The United Republic of Tanzania

Ministry of Health

The National Malaria Strategic Plan

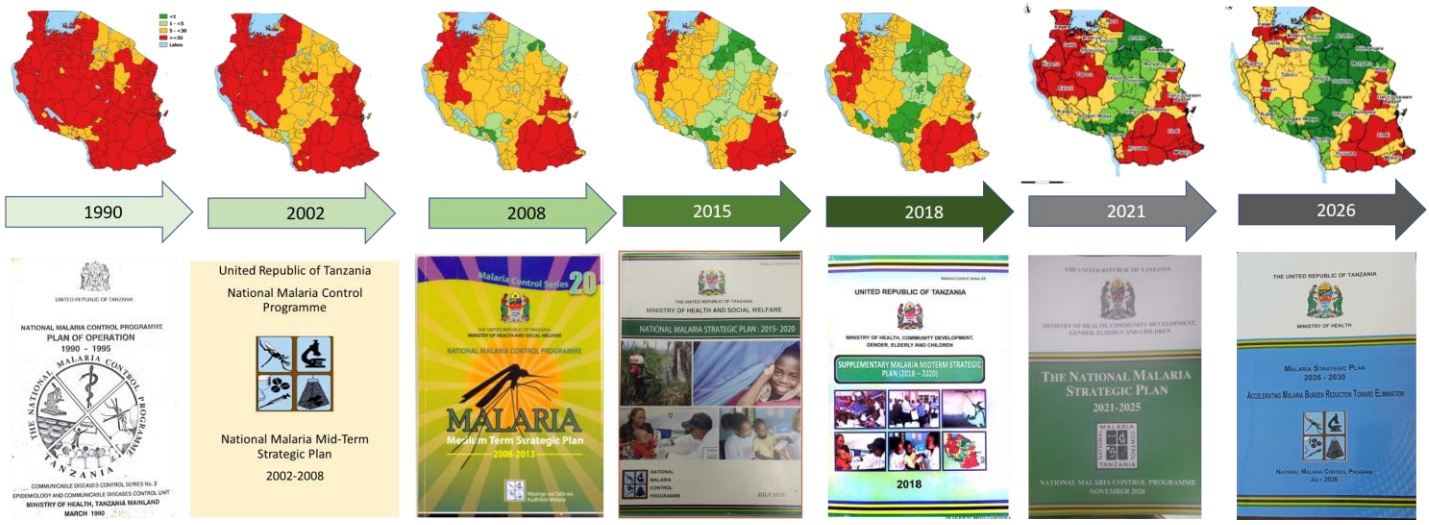
2026 – 2030

Accelerating Malaria Burden Reduction Toward Elimination

National Malaria Control Program

OCTOBER 2026

Strategic plan and impact: shrinking malaria map 1990-2030



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Preface

The National Malaria Strategic Plan (NMSP) 2026–2030, provides comprehensive technical guidance to stakeholders and development partners for a five-year period from 2026 to 2030. The strategic plan builds on the achievements and lessons learned from the implementation of the 2021–2025 National Malaria Strategic Plan, with a focus on ensuring universal access to prompt malaria diagnosis and treatment, accelerating malaria burden reduction in high- and moderate-burden settings, and safeguarding gains achieved in low- and very low-burden areas. Through these efforts, the strategy aims to support the country in achieving the 2030 global malaria control targets and broader health-related development goals.

This Strategic Plan will be implemented across all levels of the health system, from national to community level, and is guided by the following key principles:

a) **Data-driven and stratified approaches** – tailoring interventions to subnational epidemiological, entomological, and operational contexts;
b) **Surveillance-led programming** – positioning surveillance as a core intervention supported by strong laboratory systems, digital platforms, and rapid response mechanisms;
c) **Preparedness for diagnostic, treatment, and insecticide policy transitions** – ensuring readiness to adopt alternative antimalarial therapies and vector control approaches in response to emerging resistance patterns, while embracing innovative technologies and approaches such as AI-supported surveillance, malaria vaccines, and mosquito repellents;
d) **Health system anchoring** – strengthening human resources, supply chains, quality of care, and community systems as integral components of malaria control;
e) **Environmental and climate risk responsiveness** – promoting climate-informed surveillance and adaptive response strategies to mitigate the impact of climate change on malaria transmission;
f) **Cross-border and multisectoral collaboration** – strengthening collaboration with regional bodies, local governments, communities, and non-health sectors to expand coverage, enhance multisectoral engagement, and accelerate progress toward malaria elimination and control. Communities will be empowered to actively participate in malaria prevention and control efforts;
g) **Financial resilience** – securing predictable, diversified, and shock-resistant financing to sustain essential malaria interventions and health system enablers;
h) **Integrated implementation** – promoting integrated delivery of interventions, where feasible, to improve efficiency, reduce costs, and maximize impact; and
i) **Gender-sensitive and inclusive programming** – addressing gender, economic, and social barriers that limit access to malaria services, while prioritizing underserved and high-risk populations, including refugees, mobile populations, persons with disabilities, rural communities, and residents of informal urban settlements.

The remarkable progress achieved in reducing the malaria burden in Tanzania over the past two decades demonstrates that substantial gains are possible through sustained investment, the right mix of strategies, and strong national commitment. With continued technical focus, collaboration, and determination, Tanzania can accelerate progress toward defeating malaria once and for all. By adopting this Strategic Plan, malaria stakeholders across the country reaffirm their commitment to the bold vision of achieving malaria elimination by 2030.



Dr. Grace E. Magembe

Permanent Secretary

Ministry of Health

Acknowledgement

The preparation of the National Malaria Strategic Plan (NMSP) 2026–2030 was coordinated under the technical leadership of the Ministry of Health (MoH) through the National Malaria Control Programme (NMCP), in collaboration with WHO Country Office, Population Services International (PSI), and Swiss Tropical Public Health (Swiss TPH).

The strategy was developed through close collaboration with government ministries, departments, agencies, development partners, research institutions, local and international experts. The development process involved extensive consultations, beginning with the end-term review of the NMSP 2021–2025 conducted from October to December 2025. The findings and recommendations from the review informed the preparation of the first draft of the NMSP 2026–2030.

The draft strategy was subsequently refined through technical working sessions of the Vector Control and Malaria Case Management Technical Working Groups (TWGs), held between February and March 2026. These TWGs comprised representatives from a broad range of malaria stakeholders, including NMCP, PMO-RALG, the Global Fund, National Institute for Medical Research, Muhimbili University of Health and Allied Sciences, Ifakara Health Institute, Malaria Atlas Project, Swiss Tropical and Public Health Institute, Path, Jhpiego and representatives from non-state actors. The revised draft was then circulated electronically to stakeholders for further review and input. Additional technical contributions were received from international experts from WHO-AFRO, the Global Fund, and other development partners. The strategy development process was finalized following the compilation and incorporation of all comments and recommendations received.

The Ministry gratefully acknowledges the significant technical coordination and support provided by NMCP, WHO Country Office, the Governments of United States and Switzerland throughout the development process.

The Ministry further extends its appreciation to the Prime Minister's Office – Regional Administration and Local Government (PMO-RALG), other ministries, departments, and agencies for providing national policy guidance and strategic information. The MoH also commends all stakeholders for their dedication and valuable technical contributions to the strategic framework, monitoring and evaluation framework, and business planning process, including the sharing of information on available and projected resources that shaped the strategy.

The Ministry also acknowledges, with sincere gratitude, the many institutions and individuals whose names may not be specifically mentioned in this statement but whose contributions were invaluable to the successful development of this Strategic Plan. Special thanks are extended to the Government of Tanzania, RBM Partnership to End Malaria, Swiss Development Cooperation, and the Global Fund for providing the financial support that enabled the successful completion of the process.

Last but not least, special appreciation is extended to Dr. Fabrizio Molteni (Swiss TPH), Dr. Jovin Kitau (WHO), Dr. Ally Mohamed (Malaria expert), Dr. Sigsbert Mkude (Jhpiego), Dr. Sijenunu Aron, Frank Chacky, and Khalifa Munisi (NMCP) for their commitment, technical leadership, and tireless efforts in coordinating the drafting process and compiling stakeholder inputs for the development of this National Malaria Strategic Plan.



Prof. Bruno Fokas Sunguya

Chief Medical Officer

Acronym:

ACT	Artemisinin-based Combination Therapy
ADDO	Accredited Drug Dispensing Outlet
ADR	Adverse Drug Reaction
AI	Artificial Intelligence
AIDS	Acquired Immunodeficiency Syndrome
AIM	Action and Investment to defeat Malaria
ALMA	African Leaders Malaria Alliance
ALu/AL	Artemether Lumefantrine
ANC	Antenatal Care
AOP	Annual Operational Plan
API	Annual Parasite Incidence
APR	Artemisinin Partial Resistance
AQ	Amodiaquine
BCC	Behaviour Change Communication
BHC	Behavioural Health Communication
BMGF	Bill and Melinda Gates Foundation
Bs	Bacillus sphaericus
Bti	Bacillus thuringiensis var. israelensis
CBHC	Community Based Health Care
CBO	Community Based Organization
CBS	Case Based Surveillance
CCA	Community Change Agent
CCHP	Comprehensive Council Health Plan
CCM	Community Case Management
CDC	Center for Disease Control and Prevention
CHAN	African Nation Championship
CHMT	Council Health Management Team
CHW	Community Health Worker
CI-MEEWS	Climate Informed Malaria Epidemic Early Warning System
CLM	Commodities and Logistics Management
CMFP	Council Malaria Focal Person
CMIS	Council Malaria Information System
CMIS	Composite Management Information System
CORP	Community Owned Resource Person
CPM	Co-Payment Mechanism
CQ	Chloroquine
CSO	Civil Society Organization
CSO	Community Social Organization
CTC	Care and Treatment Centre
DC	District Council
DDT	Dichloro Diphenyl Trichloroethane
DHIS2	District Health Information Software 2
DMIFP	District Malaria/IMCI Focal Person
DMO	District Medical Officer
DOT	Directly Observed Therapy
DQA	Data Quality Assessment
DRC	Democratic Republic of Congo
EAC	East African Community
e-IDSR	Electronic Integrated Disease Surveillance and Response
EIR	Entomological Inoculation Rate
eLMIS	electronic Logistic Management Information System
EMCT	End Malaria Council Tanzania
EPI	Expanded Programme on Immunization
FBO	Faith Based Organizations
FDA	Focal Drug Administration
fIRS	focal Indoor Residual Spraying
FY	Financial Year
GDP	Gross Domestic Product
GF	Global Fund
GLMI	Great Lakes Malaria Initiative
GoT	Government of Tanzania
GoT-HOMIS	GoT Health Operation Information System
GPS	Global Positioning System
GPSA	Government Procurement Services Agency
GTS	Global Technical Strategy
HBF	Health Basket Fund
HBHI	High Burden High Impact
HCW	Health Care Worker
HF	Health Facility
HFR	Health Facility Register
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HRHIS	Human Resources for Health Information System
HSCR	Holistic Supply Chain Review
HSSP	Health Sector Strategic Plan
HW	Health Worker
iCCM	Integrated Community Case Management
ICER	Incremental Cost-effectiveness Ratio
iCHF	improved Community Health Fund
ICT	Information Communication Technology
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education and Communication
IEC	Information Education Communication
IHI	Ifakara Health Institute
IMCI	Integrated Management of Childhood Illness
IMVC	Integrated Malaria Vector Control
IPC	Interpersonal Communication
IPC	Interpersonal Communication
IPCC	Intergovernmental Panel on Climate Change
IPD	Inpatient Department
IPTi	Intermittent Preventive Treatment for infants
IPTp	Intermittent Preventive Treatment for pregnant women
IPTsc	Intermittent Preventive Treatment in School Children
IRM	Insecticide Resistance Monitoring
IRMM	Insecticide Resistance Mitigation Management
IRMP	Insecticide Resistance Monitoring Plan
IRS	Indoor Residual Spraying
IST	Insecticide Susceptibility Testing
ITN	Insecticide Treated Net
IVD	Immunization and Vaccine Development
IVM	Integrated Vector Management
JAHSR	Joint Annual Health Sector Review
LAMP	Loop-mediated Isothermal Amplification
LGA	Local Government Authority
LLINs	Long Lasting Insecticide Treated Nets
LMIS	Logistic Management Information System
LP&R	Leadership, Partnership and Resource Mobilization
LSM	Larval Source Management
LSR	Lead Subrecipient
mCBS	Malaria Case-Based Surveillance
mCCM	Malaria Community Case Management
MCM	Malaria Case Management
MDA	Mass Drug Administration
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MDTPT	Malaria Diagnosis, Treatment and Preventive Therapies
MEEDS	Malaria Epidemic Early Detection System

