, the malaria component of MDG Target 6C has been met. Also, substantial progress has been made towards the World Health Assembly target of reducing the malaria burden by 75% by 2015, and the Roll Back Malaria (RBM) target of reducing deaths to near zero.

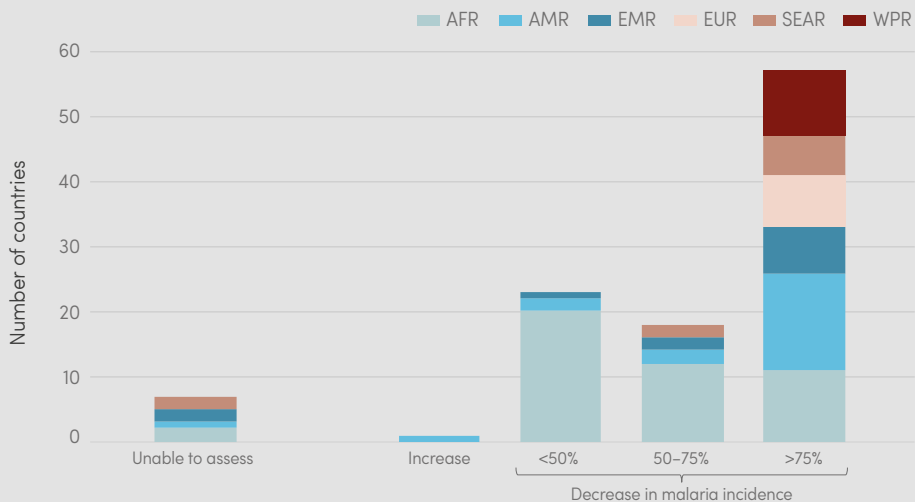


Source: WHO estimates

57 countries and territories have reduced malaria case incidence by >75%

Substantial reductions in malaria incidence and mortality rates have occurred across the globe.

Estimated change in malaria case incidence 2000–2015, by WHO region



AFR, African Region; AMR, Region of the Americas; EMR, Eastern Mediterranean Region; EUR, European Region; SEAR, South-East Asia Region; WPR, Western Pacific Region

Source: WHO estimates

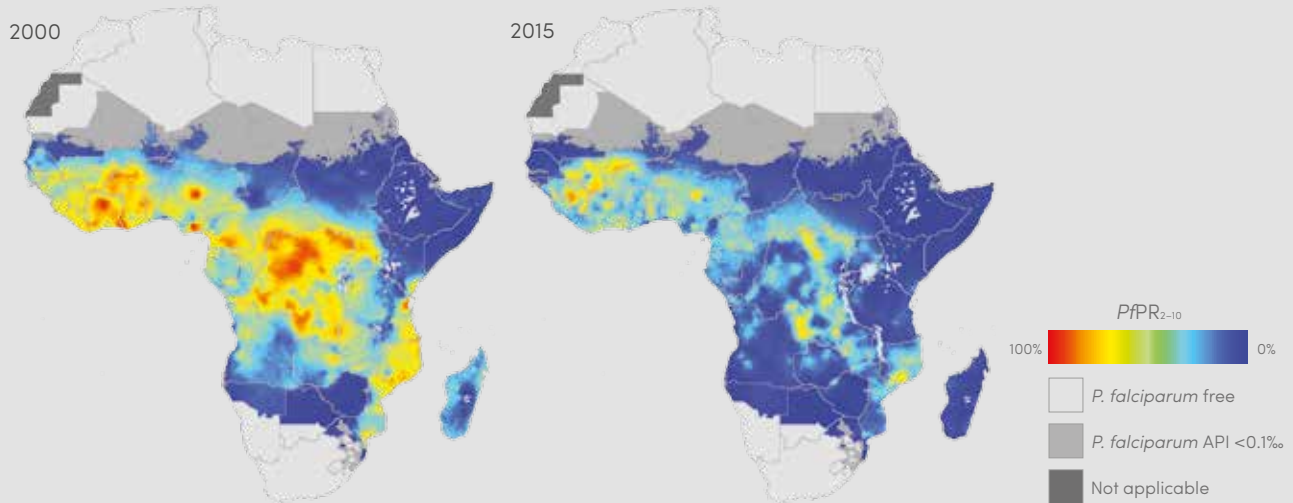


Changes in parasite prevalence

The proportion of children infected with malaria parasites has been halved in endemic areas of Africa since 2000

Infection prevalence among children aged 2–10 years is estimated to have declined from 33% in 2000 (range: 31–35%) to 16% in 2015 (range: 14–19%).

Estimated *Plasmodium falciparum* infection prevalence among children aged 2–10 years ($PfPR_{(2-10)}$) in 2000 and 2015



API, annual parasite index; $PfPR$, *P. falciparum* parasite rate

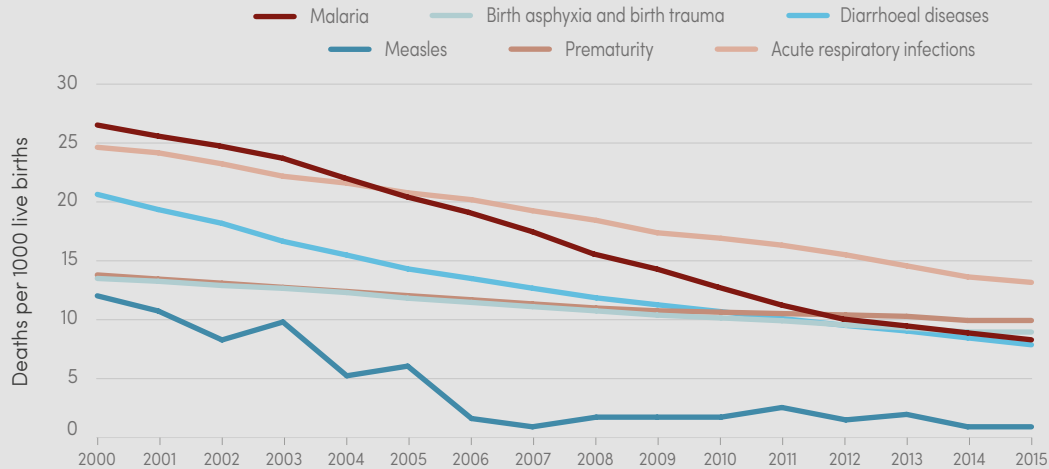
Source: Malaria Atlas Project

Leading causes of deaths in sub-Saharan Africa

Malaria is no longer the leading cause of death among children in sub-Saharan Africa

The number of malaria deaths in children aged under 5 years is estimated to have decreased from 723 000 globally in 2000 (range: 563 000–948 000) to 306 000 in 2015 (range: 219 000–421 000), with the bulk of this decrease occurring in sub-Saharan Africa. Reductions in malaria deaths have contributed substantially to progress towards achieving MDG Target 4A, which was to reduce the under-5 mortality rate by two thirds between 1990 and 2015.

