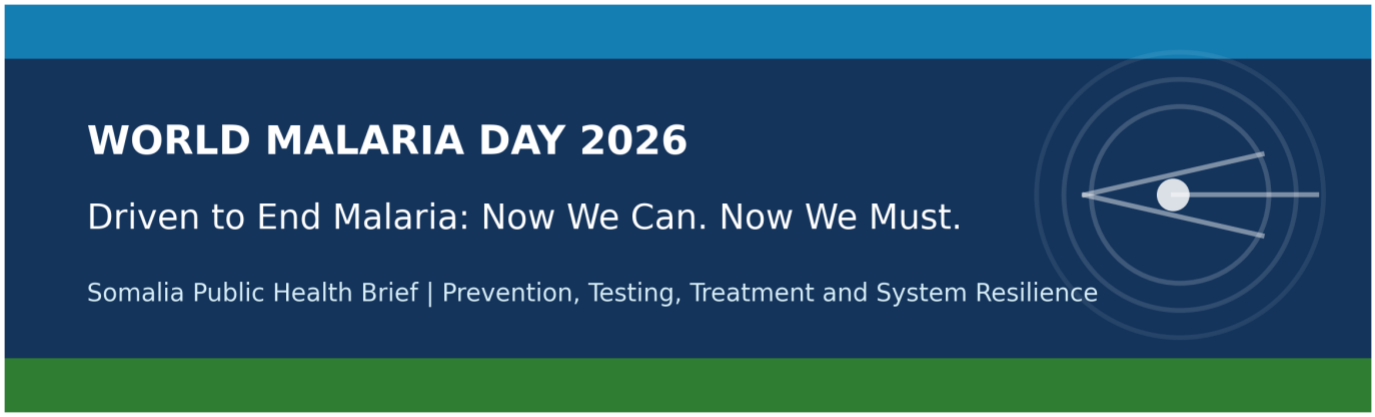

Summary of Public Health, Surveillance, and Health Systems for World Malaria Day 2026: Dedicated to Eliminating Malaria in Somalia.

Prevent bites. Test every fever. Treat confirmed malaria. Protect progress.

Core message

Malaria is preventable, diagnosable, treatable and curable. No child, pregnant woman, family or community should lose life or livelihood when effective prevention, testing and treatment are available.

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Driven to End Malaria: Now We Can. Now We Must.

25 April 2026

Data Interpretation Note

This brief intentionally distinguishes routine reported surveillance data from WHO-modeled estimates. Reported cases and deaths represent the data captured by the health system. Modeled estimates, on the other hand, approximate the true burden by accounting for underdiagnosis, underreporting, limited access to care, and incomplete mortality registration.

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Structured Overview

Section	Content
1	Executive summary and public message
2	What malaria is and how it is transmitted
3	How the public can identify malaria and danger signs
4	Diagnosis and treatment principles
5	Somalia morbidity, mortality and surveillance interpretation
6	Recent trends, regional position and global context
7	Current threats: climate, displacement, urban vectors and resistance
8	Vaccines and future preparedness
9	Action agenda for households, facilities, policy makers and partners

1. Executive Summary

Malaria remains a clear indicator of public health performance. It is both preventable and treatable, yet it can cause rapid illness, death, household impoverishment, and strain on health services. For Somalia, World Malaria Day 2026 serves as a reminder of the progress made and a call to address the gaps that continue to facilitate malaria transmission, underdiagnosis, and underreporting.

The 2026 global theme, “Driven to End Malaria: Now We Can. Now We Must,” encapsulates the central message for Somalia. Scientific advancements, including improved diagnostics, effective artemisinin-based combination therapies, next-generation vector control tools, and WHO-recommended malaria vaccines, are progressing. However, these tools will only save lives if effectively delivered through robust primary health care, reliable supply chains, responsive surveillance, community trust, and sustainable financing.

Somalia has demonstrated measurable progress. WHO Somalia reported a decline in malaria prevalence in the most affected areas from 20.1% in 2015 to 4.1% in 2023. Incidence reached 3.4% in 2022 before increasing to 4% in 2023 due to drought and floods. Nevertheless, the country

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remains vulnerable. A 2026 WHO/Health Cluster public health analysis revealed a 59% increase in malaria caseload from 8,080 cases in 2024 to 12,847 cases in 2025. This increase was attributed to heightened mosquito vector density, displacement, overcrowding, limited primary health care access, and low awareness.

The most crucial policy lesson is that malaria is not solely a mosquito-borne issue. It also encompasses health system, climate, displacement, poverty, and equity challenges. Somalia's response must therefore integrate household prevention, early diagnosis, appropriate treatment, environmental and vector control measures, robust routine reporting, and private sector involvement.