MEEWS	Malaria Epidemic Early Warning System
MFT	Multiple First: Line Therapy
MIS	Malaria Indicator Surveys
MoFP	Ministry of Finance and Planning
MoH	Ministry of Health
MPR	Malaria Programme Review
MRC	Mass Replacement Campaign
mRDT	Malaria Rapid Diagnostic Test
MSD	Medical Stores Department
MSDQI	Malaria Services & Data Quality Improvement
MTEF	Medium Term Expenditure Framework
MTR	Mid-Term Review
MUHAS	Muhimbili University of Health and Allied Science
MVES	Malaria Vector Entomological Surveillance
NAP	National Adaptation Plan
NBS	National Bureau of Standards
NEMC	National Environmental Management Council
NGMDT&PT	National Guidelines Malaria Diagnosis Treatment and Preventive Therapies
NGO	Non-Governmental Organization
NHAs	National Health Accounts
NHIF	National Health Insurance Funds
NIMR	National Institute for Medical Research
NMCP	National Malaria Control Programme
NMSP	National Malaria Strategic Plan
NSA	Non-State Actor
NSP	National Strategic Plan
NSVC	National Strategy for Vector Control
NTD	Neglected Tropical Disease
OPD	Outpatient Department
OR	Operational Research
PAAR	Prioritized Above Allocation Request
PDMC	Post-Discharge Malaria Chemoprevention
Pf	Plasmodium falciparum
pfhrp2	Plasmodium falciparum Histidine Rich Protein 2
pfhrp3	Plasmodium falciparum Histidine Rich Protein 3
PFM	Public Financial Management
PHC	Primary Health Care
PLWHA	People Living With HIV/AIDS
PMC	Perennial Malaria Chemoprevention
PMCTC	Prevention of Mother to Child Care
PMI	President's Malaria Initiative
PMO-RALG	Prime Minister's Office Regional Administration and Local Government
RALG	Regional Administration and Local Government
PMS	Post Marketing Surveillance
PPE	Personal Protective Equipment
PPM	Pooled Procurement Mechanism
PPP	Public Private Partnership
PR	Principal Recipient
PSI	Population Service International
PSM	Procurement and Supply Chain Management
PSU	Pharmaceutica Supply Unit
PW	Pregnant Women
PWD	Person with Disabilities
QA	Quality Assurance
QAACT	Quality Assured ACT
R&D	Research and Development
RBM	Roll Back Malaria
RCH	Reproductive and Child Health
RCHS	Reproductive and Child Health Services
RDT	Rapid Diagnostic Test
RHMT	Regional Health Management Team
RMFP	Regional Malaria Focal Person
RMO	Regional Medical Officer
RRT	Rapid Response Team
RSSH	Resilient and Sustainable Systems for Health
s.l.	Sensu Lato
s.s.	Sensu Stricto
SA	Strategic Approach
SADC	Southern African Development Community
SBC	Social Behaviour Change
SBC&A	SBC & Advocacy
SBCA&CE	SBCA and Community Engagement
SCD	Sickle Cell Disease
SDG	Sustainable Development Goal
SDM	Service Delivery Mechanism
SI	Strategic Intervention
SMC	Seasonal Malaria Chemoprevention
SMEL	Surveillance, Monitoring, Evaluation, Learning
SMMP	Supplementary Malaria Midterm Strategic Plan
SMPS	School Malaria Parasitological Survey
SNP	School Net Programme
SO	Strategic Objective
SOP	Standard Operating Procedure
SP	Sulfadoxine Pyrimethamine
SR	Sub Recipient
SSR	Sub sub recipient
SWAp	Sector Wide Approach
Swiss TPH	Swiss Tropical and Public Health Institute
TACT	Triple ACT
TBD	To be Defined
tDA	targeted Drug Administration
TDHS	Tanzania Demographic and Health Survey
TES	Therapeutic Efficacy Studies
tIRS	targeted Indoor Residual Spraying
TMC	Targeted Mass Campaign
TMDA	Tanzania Medicine & Medical Devices Authority
TNCM	Tanzania National Coordinating Mechanism
TNVS	Tanzania National Voucher Scheme
TOR	Term of Reference
TPHPA	Tanzania Plant Health and Pesticide Authority
TPR	Test Positivity Rate
TRC	Targeted Replacement Campaign
TWG	Technical Working Group
TZS	Tanzanian Shillings
U5	Under Five
UCS	Unified Community System
UHC	Universal Health Coverage
UMSR	Urban Malaria Surveillance and Response
UN	United Nations
UNICEF	United Nations Children's Fund
UNOPS	United Nation Office for Project Services
USAID	US Agency for International Development
USG	United States Government
VCI	Vector Control Intervention
WB	World Bank
WHO	World Health Organization
WMO	World Meteorological Association
WMR	World Malaria Report

Executive Summary

Introduction: Malaria remains a major public health challenge in mainland Tanzania. Since the early 2000s, the country has experienced a sustained decline in malaria burden, driven by the scale-up of insecticide-treated nets (ITNs), improved access to prompt diagnosis and effective treatment and strengthened programme coordination. As transmission has declined, malaria epidemiology in Tanzania has become increasingly heterogeneous, with lower transmission observed along a north-east to south-west corridor, and persistently higher burden in the north-western and south-eastern zones. This evolving epidemiological pattern reflects a transition from widespread endemicity to more focalized transmission, underscoring the need for stratified and geographically targeted interventions. Such an approach enables strategic prioritization of investments to maximize impact and accelerate burden reduction in moderate- and high-transmission areas, particularly among disadvantaged and high-risk populations. At the same time, it supports efforts to further suppress transmission in low-burden areas and advance toward malaria elimination in very low-transmission settings. This National Malaria Strategic Plan aims to ensure that Tanzania consolidates the gains achieved in malaria control while accelerating progress toward the national vision of a malaria-free society.

Malaria Situation analysis: Between 2021 and 2025, Tanzania made measurable progress in reducing the malaria burden. The Annual Parasite Incidence (API) declined substantially from approximately 76 cases per 1,000 population in 2021 to 43 cases per 1,000 population in 2025, representing a 43% reduction over the period. Malaria mortality also declined significantly, with facility-based mortality rates decreasing by approximately 42%, from 3.3 deaths per 100,000 population in 2021 to 1.9 deaths per 100,000 population in 2025. The prevalence of malaria among children under five years of age also improved, although at a more modest pace. The 2022 Malaria Indicator Survey (MIS) reported a prevalence of 8.1%, while more recent data from the School Malaria Parasitological Survey (SMPS) 2025 suggest a decline to approximately 5.7%. Despite these encouraging national trends, malaria transmission remains uneven across the country, with persistently high prevalence, incidence, and mortality observed in several regions, particularly in the north-western and south-eastern zones. Regions with consistently high burden include Kagera, Kigoma, Mara, Tabora, Geita, Ruvuma, Lindi, and Mtwara.

Malaria continues to disproportionately affect vulnerable populations, particularly children under five years of age, adolescents, and pregnant women. Children under five continue to experience the highest burden of severe malaria morbidity, with consistently higher incidence rates compared to older age groups throughout the 2021–2025 period. Pregnant women also remain a high-risk group. Routine antenatal care (ANC) data indicate that malaria positivity among pregnant women declined from approximately 7.7% in 2021 to about 3.9% in 2025, reflecting both reduced transmission and improved testing coverage. However, significant regional variation persists, mirroring broader patterns of malaria transmission. School-aged children (5–16 years) are increasingly recognized as an important reservoir for malaria transmission, often harboring parasites without showing symptoms and thereby sustaining community-level transmission. Nationally representative surveys demonstrated a substantial decline in malaria prevalence among this age group, from 21.6% in 2015 to 7.5% in 2025.

Malaria Program performance: The goal of the concluded National Malaria Strategic Plan (NMSP) 2021–2025 was to reduce national malaria prevalence from 7.5% in 2017 to below 3.5% in 2025 through the implementation of three core strategies: Integrated Malaria Vector Control (IMVC), malaria case management, and surveillance. Findings from the end-term review of the NMSP 2021–2025 (Malaria Programme Review [MPR] 2025) indicate that, although progress was made, the overall goal of the Strategic Plan was not achieved, with the target missed by approximately 40%. Coverage of vector control interventions remained below national targets during the implementation period. Although LLINs remained the primary vector control intervention, population access to an LLIN within the household reached only 69% in 2025, compared with the national target of 85%. This level of coverage was insufficient to achieve and sustain universal protection, particularly in high-transmission settings. Similarly, the target of providing indoor residual spraying (IRS) in 25% of the population at risk was not achieved. IRS implementation was progressively reduced and discontinued from 2023 onwards due to funding constraints, resulting in the loss of an important complementary vector control intervention in selected high-transmission areas. Performance in malaria case management improved during the implementation of the NMSP 2021–2025, although targets were not met and important equity gaps persisted. Improvements were observed in both prompt diagnosis and timely treatment of malaria among children under five years of age, reflecting continued investments in strengthening case management services. The proportion of children under five years of age with fever who received a malaria diagnostic test on the same day or the day following onset of illness increased from 43% in 2017 to 50% in 2025. Similarly, the proportion of febrile children under five who received recommended antimalarial treatment within the same or next day after fever onset increased from 25.2% to 41% over the same period. Marked disparities in service coverage persisted across

population groups. Children residing in rural areas and those from households in the lowest wealth quintiles continued to have lower access to timely malaria testing and appropriate treatment compared with children living in urban areas and households in higher wealth quintiles. These inequities suggest persistent barriers to accessing quality malaria services, including geographical, socioeconomic, and health system constraints.

The MPR 2025 further revealed suboptimal implementation of the core strategic interventions. During the Strategic Plan period, only 47% of planned malaria vector control interventions, 53% of malaria case management interventions, and 57% of surveillance, monitoring, and evaluation interventions were fully implemented. The principal reason for this underperformance was inadequate financing, driven by limited domestic investment in malaria control, withdrawal of PMI support, and reductions in Global Fund financing in 2025. In contrast, supportive strategies demonstrated relatively stronger performance. Approximately 78% of commodities and logistics management interventions, 80% of social and behaviour change communication (SBCC) interventions, and 80% of programme management interventions were fully implemented during the Strategic Plan period. Availability of malaria commodities at the Medical Stores Department (MSD) and service delivery points remained generally satisfactory throughout the implementation period. The MPR 2025 recommended that malaria partners and stakeholders intensify advocacy for increased domestic financing for malaria control interventions. The review also emphasized the need to continue prioritizing access to malaria testing and treatment beyond health facilities, particularly in rural areas and among populations in the lowest wealth quintiles, in order to improve equitable access to services. Additional recommendations included improving coverage of vector control interventions, expanding the use of digital and social media platforms for malaria communication and community engagement, and integrating logistics and service data systems to strengthen data quality and consistency across platforms.

National Malaria Strategic Plan 2026-2030: The vision of the National Malaria Strategic Plan (NMSP) 2026–2030 is **"Tanzania becomes a society free from malaria."** To realize this vision, the Strategic Plan is guided by four overarching goals: 1) **Reduce malaria transmission measured by parasite prevalence in children under the age of five** from 5.7% in 2025 to 1.4% in 2030; 2) **Reduce malaria mortality** from 1.9 deaths per 100,000 population in 2025 to 1.1 deaths per 100,000 population by 2030; 3) **Reduce malaria case incidence** from 43 cases per 1,000 population in 2025 to 15 cases per 1,000 population by 2030; 4) **Increase the proportion of councils with very low malaria transmission** from 29% in 2025 to 43% by 2030.

The NMSP 2026–2030 is structured around six strategic objectives: 1) **To reduce malaria parasite transmission** by accelerating the implementation of targeted, evidence-based, and integrated malaria prevention interventions; 2) **To prevent malaria-related mortality** through universal access to appropriate malaria diagnosis and effective treatment; 3) **To provide timely, reliable, and actionable malaria information** to support evidence-based decision-making across different transmission settings and ensure that available resources are utilized in the most cost-effective manner; 4)**To ensure timely availability of safe, efficacious, and quality-assured malaria commodities and supplies** at all service delivery points; 5) **To strengthen an enabling environment** that empowers individuals and communities at risk of malaria to consistently protect themselves and their families, while promoting timely care-seeking and appropriate utilization of malaria services; and 6) **To strengthen efficient and effective implementation of malaria interventions** through accountable leadership, coordination, and strategic partnerships.

Implementation framework: This Strategic Plan will be implemented across all levels of the health system, from national to community level. In addition, non-health sectors will be actively engaged in adopting malaria-relevant interventions in order to expand intervention coverage, strengthen multisectoral collaboration, and accelerate progress toward malaria elimination. Implementation of the NMSP 2026–2030 will be operationalized through Annual Operational Plans (AOPs), which will be developed each year to: a) assess the status of implementation of planned interventions and activities; b) review financial inputs, funding gaps, and resource allocation; and c) monitor implementation progress against planned activities and timelines. The implementation of the Strategic Plan will also be reviewed through mid-term and end-term evaluations conducted in accordance with WHO Malaria Programme Review guidelines.

The National Malaria Control Programme (NMCP) will be responsible for the overall coordination and management of both malaria control and elimination efforts in the country. During the implementation period of this Strategic Plan, the NMCP will develop and update technical guidelines to support implementation of strategic interventions, guided by WHO recommendations and inputs from Technical Working Groups (TWGs) and development partners' technical teams. Furthermore, the NMCP, in collaboration with the Prime Minister's Office – Regional Administration and Local Government (PMO-RALG), development partners, and implementing partners, will continue to facilitate the effective and efficient implementation of malaria interventions nationwide. Technical Working Groups (TWGs) will remain the principal consultative and advisory bodies, providing the Ministry of Health and NMCP with technical recommendations and guidance on malaria control and elimination interventions.

1. Policy and Programming Environment

Malaria control and elimination in Mainland Tanzania is influenced by a complex interplay of factors, including national development priorities, health policies, global technical guidance, regional collaboration, and health system capacity in terms of staffing, financing, and service delivery. Together, these elements create both opportunities and constraints that shape how the National Malaria Control Programme (NMCP) plans, implements, and monitors interventions aimed at reducing malaria burden and advancing toward elimination aligned with the Health Sector Strategic Plan (HSSP) planning cycle.

National development and health policy frameworks

Malaria programming is anchored in Tanzania's long-term development agenda. The *Tanzania Development Vision 2025*[1] emphasizes high-quality livelihoods, human development and equitable access to essential services, positioning health as a key driver of economic growth and poverty reduction. The transition toward *Development Vision 2050*[2] reinforces the importance of a resilient, equitable and technologically advanced health system as a foundation for national prosperity.

The *National Health Policy (2017)*[3] prioritizes disease prevention, health promotion, equitable access and quality of care. Malaria is identified as a major public health priority requiring strengthened surveillance, effective vector control, quality-assured diagnosis and treatment and sustained community engagement.

The *Health Sector Strategic Plan V (HSSP V, 2021-2026)*[4] operationalizes these commitments through a focus on Universal Health Coverage (UHC), quality improvement, human resources for health, digital health, supply chain strengthening and robust monitoring and evaluation systems. Malaria remains a leading contributor to morbidity and mortality and the plan emphasizes integrated, community-centred and data-driven approaches to disease control.

Governance, regulation and institutional arrangements

Tanzania's decentralized governance system assigns significant responsibility for health service delivery to regional and council levels. The Ministry of Health provides stewardship, policy direction, standards and national coordination, while the Prime Minister's Office-Regional Administration and Local Government (PMO-RALG) oversees implementation through Regional and Council Health Management Teams. Health facility governing committees provide localized oversight and accountability.

Sector coordination mechanisms, including the Sector-Wide Approach (SWAp), Joint Annual Health Sector Reviews (JAHSR) and technical working groups, facilitate policy alignment and partner coordination. However, persistent challenges have been identified, including inconsistent functionality of coordination platforms, delays in financial disbursement to councils, fragmented off-budget financing, limited dissemination of guidelines to primary health facilities and variable capacity of local governance structures. These constraints directly affect the timely implementation, coverage and quality of malaria interventions.

A wide range of legal and regulatory frameworks, including public health, pharmaceutical, diagnostic, environmental health and laboratory system regulations further support malaria programming. These instruments enable safe and effective delivery of vector control, case management and surveillance interventions.

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[1] United Republic of Tanzania. (1999). *Tanzania Development Vision 2025*. Dar es Salaam: Planning Commission.

[2] United Republic of Tanzania. (2023). *Tanzania Development Vision 2050*. Dodoma: Ministry of Planning and Investment.

[3] United Republic of Tanzania. (2017). *National Health Policy (2017)*. Dodoma: Ministry of Health, Community Development, Gender, Elderly and Children.