Leading causes of death* among children aged under 5 years in sub-Saharan Africa, 2000–2015



*Conditions that are responsible for more than 10 deaths per 1000 live births during any time between 2000 and 2015 are shown.

Source: WHO estimates

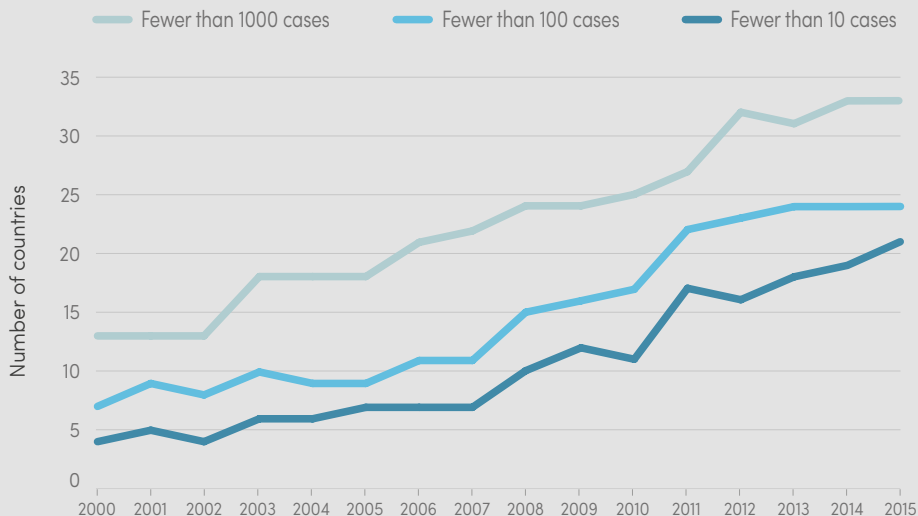


Progress to malaria elimination

An increasing number of countries are moving towards elimination of malaria

Whereas only 13 countries were estimated to have fewer than 1000 malaria cases in 2000, 33 countries are estimated to have achieved this milestone in 2015. In 2014, 16 countries reported zero indigenous cases (Argentina, Armenia, Azerbaijan, Costa Rica, Georgia, Iraq, Kyrgyzstan, Morocco, Oman, Paraguay, Sri Lanka, Tajikistan, Turkey, Turkmenistan, United Arab Emirates and Uzbekistan).

Number of countries with fewer than 1000, 100 and 10 cases, 2000–2015

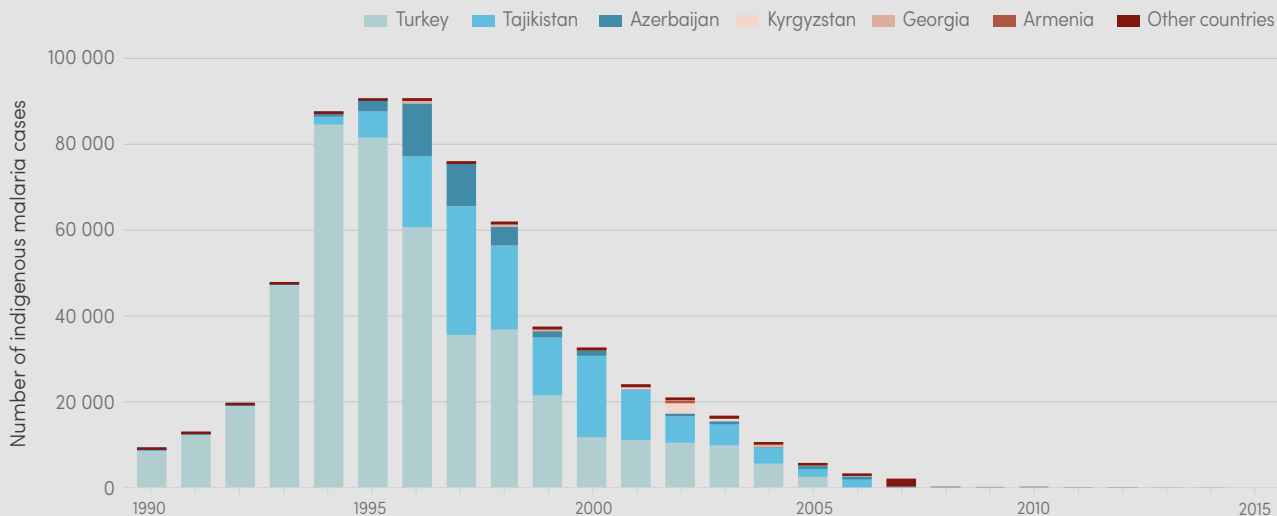


Source: WHO estimates

In 2015, the WHO European Region reported zero indigenous malaria cases for the first time

In 2000, there were 32 394 indigenous cases of malaria in the WHO European Region. By 2005, control efforts had reduced this number to 5072, and the nine affected countries made a commitment through the Tashkent Declaration to eliminate malaria from the region by 2015. The number of indigenous malaria cases decreased to just 179 in six countries in 2010. The last indigenous case of *Plasmodium falciparum* malaria in the region was reported in Tajikistan in 2009. The years 2011 and 2012 saw renewed malaria transmission – in Georgia (isolated cases), and in Greece and Turkey (localized outbreaks) – but these resurgences were brought under control, and no indigenous cases were detected in 2015.