.

GLOBAL CASES 2024	GLOBAL DEATHS 2024	AFRICAN REGION SHARE
282M	**610K**	**95%**
WHO estimate across 80 countries [2]	A slight increase from 2023 [2]	Cases and deaths in 2024 [2]

SOMALIA REPORTED CASES	SOMALIA ESTIMATED CASES	SOMALIA ESTIMATED DEATHS
32,983	**1.01M**	**2,592**
Confirmed cases reported in 2024 [3]	WHO modelled 2024 burden [3]	WHO modelled 2024 burden [3]

Interview line

"Somalia is not a minor malaria country in its region. It is among the high burden malaria countries in the Eastern Mediterranean Region, and malaria control must remain a national public health priority."

2. What Is Malaria?

Malaria is a serious infectious disease caused by Plasmodium parasites. In Africa and Somalia, Plasmodium falciparum is the predominant and most virulent species. According to Somalia's National Malaria Strategic Plan, P. falciparum accounts for over 90% of malaria cases in the country [5].

From a public health perspective, malaria is not transmitted through contaminated food, poor air quality, or ordinary person-to-person contact. Its primary mode of transmission occurs when an

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infected female Anopheles mosquito bites an individual, introducing malaria parasites directly into the bloodstream.

Although malaria is both preventable and treatable, prompt intervention is essential. Early symptoms can resemble other febrile illnesses, and untreated P. falciparum infections may quickly develop into severe disease, especially among children under five, pregnant women, displaced populations, travellers, and individuals with compromised immune systems [2].

How malaria is transmitted

Transmission dimension	Public explanation
Primary route	Bite of an infected female Anopheles mosquito.
Not the usual route	Malaria does not usually spread like flu, COVID 19 or measles.
Rare routes	Blood transfusion, contaminated needles, or mother to child transmission can occur but are uncommon compared with mosquito borne transmission.
Somalia seasonality	Transmission often follows the spring rains (May August) and autumn rains (December January), with higher risk in riverine and southern areas and unstable epidemic prone transmission in some northern and central areas [5].

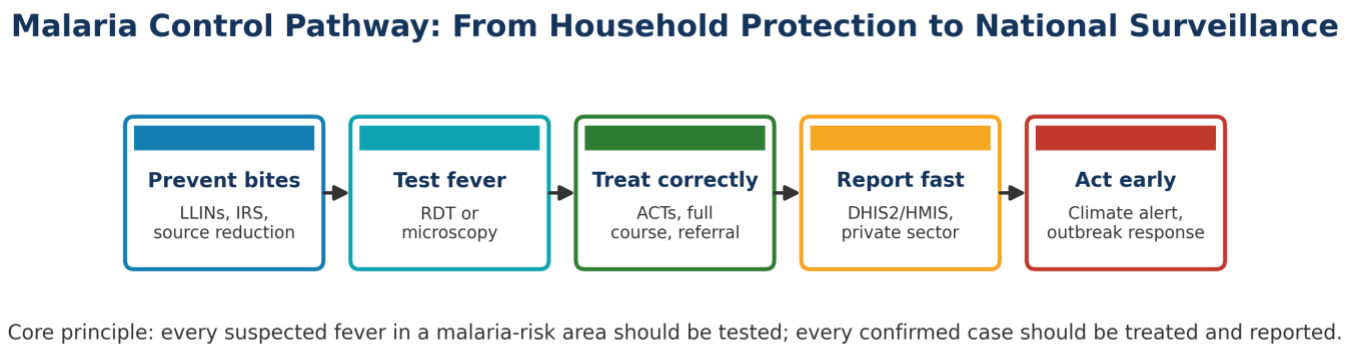

Figure 1. Malaria control pathway: from prevention to surveillance and early response.

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3. How Can the Public Identify Malaria?

The most crucial public health instruction is straightforward and practical: any fever in a malaria-endemic region should be tested. Individuals should refrain from making assumptions, delaying medical attention, or self-medicating. Testing safeguards the individual patient, ensures the efficacy of medications, and facilitates the early detection of outbreaks within the country.

Clinical area	Key signs and symptoms
Common symptoms	Fever; chills; sweating; headache; body pain; joint pain; nausea; vomiting; loss of appetite; weakness; tiredness; dizziness.
Children may also show	Poor feeding; irritability; unusual sleepiness; reduced activity; inability to play normally.
Danger signs requiring urgent care	Convulsions; confusion or loss of consciousness; repeated vomiting; difficulty breathing; severe weakness; inability to sit, drink or breastfeed; yellow eyes; dark urine; severe anaemia; fever in pregnancy; fever in a child under five.