[4] United Republic of Tanzania. (2021). *Health Sector Strategic Plan V (2021–2026)*. Dodoma: Ministry of Health, Community Development, Gender, Elderly and Children.

Global strategic and technical commitments

Tanzania's malaria response is aligned with global and regional commitments. The WHO *Global Technical Strategy for Malaria (2016–2030)*[5] provides the overarching framework, with targets to reduce malaria incidence and mortality by at least 90% by 2030. The strategy emphasizes universal access to prevention, diagnosis and treatment; transformation of surveillance into a core intervention; and tailoring of responses to local epidemiology. These pillars align closely with Tanzania's shift toward stratified, evidence-based programming.

The *Sustainable Development Goals (SDGs)*[6], particularly SDG 3.3 on ending malaria, places malaria within a broader development agenda that includes poverty reduction, improved nutrition, water and sanitation, gender equality and climate resilience.

As one of the WHO-designated *High Burden–High Impact (HBHI)*[7] countries, Tanzania is committed to using data for action, optimizing intervention mixes, mobilizing resources and strengthening accountability to accelerate progress.

Regional and cross-border cooperation

Malaria transmission in East and Central Africa is highly interconnected. Tanzania participates in regional initiatives such as the *Great Lakes Malaria Initiative (GLMI)*[8] under the East African Community, which promotes coordinated cross-border responses, including harmonized policies, synchronized interventions and data sharing.

These efforts are particularly relevant for high-transmission regions bordering Lake Victoria and Lake Tanganyika, where population mobility and shared ecological conditions sustain transmission. Tanzania is also engaged in regional efforts to monitor and respond to emerging antimalarial drug resistance, including artemisinin partial resistance, through strengthened surveillance and coordinated policy responses.

Malaria epidemiology and programmatic context

Malaria remains a major public health challenge in mainland Tanzania, with marked heterogeneity in transmission intensity. High-burden areas are concentrated in the Lake and Western zones, while several Northern and Central regions have achieved low transmission. Vulnerable populations, including children under five years of age, pregnant women, and rural communities, continue to bear a disproportionate burden.

Malaria programming is currently characterized by a core package of vector control, case management and specific preventive interventions. However, programme performance is increasingly shaped by operational and contextual factors, including insecticide resistance, variable coverage and utilization of interventions, uneven access to quality diagnosis and treatment and persistent gaps in preventive service delivery such as intermittent preventive treatment of malaria in pregnancy (IPTp).

These dynamics underscore the need for a transition toward more stratified, data-driven, and adaptive approaches that respond to local epidemiological and operational realities.

Health system realities shaping malaria programming

Service delivery and quality: Expansion of the health facility network has improved access; however, disparities in service readiness and quality persist. Gaps in provider competencies, adherence to treatment guidelines, and functionality of referral systems and integration of service delivery continue to undermine effective malaria case detection, accurate diagnosis, appropriate treatment and consistent follow-up care.

Human resources for health: Shortages and inequitable distribution of skilled health workers, particularly in high-burden areas, continue to constrain service delivery. Community health systems remain underdeveloped, with gaps in training, deployment,

[5] World Health Organization. (2015). *Global Technical Strategy for Malaria, 2016 -2030*. Geneva: World Health Organization.

[6] United Nations. (2015). *Transforming our world: The 2030 Agenda for Sustainable Development*. New York: United Nations.

[7] World Health Organization. (2018). *High burden to high impact: A targeted malaria response*. Geneva: World Health Organization.

[8] East African Community. (2021). *Great Lakes Malaria Initiative (GLMI) strategic plan 2021–2025*. Arusha, Tanzania: East African Community Secretariat.

supervision and sustainable financing, limiting their effectiveness in promoting demand, facilitating early care seeking and improve uptake of malaria interventions.

Diagnostics, laboratories and supply chains: Diagnostic capacity and supply chain performance have improved significantly in recent years. Routine data indicate that stock-out levels of malaria commodities, remain generally below 10%, reflecting strengthened quantification, procurement and distribution systems. However, persistent last-mile challenges and residual weaknesses in these systems occasionally result in stock-out of essential diagnostics and medicines, undermining both case management and the quality of surveillance.

Digital health and surveillance systems: Investments in digital platforms, including DHIS2 and electronic reporting systems, offer significant opportunities to strengthen malaria surveillance. However, limitations in connectivity, system interoperability and data use capacity at health facility and council levels continue to constrain the effective transformation of surveillance into a core intervention.

Community systems and social determinants: Effective malaria control depends on strong community engagement. However, community health worker systems are not fully institutionalized and broader social determinants, such as poverty, housing conditions, water and sanitation and gender inequities, continue to shape exposure, vulnerability and health-seeking behaviour, limiting the overall effectiveness of interventions

Health financing and sustainability: Despite increases in domestic health financing, malaria control remains heavily dependent on external funding. Financing flows to subnational levels are often delayed and unpredictable and investments are disproportionately concentrated on commodities rather than critical system enablers. Recent funding disruptions have highlighted vulnerabilities in commodity security and community systems, underscoring the need for more predictable, diversified and resilient financing mechanisms.

Emerging risks and future considerations

Antimalarial drug resistance: The emergence and spread of artemisinin partial resistance in the region, including its confirmation in Tanzania, pose a significant threat to malaria control. Strengthened therapeutic efficacy monitoring, timely treatment policy adaptation and procurement readiness for alternative antimalarial therapies are essential.

Diagnostic evasiveness: Single mutations in the histidine –rich protein hrp2/3 genes has been reported in northwest south highland Tanzania, suggesting high risk of diagnostic failure in detecting malaria parasites.

Insecticide resistance: Increasing resistance to commonly used insecticides threaten the effectiveness of vector control interventions, necessitating resistance monitoring, product diversification and integrated vector management approaches.

Invasive Anopheline mosquitoes: No invasive Anopheline mosquito species, including *Anopheles stephensi*, have been detected in Tanzania. Following the WHO vector alert issued in 2019, Tanzania strengthened surveillance for *Anopheles stephensi* through routine entomological surveillance in 32 sentinel sites established since 2015, with targeted surveillance intensified from 2022 in high-risk regions located in coastal areas, major transport corridors and points of entry namely Dar es Salaam, Tanga, and Kilimanjaro.

Climate change and environmental pressures: Climate changes, including alterations of rainfall patterns, temperature and extreme weather events are altering malaria transmission dynamics, increasing receptivity in some areas, shifting seasonality, disrupting health service delivery and impacting human livelihood. This calls for strengthened climate monitoring.

Population mobility and urbanization: Cross-border movement and rapid urbanization are creating new transmission patterns, particularly in peri-urban and informal settlements, requiring tailored surveillance and intervention approaches.

System resilience and emergency preparedness: Global health emergencies and funding shocks have exposed vulnerabilities in programme continuity. Strengthening resilience through contingency planning, emergency stock mechanisms and flexible financing is critical to sustaining gains against malaria.

Implications for the National Malaria Strategic Plan

In response to this policy and programming environment, the National Malaria Strategic Plan must be:

Data-driven and stratified: Tailoring interventions to subnational epidemiological, entomological and operational contexts.

Surveillance-led: Positioning surveillance as a core intervention supported by strong laboratory systems, digital platforms and rapid response mechanisms.

Prepared for diagnostic, treatment and insecticides policy transitions: Ensuring readiness to adopt alternative antimalarial therapies based on emerging resistance patterns. Embracing new technologies and approaches to enhance malaria control such as AI surveillance, vaccines, and mosquito repellants.

Health system-anchored: Strengthening human resources, supply chains, quality of care and community systems as integral components of malaria control.

Environmental and Climate risk factors: Climate-informed surveillance and adaptive response strategies are needed to mitigate the impact of climate change on malaria.

Cross-border and multisectoral: Enhancing collaboration with regional bodies, other sectors, local governments and communities.

Empowering communities: help communities to actively participate to control interventions.

Financially resilient: Securing predictable, diversified and shock-resistant financing to sustain essential malaria interventions and system enablers.

Integration: Implementing interventions in an integrated approach (where feasible) to reduce costs and improve efficiency.

Gender sensitive and Inclusive: Addressing gender, economic and social barriers affecting access to malaria services, prioritizing underserved and high-risk groups such as refugees, mobile populations, persons with disabilities, rural communities and informal urban residents.

2. Situational Analysis

Historical context and epidemiological transition

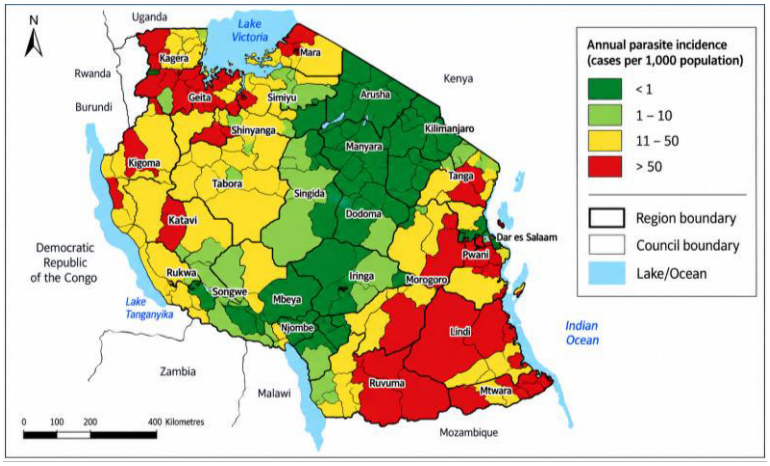
Malaria has long been one of the most significant public health challenges in mainland Tanzania, characterized by widespread transmission and substantial morbidity and mortality. Early control efforts, dating back to the colonial period, demonstrated that the malaria burden could be reduced through targeted interventions such as larval control, environmental management, and later, chemotherapeutic approaches. However, these interventions were geographically limited and were not sustained at scale. Following independence, malaria remained highly endemic for several decades, with control efforts focused primarily on the presumptive treatment of febrile illness using chloroquine rather than on coordinated prevention strategies. Consequently, malaria transmission remained widespread throughout the 1970s and 1980s.

A more coordinated national response emerged with the establishment of the National Malaria Control Programme (NMCP) in 1990, marking a shift toward structured malaria control through strengthened policy leadership, technical guidance, and coordinated implementation. Beginning in the early 2000s, the programme progressively scaled up key interventions, including long-lasting insecticidal nets (LLINs), improved diagnostic services, and artemisinin-based combination therapies (ACTs). Although malaria transmission remained high throughout the 1990s—with parasite prevalence among children aged 2–10 years exceeding 40% and a substantial burden of disease, particularly among children under five years of age and pregnant women—the expansion of these interventions led to a sustained decline in malaria burden from the early 2000s onward. This progress was driven by increased coverage of insecticide-treated nets, improved access to prompt diagnosis and effective treatment, targeted vector control measures, and strengthened programme coordination. As transmission declined, malaria epidemiology became increasingly heterogeneous, with lower transmission observed along a north-east to south-west corridor and persistently higher burden in the north-western and south-eastern regions.

Geographic heterogeneity and stratification

The growing heterogeneity led to a major strategic shift during the 2015–2020 period, with adoption of a stratified approach to malaria control. Malaria transmission in mainland Tanzania is increasingly heterogeneous, with clear spatial variation across regions, councils and epidemiological strata. Councils were classified into very low, low, moderate, and high transmission strata using multiple epidemiological indicators (Figure 1)[9]. This induced a transition from generalized scale-up to geographically targeted interventions based on burden and risk.

Figure 1: Malaria Stratification Map - 2025

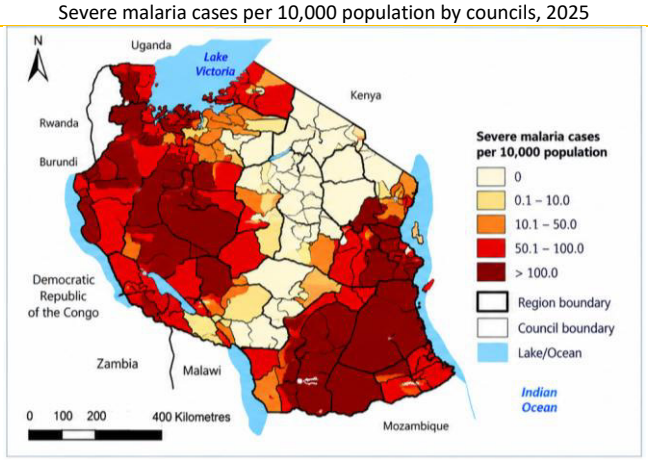


[9] Mapping malaria risk is done using routine and non-routine data from DHIS2 and SMPS respectively. The selected indicators are the mix of WHO recommended indicators and country-tailored indicators. The following indicators were selected based on the availability, frequency and robustness of malaria data: 1) Parasite prevalence in school children from school surveys 2) malaria test positivity rate (TPR), 3) annual parasite incidence (API), 4) confirmed malaria incidence and 5) malaria positivity rate in pregnant women.

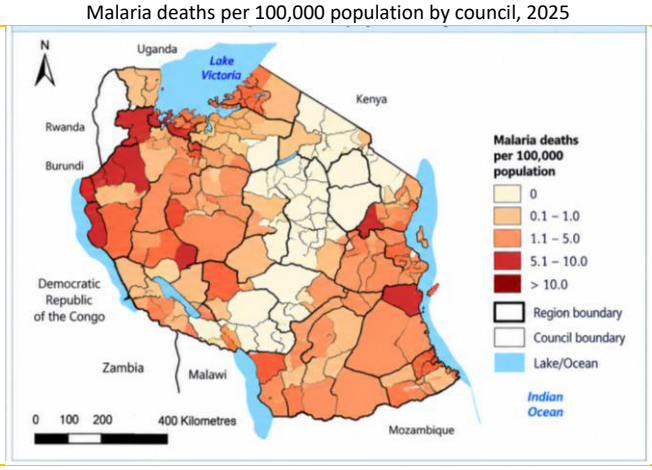
The same heterogeneity pattern, further than the one observed in the transmission risk mapping described above, is also reflected in the distribution of reported severe malaria and malaria related mortality as described in Figure 2.

