KEY MESSAGES

1. Malaria continues to strike hardest against pregnant women and children in Africa. Countries and their development partners should prioritize support for these two most-at-risk groups.

2. On a global scale, there was exceptional headway made in reducing the burden of malaria in the period 2000–2015 – proof that progress is possible. Many countries with a low burden of malaria are moving quickly towards elimination. However, the rate of progress has slowed in recent years, and critical targets will likely be missed.

3. To get back on track, stepped-up action is needed across all endemic countries, particularly in countries hardest hit by malaria.

4. New malaria-fighting tools and strategies will be critical to accelerate the pace of progress.

5. Stepped-up financing is also essential. In 2018, total funding for malaria control and elimination reached an estimated US$ 2.7 billion, falling far short of the US$ 5 billion funding target of the Global technical strategy for malaria 2016–2030.

6. Ultimately, universal health coverage is key to success. All people at risk of malaria – particularly pregnant women and children – must have access to the primary health care services they need to prevent, diagnose and treat this deadly disease.
KEY MESSAGE 1

Malaria continues to strike hardest against pregnant women and children in Africa. Countries and their development partners should prioritize support for these two most-at-risk groups.

Malaria infection during pregnancy carries substantial risks for the pregnant woman, her fetus and the newborn child

- Malaria infection in pregnancy compromises the mother’s health and can lead to her death. In 2018, an estimated 11 million pregnant women living in 38 countries with moderate-to-high transmission in sub-Saharan Africa were infected with malaria (29% of all pregnancies).

- Malaria in pregnancy also impacts the health of the fetus, which can lead to preterm birth and low birth weight, major contributors to neonatal and infant mortality. In 2018, an estimated 872,000 children in 38 African countries were born with a low birth weight due to malaria in pregnancy.

- The report shows a strong positive correlation between malaria and anaemia in children under the age of 5 living in sub-Saharan Africa. About 24 million children in the region were infected with the P. falciparum parasite in 2018; of these, 12 million had moderate anaemia and 1.8 million had severe anaemia. Severe anaemia is a major contributor to child mortality.

Estimated prevalence of exposure to malaria infection during pregnancy in moderate and high-transmission areas of sub-Saharan Africa, 2018

Coverage of key malaria control interventions for young African children has expanded

- Insecticide-treated nets (ITNs): WHO recommends that all children living in malaria-affected areas sleep under an ITN. In 2018, an estimated 61% of children under five living in sub-Saharan Africa slept under an ITN compared to 26% in 2010.

1. Deficiency in iron is thought to be the most common cause of anaemia
• **Seasonal malaria chemoprevention (SMC):** For children under 5 living in Africa’s Sahel subregion, WHO recommends seasonal malaria chemoprevention. In 2018, of the 31 million children living in SMC-eligible areas, 19 million (62%) were given this preventive malaria therapy during the high-transmission rainy season.

• **Intermittent preventive treatment in infants (IPTi)** is another WHO-recommended approach for protecting young African children in malaria-affected areas from disease and death. In 2019, Sierra Leone became the first country to roll out this effective prevention strategy.

• **Diagnosing malaria infection and providing prompt treatment** with an effective antimalarial are critical to reducing severe malaria-related disease and death. Based on surveys conducted in 29 sub-Saharan African countries, the percentage of children with a fever that received a diagnostic test in the public health sector reached 76% in the period 2015–2018 compared to 48% in the previous four-year period. This steep jump in coverage was due, in large part, to the greater availability of inexpensive and high-quality rapid diagnostic tests in the public sector.

The report also documents progress in protecting pregnant women in Africa from malaria using WHO-recommended tools

• **Insecticide-treated nets:** WHO recommends the use of insecticide-treated nets (ITNs) for all pregnant women living in malaria-affected areas of sub-Saharan Africa. In 2018, an estimated 61% of pregnant women in the region slept under an ITN, up from 26% in 2010.

• **Intermittent preventive treatment in pregnancy (IPTp):** WHO also recommends at least three or more doses of IPTp for all pregnant women living in malaria-affected areas in the region. In 2018, 31% of pregnant women in 36 African countries received the recommended three or more doses of IPTp, up from 22% in 2017 and 2% in 2010. Notably, Burkina Faso and United Republic of Tanzania reached IPTp coverage of more than 50% in 2018.