Indigenous malaria cases in the WHO European Region, by country, 1990–2015



Source: National malaria control programme reports and WHO estimates

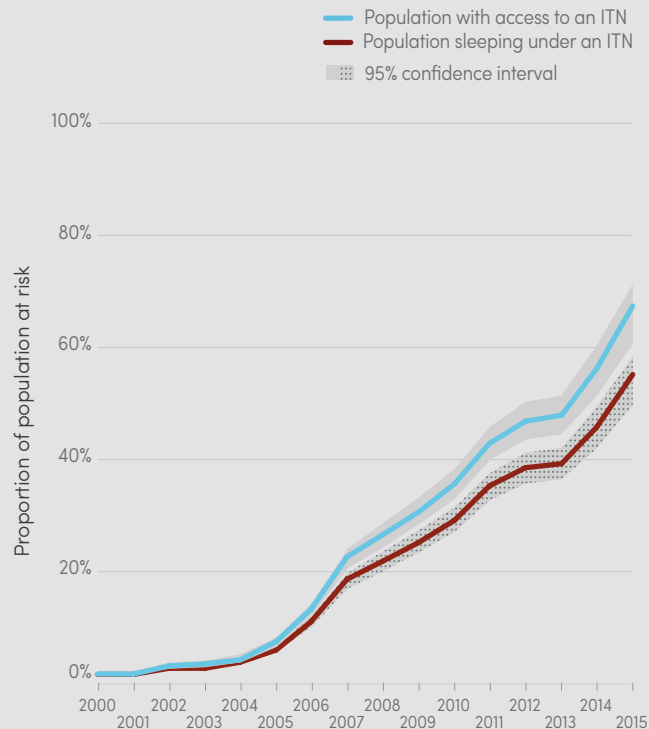


Insecticide-treated mosquito nets (ITNs)

The proportion of the population at risk of malaria in sub-Saharan Africa with access to and sleeping under an ITN has increased dramatically since 2000

The proportion of the population sleeping under an ITN increased from less than 2% in 2000 to an estimated 55% in 2015 (range: 50–58%). Ensuring access to ITNs has been critical to increasing the proportion of the population sleeping under an ITN. Nearly 500 million ITNs were delivered to countries in sub-Saharan Africa between 2013 and 2015, and the proportion of the population with access to an ITN increased to an estimated 67% in 2015 (range: 61–71%).

Proportion of the population at risk with access to an ITN and proportion sleeping under an ITN in sub-Saharan Africa, 2000–2015

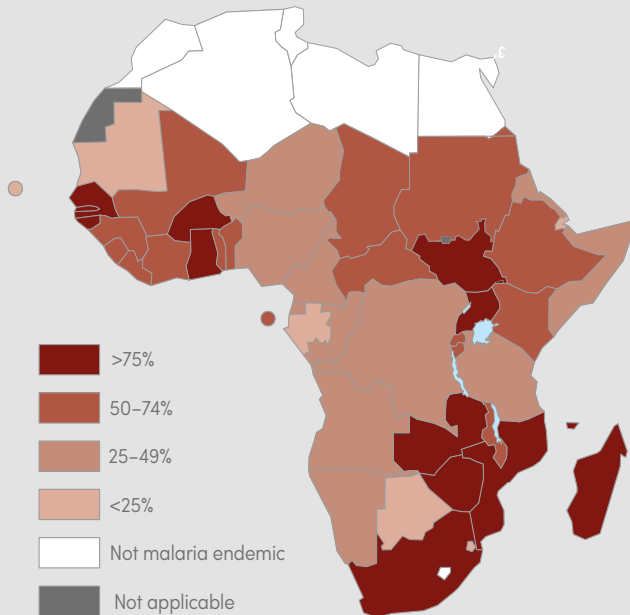


ITN, insecticide-treated mosquito net

Source: ITN coverage model from Malaria Atlas Project, with further analysis by WHO

Indoor residual spraying (IRS)

Percentage of the population protected by IRS or with access to ITNs in sub-Saharan Africa, 2014



IRS, indoor residual spraying; ITN, insecticide-treated mosquito net
Source: National malaria control programme reports and insecticide-treated mosquito net coverage model from Malaria Atlas Project, with further analysis by WHO

The proportion of the population at risk protected by IRS has declined in recent years

National malaria control programmes (NMCPs) often target only selected populations for IRS. The proportion of the population at risk protected by IRS declined globally from a peak of 5.7% in 2010 to 3.4% in 2014. Decreases were seen in all regions except the WHO Eastern Mediterranean Region. The WHO African Region had the largest number of persons and the largest proportion of the population at risk protected by IRS in 2014.

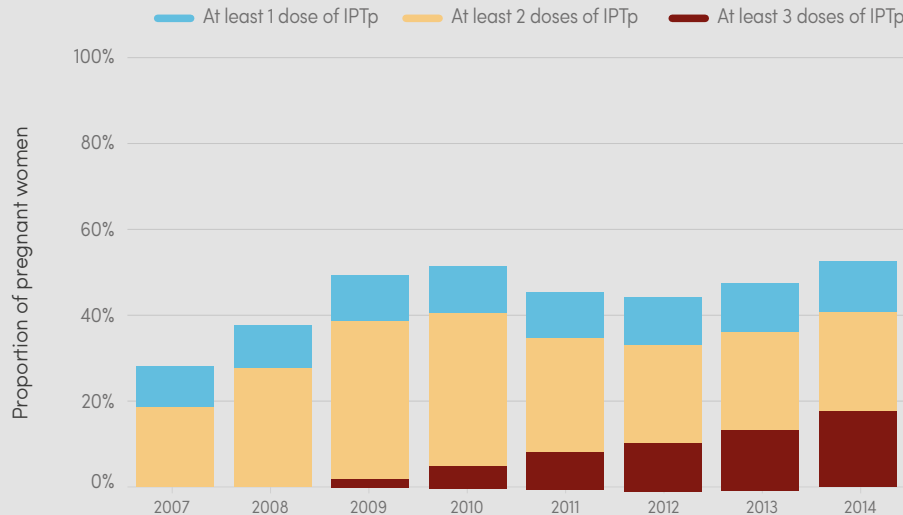


Chemoprevention in pregnant women

The proportion of pregnant women receiving three or more doses of preventive therapy for malaria has increased in recent years, but is still less than 20%

Since WHO revised its recommendation in 2012, the proportion of pregnant women receiving at least three doses of intermittent preventive treatment in pregnancy (IPTp) has increased. In 2014, an estimated 52% of eligible pregnant women received at least one dose of IPTp, 40% received two or more doses, and 17% received three or more doses.