Public warning

"Do not wait for malaria to become severe. Fever plus malaria risk should trigger testing within 24 hours."

4. Diagnosis: Test Before Treatment

WHO recommends that suspected malaria should be confirmed with parasite based diagnostic testing, either microscopy or a rapid diagnostic test, before treatment where testing is available [2]. This principle is especially important in Somalia because fever may also be caused by respiratory infections, dengue, measles, cholera related dehydration, urinary infection, sepsis or other conditions.

Testing safeguards the patient and the health system. Treating without testing can waste medicines, miss the true cause of illness, distort surveillance data and increase the risk of drug resistance.

Diagnostic tool	Explanation and health system value
Rapid Diagnostic Test (RDT)	A small blood test, often from a finger prick, that can provide quick results and support early treatment decisions.
Microscopy	A blood slide examined under a microscope. It can confirm parasites and may provide additional information on species and parasite density where capacity exists.

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Diagnostic tool	Explanation and health system value
Quality assurance	RDT and microscopy systems require training, supervision, quality control, stock management and reliable reporting.

Treatment and drugs

Malaria is treatable, but the right medicine must be given after testing, at the correct dose and for the full course. Artemisinin based combination therapies (ACTs) remain central to effective treatment for P. falciparum malaria [2].

Somalia's National Malaria Strategic Plan states that artemether lumefantrine is recommended as first line treatment for uncomplicated malaria across all species, while dihydroartemisinin piperaquine is used as second line treatment for uncomplicated falciparum malaria. The same strategic plan reinforces the need for mandatory parasitological testing of presumptive malaria cases [5].

Severe malaria is a medical emergency. Patients with danger signs require urgent facility based care, referral when needed and appropriate injectable treatment followed by oral ACT when clinically suitable.

Public advisory	Message
Do	Get tested early; take the full course exactly as prescribed; return to care if fever persists; prioritize children under five and pregnant women.
Do not	Do not buy random antimalarial medicines without testing; do not stop treatment when fever improves; do not share incomplete medicines; do not use counterfeit or expired drugs.

5. Somalia Malaria Morbidity and Mortality Data

Somalia's malaria burden should be interpreted through two complementary lenses: routine reported surveillance data and WHO modelled burden estimates. The first describes what has been captured by health facilities and surveillance systems; the second estimates the likely true burden after accounting for under diagnosis, under reporting, limited access to care and incomplete mortality registration.

Indicator	Latest value	Year	Interpretation
Reported confirmed malaria cases	32,983	2024	Confirmed cases reported through the health sector.

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Indicator	Latest value	Year	Interpretation
WHO estimated malaria cases	1,012,760	2024	Estimated true burden after adjustment for under reporting and access gaps.
Estimated case uncertainty range	542,000 1,752,000	2024	Likely range around the WHO point estimate.
Estimated malaria incidence	53.3 per 1,000 population at risk	2024	Calculated from WHO estimated cases and population denominator.
Reported population at risk	17,964,914	2024	Routine surveillance denominator in Annex 4I.
High risk population	5,890,605	2024	Population living in higher transmission risk areas.
Low risk population	12,074,309	2024	Population living in lower transmission risk areas.