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2. IPTi has been recommended by WHO since 2010 following evidence of significant impact on clinical malaria incidence, severe anaemia and death among infants.

3. An estimated 50% of the overall population in sub-Saharan Africa slept under an ITN in 2018 compared to 29% in 2010.

4. WHO recommends IPTp with the antimalarial drug sulfadoxine-pyrimethamine. IPTp doses should be given at monthly intervals starting as early as possible in the second trimester during antenatal care visits.
Despite progress, critical gaps in access to core tools must be urgently addressed

- Approximately two thirds of pregnant women in Africa do not receive the recommended number of IPTp doses during their visits to antenatal care (ANC) facilities. Moreover, many women do not complete the recommended number of ANC visits over the course of their pregnancies. Improved quality of care and increased ANC attendance are missed opportunities which, if harnessed, could provide a much-needed boost in the fight against malaria.

- Access to health care for African children showing signs of a fever remains low. Based on surveys conducted in sub-Saharan Africa between 2015 and 2018, a high proportion of febrile children (36%) do not receive any medical attention.

**KEY MESSAGE 2**

On a global scale, there was exceptional headway made in reducing the burden of malaria in the period 2000–2015 – proof that progress is possible. Many countries with a low burden of malaria are moving quickly towards elimination. However, the rate of progress has slowed in recent years, and critical targets will likely be missed.

More countries with a low burden of malaria are nearing the goal of zero malaria

- In 2018, 49 malaria-endemic countries reported less than 10 000 cases of the disease, up from 40 countries in 2010. Twenty-seven countries had less than 100 cases – a strong indicator that elimination is within reach – up from 17 countries in 2010.

- In 2018, two countries were awarded the official WHO certification of malaria elimination: Paraguay and Uzbekistan. Two more countries – Algeria and Argentina – were certified malaria-free in 2019. The certification is granted when a country is able to prove, beyond a reasonable doubt, that the chain of indigenous malaria transmission has been interrupted for at least three consecutive years. Globally, a total of 38 countries and territories have achieved this milestone.

- At least 10 countries that are part of the WHO “E-2020” initiative are on track to reach the 2020 elimination milestone of the Global technical strategy for malaria 2016–2030 (GTS): Algeria, Belize, Bhutan, Cabo Verde, China, El Salvador, the Islamic Republic of Iran, Malaysia, Suriname and Timor-Leste. In 2015, all of these countries were malaria endemic; now they have either achieved zero malaria cases or are nearing the finish line.

There has been a continued decline in malaria cases and deaths in the Greater Mekong Subregion

- Across the six countries of this subregion – Cambodia, China (Yunnan Province), Lao People’s Democratic Republic, Myanmar, Thailand and Viet Nam – there was 76% reduction in malaria cases and a 95% drop in deaths in the period 2010 to 2018. Notably, the report shows a steep decline in cases of *P. falciparum* malaria, a primary target in view of the ongoing threat of antimalarial drug resistance.
• In 2018, Cambodia reported zero malaria-related deaths for the first time in the country’s history; China reported its second consecutive year of zero indigenous malaria cases; and Thailand reported a 38% drop in *P. falciparum* cases over the previous year.

**Through the global malaria response, millions of cases and deaths have been averted since 2000**

• For example, had case incidence and death rates remained at 2000 levels globally, there would have been an estimated 321 million cases of the disease in 2018 (vs. 228 million) and 995 000 deaths (vs 405 000).

**Comparison of current estimated malaria cases with expected cases had malaria incidence remained at 2000 levels globally**

**Comparison of current estimated malaria deaths with expected deaths had malaria incidence remained at 2000 levels globally**

**However, in recent years, global progress in reducing the rate of new infections has slowed**

• In 2018, there were an estimated 228 million cases compared to 231 million in 2017.