Proportion of pregnant women receiving IPTp, by number of doses, sub-Saharan Africa, 2007–2014



IPTp, intermittent preventive treatment in pregnancy

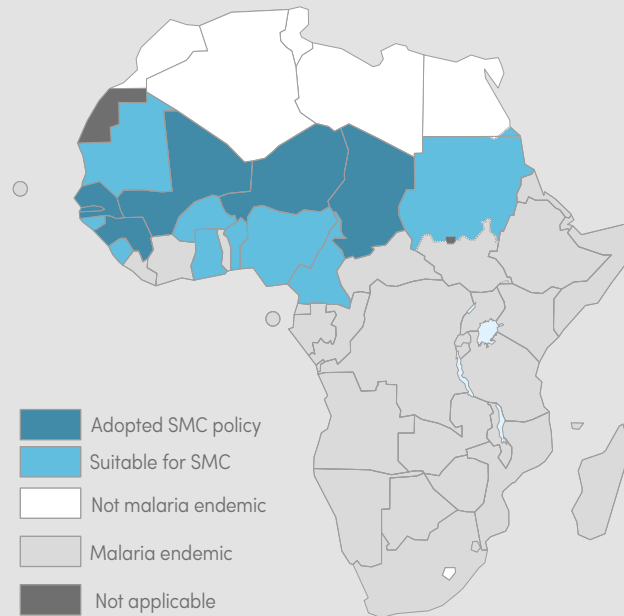
Source: WHO estimates using national malaria control programme reports and United Nations population estimates

Adoption and implementation of chemoprevention in children has been limited

As of 2014, six of the 15 countries suitable for seasonal malaria chemoprevention, and two outside the Sahel subregion, had adopted the policy (Congo and Togo). One country had adopted intermittent preventive treatment in infants (IPTi).

Pilot implementation of the first malaria vaccine (RTS,S/ASO1) was recommended by WHO's Strategic Advisory Group of Experts on Immunization (SAGE) and the Malaria Policy Advisory Committee (MPAC).

Countries suitable for SMC and where an SMC policy has been adopted (as of 2014)



SMC, seasonal malaria chemoprevention

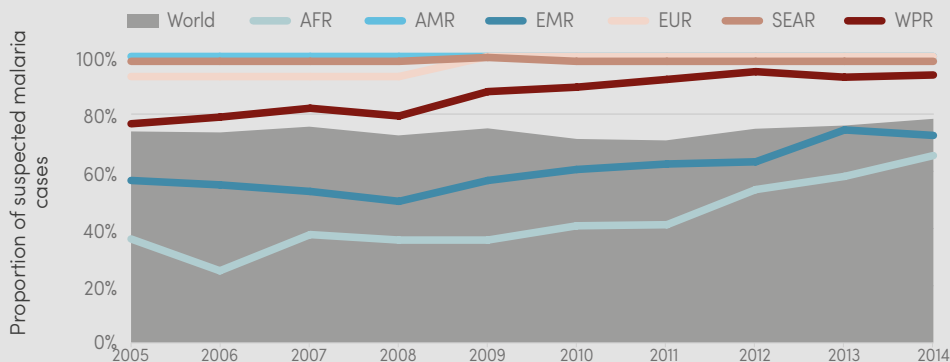


Diagnostic testing

The proportion of suspected malaria cases receiving a malaria diagnostic test has increased steadily since 2005

The proportion of suspected malaria cases presenting for care in the public sector that receives a malaria diagnostic test increased from 74% in 2005 to 78% in 2014. The global trend is dominated by countries in South-East Asia, particularly India. The WHO African Region has had the largest increase in levels of malaria diagnostic testing, from 36% of suspected malaria cases tested in 2005, to 41% in 2010 and 65% in 2014.

Proportion of suspected malaria cases attending public health facilities that received a diagnostic test, by WHO region, 2005–2014



AFR, African Region; AMR, Region of the Americas; EMR, Eastern Mediterranean Region; EUR, European Region; SEAR, South-East Asia Region; WPR, Western Pacific Region

Source: National malaria control programme reports

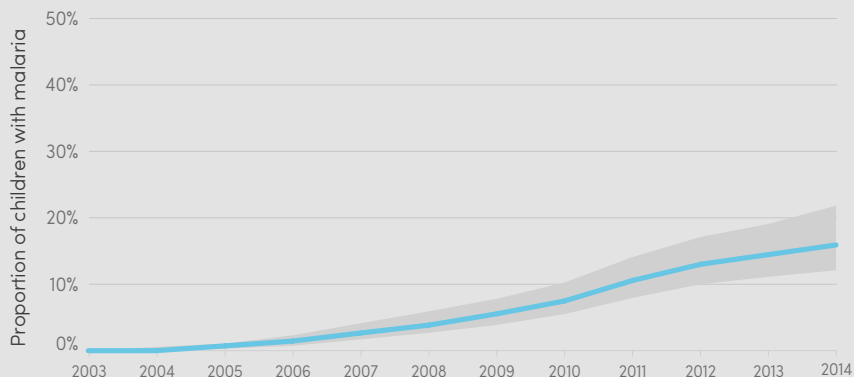
Treatment with artemisinin-based combination therapies (ACTs)

The proportion of malaria cases in sub-Saharan Africa receiving treatment with ACTs has increased, but is still less than 20%

The proportion of children in sub-Saharan Africa with *P. falciparum* malaria receiving ACT is estimated to have increased to 16% in 2014 (range: 12–22%). A major reason for this low percentage is that a high proportion of children with fever are not taken for care, or use the informal private sector, where they are less likely to obtain ACTs for treatment.

Although the proportion of malaria cases receiving an ACT has increased, the proportion treated with other antimalarial medicines has decreased since 2000. Hence, an increasing proportion of children with malaria who receive treatment are treated with an ACT (median 47% among 18 household surveys conducted in 2013–2015).

Estimated proportion of children aged under 5 years with confirmed *Plasmodium falciparum* malaria who received ACTs, sub-Saharan Africa, 2003–2014



ACT, artemisinin-based combination therapy

Source: Malaria treatment model from the Center for Applied Malaria Research and Evaluation (Tulane University), the Global Health Group (University of California, San Francisco) and the Malaria Atlas Project (University of Oxford).