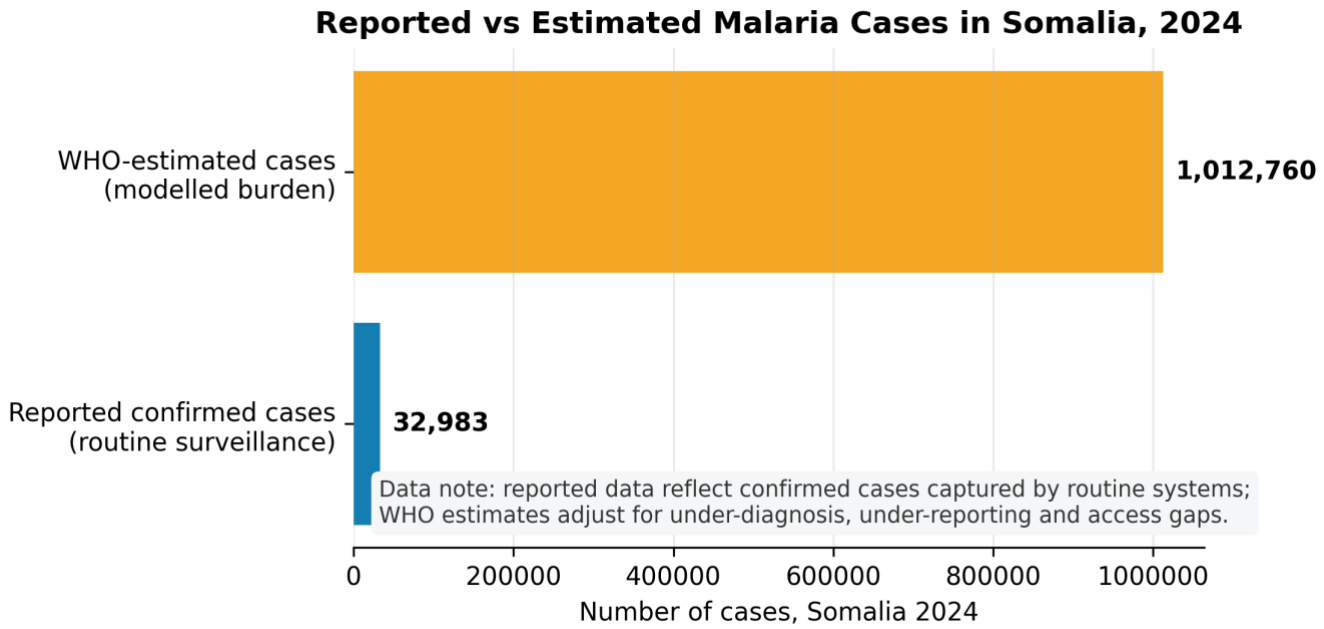

Figure 2. Reported versus estimated malaria cases in Somalia, 2024.

Indicator	Latest value	Year	Interpretation
Reported malaria deaths	1	2024	Deaths reported through routine surveillance.
WHO estimated malaria deaths	2,592	2024	Estimated true mortality burden.
Estimated death uncertainty range	930 5,370	2024	Likely range around the WHO estimate.
Estimated malaria mortality rate	13.6 per 100,000 population at risk	2024	Calculated from WHO estimated deaths and population denominator.

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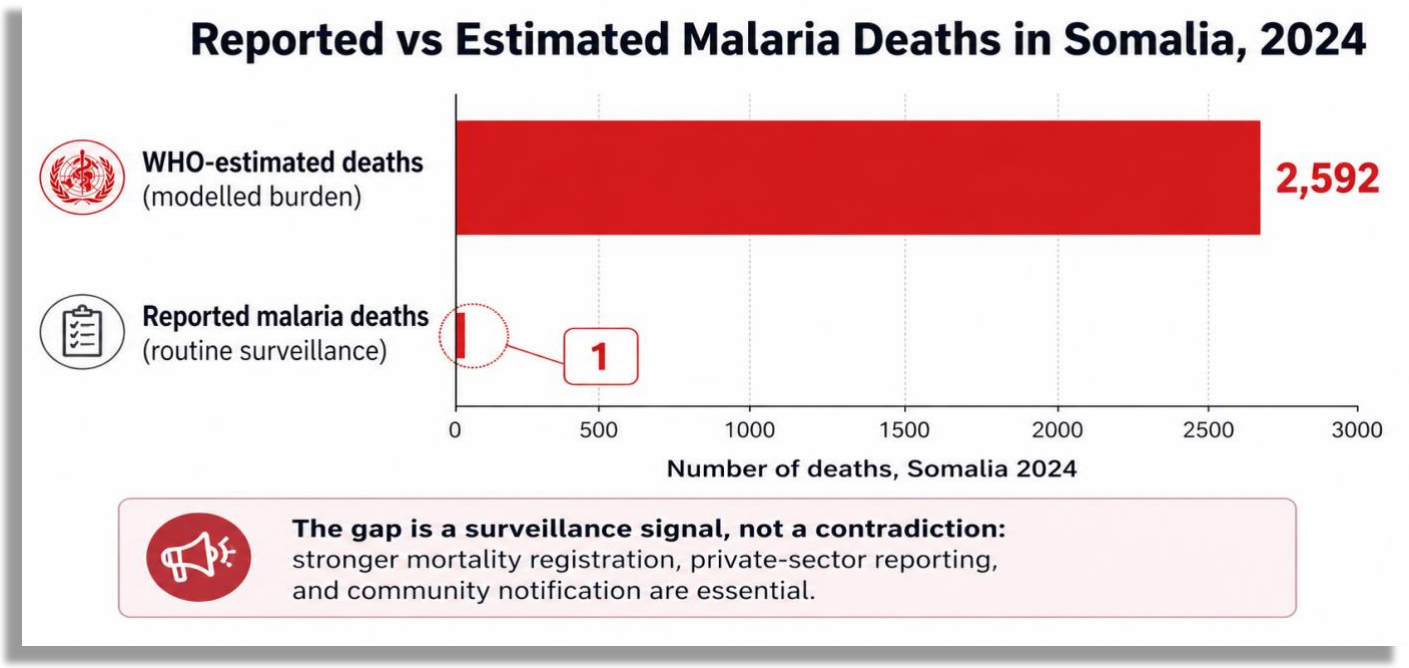