Figure 2: Council distribution of malaria severe morbidity and mortality

Severe malaria cases per 10,000 population by councils, 2025



Malaria deaths per 100,000 population by council, 2025



Malaria burden trends (2021 –2025)

Progress in Malaria Morbidity and Mortality

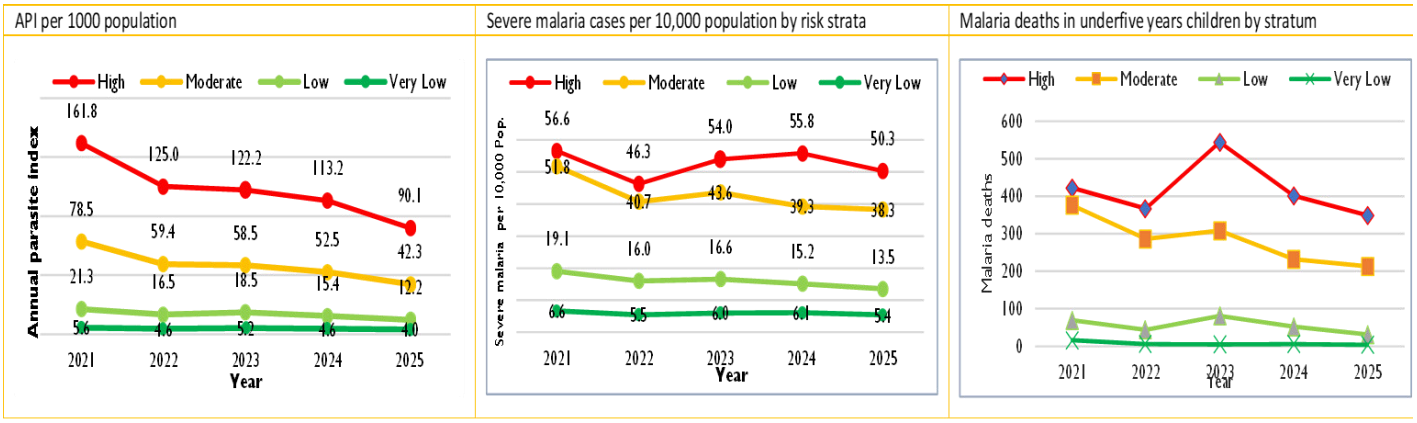
Between 2021 and 2025, Tanzania made measurable progress in reducing the malaria morbidity and mortality rates, although national targets were not fully achieved.

The Annual Parasite Incidence (API) declined substantially from approximately 76 cases per 1,000 population in 2021 to 43 per 1,000 population in 2025, representing an estimated 43% reduction over the five-year period. Despite this achievement, the API remained above the national target of fewer than 30 cases per 1,000 population at risk by 2025. The decline in API was observed across all epidemiological strata, as shown in Figure 3.

Severe malaria incidence also declined across all transmission risk strata (Figure 3), with the High and Moderate risk areas continuing to account for the majority of cases compared to the Low and Very Low risk strata. While the overall trend reflects a steady reduction in severe malaria, marked regional disparities persist. In 2025, the regions of Mara, Ruvuma, Kagera, Kigoma, Mtwara, and Lindi recorded the highest severe malaria rates, each exceeding 40 cases per 10,000 population. In contrast, the Arusha, Kilimanjaro, and Manyara regions reported the lowest rates, with fewer than 5 cases per 10,000 population. These patterns indicate a transition from widespread endemic transmission to more localized, focal transmission, highlighting the need for stratified and geographically targeted malaria control interventions.

Malaria mortality also declined significantly during the same period. Facility-based mortality decreasing by 42%, from 3.3 to 1.9 deaths per 100,000 population between 2021 to 1.9 deaths per 100,000 population in 2025. Despite this progress, mortality remained disproportionately high in several high-burden regions. In 2025, Katavi, Geita, and Mara regions recorded mortality rates above 2 deaths per 100,000 population, whereas low-transmission regions including Kilimanjaro, Singida, Manyara, Arusha and Dodoma reported mortality rates below 0.5 deaths per 100,000 population as illustrated in Figure 2 above. Furthermore, malaria-related deaths as a proportion of all inpatient department (IPD) deaths declined from 7.5% in 2021 to 3.2% in 2025, representing a 57% reduction. This decline suggests improvements in malaria prevention, timely diagnosis, case management, and access to effective treatment services.

Figure 3: Malaria incidence, severe morbidity and mortality by epidemiological risk

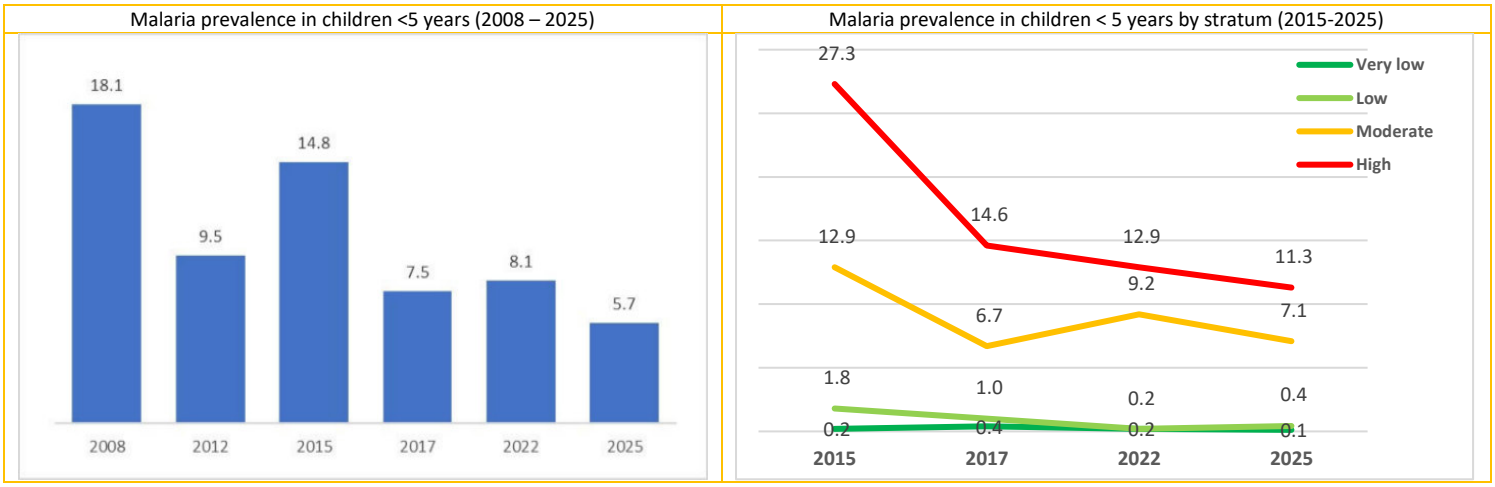


Overall, the observed reductions in malaria incidence, severe disease, and mortality demonstrate significant progress towards national malaria control objectives. However, persistent subnational disparities underscore the importance of sustaining universal core interventions while intensifying tailored, stratified responses in high-transmission and high-mortality areas.

Progress in Malaria Transmission

Prevalence of malaria among children under five has shown modest improvement over the time. The Malaria Indicator Survey (MIS) 2022 reported a prevalence of 8.1%, while 2025 School Malaria Parasitological Survey (SMPS) observed a decline to 5.7% (Figure 4). These levels remain above targets, indicating that transmission reduction has been slower than anticipated.

Figure 4: Malaria parasite prevalence in children < 5 years (Source: MIS 2008-2022, SMPS 2025[10])



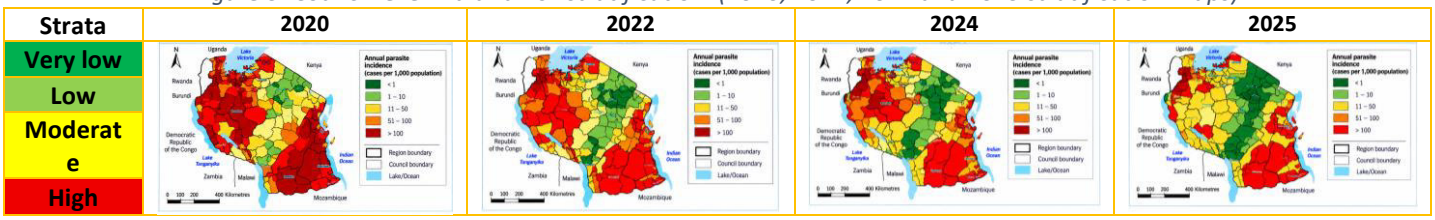
Analysis of the 2025 malaria stratification indicates continued progress towards lower transmission intensity across the country. Over the 2020–2025 period, there has been a gradual shift in both administrative units and population towards lower transmission strata, reflecting the overall reduction in malaria burden and the impact of sustained malaria control interventions. The proportion of councils classified as very low transmission increased from 20% in 2020 to 29% in 2025 (Table 1 and Figure 5), while the population residing in these areas nearly doubled, increasing from approximately 9.5 million to 17.4 million people. Conversely, the number of councils classified as high transmission declined substantially during the same period, indicating a progressive contraction of areas experiencing intense malaria transmission.

[10] MIS: Under-five prevalence for 2008 -2022 is from Malaria Indicator Surveys. The 2025 School Malaria Parasitological Survey (SMPS) was extended to include community level to ascertain the prevalence of malaria among under five children.

Table 1: Council level malaria risk stratification: Number of Councils by strata and year

Strata	Number of Councils			
	2020	2022	2024	2025
Very low	36	38	52	54
Low	32	32	36	40
Moderate	52	57	71	63
High	64	57	25	27

Figure 5: Council level malaria risk stratification: (2020, 2022, 2024 and 2025 stratification maps)



Despite these encouraging gains, the persistence of high and moderate transmission strata as the primary contributors to the national malaria burden highlights the heterogeneous nature of malaria transmission in Tanzania. These findings underscore the importance of maintaining a stratified malaria control approach, with intensified, geographically targeted interventions in persistent transmission hotspots, while sustaining surveillance and prevention efforts in low- and very low-transmission areas to prevent resurgence and support progress towards malaria elimination.

Population groups at risk

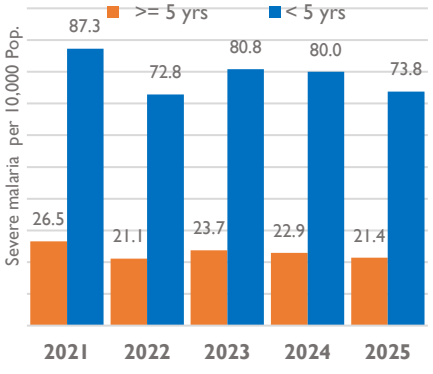
Malaria burden remains unevenly distributed across population groups, with certain groups experiencing disproportionately higher risk. **Children under five years of age** continue to bear the greatest burden of severe malaria morbidity, consistently recording higher incidence rates than older age groups throughout the 2021-2025 period (Figure 6). **Pregnant women** also remain a key risk group, despite notable progress: routine antenatal care (ANC) data show malaria positivity among pregnant women declined from approximately 7.7% in 2021 to 3.9% in 2025, reflecting both reduced transmission and improved testing coverage. However, geographic variation persists, mirroring broader transmission patterns (Figure 6).

School-aged children (5–16 years) have emerged as an increasingly significant reservoir of malaria. Often harbouring parasites without symptoms, sustaining transmission even as prevalence declines. Nationally representative surveys revealed a drop in malaria prevalence from 21.6% in 2015 to 7.5% in 2025. Yet, this age group has consistently registered higher prevalence rates compared to both under-five children and older populations.

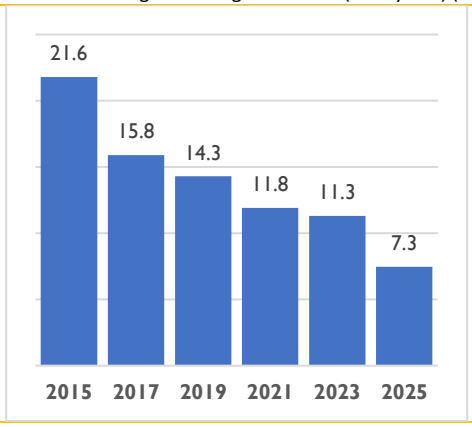
The above findings underscore that, despite overall progress, malaria continues to disproportionately affect **young children, adolescents, and pregnant women** - groups that remain central to the fight against malaria.

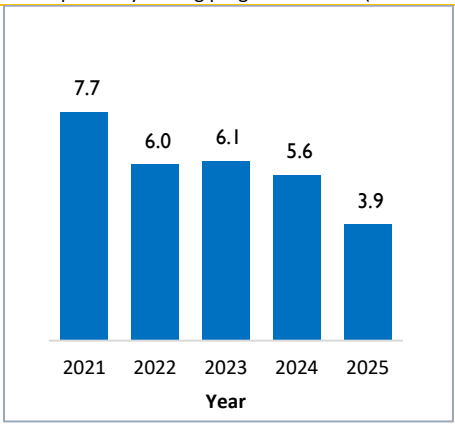
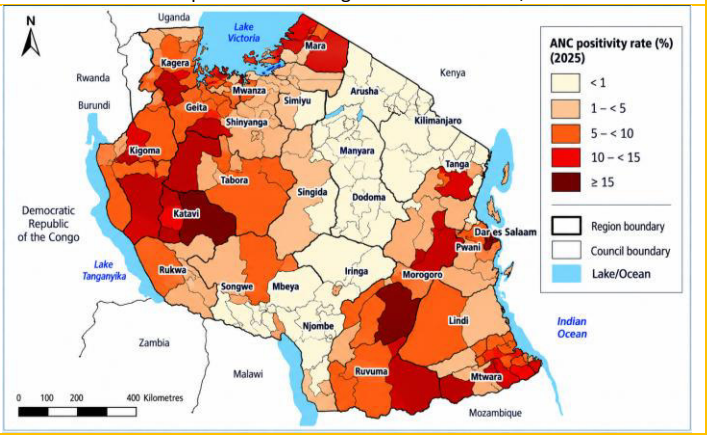
Figure 6: Evidence of population at risk: incidence of severe malaria morbidity by age groups, pregnant women malaria test positivity rate, and School age children prevalence

Severe malaria cases per 10,000 population by age groups (2021-2025)



Malaria prevalence among school -aged children (5-16 years) (2015-2025)



Malaria positivity among pregnant women (2021-2025)	Malaria prevalence among PW at council level, 2025
	

Parasite and Vector dynamics

Malaria epidemiology in Mainland Tanzania is influenced not only by differences in burden over time and place, but also by the composition of parasite species and mosquito vector populations.

Plasmodium falciparum remains the dominant malaria parasite, accounting for approximately 96% of infections. The remaining infections are mainly due to *P. malariae* and *P. ovale*, either occurring as mono-infections or mixed infections. Emerging molecular evidence indicates that *P. ovale* may occur at relatively higher prevalence in some councils, while *P. vivax*, previously considered negligible, has also been detected in the north-western Lake Zone. These findings suggest that parasite diversity may be broader than previously assumed, particularly as transmission declines and becomes more localized.