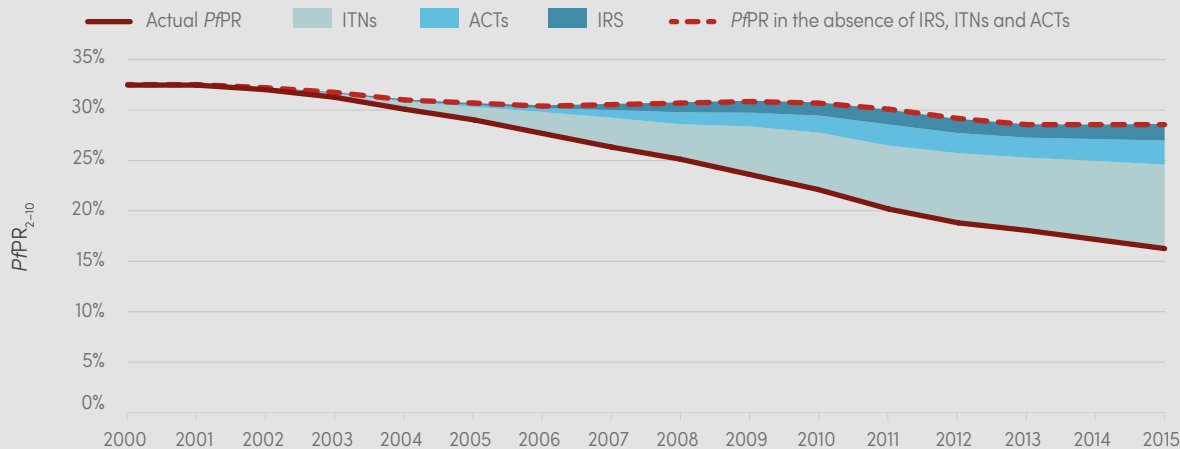


Impact of malaria interventions

Most of the decline in malaria in sub-Saharan Africa since 2000 can be attributed to malaria interventions

Parasite prevalence among children aged 2–10 years is estimated to have decreased from 33% in 2000 (range: 31–35%) to 16% in 2015 (range: 14–19%). It is estimated that malaria control interventions accounted for 76% of this decline, and for 70% of the reduced number of cases.

Proportion of children in sub-Saharan Africa infected with *Plasmodium falciparum* with and without interventions, 2000–2015



ACT, artemisinin-based combination therapy; IRS, indoor residual spraying; ITN, insecticide-treated mosquito net; PPR, *P. falciparum* parasite rate. The red line shows the actual prediction and the dotted red line a counterfactual prediction in a scenario without coverage by ITNs, ACT or IRS. The coloured regions indicate the relative contribution of each intervention in reducing PPR_{2–10} throughout the period.

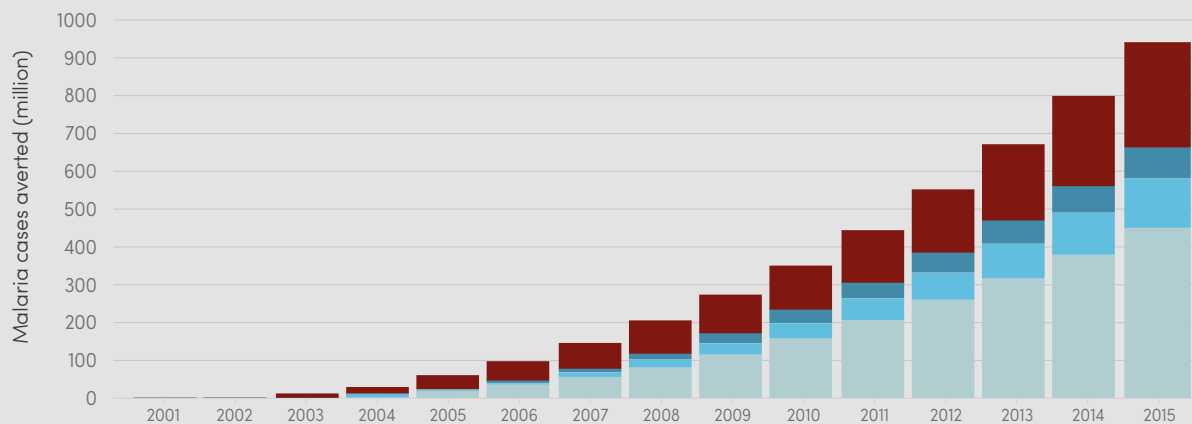
Source: Malaria Atlas Project

Malaria prevention and treatment measures are estimated to have averted more than 650 million malaria cases between 2001 and 2015

It is estimated that 1.2 billion fewer malaria cases and 6.2 million fewer malaria deaths occurred globally between 2001 and 2015 than would have been the case had incidence and mortality rates remained unchanged since 2000. In sub-Saharan Africa, it is estimated that 943 million fewer malaria cases occurred, and that malaria interventions were responsible for 70% of this reduction, averting 663 million malaria cases (range: 542–753 million).

Predicted cumulative number of malaria cases averted by interventions, sub-Saharan Africa, 2000–2015

■ Cases averted due to ITNs
 ■ Cases averted due to ACTs
 ■ Cases averted due to IRS
 ■ Total cases averted not attributable to IRS, ITNs, or ACTs



ACT, artemisinin-based combination therapy; IRS, indoor residual spraying; ITN, insecticide-treated mosquito net

Source: Malaria Atlas Project estimates of cases averted attributable to ITNs, ACTs, and IRS and WHO estimates of total cases averted

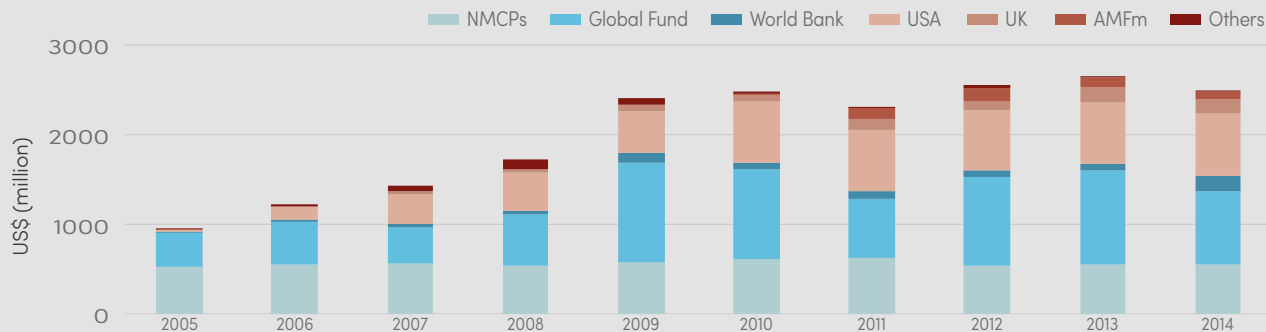


Financing of malaria control programmes

Investments in malaria control have increased substantially in the past decade

Global financing for malaria control increased from an estimated US\$ 960 million in 2005 to US\$ 2.5 billion in 2014. Of the total invested in 2014, international investments accounted for 78% (US\$ 1.9 billion) and governments of malaria endemic countries for 22% (\$550 million). However, international funding for malaria control decreased by 8% and domestic funding increased by 1% between 2013 and 2014.

