Mapping *Plasmodium falciparum* Mortality in Africa between 1990 and 2015

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**BACKGROUND**

Malaria control has not been routinely informed by the assessment of subnational variation in malaria deaths. We combined data from the Malaria Atlas Project and the Global Burden of Disease Study to estimate malaria mortality across sub-Saharan Africa on a grid of 5 km² from 1990 through 2015.

**METHODS**

We estimated malaria mortality using a spatiotemporal modeling framework of geolocated data (i.e., with known latitude and longitude) on the clinical incidence of malaria, coverage of antimalarial drug treatment, case fatality rate, and population distribution according to age.

**RESULTS**

Across sub-Saharan Africa during the past 15 years, we estimated that there was an overall decrease of 57% (95% uncertainty interval, 46 to 65) in the rate of malaria deaths, from 12.5 (95% uncertainty interval, 8.3 to 17.0) per 10,000 population in 2000 to 5.4 (95% uncertainty interval, 3.4 to 7.9) in 2015. This led to an overall decrease of 37% (95% uncertainty interval, 36 to 39) in the number of malaria deaths annually, from 1,007,000 (95% uncertainty interval, 666,000 to 1,376,000) to 631,000 (95% uncertainty interval, 394,000 to 914,000). The share of malaria deaths among children younger than 5 years of age ranged from more than 80% at a rate of death of more than 25 per 10,000 to less than 40% at rates below 1 per 10,000. Areas with high malaria mortality (>10 per 10,000) and low coverage (<50%) of insecticide-treated bed nets and antimalarial drugs included much of Nigeria, Angola, and Cameroon and parts of the Central African Republic, Congo, Guinea, and Equatorial Guinea.

**CONCLUSIONS**

We estimated that there was an overall decrease of 57% in the rate of death from malaria across sub-Saharan Africa over the past 15 years and identified several countries in which high rates of death were associated with low coverage of antimalarial treatment and prevention programs. (Funded by the Bill and Melinda Gates Foundation and others.)
MEASURING THE BURDEN OF MALARIA according to age and geographic area and over time is important for malaria-control programs and health care providers for planning, implementing, monitoring, and evaluating control and elimination efforts.1,2 The Malaria Atlas Project has produced high-spatial-resolution (5-km²) estimates of the prevalence of malaria infection (parasite rate) and clinical incidence rates in sub-Saharan Africa from 2000 through 2015.3 In parallel, the Global Burden of Diseases, Injuries, and Risk Factors Study (GBD), also known as the Global Burden of Disease Study, has produced national-level estimates of morbidity and mortality from malaria on an annual basis since 1990.4,5

To date, no high-spatial-resolution estimates of malaria mortality have been available. Understanding the spatial and temporal distribution of malaria deaths is important for measuring the effect of investments in malaria control, for which development assistance totaled $2.3 billion in 2015.6 Enhanced geographic data on disease burden will also better target populations that are disproportionately affected by malaria and in whom future prevention and treatment interventions have the potential for greatest benefit.

We integrated the work of the Malaria Atlas Project and the GBD 2015 to produce estimates of age-specific and sex-specific malaria mortality in sub-Saharan Africa for each 5-km² grid cell and for individual years from 1990 through 2015.

METHODS

OVERVIEW

We estimated malaria mortality by combining estimates of the following variables within a geospatial modeling framework: the clinical incidence of malaria at the level of a 5-km² grid, according to age and year; effective antimalarial drug treatment of clinical malaria cases at the level of a 5-km² grid, according to year; and the case fatality rate among untreated persons with malaria. Fig. 1 summarizes the estimation procedure.

We used simulation analysis to determine the uncertainty level in the final estimate of malaria mortality on the basis of the uncertainty levels of each previous estimation step. We elaborate on the estimation of these variables below; further details are provided in the Supplementary Appendix, available with the full text of this article at NEJM.org.
model, along with high-resolution gridded population maps, to generate 5-km² spatiotemporal estimates of the number of clinical malaria cases in each grid cell for each age group and year.