The vector profile is similarly diverse. Transmission is driven primarily by members of the *Anopheles funestus* group and the *Anopheles gambiae* complex. Among these, *An. funestus* has been the dominant vector in many settings, followed by *An. arabiensis* and *An. gambiae sensu stricto*.

Vector behaviour varies across species. *An. funestus* and *An. gambiae s.s.* are predominantly indoor-feeding and indoor-resting, making them more responsive to indoor interventions such as LLINs and indoor residual spraying (IRS). In contrast, *An. arabiensis* exhibits more flexible feeding and resting behaviour, including outdoor biting, reducing the effectiveness of indoor-only interventions.

Additional vector species, including *An. merus*, *An. rivulorum*, *An. parensis*, *An. leesoni*, and secondary vectors such as *An. pharoensis* and *An. coustani*, have also been documented. This diversity highlights the need for adaptive and context-specific vector control strategies.

Emerging risks and threats

Biological and ecological threats are becoming increasingly important in shaping malaria transmission dynamics in Tanzania.

Artemisinin partial resistance (APR) in Tanzania was first documented in Karagwe District Council in 2022 and associated with delayed parasite clearance and the presence of validated *pfk13* R561H mutations. Follow-up therapeutic efficacy studies in Kyerwa and Ngara District Councils have been conducted to assess the extent of spread. This development poses a significant threat to current first-line treatments and underscores the need for strengthened therapeutic efficacy surveillance and preparedness for policy adaptation.

In parallel, insecticide resistance continues to be reported across multiple vector populations, potentially reducing the effectiveness of core vector control interventions.

The emergence of *Anopheles stephensi*, an invasive vector with the potential to sustain urban malaria transmission, introduces an additional layer of risk, particularly in rapidly urbanizing areas. These risks, combined with environmental and climatic variability, highlight the increasing complexity of malaria control and the need for enhanced surveillance, adaptive strategies, and sustained vigilance.

3. Review of NMSP 2021-2025 Implementation

Program performance towards the NMSP 2021 -2025 Goal

The National Malaria Strategic Plan (NMSP) 2021-2025 was anchored on two targets: a principal target to reduce malaria prevalence and an auxiliary target to reduce incidence. The incidence target was introduced as a stable longitudinal measure to complement prevalence estimates, which can be influenced by seasonality and survey biases.

The principal goal aimed to reduce the average national malaria prevalence in children under five years from 7.5% in 2017 to 5.5% at mid-term, and further to below 3.5% by 2025. However, the Mid-Term Review (MTR) in 2023 revealed that the mid-term target was not achieved, with prevalence rising to 8.1% (MIS 2022). Unfortunately, during the NMSP implementation period, the Malaria Indicator Survey (MIS) was conducted only once in 2022 corresponding with the MTR, leaving no data point for 2025.

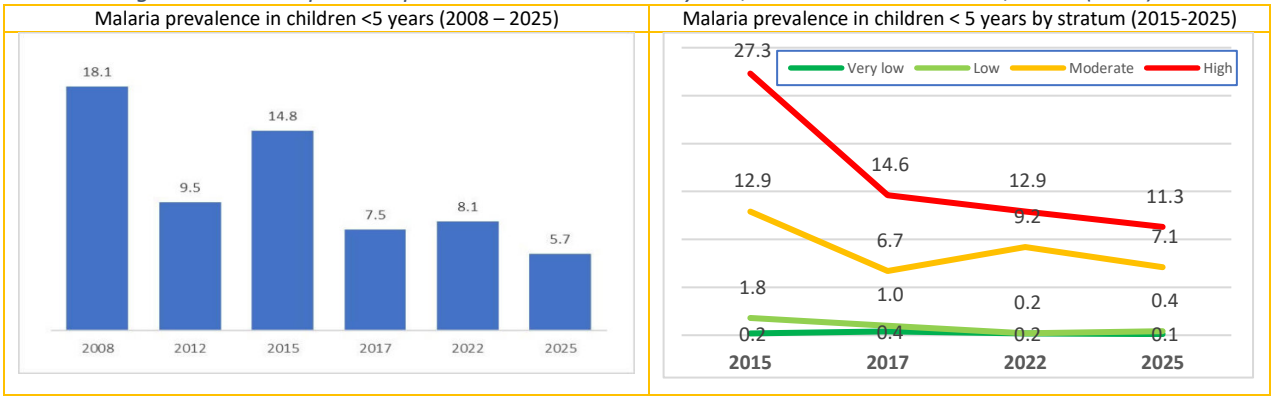
To address this gap, the School Malaria Parasite Survey (SMPS), which has been conducted biennially since 2014/2015 among school-aged children (5–16 years), was expanded in 2025 to include community-level and under-five children' data. The 2025 SMPS reported a 5.7% prevalence among children under five years, which is presented alongside MIS results in Table 2 and Figure 7. This provides a continuum of evidence to supplement the inconsistent MIS data for both national and strata-specific targets.

Table 2: Goal indicator, definition and targets

Indicator definition		Numerator		Denominator	
Malaria prevalence in children aged less than 5 years (pfpr6-59months)		Number of children aged less than 5 years positive for malaria parasites		Number of children tested	
Indicator	Baseline MIS 2017	Target 2023	Achievements MTR 2022 MIS (*)	Target 2025	Achievements MPR 2025 SMPS (**)
National	7.5%	5.0%	8.1%	<3.5%	5.7%
Very Low	0.4%	0.2%	0.2%	0.0%	0.1%
Low	1.0%	0.5%	0.6%	0.3%	0.4%
Moderate	6.7%	3.5%	9.2%	1.5%	7.1%
High	14.6%	7.5%	12.2%	3.5%	11.3%

(*) Mid-term results based on MIS. Sample 4,773 children under the age of five years. Risk classification is according to 2020 risk stratification at regional level.
(**) end of term results based on SMPS, community arm. Sample 10,057 children under the age of five years. Risk classification is according to 2020 risk stratification at council level.

Figure 7: Malaria parasite prevalence in children < 5 years; Source: MIS 2008-2022, SMPS (2025)

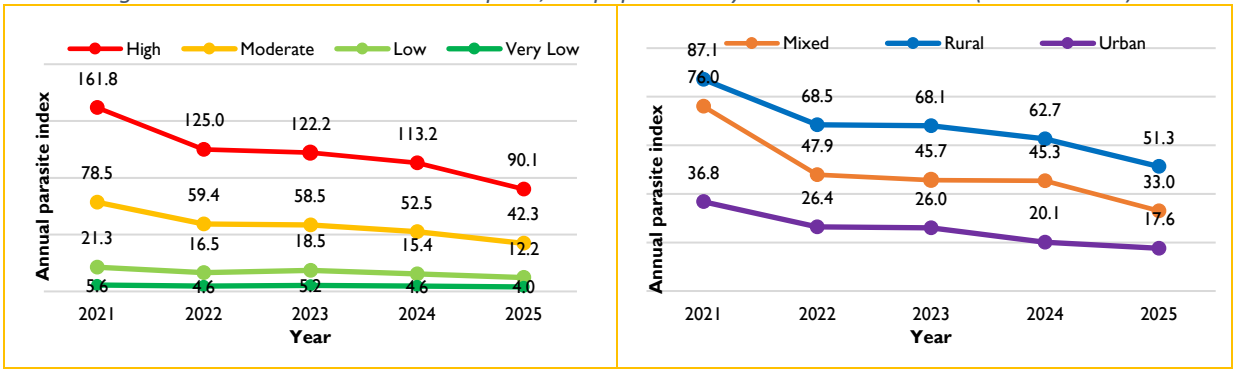


The auxiliary target for the national goal in the NMSP (2021 – 2025), was to decrease the Annual Parasite Incidence (API) from an average of 104 per 1000 in 2020, to less than 30 per 1000 population in 2025. The API, which measures the number of positive malaria laboratory tests per thousand people, has shown a steady decline from 2020 to 2025 (Table 3). Over these six years, though the target was not met, the API dropped notably from 105 per 1,000 population in 2020 to 43 per 1,000 population in 2025, indicating a significant reduction in malaria cases. Overall, the API trend shows a decline across all epidemiological strata (Table 3). In terms of residence, rural and mixed areas report higher APIs than urban settings; however, all types of residences demonstrate a consistent downward trend over the years (Figure 8).

Table 3: Annual Parasite Incidence (API) by strata

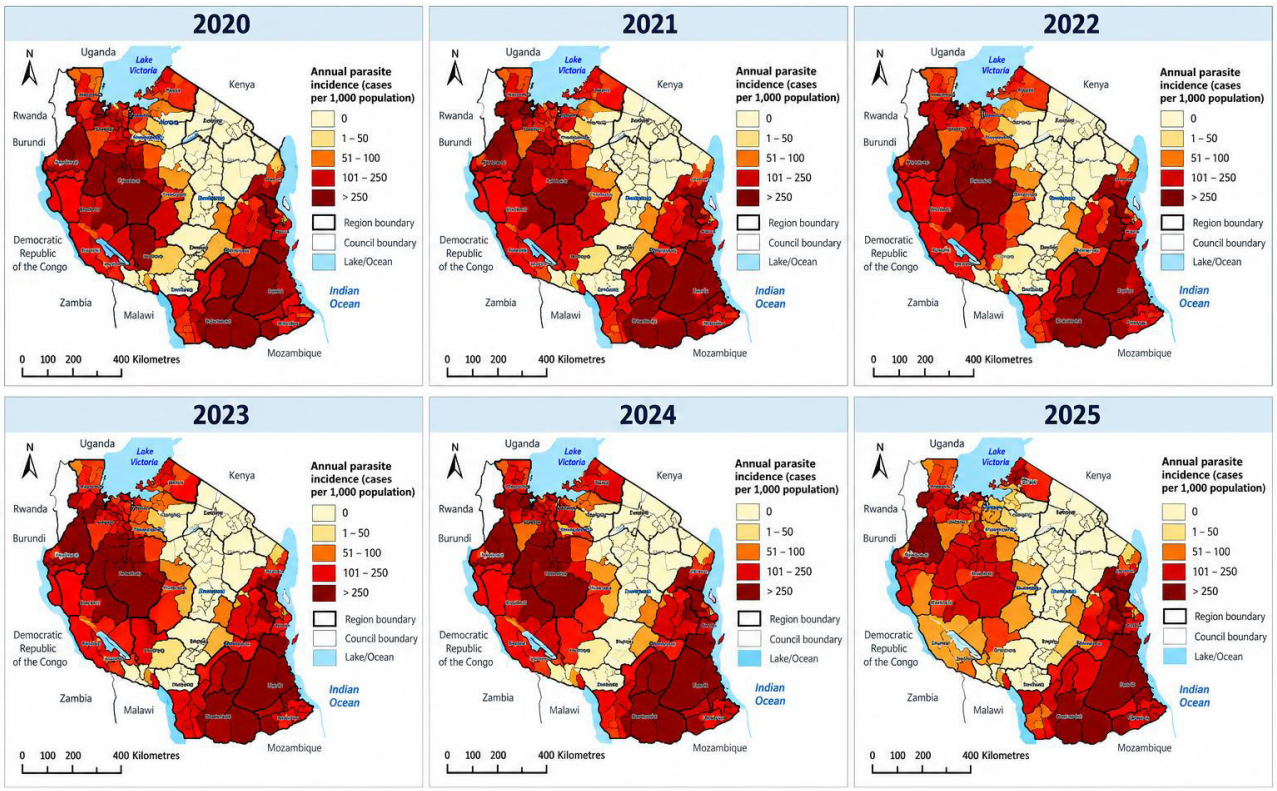
Stratum	Indicator definition: Numerator: Confirmed malaria cases Denominator: Population at risk per 1,000				
	Baseline DHIS 2020	Target 2023	Achievements (DHIS 2022)	Target 2025	Achievements (DHIS 2025)
National	104.7	60	58.8	< 30	43.2
Very Low	9.7	3	4.6	1	4.0
Low	29.5	12	16.5	< 6	12.2
Moderate	116.7	60	59.4	30	42.3
High	215.0	125	125.0	< 60	90.7
Urban	48.3	25	26.4	12	17.6

Figure 8: Annual Parasite Incidence per 1,000 population by strata and residence (2021 to 2025)



The regional API distribution shows a marked difference across regions with the number of regions with API above 50 decreasing from 2020 to 2025. A similar trend is seen at the council level, with the number of councils reporting an API below 50 per 1,000 population increasing between 2020 and 2025 (see Figure 9).

Figure 9: Council level Annual Parasite Incidence: (2020 to 2025)



Program performance towards the NMSP 2021 -2025 Outcomes

Level of attainment of malaria Vector Control outcome indicators

LLINs: LLINs was the main Vector control intervention. during the implementation of the NMSP 2021-2025.

The strategic approach for long-lasting insecticidal nets (LLINs) was stratified to ensure universal access according to malaria transmission settings. Population access to LLINs serves as a proxy for household use, based on the assumption that every LLIN in the household is used by two people.

Overall LLIN access in 2025, as reported by the School Malaria Parasite Survey (SMPS), stood at 69%, well below the national target of **85%**. None of the strata achieved their respective targets, although access was relatively higher in high and moderate transmission settings. Two key factors contributed to this shortfall:

- **Target-setting limitations**: The targets did not account for the withdrawal of mass distribution campaigns in low and very low transmission areas since 2018. This structural gap made it impossible for these strata to reach the 85% benchmark, thereby lowering the overall national average.
- **Delayed mass campaigns**: Implementation in moderate and high transmission settings was disrupted by the withdrawal of US PMI funding in 2025, further constraining coverage.

These findings highlight the need for **adaptive target-setting** and **sustainable financing** to ensure equitable LLIN access across all transmission settings.

Quality Larval Source Management (LSM): The strategic approach aimed at implementing appropriate, sustainable and quality Larviciding. During the period of the previous NMSP 2021 - 2025, quality Larviciding was planned to be implemented in 32 councils, however, only three (3) councils conducted quality larviciding: Handeni DC, Tanga CC and Lushoto DC representing High, moderate and low malaria transmission risk respectively. Larviciding within the three councils was implemented as part of a pilot study to generate experience and evidence on operationalization and impact of the intervention, per different malaria risk strata.

Indoor Residual Spraying (IRS): Donor funding for IRS was initially prioritized alongside LLINs to sustain implementation throughout the previous NMSP 2021 - 2025 period. However, resource constraints led to a progressive scale-down of IRS operations, which were discontinued by the second year (2022) of the NMSP implementation cycle. This reduction in coverage limited the continuity of IRS as a complementary vector control measure in targeted high-risk areas.