Investments in malaria control activities by funding source, 2005–2014



AMFm, Affordable Medicine Facility–malaria; Global Fund, Global Fund to Fight AIDS, Tuberculosis and Malaria; NMCP, national malaria control programme; UK, United Kingdom; USA, United States of America.

Annual values have been converted to constant 2014 US\$ using the gross domestic product implicit price deflator from the USA in order to measure funding trends in real terms.

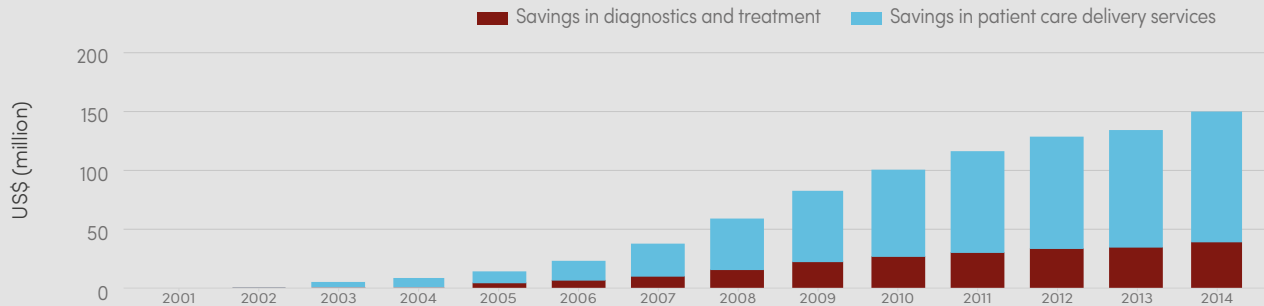
Source: ForeignAssistance.gov, Global Fund, NMCPs, Organisation for Economic Co-operation and Development creditor reporting system, the World Bank Data Bank

Cost savings due to malaria interventions

Malaria interventions led to health service savings of US\$ 900 million in sub-Saharan Africa between 2001 and 2014, owing to the reduced number of cases requiring treatment

Diagnosis and treatment of malaria incurs significant costs. The amount of money spent on diagnosing and treating malaria patients rose between 2001 and 2014 because of increasing use of diagnostic tests and ACTs. However, the increase has been curtailed by reductions in the number of malaria cases (as a result of malaria interventions). The reductions in malaria case incidence attributable to malaria control activities are estimated to have saved about US\$ 900 million on the malaria case management costs in sub-Saharan Africa between 2001 and 2014. These estimates consider only savings to health services, they exclude savings to households.

Provider savings in malaria case management costs attributable to expansion of malaria control activities, 2001–2014



Annual values have been converted to constant 2014 US\$ using the gross domestic product implicit price deflator from the USA in order to measure savings trends in real terms.

Source: Data on malaria cases averted as per Section 2.3 of the main report. Data on treatment-seeking behaviour, parasitological diagnosis and treatment coverage as per Sections 3.5 and 3.6 of the main report. WHO-CHOICE database on price estimates for outpatient care visit and inpatient bed stay; Management Science for Health International Drug Price Indicator Guide, and Global Fund Price and Quality Reporting Tool for commodity prices.

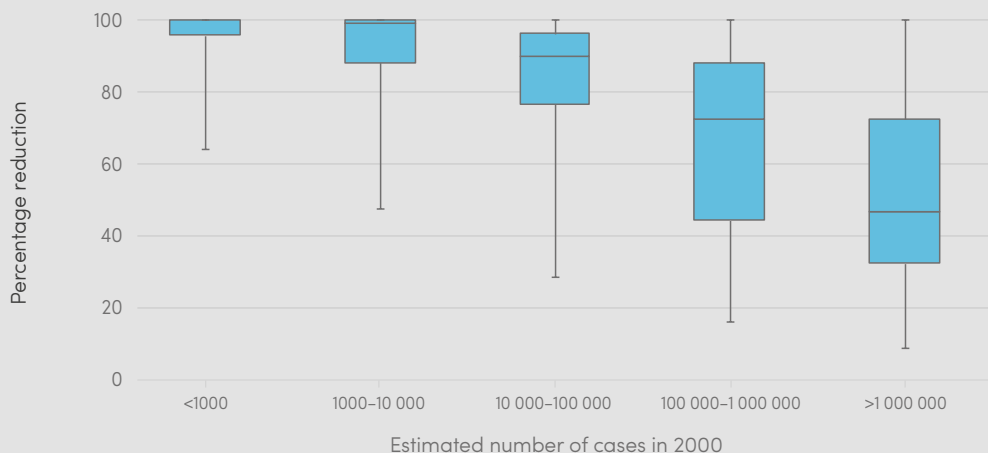


Challenges

Decreases in malaria incidence and mortality were slowest in countries that had the highest number of malaria cases and deaths in 2000

Despite the progress in reducing malaria cases and deaths, malaria remains a major public health problem in many countries of the world. It has been slowest to decline in countries that had the highest number of cases and deaths in 2000. Reductions in incidence need to be greatly accelerated in these countries if global progress is to be improved.