**EFFECTIVE ANTIMALARIAL DRUG TREATMENT**

We used a spatiotemporal model of geolocated survey data for antimalarial drug use in children with fever to estimate the year-specific coverage of any antimalarial drug at the level of a 5-km² grid. The country-specific and year-specific treatment efficacy of chloroquine and sulfadoxine–pyrimethamine was estimated with a spatiotemporal model of in vivo efficacy studies that were identified from the scientific literature and the World Health Organization (WHO) database of antimalarial drug resistance. For sub-Saharan Africa, we assumed no drug resistance for artemisinin-based combination therapy. We estimated the relative use of chloroquine, sulfadoxine–pyrimethamine, and artemisinin-based combination therapy in a given country in a given year using a spatiotemporal model of survey data for antimalarial drug use in children with fever, which was supplemented by program data for the supply of artemisinin-based combination therapy. The combination of these data provided an estimate of effective antimalarial drug coverage, which reflected the overall drug treatment rate; the relative use of chloroquine, sulfadoxine–pyrimethamine, and artemisinin-based combination therapy; and the corresponding year-specific and country-specific drug efficacy. These estimates were applied to the estimates of clinical malaria incidence to determine the number of untreated or ineffectively treated cases for each grid cell.

**MALARIA CASE FATALITY RATE**

The GBD systematically compiles and analyzes cause-of-death data from all available sources (vital statistics, verbal autopsy, registries, and surveillance, census, and survey data). For sub-Saharan Africa, cause-of-death data are primarily from verbal autopsy. The GBD list of causes uses categorical attribution of deaths to a single underlying cause, according to the principles outlined in the International Statistical Classification of Diseases and Related Health Problems (ICD). We estimated case fatality and death rates on the basis of this principle — that is, we did not include increased mortality from other causes associated with the presence of malaria (indirect effects of malaria on mortality from other causes). For each study data point (Table S4 in the Supplementary Appendix), after data processing for comparability and geolocating each study by latitude and longitude, we calculated the malaria cause fraction (i.e., the number of deaths attributable to malaria divided by all deaths in each study) and multiplied this number by the estimated national rate of death from any cause from the GBD to determine the rate of death from malaria. The malaria mortality for each data point was divided by the corresponding age, sex, year, and geolocated incidence of untreated or ineffectively treated malaria to determine the case fatality rate among untreated persons with malaria.

We modeled the logit of the case fatality rate in a mixed-effects regression with the log rate of death from any cause and sex as fixed effects and the site of the study as a random effect. Data in the regression analysis were weighted according to sample size. We predicted malaria mortality according to age, sex, and year by applying the estimated case fatality rate to the estimate of untreated incidence for each 5-km² grid cell. To ensure that the sum of cause-specific mortality was equivalent to all-cause mortality, we used the CoDCorrect algorithm to rescale the sum of national-level cause-specific estimates to equal national-level all-cause mortality.

**DATA ACCESS AND SHARING**

This study complied with the Guidelines for Accurate and Transparent Health Estimates Reporting (GATHER; http://gather-statement.org/). Researchers using GATHER agree to disclose definitions of health indicators, provide access to statistical source codes, and make data and analyses publicly available. GATHER is meant to aid in the replication of results and in collaboration. In keeping with GATHER, all data citations, code, analyses, and results associated with this study are available on either the Institute for Health Metrics and Evaluation website (http://ghdx.healthdata.org/gbd-2015) with respect to the analysis of mortality or the Malaria Atlas Project website (www.map.ox.ac.uk/gather-compliance/) with respect to the analysis of infection prevalence and clinical incidence.

**RESULTS**

**NATIONAL AND CONTINENTAL-SCALE TRENDS IN MALARIA MORTALITY**

From 1990 through 2000 in sub-Saharan Africa, despite declines in mortality from many other
causes, the estimated malaria death rate remained largely flat in West Africa and rose in Central Africa (Fig. 2A), events that were driven primarily by resistance to chloroquine. A comparison among the regions of Africa after 2000 shows a continent-wide decline in estimated death rates, although the decrease began earlier and more rapidly in East Africa before decelerating in recent years. In both Central and West Africa, declines were modest until 2005, but then the
Figure 3 (facing page). Estimated Number and Rate of Plasmodium falciparum Deaths in Sub-Saharan Africa in 2015.