Level of attainment of Malaria Testing and Treatment outcomes

Malaria Testing: The malaria testing indicator, standardized globally, is used to assess access to diagnostic services. In Tanzania, the Malaria Indicator Survey (MIS) 2022, conducted at the mid-point of the NMSP implementation period, reported a testing rate of 48%, which improved slightly to 50% in 2025. Despite this progress, both the mid-term and end-term national targets were not achieved, and none of the epidemiological strata met their respective targets. Testing rates were comparatively lower in very low malaria risk areas, reflecting uneven access.

During the implementation period of the 2021–2025 National Malaria Strategic Plan (NMSP), a total of 99,837,317 malaria tests were conducted; 70,541,992 (70.7%) in public facilities and 29,295,325 (29.3%) in private facilities. A total of 17,625,260 (17.6%) uncomplicated malaria cases were diagnosed through outpatient departments (OPD), of which 14,765,441 (83.8%) cases were reported from public health facilities and 2,859,819 (16.2%) from private health facilities. To further expand access, community outlet testing was introduced across 35 high-burden councils, with the expectation that these outlets would contribute at least 25.8% of total reported cases in the HMIS/DHIS2 system. These efforts translated into an Annual Blood Examination Rate (ABER) consistently above 25% throughout the five years, reflecting sustained expansion of malaria diagnostic services across both public and private sectors. This achievement contributed to improved access to timely diagnosis and treatment.

Malaria Treatment: Children under five years of age are representative vulnerable groups to assess the access to appropriate, quality and timely treatment. The 2025 SMPS showed treatment uptake is decreasing with increasing wealth quintile as they have more access to laboratory testing which can exclude malaria as a cause of fever and target the appropriate treatment.

Between 2021 and 2025, a cumulative total of 20,073,743 antimalarial treatment doses were dispensed nationwide, comprising 17,405,457 (66.3%) doses distributed through public health facilities and 2,668,286 (33.7%) through private health facilities. This

demonstrates continued progress in ensuring access to effective malaria treatment services and strengthening case management across all levels of healthcare delivery.

Malaria Chemoprevention (IPTp3 and IPTsc): Over the 2021–2025 NMSP implementation period, a total of 9,187,818 pregnant women received the third dose of Intermittent Preventive Treatment in pregnancy (IPTp3) during antenatal care attendance. Coverage increased from 69.0% in 2021 to 77.2% in 2025 among PW attending their third ANC visits, indicating significant progress in the uptake of IPTp3 services. Furthermore, under the Intermittent Preventive Treatment for schoolchildren (IPTsc) initiative, 278,892 students from 491 schools were reached. Of these 73% receiving the first round and 57% receiving the second round of treatment, demonstrating progress in expanding malaria chemoprevention interventions among school-age children.

Summary of **MPR Identified Challenges and Recommended Strategic Directions** are listed in Annex 2

Financing of the National Malaria Strategic Plan, 2021–2025

The estimated resource requirement for implementation of the National Malaria Strategic Plan (NMSP) 2021–2025 was USD 953.3 million. By the end of the implementation period, approximately 51% of the required resources had been mobilized, leaving a financing gap of about 49% (Table 4). This funding shortfall constrained the full implementation of several planned interventions and limited the programme's ability to achieve all strategic targets.

Malaria financing remained heavily dependent on external sources, which accounted for approximately 87% of total funding during the five-year period. Domestic financing remained limited, highlighting the programme's continued vulnerability to fluctuations in donor support and emphasizing the need for increased and sustainable government investment.

Several factors contributed to the financing gap. First, some key interventions—including larval source management (LSM), indoor residual spraying (IRS), and selected malaria preventive therapies—received limited financial support. Second, reductions in external financing, particularly following the withdrawal of support from the United States Government (USG) and the subsequent reprioritization and resizing of Global Fund grants, further constrained available resources. These funding limitations affected the scale and geographical coverage of several high-impact interventions, particularly in areas with persistent malaria transmission.

The financing experience during the 2021–2025 NMSP highlights the importance of diversifying funding sources, increasing domestic resource mobilization, and strengthening financial sustainability to ensure uninterrupted implementation of priority malaria interventions and accelerate progress towards national malaria control and elimination goals.

Table 4: Need, availability of funds and gap by year (2021 - 2025)

YEAR	Total anticipated / anticipated	NSP	gap
2021	$ 88,035,683	$ 160,023,947	$ 71,988,264
2022	$ 101,071,545	$ 178,410,125	$ 77,338,580
2023	$ 104,438,958	$ 201,471,176	$ 97,032,218
2024	$ 70,401,161	$ 202,999,205	$ 132,598,044
2025	$ 122,870,002	$ 210,380,437	$ 87,510,435
2021-2025	$ 486,817,349 (51%)	$ 953,284,890	$ 466,467,541 (49%)

Two major changes have been observed in the implementation of the previous NMSP (2021-2025) compared to the preceding period (2013-2020). The first one is the two-fold increase of proportional domestic funding allocation for malaria from 6% to 13%. It should be noted that the increased Government contributions in the two last years of the NMSP (2024 and 2025) were due to its commitment to procuring bio-larvicides and to covering financial gaps resulting from reduced partners contributions. The second notable change is the decline in USG contributions from 36% to 30% in the NMSP 2021–2025 compared to the preceding period (2013-2020). It should be noted that during the previous NMSP (2021-2025), PMI contribution declined significantly from 37.5 million USD in 2021 to virtually zero in 2025. Global Funds contributions have fluctuated annually, largely driven by procurement cycles, particularly the timing and scale of insecticide treated nets, (ITN) purchases associated with targeted replacement campaigns. (Table 5).

Table 5: Financial contributions (2021-2025) for malaria control in Tanzania

Year	Government of Tanzania	Others	United States Government	The Global Fund
2021	$6,970,320	$ 4,366,473	$ 37,560,000	$ 39,138,891
2022	$7,104,525	$ 5,537,321	$ 36,531,590	$ 51,898,109
2023	$7,204,899	$ 5,944,937	$ 35,596,133	$ 55,692,989
2024	$11,366,352	$ 4,924,680	$ 36,438,637	$ 17,671,491
2025	$30,996,150	$ 5,000,000		$ 86,873,852

The budgetary allocation for the MoH fluctuates from 2.7% to 4.2% of the entire Government budget (Table 6). A more realistic figure on health sector allocation is based on analysis that is more complex and is provided by Policy Forum (an NGO network). Their post budget analysis for the FY 2024/25 reported a comprehensive contribution for health equal to 5.4% and 5.1% for the financial years 2023/24 and 2024/25 respectively. This is still an underachievement in respect to the Abuja declaration target of 15% of allocation for the health sector.

Table 6: Government and Ministry of Health allocated budget (2021- 2025)

Year	United Republic of Tanzania	Ministry of Health (MoH) (*)	MoH/URT (*)
2021	$ 10,612,287,785	$ 444,536,046	4.2%
2022	$ 11,792,197,589	$ 444,681,175	3.8%
2023	$ 17,630,856,129	$ 478,569,276	2.7%
2024	$ 15,808,854,953	$ 462,976,153	2.9%
2025	$ 17,532,079,976	$ 575,521,166	3.3%

(*) not including external contributions and allocation for health sector to other ministries (e.g. PMO-RALG)

4. The Strategy

Strategic Framework

Vision

A Tanzania where every person lives free from malaria

Mission

Ensure all people in Tanzania have equitable and gender responsive access to sustainable, quality, effective, safe and affordable malaria preventive and curative services through efficient collaborative partnership and community ownership

Goals

The goals and targets outlined in this strategic plan provide a clear framework for guiding programme implementation and measuring progress toward achieving national health priorities. These targets will serve as key benchmarks for monitoring performance, identifying gaps, and driving evidence-based actions toward improved health outcomes. See Table 7.

Table 7: Goals and Targets[11]

Goals	Baseline	Milestones	Targets	
		2025	2028	2030
Reduce malaria prevalence rate in children under the age of five years by at least 90% from 2015 levels	**14% (2015)**	**5.7%**	**3.5%**	**1.4%**
Reduce malaria mortality rates per 100,000 population by at least 90% compared with 2015	**11.3 (2015)**	**1.9**	**1.5**	**1.1**
Reduce malaria case incidence by at least 90% compared to 2015	**150 (2015)**	**43.3**	**29.2**	**15.0**
Increase the proportion of Councils with very low malaria transmission	**15% (2018)**	**29%**	**38%**	**43%**

Strategic Outline

The strategic outline provides the overall direction for programme implementation by outlining key priorities, interventions, and approaches necessary to achieve the intended goals and targets.

SO	Strategic Objectives
1	Reduce malaria parasite transmission by accelerating the implementation of targeted, recommended, evidence-based, integrated malaria preventive interventions.
2	To prevent the occurrence of mortality related to malaria infection through universal access to appropriate diagnosis and treatment.
3	To provide timely and reliable information on malaria and its control needed to take appropriate actions in different transmission risk and ensure resources are used in the most cost-effective manner.
4	Ensure timely availability of safe, efficacious and quality malaria commodities and supplies at the service delivery points.
5	To strengthen an enabling environment that empowers individuals and communities at risk of malaria to constituently protect themselves and their families and seek timely and appropriate malaria care.
6	To strengthen efficient and effective implementation of malaria strategies through accountable leadership and partnership.

[11] NMSP targets have been set to align with WHO GTS (2016-2030) targets, hence the use of 2015 baseline.

Strategic Objective 1: Reduce malaria parasite transmission by accelerating the implementation of targeted, recommended, evidence-based, integrated malaria prevention interventions (Malaria Prevention)

In 2024, the 11 HBHI countries (excluding India, and including the Sudan) were responsible for 64% of global malaria cases and 68% of deaths. United Republic of Tanzania is among the 11 countries accounting for 3.3% of all malaria cases estimates in 2024 (WMR 2025). This strategic area **Malaria Prevention** and its strategic objective focuses on accelerating reduction of malaria transmission and subsequent malaria cases by implementing following strategic approaches:

SA	Strategic Approaches
1.1	Accelerate the reduction of malaria burden in **high and moderate transmission risk** areas.
1.2	Promote malaria elimination efforts by protecting the population at risk of infection in areas with **low malaria endemicity.**
1.3	Promote malaria prevention efforts by protecting the population at risk of infection in **urban areas.**
1.4	Establish cross cutting-malaria prevention initiatives across all malaria strata.

Strategic Approach 1.1: Accelerate the reduction of malaria burden in high and moderate transmission risk areas

Situation and rationale: Although malaria transmission in Tanzania has declined overall, high and moderate transmission councils continue to carry most of the national disease burden. The 2025 MPR shows that parasite prevalence and API remain substantially higher in these strata, with under five prevalence reaching 11.3% in high-risk areas and API above 90 per 1,000 population. The 90 councils classified in high and moderate transmission risk according to 2025 stratification (half of country population) accounts for 82% and 93% of the malaria cases in under-fives and five years and above respectively. These findings confirm the need for accelerated, tailored and multi modal intervention packages in high and moderate transmission areas to drive substantial burden reduction. The Vector Technical Working Group 2026 and the NMSP 2021-2025 emphasizes on restoring and maintaining high ITN access, deploying targeted IRS in resilient, extremely high infection pockets, expanding LSM in suitable epidemiological and operational settings, and scaling chemo-preventive services for biologically and socioeconomically vulnerable groups. Allocation of resources should follow updated risk stratification and routine surveillance data to maximize impact.

Strategic direction: Implementation will focus on intensifying universal ITN access in high and moderate strata through mass campaigns, school-based distribution and routine ANC/EPI channels, addressing the decline in ITN coverage documented in the MPR. Targeted IRS will be deployed selectively in persistent resilient transmission pockets and as part of emergency response in outbreak prone councils LSM will be strengthened and expanded beyond pilot councils, with improved operational quality, multisectoral environmental management, and use of innovative technologies. Chemoprevention will be scaled through IPTp, IPTsc, PMC, SMC, PDMC, and malaria vaccination. Together, these layered interventions will accelerate burden reduction in councils where malaria transmission remains concentrated.

Deliverables: a) achieve and maintain 80% ITN access; b) implement targeted IRS in eligible hotspots with resilient, extremely high transmission to protect approximately 5% of the population in this stratum and to mitigate emergency situations; c) expand LSM coverage in suitable settings; and d) scale up the delivery of chemoprevention, including IPTp, IPTsc, PMC, SMC, PDMC and malaria vaccination.

Under the Strategic Approach Malaria burden reduction (1.1), the following Strategic Interventions will be implemented:

SI	Strategic Intervention
1.1.1	Ensure universal ITN coverage through mass campaign and continuous distribution to ensure optimal population ITN access of 80% in high and moderate malaria transmission risk strata.
1.1.2	Implement targeted IRS to reduce malaria burden in prioritized areas of extremely high transmission and high population vulnerability.
1.1.3	Support targeted Larval Source Management (LSM) as part of integrated vector management in appropriate epidemiological and operational settings.
1.1.4	Implement and scale up evidence-based malaria chemoprevention and vaccination strategies to protect vulnerable populations from malaria infection, disease, and related complications.

Table 8 depicts the strategic interventions, Service Delivery Mechanisms (SDM) and number of councils targeted for implementation per transmission risk strata.

Table 8: Strategic interventions, Service Delivery Mechanisms by transmission risk and number of councils targeted

Malaria transmission risk Stratum	Strategic Interventions	Service Delivery Mechanism	Number of councils	NSP section
High	1.1.1 ITN	TMC	26	1.1.1.1
		SNP	26	1.1.1.2
		RCH	26	1.1.1.3
	1.1.2 IRS	Targeted IRS	TBD (*)	1.1.2.1
		IRS in emergecy situation	TBD (**)	1.1.2.2
	1.1.3 LSM	Environmental management	26	1.1.3.1
		Targeted larviciding	26	1.1.3.2
	1.1.4 Preventive Therapies	IPTp	26	1.1.4.1
		IPTsc	26	1.1.4.2
		SMC	9	1.1.4.3
		PMC	26	1.1.4.4
		PDMC	26	1.1.4.5
		Vaccine	TBD (**)	1.1.4.6
Moderate	1.1.1 ITN	TMC	61	1.1.1.1
		SNP	61	1.1.1.2
		RCH	61	1.1.1.3
	1.1.3 LSM	Targeted larviciding	61	1.1.3.1
		Environmental management	61	1.1.3.2
	1.1.4 Preventive Therapies	IPTp	61	1.1.4.1
		PMC	61	1.1.4.4
		PDMC	61	1.1.4.5
(*) Targeted transmission resilient hotspots (**) Will be implemented in the event of emergency/special situation (***) Will be informed by feasibility plan expected by MSP Midterm				

Strategic Intervention (1.1.1): Ensure universal ITN coverage through mass campaign and continuous distribution to ensure optimal population ITN access of 80% in high and moderate malaria transmission risk strata.