Figure 3. Reported versus estimated malaria deaths in Somalia, 2024.

"In 2024, Somalia reported just over 32,000 confirmed malaria cases and one malaria related death through routine surveillance. However, WHO modelled estimates suggest the true burden may be much higher, at about 1 million cases and around 2,600 deaths. This gap highlights the urgent need to strengthen testing, reporting, private sector notification, community surveillance and mortality registration."

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6. Recent Trends, Regional Position and Global Context

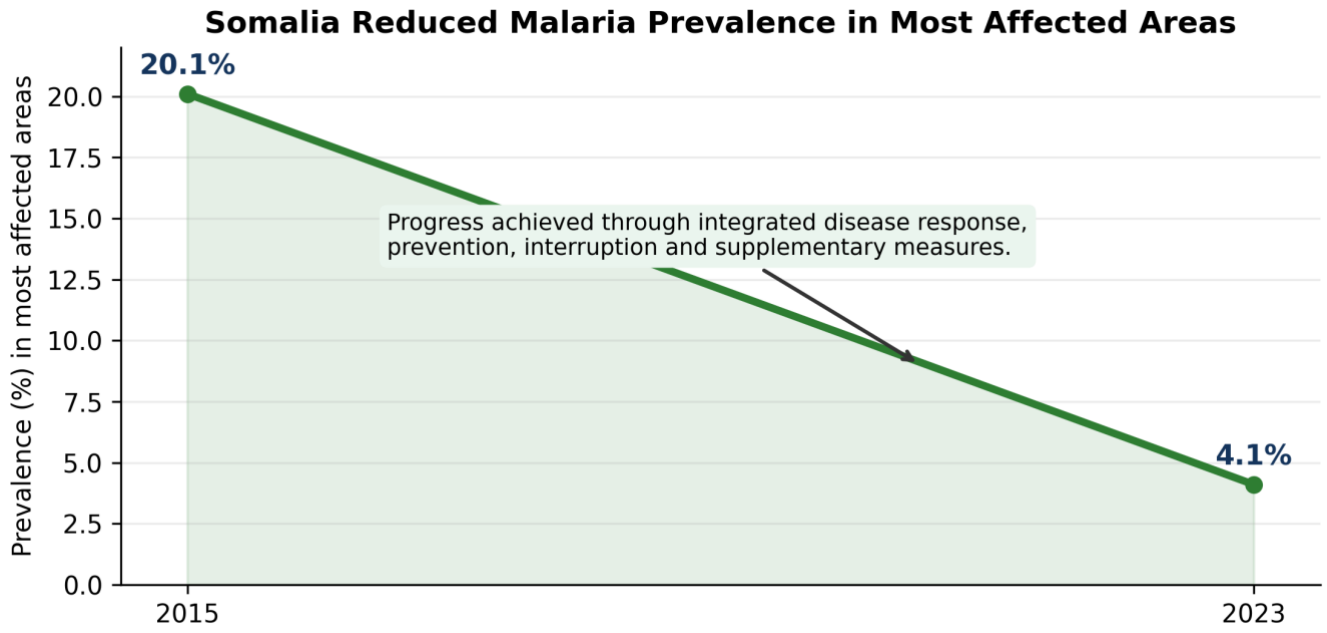

Figure 4. Decline in malaria prevalence in Somalia's most affected areas, 2015 2023.