Estimates are provided for each 5-km² grid cell within the previously defined limits of stable Plasmodium falciparum (Pf) transmission. Shown are the estimated number of deaths (Panels A, C, and E) and deaths per 10,000 population per year (Panels B, D, and F) per grid cell for children 4 years of age or younger (Panels A and B), those 5 to 14 years of age (Panels C and D), and persons 15 years of age or older (Panels E and F).

Both metrics display enormous heterogeneity across the continent and within individual countries, although such heterogeneity is more pronounced for the numbers of malaria deaths than for the rates. Notable are areas in which moderate-to-high estimated rates of death coincide with densely populated regions, leading to foci of a high estimated number of malaria deaths across, for example, much of Nigeria, southern and eastern Democratic Republic of Congo, Lake Victoria coastal regions, and parts of Malawi and Mozambique.

Comparing the maps of the numbers and rates of malaria deaths reveals distinct geographic patterns that convey different but complementary information. Regions with large numbers of deaths may not have the highest rates of death but nevertheless represent the need for concentration of resources and commodity provision to reduce disease burden. Conversely, many regions with very high mortality rates are associated with only moderate or low population densities but present challenges for preventive and vector-control activities. These comparisons are often apparent within a single country. In Nigeria, for example, the most densely populated southern regions contribute the largest share of estimated deaths, despite having lower estimated death rates than the more rural, higher-transmission areas to the north.

A comparison among age groups highlights the markedly higher vulnerability to death from malaria among children younger than 5 years of age, and this risk is reflected in both the highest rates and highest numbers of deaths across the continent in this age group. However, the share of estimated malaria deaths between children younger than 5 years of age and those 5 years of age or older varies considerably according to geographic region (Fig. 4A). This variation highlights...
the use of these estimates for informing malaria control and treatment strategies that are tailored to the demographic structure of local malaria burdens. Such efforts will become increasingly important as the malaria burden is further reduced and shifts from children toward adults (Fig. 4B). As transmission declined between 2000 and 2015, the share of annual malaria deaths in children 4 years of age or younger and in those 5 to 14 years of age decreased (from 78.7% to 73.5% and from 6.7% to 4.8%, respectively), and the share in persons 15 years of age or older increased (from 14.6% to 21.7%). An expanded set of mapped estimates according to age group and year is provided in Figs. S2 and S3 in the Supplementary Appendix.

TARGETING MALARIA-CONTROL STRATEGIES

Despite illustrating the progress in reducing the burden of malaria, our maps also reveal large swaths of Africa where estimated malaria mortality remains high and the coverage of prevention and treatment remains low, which shows the potential to save hundreds of thousands more lives by further scaling up malaria control. Efforts to localize malaria control currently do not use detailed geographic descriptions of case rates. Fig. 5 shows the regions of highest estimated risk of death from malaria and low coverage of drug treatment and insecticide-treated bed nets in 2015. For drug treatment, areas with the highest estimated mortality (>20 malaria deaths per 10,000) and low antimalarial drug coverage (<30%) are concentrated in the southern half of Mali; the border areas between Mali, Burkina Faso, Niger, Benin, and Nigeria; west Guinea; southeast Democratic Republic of Congo; and various hotspots in Niger, Cameroon, Central African Republic, Angola, and Ivory Coast (Fig. 5A). Areas with lower estimated malaria mortality (10 to 20 malaria deaths per 10,000) and low drug coverage (<30%) encompass much of West Africa, Central African Republic, and Democratic Republic of Congo, as well as parts of Angola, Mozambique, and Zambia. For insecticide-treated bed nets, coverage is relatively higher, as expected; however, areas with the highest estimated mortality (>20 malaria deaths per 10,000) and low coverage of insecticide-treated bed nets (<50% of people at risk sleeping under an insecticide-treated bed net) remain in focal areas throughout West and Central Africa, notably in Guinea, Burkina Faso, Niger, Nigeria, Cameroon, and Angola21 (Fig. 5B). Figure 5 also highlights areas

Figure 4. Age Pattern of Malaria Mortality in 2015.