Insecticide-treated net (ITNs) distribution through Targeted Mass Campaign (TMC), School Net distribution (SNP) and provision to biologically vulnerable populations through ANC and EPI clinics will be implemented in high and moderate malaria risk strata to achieve and sustain an ITNs population access level of 80%. School-based ITN distribution (SNP) will be conducted between campaign cycles, one year after each TMC, while continuous distribution through Antenatal Care (ANC) and the Expanded Programme on Immunization (EPI) will be maintained to sustain coverage. In the high and moderate malaria transmission areas the population access to an ITNs is 70% and 65% respectively, below the expected target of 80%. To address this gap, Tanzania will continue implementing a combined "catch-up" and "keep-up" approach, which has been adopted in previous Malaria Strategic Plans (MSPs). Between 2021 and 2025, a total of 13,946,619 ITNs were distributed through targeted replacement campaigns in high-burden areas. These efforts were supplemented by continuous distribution through ANC, EPI, and schools, which provided 12,230,317, 10,788,024, and 8,599,106 ITNs, respectively. The national insecticide resistance monitoring profile will guide the selection of appropriate ITN types. Quantification of ITN requirements has been based on the Roll Back Malaria (RBM/UNOPS, 2022) guidance for achieving 80% ITN population access. In the period 2026-2030, a total of 68,024,162 ITNs will be issued through TMC and SNP in 87 high and moderate burden councils and through ANC/EPI clinics in all 90 high and moderate transmission risk councils. ITN distribution procedures will follow existing Guidelines, Operational Manuals and Standard Operating Procedures.

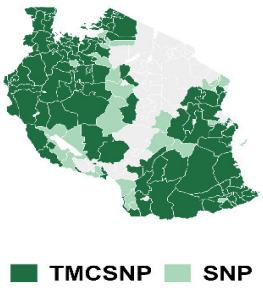


Figure 10: Councils eligible for universal ITN distribution

Under the Universal ITN coverage (1.1.1) the following Service Delivery Mechanisms will be implemented:

SDM	Service Delivery Mechanisms
1.1.1.1	Implement targeted mass campaign in high and moderate malaria transmission strata.
1.1.1.2	Implement annual ITN distribution in between targeted mass campaigns through School Net Program (SNP) to maintain optimal coverage.
1.1.1.3	Distribute ITNs to biologically vulnerable groups (pregnant women and infants) through ANC and EPI clinics.

SDM 1.1.1.1: Implement targeted mass campaign in high and moderate malaria transmission strata

Prioritizing Targeted Mass Campaigns (TMC) in high and moderate malaria transmission strata ensures optimal resource use, maximizes epidemiological impact, and strengthens evidence-based targeting to achieve the greatest reductions in malaria burden. Ideally periodic mass distribution campaigns are expected to boost access to nets and is expected to be repeated every 3 years. Between 2026–2030, a total of 41,581,476 ITNs will be distributed through TMCs. Of these, 22,454,226 will be delivered during Phase 1 (2026–2028).

SDM 1.1.1.2 Implement annual ITNs distribution in between targeted mass campaigns through SNP to maintain optimal coverage

School-based ITN distribution will be conducted between targeted mass campaigns to maintain sufficient ITN coverage in councils within high and moderate malaria transmission strata. Tanzania is conducting annual ITN distribution using primary school outlets to keep up the coverage in between replacement campaign since 2012. In the 2026-2030 period a total of 12,212,719 ITNs will be distributed through the SNP. Of these 6,457,158 will be issued during Phase 1 (2026 -2028).

SDM 1.1.1.3 Distribute ITNs to biologically vulnerable groups (pregnant women and infants) through ANC and EPI clinics

ITNs distribution for pregnant women and infants will be implemented in all malaria transmission strata, including urban areas. Distribution will occur during the first ANC visit for pregnant women and during MR1 vaccination for infants at EPI clinics. In the 90 high and moderate malaria transmission councils, a total of 14,229,968 ITNs will be distributed to pregnant women and infants through ANC and EPI clinics during 2026-2030.

Strategic Intervention (1.1.2): Targeted Indoor Residual Spray for resilient malaria transmission hotspots and high population vulnerability

A remarkable decline in malaria burden has been recorded across high- and moderate-transmission councils over the past five years. Despite this significant progress, evidence indicates the persistence of resilient malaria transmission hotspots within some of these councils. These hotspots have been identified through exceptionally high malaria positivity rates among pregnant women attending antenatal care (ANC) services and elevated malaria prevalence among primary school children. Approximately 5% of RCH clinics and primary schools report infection rates consistent with hyperendemic or holoendemic malaria transmission. The factors contributing to the persistence of these hotspots are not yet fully understood; however, they may be associated with inadequate levels of protection against malaria and/or suboptimal access to quality malaria diagnosis and treatment services. Given the relatively uniform implementation of malaria preventive interventions across both hotspot and surrounding lower-transmission areas, additional targeted interventions are proposed for identified areas of persistent high malaria transmission. These interventions will include targeted IRS and other selective chemoprevention strategies, as appropriate, to accelerate reductions in malaria transmission and burden. Implementation of IRS will be guided by national Integrated Vector Management (IVM) Guidelines, IRS Standard Operating Procedures, the IRS Operational Manual for Malaria Transmission Control and Elimination, and relevant guidance from the World Health Organization (WHO). These frameworks will ensure the quality, safety, and effectiveness of IRS operations. A strong community-based approach will be emphasized to enhance community acceptance, ownership, and participation in intervention activities. Strengthening local capacity and engagement will be critical for ensuring the sustainability and long-term effectiveness of IRS and other targeted malaria control interventions in resilient transmission hotspots.

Under the Strategic Intervention Targeted IRS (1.1.2) the following Service Delivery Mechanisms will be implemented:

SDM	Service Delivery Mechanisms
1.1.2.1	Apply selective IRS in areas with extremely high infection rate (residual hyper and holo-endemic areas).
1.1.2.2	Implement IRS in response to alarming emergency and special situation in high/moderate transmission areas.

SDM 1.1.2.1: Apply selective IRS in areas with extremely high infection rate (residual hyper and holo-endemic areas)

Selective IRS will be prioritized in identified extremely high transmission areas that have consistently recorded antenatal care (ANC) malaria positivity rates of ≥20% over the last three years and school malaria parasitemia survey (SMPS) prevalence rates of ≥40%. As a targeted burden-reduction intervention, IRS aims to rapidly reduce transmission and protect communities at highest risk. The intervention will complement routine Insecticide-Treated Net (ITN) distribution and, where appropriate, be integrated with additional chemoprevention strategies.

During the 2026–2030 period, IRS will be implemented in approximately 88,000 household structures across about 140 residual high-transmission foci (an average of two areas per council) located within 70 high- and moderate-transmission councils. Through this targeted approach, ANC malaria positivity rates in the intervention areas are expected to decline from over 20% to below 10%, while SMPS parasite prevalence is projected to decrease from more than 40% to below 20%, contributing substantially to malaria burden reduction in these persistent transmission hotspots.

SDM 1.1.2.2: Implement IRS in response to alarming emergency and special situation in high/moderate transmission areas

Ecological and population vulnerability are expected to increase in the near future due to the combination of different factors such as climate change, periodic extreme climate variation, population movements, internal migration patterns, increased transmission instability due to current epidemiological transition and, consequent decreased population immunity. Given the above inherent risks, it is essential for the programme to maintain readiness to rapidly respond to any emerging malaria emergency or special situation detected through routine surveillance or early warning systems. Regions and councils in areas with complex emergency situations will coordinate and guide stakeholders in the implementation of IRS**.**

Strategic Intervention (1.1.3): Support targeted Larval Source Management in appropriate epidemiological and operational settings

The rationale for LSM, including larviciding application, in high-transmission malaria areas is that it reduces mosquito populations density at the breeding sites, lowers malaria transmission, complements ITNs (and IRS), helps manage insecticide resistance, and strengthens integrated vector management. It is especially useful where mosquito breeding sites can be identified, accessed, and treated regularly. The use of biolarvicides, remains a national priority intervention in Tanzania. The Government currently supports implementation across all councils through procurement of biolarviciding and training of key implementers[12]. Integrated Vector Management Guidelines and Standard Operating Procedures for malaria vector control and World Health Organization operational manual for Larval Source Management will guide stakeholders to support the implementation of LSM intervention. During the implementation of this strategic plan, the Central Government is expected to continue allocating funds for the procurement of biolarvicides while the Prime Minister's Office Regional Administration and Local Government (PMO-RALG) will coordinate the implementation of quality LSM at respective levels. A comprehensive LSM "Enabling Environment Package" will be developed and operationalized for targeted councils, including selection of priority areas to be targeted for LSM, annual costed LSM operational plans, documented resource allocations, trained vector control teams, completed supervision reports, and community engagement materials and activities supporting effective LSM implementation.

Under the Strategic Intervention Targeted LSM (1.1.3) the following Service Delivery Mechanisms will be implemented:

[12] In the financial year 2024/2025 and 2025/2026 respectively, the government has availed 15 billion Shillings for procurement 1,250,000 liters of biolarvicides from the local manufacturing plant and 4 billion for procurement of 16,000 knapsack sprayers to facilitate effective application of biolarvicides

SDM	Service Delivery Mechanisms
1.1.3.1	Implement integrated environment management interventions through coordinated partnership with local councils, private and non-health sectors and the community to reduce mosquito-breeding sites.
1.1.3.2	Apply appropriate and quality biolarvicides according to guidelines, standard operating procedures and new emerging technologies.

SDM 1.1.3.1: Implement integrated Environment management interventions through coordinated partnership with local councils, private and non-health sectors and the community to reduce mosquito breeding sites.

Environmental management interventions require involvement of non-health sector agencies and ministries. The NMCP has facilitated the development of a multisectoral framework and operational plan for the implementation of environment management activities across the private and non-health sectors. Each sector has appointed a focal person responsible to oversee the implementation of malaria Smart Actions that will have an impact on reducing man-made breeding habitats (Annex 3).

SDM 1.1.3.2: Apply appropriate and quality biolarvicides according to guidelines, standard operating procedures and new emerging technologies

Due to the ecological complexity and the magnitude of breeding habitats in higher malaria transmission areas, larviciding is especially useful where mosquito breeding sites can be easily identified, accessed, and treated regularly. Its effectiveness is greatest where mapping is accurate and community participation is strong. Therefore, NMCP will continue to support the implementing authorities at Council level by increasing their knowledge and skills to implement larviciding according to the guidelines and standard operating procedures.

Strategic Intervention (1.1.4): Implement and scale up evidence-based malaria chemoprevention and vaccination strategies to protect vulnerable populations from malaria infection, disease, and related complications.

Malaria chemoprevention is a highly justified intervention in Tanzania, particularly in areas with moderate to high malaria transmission, where it can substantially contribute to reducing malaria morbidity and mortality. The rationale for implementing chemoprevention is grounded in the country's malaria epidemiology, the heightened vulnerability of specific population groups, and the proven effectiveness of preventive antimalarial treatment in reducing; uncomplicated malaria episodes; severe malaria, malaria-related anemia, hospital admissions, and child mortality. Chemoprevention targets population groups at the highest risk of malaria infection and its adverse consequences, including: a) **Pregnant women** – who are at increased risk of maternal anemia, miscarriage, stillbirth, low birth weight, and neonatal mortality associated with malaria infection during pregnancy; b) **Infants and children under five years of age** – who bear the highest risk of severe malaria, including cerebral malaria, severe anemia, and malaria-related death due to their limited immunity; and c) **School-aged children** – who often serve as an important reservoir of asymptomatic malaria infection, contributing to sustained community transmission and ongoing disease burden. Malaria vaccine reduces clinical and severe cases of malaria by about one-third in 5–17-month-old children. Notably, the vaccine provides this protection in settings where there is ongoing use of other effective malaria prevention and treatment interventions. Two malaria vaccine are currently recommended by the WHO for use in malaria-endemic regions: (RTS,S and R21).

During this National Strategic Plan (NSP) period, Tanzania will implement a comprehensive package of malaria chemoprevention interventions. These include: (a) continued provision of Intermittent Preventive Treatment in Pregnancy (IPTp); (b) introduction of Perennial Malaria Chemoprevention (PMC); (c) introduction of Seasonal Malaria Chemoprevention (SMC) in areas with seasonal transmission; (d) Implementation of Intermittent Preventive Treatment in school-aged children (IPTsc); and (e) introduction of Post -Discharge Malaria Chemoprevention (PDMC) for eligible children recovering from severe anemia. These interventions will be delivered through integrated and sustainable service delivery platforms. Antenatal care services will continue to serve as the primary platform for IPTp and PMC delivery, schools will be utilized for IPTsc implementation, and community-based delivery mechanisms will support the rollout of SMC and PDMC. Leveraging existing health and community systems will enhance coverage, efficiency, and sustainability of these interventions.

Malaria chemoprevention will complement the protection provided by vector control interventions by offering an additional layer of protection during periods of heightened vulnerability. By maintaining therapeutic concentrations of antimalarial drugs in the bloodstream, chemoprevention reduces the risk of infection, clinical disease, and severe outcomes. In addition, certain

chemoprevention strategies can reduce gametocyte carriage, thereby lower the human reservoir of infection and contribute to reduced malaria transmission. This effect is particularly important for interventions targeting school-aged children, among whom asymptomatic infections are common and often sustain community transmission.

The implementation of targeted chemoprevention interventions among vulnerable populations has the potential to substantially reduce malaria-related illness and deaths, improve maternal and child health outcomes, and accelerate progress toward national malaria control and elimination goals. The proposed chemoprevention interventions are supported by strong evidence of safety, efficacy, cost-effectiveness, and operational feasibility in malaria-endemic settings. As such, they represent a valuable addition to Tanzania's malaria control portfolio and will complement existing vector control and case management interventions. Selection and deployment of specific chemoprevention strategies will be guided by local epidemiological conditions, transmission patterns, operational feasibility, available resources, and national and international policy recommendations, including guidance from the World Health Organization.

Under the Strategic Intervention Chemoprevention and Vaccine (1.1.4), the following Service Delivery Mechanisms will be implemented:

SDM	Service Delivery Mechanism
1.1.4.1	Increase the uptake of IPTp3+ among pregnant women at the health facilities to reduce vulnerability in pregnancy.
1.1.4.2	Strengthen the implementation of IPTsc in current implementing areas and scale up in selective high and moderate transmission areas to reduce the risk of malaria in school-aged children and to mitigate malaria transmission.
1.1.4.3	Introduce and scale up provision of seasonal malaria chemoprevention (SMC) in eligible high burden councils.
1.1.4.4	Introduce and scale up provision of perennial malaria chemoprevention (PMC) in eligible high burden councils.
1.1.4.5	Introduce and scale up provision of Post Discharge Malaria Chemoprevention (PDMC) among under five children admitted with severe malaria.
1.1.4.6	Introduction and scale-up of malaria vaccination within the country's existing immunization program in high malaria transmission risk areas.