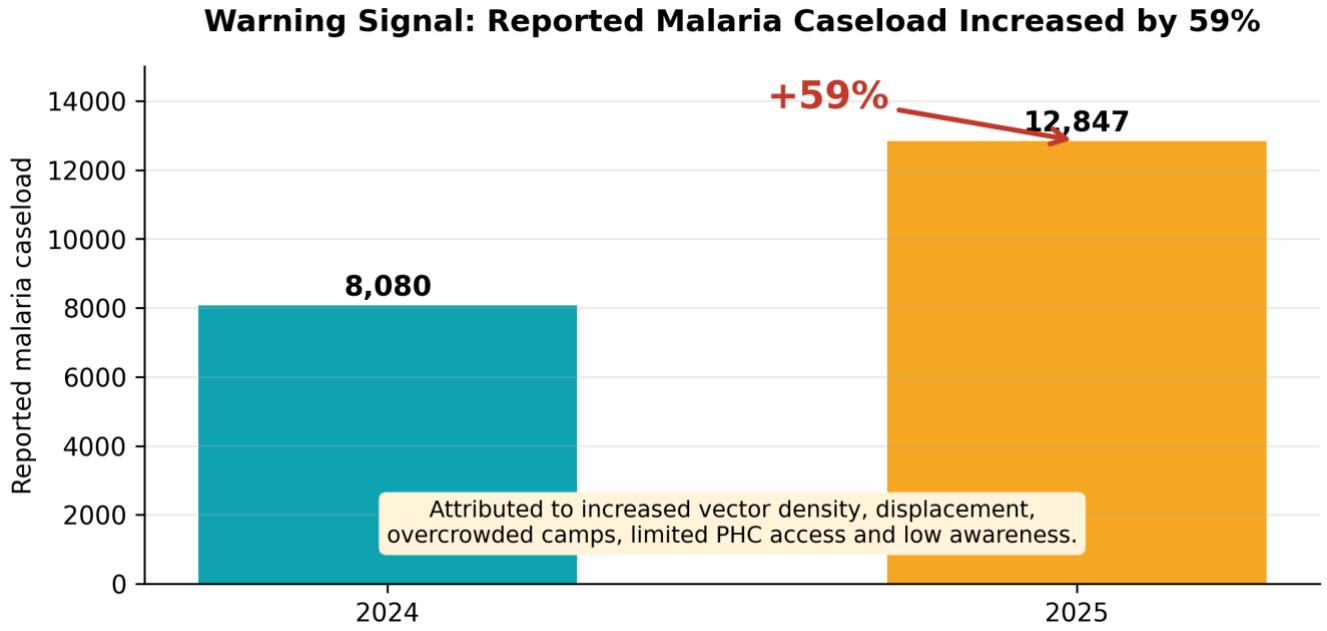

Figure 5. Recent warning signal in reported malaria caseload, 2024 2025.

Somalia has achieved important progress, but the situation remains fragile. WHO Somalia reported that malaria prevalence in the most affected areas decreased from 20.1% in 2015 to 4.1% in 2023; the malaria programme reduced disease incidence to 3.4% in 2022, but incidence increased to 4% in 2023, partly due to droughts and floods [4].

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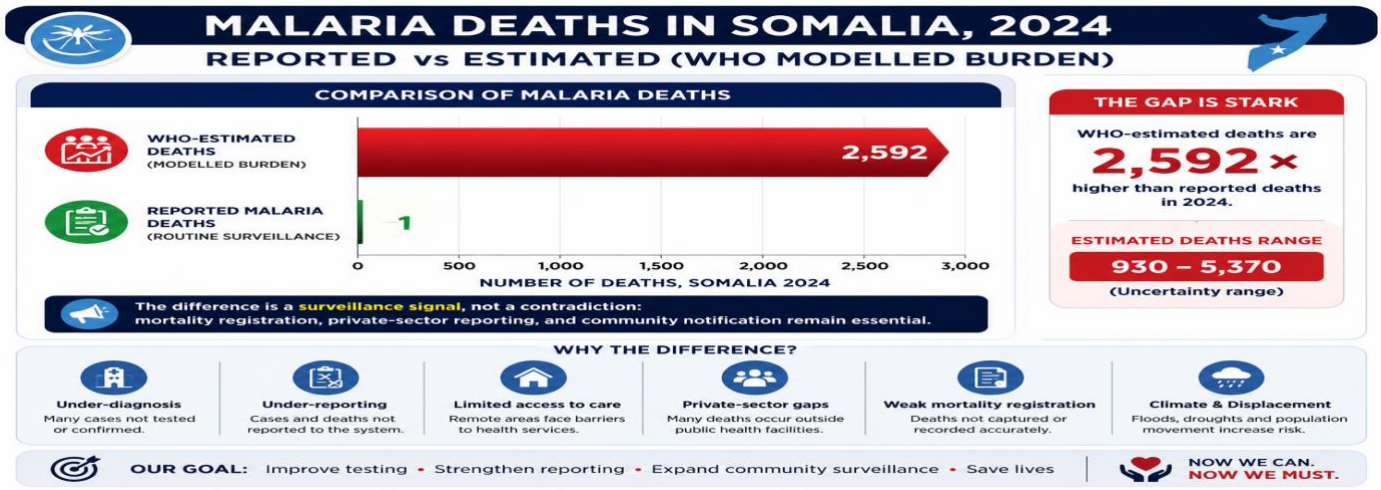
A more recent WHO/Health Cluster Somalia public health situation analysis reported a 59% increase in malaria caseload from 8,080 cases in 2024 to 12,847 cases in 2025, attributed to increased mosquito vector density, especially in Puntland and Somaliland, as well as displacement, overcrowded camps, limited access to primary health care and low awareness [6].