Reduction in malaria incidence in 2000–2015 versus estimated number of cases in a country in 2000



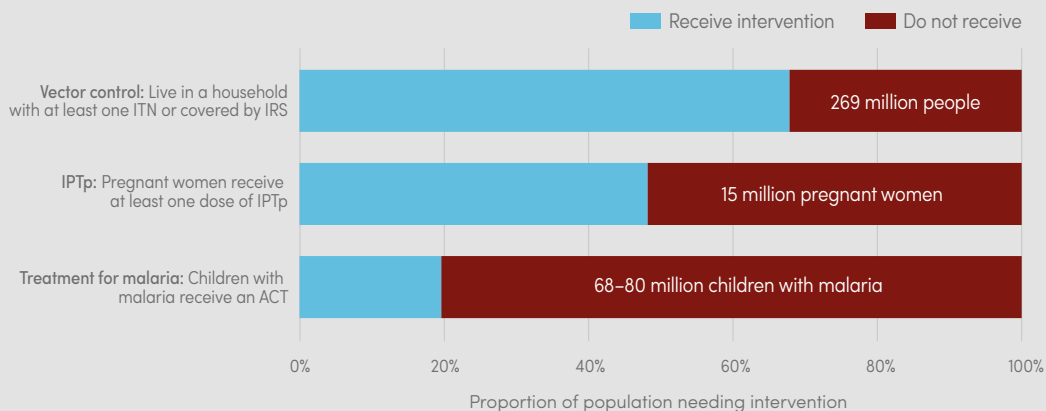
Two countries with increases (negative decreases) have been excluded from the chart.

Source: WHO estimates

Millions of people still do not receive the services they need

In sub-Saharan Africa in 2014, some 269 million of the 834 million people at risk of malaria lived in households without a single ITN or IRS, 15 million of the 28 million pregnant women at risk did not receive a single dose of IPTp, and between 68 and 80 million of the 92 million children with malaria did not receive ACT. The types of gaps and the problems to be addressed vary, depending on the intervention.

Proportion and number of people not receiving an intervention, sub-Saharan Africa, 2014



ACT, artemisinin-based combination therapy; IPTp, intermittent preventive treatment in pregnancy; IRS, indoor residual spraying; ITN, insecticide-treated mosquito net

Source: ITN coverage model from the Malaria Atlas Project, with further analysis by WHO; WHO estimates of IPTp coverage using NMCP reports and United Nations population estimates; malaria treatment model from the Malaria Atlas Project (University of Oxford), Center for Applied Malaria Research and Evaluation (Tulane University), Global Health Group (University of California, San Francisco)

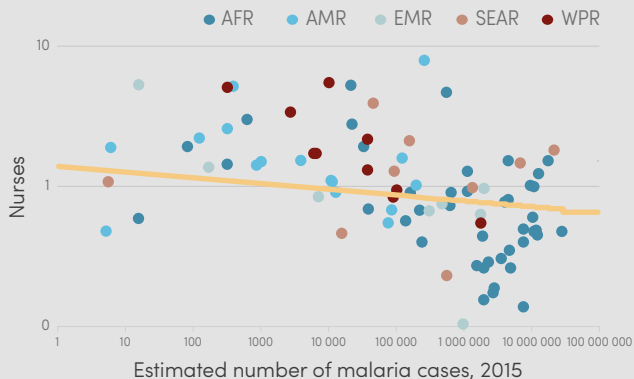


Challenges

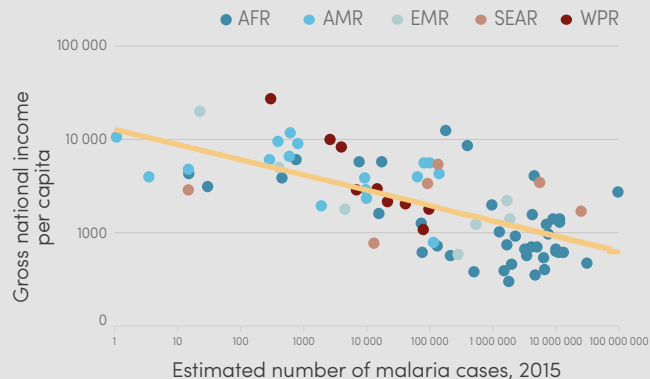
Malaria is concentrated in countries with weaker health systems and lower national incomes

Ratios of staff to population are lower in countries with the highest numbers of malaria cases. The ability to finance an expansion of the health services and to fill coverage gaps is constrained by lower national incomes in countries with the highest malaria burden.

Number of nurses per 1000 population (malaria endemic countries) versus estimated number of malaria cases*



Gross national income per capita versus estimated number of malaria cases, by WHO region, 2015



* Year of observation varies by country, ranging from 2005 to 2012

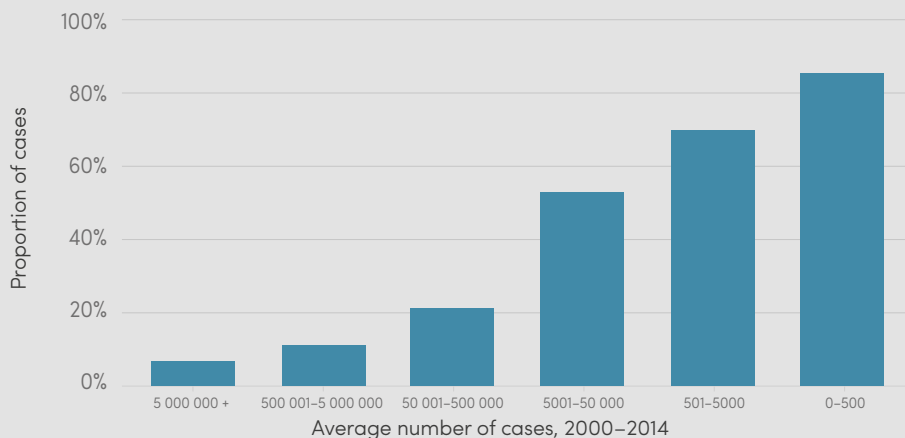
AFR, African Region; AMR, Region of the Americas; EMR, Eastern Mediterranean Region; SEAR, South-East Asia Region; WPR, Western Pacific Region

Source: WHO estimates and the World Bank Data Bank

***P. vivax* malaria is a significant public health issue in many parts of the world, and predominates in countries that are prime candidates for malaria elimination**

P. vivax is estimated to have been responsible for 13.8 million malaria cases globally in 2015, and to have accounted for about half the total number of malaria cases outside Africa. Severe cases and deaths due to *P. vivax* malaria have been reported from all endemic regions. Because of the difficulty in controlling *P. vivax*, its incidence has decreased more slowly than that of *P. falciparum* in locations where the two species coexist. *P. vivax* may then persist as the principal cause of malaria and pose the main challenge to malaria elimination. Indeed, *P. vivax* predominates in countries with the lowest incidence of malaria, accounting for more than 70% of cases in countries with fewer than 5000 reported cases each year.