• The global incidence rate of malaria (number of cases per 1000 population) fell from 71 in 2010 to 57 in 2014 and remained at similar levels through 2018.\(^5\)

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\(^5\) A global malaria case incidence rate of 45 per 1000 population was required in 2018 in order to be on track to reach the GTS milestone of a 40% reduction in case incidence by 2020 (baseline 2015).
Global progress in reducing deaths has also slowed

- Estimated deaths due to malaria fell globally from 585,000 in 2010 to 405,000 in 2018. However, the rate of reduction of malaria mortality was slower in the period 2016–2018 than in the period 2010–2015.
- Children under the age of 5 accounted for two thirds (67%) of global malaria deaths in 2018.

The global burden of malaria remains heavily concentrated in the WHO African Region

- In 2018, the WHO African Region accounted for 93% of all cases in 2018. More than half of all cases were in six countries: Nigeria (25% of cases); Democratic Republic of the Congo (12%); Uganda (5%); Côte d’Ivoire, Mozambique and Niger (4% each).
- About 3.4% of all malaria cases were in the WHO South-East Asia Region and 2% in the WHO Eastern Mediterranean Region.

Progress towards critical global targets remains off track

- The Global technical strategy calls for reductions in case incidence and death rates of at least 40% by 2020, compared to a 2015 baseline. In view of recent trends, these two targets will likely be missed.
- Progress towards the malaria target of WHO’s Global Programme of Work, which aims to halve malaria deaths by 2023, and the target of the Sustainable Development Goals, which calls for ending malaria worldwide by 2030, is also off track.

Comparison of progress in malaria case incidence considering 3 scenarios: current trajectory (blue), GTS targets achieved (green) and worst-case scenario (red)
KEY MESSAGE 3

To get back on track, stepped-up action is needed across all endemic countries, particularly in countries hardest hit by malaria.

The country-led “High burden high impact” (HBHI) approach provides a response that can help ensure future success in malaria control

- HBHI was launched in 2018 by WHO and the RBM Partnership to End Malaria as a mechanism to accelerate progress in countries that carry the highest burden of the disease.
- The response is being led by 11 countries that, together, accounted for approximately 70% of the world’s malaria burden in 2017: Burkina Faso, Cameroon, Democratic Republic of the Congo, Ghana, India, Mali, Mozambique, Niger, Nigeria, Uganda and the United Republic of Tanzania.
- In 2018, there were an estimated 155 million malaria cases in these 11 countries. Two HBHI countries achieved significant reductions in malaria cases in 2018 over the previous year: India (2.6 million fewer cases) and Uganda (1.5 million fewer cases). Two countries reported significant increases: Nigeria (3.4 million more cases) and Ghana (0.5 million more cases).
- The HBHI approach is founded upon four pillars: political will to reduce the toll of malaria; strategic information to drive impact; better guidance, policies and strategies; and a coordinated national malaria response.
- Over the last year, HBHI countries and their development partners have been collecting and analysing malaria data to better understand the geographic distribution of the disease and the impact of specific actions taken against malaria. These analyses will enable countries to use available funds in a more effective, efficient and equitable way.
- By November 2019, the HBHI approach had been initiated in nine high burden countries in Africa. Countries have developed detailed activity plans to address the challenges revealed during the assessments.
- Other key response highlights from 2019 include the launch or strengthening of social mobilization and advocacy movements through the “Zero malaria starts with me” campaign and the initiation of a process for developing national malaria data repositories.
- An estimated US$ 9.4 billion in funding was directed to the 11 HBHI countries in the period 2010–2018, of which 82% came from international sources. With the exception of India, direct domestic malaria investments in HBHI countries remain low.

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KEY MESSAGE 4

New malaria-fighting tools and strategies will be critical to accelerate the pace of progress.

In September 2019, the WHO Director-General issued a “malaria challenge”, calling on the global health community to ramp up investment in the research and development of new malaria-fighting tools and approaches.

- Over the next few decades progress in the fight against malaria will likely be shaped by technological advances and innovations in new tools, such as new diagnostics and more effective antimalarial medicines.

Vector control

- A number of new tools, technologies and approaches for malaria vector control have been submitted to WHO for evaluation. If these tools demonstrate efficacy in controlling the disease, WHO will formulate new policy recommendations or amend existing ones to support their deployment in malaria-affected countries.

- Tools currently under evaluation include, for example, new types of insecticide-treated nets, spatial mosquito repellants, vector traps, gene-drive approaches and sugar baits designed to attract and kill Anopheles mosquitoes. See here for an overview.