Panel A shows the estimated percentage of all malaria deaths in 2015 that occurred in children 4 years of age or younger in each 5-km² pixel in sub-Saharan Africa. Panel B shows the relationship between estimated all-age death rates per pixel (x axis) and the estimated percentage of all malaria deaths in children 4 years of age or younger (y axis). Each pixel is plotted with the density of pixels indicated by the color shading (with highest density in red). The solid and dashed lines indicate the mean and 95% confidence intervals, respectively, of a locally estimated scatterplot-smoothed (loess) regression used here to visualize the central tendency of this relationship.
DISCUSSION

Because data on malaria mortality remain challenging to define and collect, such data are relatively sparse in sub-Saharan Africa. Here, we have developed an approach that leverages data on the prevalence of malaria and clinical incidence (and relationships between these metrics) to generate more detailed subnational estimates of malaria mortality in sub-Saharan Africa and how rates of death have changed before and during the recent era of malaria-control efforts.

The declines in estimated malaria mortality across the continent support the value of the recent global push to control the disease. The ability to audit in detail where control efforts have and have not yielded declines can also identify case studies to further inform efforts needed to reach the new Sustainable Development Goal target to end the epidemic of malaria by 2030.22 At the same time, the historical trend in estimated malaria mortality in the 1990s, which was driven by chloroquine resistance, serves as a stark warning. Existing gains and future effects could be reversed if artemisinin resistance is not managed appropriately. Furthermore, given the central role of insecticide-treated bed nets in reducing the burden of malaria during the past decade, pyrethroid resistance will also need to be managed carefully.

Our estimates further highlight that the residual burden of deaths from malaria remains intolerably large and that the scope for enhanced control is substantial.21 The examples provided here of identifying high-risk areas that have low coverage of interventions form the basis for much more sophisticated targeting of prevention and treatment efforts. This potential for increased efficiency and effectiveness of programmatic efforts is critical in a climate of plateauing development assistance for health.6 With the generation of estimates at a level of 5 km², targeting could be carried out at the level of individual health facility catchments or villages or aggregated to any desired level at district, province, national, or international levels.

The provision of age-specific maps facilitates targeting not just according to geographic area but also according to demographic strata. The variable age pattern in the share of estimated malaria deaths — ranging from more than 80% of deaths at death rates of more than 25 per 10,000 to less than 40% at levels below 1 per 10,000 among children younger than 5 years of age makes it critical to target prevention strategies更有针对性。
age — also highlights the importance of malaria-control programs that can adapt to an older target population as malaria control is scaled up and disease burden reduced. This changing age profile of burden will probably affect clinical management such as drug treatment.

As for previous rounds of annual estimates, our estimates of total malaria mortality across the continent in 2015 are somewhat higher than those presented by the WHO for that year, although we estimated similar proportional declines in both rates and numbers of deaths during the 2000–2015 period. Both estimation processes incorporate the same underlying spatiotemporal malaria parasite rate and clinical-incidence predictions, but differences stem from the mortality data that are included and the modeling.

Our analysis allows detailed subnational depiction of malaria mortality in Africa, but it is important to recognize a number of limitations. First, sparse data with a reliance on verbal autopsy remain the norm for causes of death in sub-Saharan Africa. Our estimates depend on the accuracy of verbal autopsy, which is notably lower than medical certification of causes of death.

Increased precision of future estimates may be realized by integrating hospital-based data on malaria case fatality rates. Second, our estimates quantify malaria mortality according to ICD rules; future efforts could include rates of death from other causes that are increased by malaria infection. Third, we relied on national-level rates of death from any cause (with the exception of Kenya) to determine the case fatality rate. No systematic analysis of subnational variation in all-cause mortality rates according to age, sex, and time is currently available. This assumption will bias our estimates if there is a correlation between the fraction of malaria deaths observed in the study data and subnational variation in all-cause mortality. Finally, the time resolution of our estimates is limited to calendar years. Strong seasonal patterns exist for malaria burden as well as the coverage of interventions. Producing monthly estimates would better assist decision makers in timely planning, implementation, and monitoring of malaria control.

Substantial progress has been made in reducing the burden of malaria, but a large unfinished agenda remains. The risk of death from malaria is a complicated function of environmental, demographic, and programmatic factors that can result in highly localized patterns of risk. Data on the geographic and temporal distribution of the risk of death from malaria and its associated factors are important in the planning, implementing, and refining of control strategies to reach the goal of eradicating malaria.

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Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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