Proportion of reported malaria cases due to *Plasmodium vivax*, countries with different average caseloads between 2000 and 2014



Source: National malaria control programme reports and WHO estimates



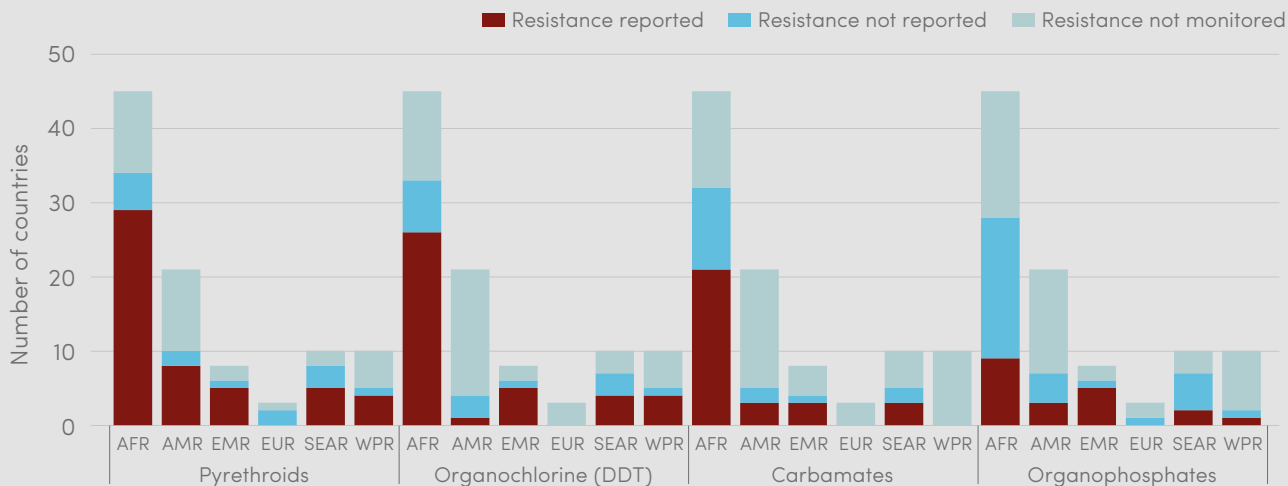
The effectiveness of insecticide-based vector control is threatened as malaria mosquitoes develop resistance to the insecticides used in ITNs and IRS

Of the 78 countries reporting any monitoring data since 2010, 60 reported resistance to at least one insecticide in one malaria vector population, and 49 reported resistance to insecticides from two or more insecticide classes. Pyrethroid resistance was detected in all major malaria vectors, with three quarters of countries that monitored this insecticide class in 2014 reporting resistance. However, long-lasting insecticidal nets remain effective, despite resistance.

Antimalarial drug resistance has substantial implications for malaria control and global public health

P. falciparum resistance to artemisinins has now been detected in five countries in the Greater Mekong subregion. Despite the observed changes in parasite sensitivity, patients continue to respond to combination treatment, provided the partner drug remains effective. The efficacy of artemether-lumefantrine in Africa and South America remains high, as does artesunate-amodiaquine in Africa. Artesunate-mefloquine requires vigilant monitoring in South-East Asia and South America. The efficacy of artesunate-sulfadoxine-pyrimethamine is compromised in areas with resistance to SP. The efficacy of dihydroartemisinin-piperazine is low in areas with existing piperazine resistance. Treatment or prophylactic failure with chloroquine for *P. vivax* malaria has been observed in 24 countries.

Insecticide resistance and monitoring status, by insecticide class and WHO region, 2010–2014



Reported use of class for malaria vector control, 2014

ITNs	42	19	8	3	10	10	–	–	–	–	–	–	–	–	–	–	–	–	–	–				
IRS	11	9	4	3	7	6	6	0	0	0	1	0	8	3	4	0	1	0	4	2	0	0	1	0

AFR, African Region; AMR, Region of the Americas; DDT, dichloro-diphenyl-trichloroethane; EMR, Eastern Mediterranean Region; EUR, European Region; IRS, indoor residual spraying; ITN, insecticide-treated mosquito net; SEAR, South-East Asia Region; WPR, Western Pacific Region

Source: National malaria control programme reports, African Network for Vector Resistance, Malaria Atlas Project, President's Malaria Initiative (United States), scientific publications





GLOBAL TECHNICAL STRATEGY FOR MALARIA 2016–2030



To address remaining and emerging challenges, WHO developed the Global technical strategy for malaria 2016–2030

The vision of WHO and the global malaria community is a world free of malaria. The *Global technical strategy for malaria 2016–2030* sets the most ambitious yet feasible targets for reductions in malaria cases and deaths since the malaria eradication era. It also provides a framework for developing programmes that are tailored to local circumstances, with the aim of accelerating progress towards malaria elimination.

Goals, milestones and targets of the *Global technical strategy for malaria 2016–2030* and Action and investment to defeat malaria 2016–2030

Vision	A world free of malaria			
	Goals	Milestones		Targets
		2020	2025	2030
1. Reduce malaria mortality rates globally compared with 2015	At least 40%	At least 75%	At least 90%	
2. Reduce malaria case incidence globally compared with 2015	At least 40%	At least 75%	At least 90%	
3. Eliminate malaria from countries in which malaria was transmitted in 2015	At least 10 countries	At least 20 countries	At least 35 countries	
4. Prevent re-establishment of malaria in all countries that are malaria free	Re-establishment prevented	Re-establishment prevented	Re-establishment prevented	

The *Global technical strategy for malaria 2016–2030* can be found at: http://www.who.int/malaria/areas/global_technical_strategy/en/



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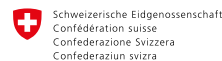
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“Target 6C of the MDGs – halting and beginning to reverse the global incidence of malaria by 2015 – has been achieved [...] Global progress in malaria control over the last 15 years is nothing short of remarkable.”

Dr Margaret Chan
Director-General
World Health Organization



Swiss Agency for Development
and Cooperation SDC



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