Malaria vaccine

- In 2019, three countries – Ghana, Kenya and Malawi – introduced the RTS,S malaria vaccine in selected areas through a WHO-coordinated pilot programme. The vaccine has been shown through rigorous clinical trials to reduce four in 10 malaria cases in young children. Evidence and experience from the programme will inform future policy decisions on the vaccine’s potential wider deployment.

- The vaccine programme has been launched in partnership with Ministries of Health of the three countries, PATH, and GSK, the vaccine manufacturer. The programme is funded through contributions from Gavi, the Vaccine Alliance, the Global Fund and Unitaid.

KEY MESSAGE 5

Stepped-up financing is also essential. In 2018, total funding for malaria control and elimination reached an estimated US$ 2.7 billion, falling far short of the US$ 5 billion funding target of the the Global technical strategy for malaria 2016–2030.

- Over the period 2010–2018, nearly 70% of total malaria funding was provided by international sources. Governments of malaria-endemic countries contributed about 30% of total funding, with investments reaching US$ 0.9 billion in 2018.

- The United States of America contributed approximately 37% of total funding for malaria control and elimination for the period 2010–2018. The United Kingdom of Great Britain and Northern Ireland...
contributed about 9% of total funding, followed by France (4.5%), Germany (3.2%) and Japan (3.1%).

Funding for malaria control and elimination over the period 2010–2018 (% of total funding), by source of funds (constant 2018 US$)

• Approximately US$ 1 billion in malaria funding was channelled through the Global Fund in 2018.
• Approximately three quarters of total funding benefited the WHO African Region, followed by the WHO Region of the Americas (7%), the WHO South-East Asia Region (6%), the WHO Eastern Mediterranean Region and the WHO Western Pacific Region (5% each).
• In 2018, funding for basic research and product development reached US$ 663 million, marking the third consecutive year of increased funding and the largest annual investment in malaria R&D since its peak of US$ 676 million in 2009.

KEY MESSAGE 6

Ultimately, universal health coverage is key to success. All people at risk of malaria – particularly pregnant women and children – must have access to the primary health care services they need to prevent, diagnose and treat this deadly disease.

• Universal health coverage, with a well-functioning primary health system at its base, is the vital foundation to ending malaria worldwide and achieving the health-related Sustainable Development Goals.
**Integrated community case management**

- An estimated 36% of children do not access care with a trained medical provider. Integrated community case management (iCCM) is considered an effective strategy for bridging the gap in clinical care for three common childhood illnesses in sub-Saharan Africa – malaria, pneumonia and diarrhoea – in hard-to-reach and underserved communities.

- iCCM involves the use of trained community health workers to deliver health services to these communities. Although 30 countries now implement iCCM at different levels, its roll-out in most sub-Saharan African countries remains poor, mainly due to bottlenecks in health financing.

**Estimated malaria cases by WHO region, 2010–2018**

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<tr>
<th>Region</th>
<th>Lower 95% CI</th>
<th>Estimated total</th>
<th>Upper 95% CI</th>
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<tbody>
<tr>
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<td>4 000</td>
<td>3 000</td>
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<tr>
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</tr>
<tr>
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<td>13 700</td>
<td>17 400</td>
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<table>
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<th>Estimated total</th>
<th>Upper 95% CI</th>
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</thead>
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<td></td>
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</tr>
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<td>16 300</td>
<td>23 700</td>
</tr>
<tr>
<td>Estimated total</td>
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<td>15 700</td>
<td>24 100</td>
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<tr>
<td>Upper 95% CI</td>
<td>9 400</td>
<td>14 200</td>
<td>17 200</td>
</tr>
</tbody>
</table>

Ci: confidence interval; P. vivax: Plasmodium vivax; WHO: World Health Organization.
Why does this report include a special focus on the burden of malaria in pregnant women and children?

Malaria takes a particularly heavy toll on pregnant women and young children. Our analysis shows that, in 2018, an estimated 11 million pregnant women in sub-Saharan Africa were infected with malaria. This resulted in nearly 900,000 children born with a low birth weight. Globally, children account for nearly 70% of malaria-related deaths.