At the global level, WHO estimated 282 million malaria cases and 610,000 malaria deaths in 2024. The African Region accounted for about 95% of both cases and deaths, while children under five accounted for approximately three quarters of malaria deaths in the Region [2].

Level	Key message	Interpretation
World	282 million cases; 610,000 deaths in 2024	Malaria remains a major global health threat despite being preventable and treatable.
African Region	95% of cases and 95% of deaths	The Region bears the largest share of global malaria burden.
Somalia	32,983 reported confirmed cases; 1.01 million WHO estimated cases	Routine surveillance captures only part of the likely burden.
Eastern Mediterranean Region	Somalia is among high burden malaria countries	Malaria must remain a regional and national priority.



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7. Current Threats in Somalia

Threat	Why it matters
Climate shocks	Drought followed by floods can increase mosquito breeding, interrupt services and trigger outbreaks. WHO Somalia linked the 2023 rise in incidence partly to drought and floods [4].
Displacement and mobility	Nomadic communities, IDPs, refugees and cross border movement increase exposure through overcrowding, inadequate shelter, limited mosquito net use and restricted access to care.
Urban malaria vector	Somalia detected Anopheles stephensi, an invasive urban malaria vector, in several districts. This raises concern for cities where water storage, construction sites and poor drainage can support breeding [4].
Diagnostic challenges	WHO Somalia reported a P. falciparum strain that is difficult to detect with usual RDTs, highlighting the importance of quality assurance and diagnostic surveillance [4].
Drug and insecticide resistance	Global concerns about artemisinin partial resistance and insecticide resistance require continued therapeutic efficacy monitoring, rational treatment and updated vector control strategies [2].
Supply chain fragility	RDT and ACT stockouts can lead to presumptive treatment, delayed care and avoidable severe disease.

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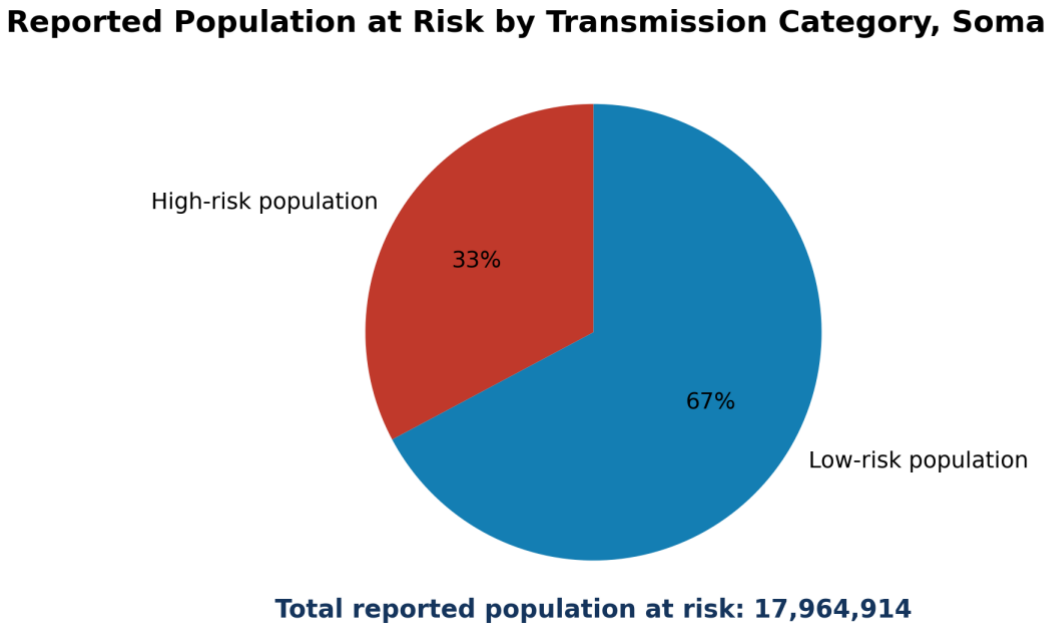

Figure 6. Reported population at risk by high and low risk categories, Somalia 2024.