The report provides important insight – grounded in strong evidence – into what happens to a pregnant woman and her fetus when the mother is infected with malaria. For example, malaria infection during pregnancy can lead to anaemia in the mother, which can result in complications in pregnancy, premature birth and a low-birth-weight child. Children who are born preterm or with a low birth weight are at a very high risk of dying in their first few weeks of life.

Even when a healthy child is born, malaria infection in children can lead to severe malaria and, very often in the highest burden countries, severe malaria anaemia, which also puts the child at greater risk of death.

What are the reasons behind the substantial increase in coverage of preventive malaria therapy seen in 2018 compared to 2017?

WHO recommends at least three doses of intermittent preventive treatment in pregnancy (IPTp) for all pregnant women living in malaria-endemic areas of sub-Saharan Africa. In recent years, coverage of the first two doses of IPTp has increased steadily, though not at a rapid rate. Notably, this year’s report shows a significant jump of about 10 percentage points in coverage of the third dose of IPTp between 2017 and 2018.

The reason is two-fold. The first is that as WHO receives more data from countries, we have been able to analyse the situation more accurately. And the second is that some countries have put significant effort into scaling up this intervention over the last couple of years. Burkina Faso, Tanzania and a few other countries, for example, have reached significant levels of coverage of the third IPTp dose.

What are the remaining barriers to IPTp access?

IPTp is delivered through antenatal care clinics (ANC). Whenever a pregnant woman seeks ANC services, she is supposed to receive a dose of IPTp after her first trimester, as long as the doses are administered at monthly intervals.

The reasons for barriers are two-fold. First, access to ANC coverage is variable: in some countries it’s very high while in others it’s moderate or even low. Often you will see reasonably high coverage of IPTp during the first visit to an ANC clinic, but lower IPTp coverage as ANC visits taper off. As such, the biggest barrier to the scale-up of IPTp is insufficient ANC coverage and/or repeat ANC access.
The second barrier is linked to health worker practices and health systems issues. Our analysis shows that about 20% of women who are eligible for IPTp do not receive the drug when they visit an ANC clinic for the first time, either because the health worker does not prescribe it or the drug is not available.

**The report shows that investment in malaria basic research and product development has been increasing steadily over the past three years. Shouldn’t more research correlate to more gains in the fight against malaria?**

A lot of malaria research is done to provide evidence either on the way we implement malaria interventions, or to allow us to better understand the epidemiology of the disease. Some of this operational and epidemiological research can feed into programmes and have immediate impact.

However, investment in the discovery and development of new tools usually takes a long time to bear fruit. Fortunately, there are some promising tools in the pipeline. The first vaccine against malaria, RTS,S, is now being evaluated through a pilot implementation programme. New types of insecticide-treated nets to fight malaria-carrying mosquitoes are also being introduced. Continued investment in the research and development of new tools will be critical to reaching our common goal of a world free of malaria.

**How does WHO arrive at its estimates for cases in the World malaria report?**

WHO applies three methods for calculating estimates of malaria cases. One method uses routine data from countries without any adjustments; in other words, we use the data “as is”, directly from the country. This approach applies to countries that have a very low number of malaria cases, high-quality surveillance systems, and are near elimination.

The second method is for countries outside of sub-Saharan Africa, excluding Botswana, Ethiopia, Namibia and Rwanda, that have a good public health surveillance system but where a large proportion of patients seek care in the private sector or do not seek treatment at all. Here, adjustments for testing rates, reporting and treatment seeking rates are applied to the reported data.

The third method applies to most countries in the WHO African Region, where surveillance systems have been historically weak. To come up with a reliable estimate, we measure the relationship between parasite prevalence and case incidence within a specific area.

**More and more patients suspected of malaria are being seen and tested in public health facilities. Does this also mean they are getting the right treatment and cure?**

It’s a good question but one without an easy answer. We know that many patients seek care in the public sector. We also know what proportion of those patients are tested for malaria.

Although the evidence suggests that most of the patients who seek care for malaria end up receiving an effective artemisinin combination therapy, the actual quality of that treatment – for example, whether patients are given the right number of doses or whether they comply with the dosage regime – is difficult to determine from the data we currently have at our disposal. But we do know that the drugs available in nearly all malaria-endemic countries remain highly efficacious.
It’s important to note that, for young children in sub-Saharan Africa showing signs of a fever, access to health care remains far too low. According to country surveys conducted in recent years, 36% of febrile children in the region were not taken for care with a trained medical provider.

**Some malaria experts believe we can actually eradicate malaria by 2050. Why don’t the targets of the global malaria strategy include a time-bound goal for achieving a malaria-free world?**

The vision of our global strategy is a malaria-free world. The targets are actually very ambitious: reductions of at least 90% in malaria morbidity and mortality, and the elimination of malaria in at least 35 countries between 2015 and 2030 – that’s an average of at least two countries becoming malaria-free each year. So it’s a highly ambitious strategy.

The reason why we don’t have a time-bound goal is that with the current tools and current levels of investment, it’s unlikely we will achieve global eradication by 2030. At the present time, we don’t have an evidence base to show that malaria can be eradicated by 2050 with existing tools, even if very high coverage levels of those tools are achieved in all malaria-endemic settings.

According to the recently released executive summary of the WHO Strategic Advisory Group on Malaria Eradication, a successful approach to malaria eradication calls for focused effort in four areas. One of the highest priorities is a renewed research and development agenda. Other priorities include access to affordable, people-centred health services; a reliable, rapid and accurate surveillance and response system; and the development of national and subnational strategies tailored to local conditions.

**What do we need to do to get back on track to meet the goals of the global strategy?**

In the *World malaria report 2017*, the main message was that the fight against malaria was at a crossroads. The key message for 2018 was that it’s time to get back on track in the global response to the disease.

To get back on track, WHO and the RBM Partnership to End Malaria launched the “High burden to high impact” (HBHI) approach in 2018. The new approach essentially recognises the need for stepped-up action across all malaria-endemic countries, and particularly in the 11 countries carrying the highest burden of the disease. Together, these 11 countries account for nearly 70% of the global burden of malaria mortality and morbidity.

A number of countries have initiated the HBHI response and are rethinking their strategic planning, interventions and investment based on four response elements. These include galvanising political will to reduce the toll of malaria; better use of strategic information to drive impact; better policy guidance, policies and strategies; and improved coordination of the response within the country – between the ministry of health, the national malaria control programmes and local partners.

So, quite clearly, enhanced effort, a smarter way of doing business and better use of the tools at our disposal, including the data, are the best ways to get back on track to meet the GTS goals.
Are drug and insecticide resistance on the rise?

WHO works with all the malaria-endemic countries to monitor the levels of both drug and insecticide resistance. What we know, at the moment, is that while there is emerging resistance to some antimalarial drugs, particularly in the Greater Mekong Subregion, all current first-line drugs used by all malaria-endemic countries remain highly efficacious.

On insecticide resistance, we are seeing increasing levels of resistance to pyrethroids across all malaria-endemic countries. Current evidence suggests that nets treated with pyrethroid insecticides should continue to be used by communities to protect themselves against malaria. However, evidence has also shown that in many areas where mosquitos have developed resistance to pyrethroids, another type of net treated with a pyrethroid and a synergist (known as a pyrethroid-PBO net) provides improved impact against malaria; the scale-up of such nets is warranted in these areas.

What other threats could affect progress in malaria control?

In terms of other threats, we are closely monitoring an emerging issue whereby malaria parasites have developed the capacity to evade detection by the most commonly-used rapid diagnostic tests. This is a problem with high prevalence in Eritrea, and we are reviewing data from several other countries in Africa. The immediate threat in moderate-to-high transmission African countries is low – diagnostic tests still remain highly sensitive – but we are looking at the situation closely.

The single biggest threat in the fight against malaria, of course, remains funding. While the global community has done an excellent job in ensuring that funding is maintained – the recent replenishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria was the single largest replenishment in the Fund’s history, for example – we still see that financing levels for malaria remain relatively flat. Unless we do things better and smarter, we may only be able to sustain the gains already made. In some settings, even maintaining the gains will be a challenge amid massive population growth.

The World malaria report 2019 and all related material can be found at: https://www.who.int/malaria/publications/world-malaria-report-2019/en/