8. Malaria Vaccines and Somalia Preparedness

Malaria vaccines are a major scientific advance, particularly for protecting children, but they do not replace mosquito nets, testing, treatment, environmental management or surveillance. They add another layer of prevention.

WHO states that both RTS,S and R21 malaria vaccines are safe and effective in preventing malaria in children. Both vaccines reduced malaria cases by more than 50% during the first year after vaccination in phase 3 trials; a fourth dose prolongs protection. WHO also reports that more than 10 million children per year are targeted for malaria vaccination across 25 African countries [7].

For Somalia, the appropriate public message is evidence based preparation rather than premature generalization: identify high risk districts, assess epidemiological eligibility, strengthen cold chain and routine immunization systems, engage communities, ensure financing and integrate vaccination with nets, diagnosis, treatment and surveillance.

Readiness area	Somalia preparation requirement
Prioritization	Use burden, seasonality, transmission intensity and vulnerability data to identify eligible high risk districts.
Delivery system	Strengthen routine immunization, cold chain, microplanning and defaulter tracing before introduction.

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Readiness area	Somalia preparation requirement
Community trust	Communicate that vaccines complement, rather than replace, nets, testing and treatment.
Integration	Link vaccine planning with UHC, PHC, child health, nutrition, malaria surveillance and emergency preparedness.

9. What Should Be Done Next?

Somalia's next phase should be practical, integrated and measurable. The emphasis should be on protecting households, strengthening facilities, improving surveillance and financing the system functions that convert tools into lives saved.

Audience	Priority actions
Public and households	Sleep under insecticide treated nets every night; seek testing within 24 hours of fever; complete treatment as prescribed; remove stagnant water; cover water containers; protect pregnant women and children under five; avoid self medication and counterfeit drugs.
Health facilities	Test every suspected case; treat confirmed cases according to national guidelines; refer severe malaria urgently; report cases promptly through HMIS/DHIS2; prevent RDT and ACT stockouts; strengthen private sector notification.
National policy and partners	Intensify surveillance in high risk and epidemic prone districts; strengthen Anopheles stephensi surveillance; use climate and rainfall data for early warning; sustain LLIN campaigns and targeted IRS; strengthen cross border coordination; invest domestic resources; prepare a vaccine introduction roadmap.
Health systems integration	Embed malaria control within UHC, primary health care, maternal and child health, emergency preparedness, health financing, procurement, community health and digital surveillance reforms.

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Core indicators for the interview and programme monitoring

Indicator	Purpose
Malaria incidence	New cases per 1,000 population at risk.
Confirmed cases	Cases confirmed by RDT or microscopy.
Test positivity rate	Proportion of tested suspected cases that are positive.
Malaria deaths and case fatality rate	Measures clinical severity, access to care and quality of management.
Suspected fever cases tested	Measures adherence to test before treatment policy.
Confirmed cases treated per guidelines	Measures quality of case management.
RDT and ACT stockout rate	Measures supply chain reliability.
LLIN ownership and use	Especially among children under five and pregnant women.
IRS coverage	Coverage in targeted areas.
Pregnancy indicators	ANC attendance, malaria testing in pregnancy and prevention where indicated.
Outbreak response time	Time from signal detection to investigation and response.
Private sector reporting	Proportion of private providers reporting confirmed cases.

"Malaria is not only a mosquito problem; it is a health system, climate, poverty, displacement and equity problem. Somalia has shown that progress is possible, but progress must be protected. Our call is clear: prevent mosquito bites, test every fever, treat confirmed malaria correctly, protect pregnant women and children, strengthen surveillance and invest in a malaria free Somalia. Now we can. Now we must."

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[1] World Health Organization. World Malaria Day 2026: Driven to End Malaria: Now We Can. Now We Must. 25 April 2026.

[2] World Health Organization. Malaria fact sheet. Updated 4 December 2025.

[3] World Health Organization. World Malaria Report 2025 Annexes: Annex 4H (population denominator and estimated malaria cases/deaths), Annex 4I (reported malaria cases by health sector), Annex 4L (reported malaria deaths), 2000 2024 and 2024 datasets.

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Figures in this brief were checked against WHO 2025 malaria fact sheet, WHO World Malaria Report 2025 annexes, WHO Somalia/EMRO updates, the Somali National Malaria Strategic Plan, WHO/Health Cluster Somalia public health situation analysis and WHO malaria vaccine Q&A. Values should be updated when new official Ministry or WHO datasets are released.