SDM 1.1.4.1: Increase the uptake of IPTp3+ among pregnant women at the health facilities to reduce vulnerability in pregnancy.

Performance indicators in DHIS2 malaria dashboard show that the proportion of pregnant women attending health facility and receiving IPTp2 and IPTp3 raised respectively to 92% and 77% in 2025, from 78% and 61% in 2021. The focus of the strategy will be to increase uptake of IPTp2 to 95% and IPTp3+ to 85% through a) Improved supply chain management of SP; b) IPTp administration at each scheduled ANC visit; and c) Improved frequency of ANC attendance. To improve delivery mechanisms where inequities in access to ANC services exist, other delivery methods, such as the use of community health workers, and routine health facility related outreaches, will be explored. Cumulatively 8,411,668 and 14,448,440 pregnant women will be targeted for IPTp3+ by end of 2028 and 2030 respectively.

SDM 1.1.4.2: Strengthen the implementation of IPTsc in current implementing areas and scale up in selective high and moderate transmission areas to reduce the risk of malaria in school-aged children and to mitigate malaria transmission.

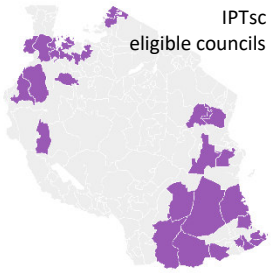


Figure 11: Councils eligible for IPTsc implementation

SMPS 2019, 2021, 2023 and 2025 have shown that school going age children in high malaria risk areas are easily carrying parasites: 7.5% national average in 2025 from 0% in Iringa and Arusha to over 20% in highly affected areas (Kagera, Mara and Geita). There is overwhelming evidence that IPTsc can reduce malaria burden among school age children and has a potential to reduce transmission in the communities[13]. IPTsc is implemented in five councils since 2024; Handeni DC, Handeni TC, Kilindi DC,

[13] Makenga, G., Seth, M.D., Baraka, V., Mmbando, B.P., Challe, D.P., Francis, F., Mhina, A., Minja, D.T.R., Chiduo, M., Mandara, C., Liheluka, E., Gesase, S., Segeja, M., Mtove, G., Kamugisha, M., Lusasi, A., Chacky, F., David, A., Thawer, S., Mohamed, A., Lazaro, S., Molteni, F., Nkayamba, A., Van geertruyden, J.P., Lusingu, J.P.A., 2023. Implementation research of a cluster randomized trial evaluating the implementation and effectiveness of intermittent preventive treatment for malaria using dihydroartemisinin-piperaquine on reducing malaria burden in school-aged children in Tanzania: met. Malar. J. 22, 7. https://doi.org/10.1186/s12936-022-04428-8

Kibondo DC, and Nyang'hwale DC. For all the 5 councils implementing IPTSc more than 70% of students received full treatment of IPTSc.

Targeted drug administration in school children through existing school systems will be rolled out in high transmission areas (Figure 11). The proposed therapeutic is the non-artemisinin combination and will be synchronized with the implementation of ACT diversification approach, including multiple first line therapies. Where applicable, the intervention will be integrated with ongoing school health initiatives such as LLIN distribution, nutritional supplementation, deworming, and menstrual hygiene programs to leverage existing structures and minimize operational costs. The program will also develop and pilot a complimentary community-based delivery mechanism for reaching out-of-school children to promote equity and strengthen monitoring, evaluation, and community engagement activities to ensure data-driven program adjustments. Based on 2025 data, a total of 1,520,636 school age children will be targeted per year in 3,208 primary schools in 27 high transmission risk councils. With an expected 80% coverage a total of 3,649,526 treatments per year will be delivered.

SDM 1.1.4.3: Introduce and scale up provision of seasonal malaria chemoprevention (SMC) in eligible high burden councils

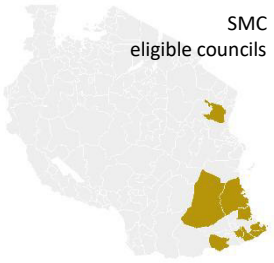


Figure 12: Eligible councils for SMC

WHO recommends that; targeted, time-bound chemo-preventive treatment can be safely implemented to significantly reduce illness and deaths from malaria among children aged 2-59 months in areas with predictable transmission patterns. This has been also confirmed in country by implementation research conducted in 2020-2021 in southern zone of Tanzania. [14]

NMCP plans to introduce **Seasonal Malaria Chemoprevention (SMC)** in 9 eligible councils in Tanzania that are fitting the following criteria (Figure 12): a) unimodal precipitation pattern with most of the rainfall concentrated in 3-4 months; b) high malaria burden; c) evidence of seasonal transmission with more than 60% of cases reported within a period of 3-4 months and d) demonstrated efficacy of selected therapeutic. The eligible councils are located in southern zone of Tanzania in Lindi and Mtwara regions (eight councils) and north eastern part of the country (one council). See Figure 12.The proposed therapeutic is the non-artemisinin combination of SP/AQ. This, in line with WHO recommendations, will reduce the medicine cost and will not interfere with the few available options to implement Multi first line therapies. Annually 342,785 children aged 2-59 months (16% of total population) will be targeted in the 9 eligible councils and consequently will be better protected against malaria. According to 4 monthly treatments during seasonal transmission peak, a total of 1,096,911 treatments is expected to be administered per year to reach 80% coverage.

SDM 1.1.4.4: Introduce and scale up provision of Perennial Malaria Chemoprevention (PMC) in eligible high burden councils

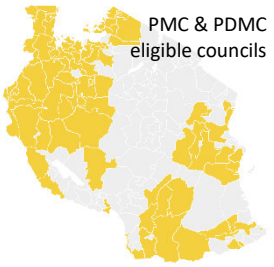


Figure 13: Councils eligible for PMC and PDMC implementation

In 2021-2022, implementation research was conducted in Nachingwea and Ruangwa councils in Lindi region. The PMC intervention showed high acceptability by health care workers and parents/guardians and feasibility to scale up PMC 3 doses co-administered with DPT2, DPT3 and Measles IVD services. In high and moderate strata, PMC provides an overall protection in the first year of life against malaria (30.3%), anemia (21.3%), hospital admissions associated with malaria parasitemia [38.1%]; and all-cause hospital admissions [22.9%]. PMC offers personal protection against clinical malaria for a period of approximately 35 days following the administration of each dose.

PMC using SP is recommended by NGMDT&PT 2026 for the high malaria risk councils (Figure 13) provided that there is evidence of sufficient efficacy. Alternative antimalarials should be explored for their efficacy in protecting infants. In areas eligible for SMC, PMC is not indicated. Surveillance of molecular markers of SP resistance, e.g. distribution and prevalence of *pfdhps 540* and 518 codon mutations, should be in place. Appropriate HMIS based reporting will be developed to accommodate PMC. Cumulatively 8,411,668

[14] Mwaiswelo, R.O., Mmbando, B.P., Chacky, F., Molteni, F., Mohamed, A., Lazaro, S., Mkalla, S.F., Samuel, B., Ngasala, B., 2021. Malaria infection and anemia status in under-five children from Southern Tanzania where seasonal malaria chemoprevention is being implemented. PLoS One 16, e0260785. https://doi.org/10.1371/journal.pone.0260785

and 14,448,440 infants in high-risk settings will be better protected against malaria complications by taking three (3) doses of SP (or alternative medicine) by end of 2028 and 2030 respectively.

SDM 1.1.4.5: Introduce and scale up provision of Post Discharge Malaria Chemoprevention among under five children admitted with severe malaria.

PDMC is giving a full course of long-acting anti-malarial drugs to children under five years old discharged from the hospital with a diagnosis of severe anemia or severe malaria for the duration of at least 3 months. In high and moderate burden councils (Figure 13), PDMC reduces mortality and readmissions in children recovering from severe malarial anemia. To guide the safe and effective implementation of post-discharge malaria chemoprevention for under-five children scheduled dosing, caregiver support, and strong follow-up and monitoring systems are necessary. Estimated 69,123 children (based on 2025 HMIS data) will be receiving three monthly ACT treatments per year.

SDM 1.1.4.6: Introduction and scale-up of malaria vaccination within the country's existing immunization program in high malaria transmission risk areas

The country's current focus is to develop a policy framework to support the adoption of malaria vaccine alongside existing malaria control measures and streamlining financial needs for the introduction and sustaining the vaccine. Reduction in vulnerability of infant and young children through the introduction of malaria vaccine is an attractive public health initiative, and its introduction will be assessed and considered during the implementation of this strategic plan. NMCP will spearhead a broad consultative process to promote an innovative delivery of recommended vaccines within the healthcare system in selected epidemiological suitable areas. By MSP mid-term (2028) a comprehensive plan, including resource mobilization process, for introduction of vaccine will be available.

Strategic Approach 1.2: Promote malaria elimination efforts by protecting the population at risk of infection in areas with low malaria endemicity

Situation and rationale: In very low-transmission areas, malaria prevention focuses mainly on targeted vector control and chemo preventive initiatives. These interventions rely heavily on surveillance, rapid diagnosis and treatment, prevention of imported cases, and rapid outbreak response. The objective is not only to protect individuals, but also to progress towards malaria elimination.

In these areas it is essential to protect the population at risk of infection and to attack residual transmission by a targeted ITN distribution mechanism, focal indoor residual spraying, larval source management for identified breeding habitats and focal chemo preventive therapies. Where malaria risk is low (and most of the time focalized), the deployment of targeted interventions improves cost-effectiveness and allow a better redistribution of available resources towards areas with sustained transmission where greater expected impact is related to the improvement of intervention coverage.

Strategic priorities: The current technical consensus recommends prioritizing the strengthening of malaria surveillance and rapid response systems. This will enable interventions to be more effectively targeted toward residual transmission hotspots, improve the detection of importation patterns, and identify populations at increased risk. Targeted distribution of insecticide-treated nets (ITNs) based on biological vulnerability is also a key priority. In suitable areas with very low transmission, efforts should focus on eliminating residual transmission through focal indoor residual spraying (fIRS) and focal drug administration (fDA).

Deliverables: a) Distribute ITNs to at least 90% of vulnerable population and in identified hotspots in 94 councils with malaria hypo-endemicity; b) implement focal IRS in identified residual transmission in very low transmission councils to protect approximately 5% of the population in this stratum; c) expand LSM surveillance and response in all 94 councils; and d) delivery of chemoprevention, including universal IPTp and focal drug administration.

Under the Strategic Approach Malaria Elimination (1.2), the following Strategic Interventions will be implemented:

SI	Strategic Intervention
1.2.1	Provide protection to selected vulnerable population living in low and very low transmission risk areas through targeted ITNs distribution.
1.2.2	Implement IRS in very low and low malaria transmission strata to interrupt transmission and mitigate epidemics.
1.2.3	Scale up quality focal LSM interventions to mitigate residual malaria transmission in low transmission risk councils and to interrupt transmission in residual foci in very low transmission risk councils.
1.2.4	Provide appropriate and effective chemo preventive services to reduce the risk of malaria and its complications and interrupt residual local transmission in hypo endemic areas.

Table 9 depicts the strategic interventions, Service Delivery Mechanisms (SDMs) and number of councils targeted for implementation per transmission risk strata.

Table 9: Strategic interventions, Service Delivery Mechanisms in hypo-endemic risk and number of councils targeted

Malaria transmission risk stratum	Strategic Interventions	Service Delivery Mechanism	Number of councils	NSP section
Low	1.2.1 ITN	RCH	40	1.2.1.1 1.2.1.2 1.2.1.3
	1.2.2 IRS	Outbreak response	TBD (***)	1.2.2.2
	1.2.3 LSM	Selective larviciding	40	1.2.3.1 1.2.3.2
		Environmental management	40	1.2.3.2
	1.2.4 Preventive Therapies	IPTp	40	1.2.4.1
		Targeted drug administration	TBD (***)	1.2.4.3
Very Low	1.2.1 ITN	RCH	54	1.2.1.1
	1.2.2 IRS	Focal response	TBD (****)	1.2.2.1
	1.2.3 LSM	LSM surveilance & response	54	1.2.3.1
		Environmental management	54	1.2.3.2
	1.2.4 Preventive Therapies	IPTp	54	1.2.4.1
		Focal drug administration	TBD (****)	1.2.4.2
(***) Response informed by MEEWS and MEEDS; (****) Response informed by CBS				

Strategic Intervention (1.2.1): Provide protection to selected vulnerable population living in low and very low transmission risk areas through targeted ITNs distribution

Very low endemicity strata may still harbor pockets of transmission risk while low endemic areas are characterized by transmission instability. In both areas, vulnerable groups remain at higher risk and have greater protection needs. Targeted ITN distribution for **biologically vulnerable populations** (pregnant women and children under five years of age) is therefore recommended. Pockets of higher malaria transmission have been documented by malaria risk micro-stratification in low and very low endemicity. These **hotspots** need to be identified, mapped and targeted with mini ITN distribution campaign to provide effective medium-term protection to the population exposed to sustained transmission. The most unstable malaria transmission councils are those classified in the low transmission risk. Due to the current low level of population protection against malaria infection, in the 40 councils of this epi-stratum, both long term **malaria rebounds** and **outbreaks** are plausible events in the period of this strategic plan. Mitigation measures should be planned to mitigate their occurrence. Special targeted ITN distribution will play a crucial role in reducing the consequences of rebounds and outbreak by providing protection to the population at risk.

Under the Strategic Intervention ITNs Targeted Distribution (1.2.1) the following Service Delivery Mechanisms will be implemented:

SDM	Service Delivery Mechanism
1.2.1.1	ITNs distribution to biological vulnerable groups, pregnant women and infants, within the RCH clinics (EPI and ANC).
1.2.1.2	Selective distribution of ITNs in identified sustained transmission hotspots within the low endemicity strata.
1.2.1.3	Mitigation of malaria incidence rebound in hypo-endemic areas through emergency procurement and distribution of ITN to targeted areas through school outlets.

SDM: 1.2.1.1: ITNs distribution to biological vulnerable groups, pregnant women and infants, within the RCH clinics (EPI and ANC)

In the 2021-2025 strategic plan in the low and very low endemicity strata, the ITNs were distributed only to pregnant women and infant children through ANC and EPI, respectively. The current strategic plan reiterates the importance to continue this targeted ITN distribution. In the 94 low and very low risk transmission councils in the period 2026-2030, a total of 14,260,501 ITNs will be issued through ANC and EPI clinics to infants and pregnant women. Among them, 8,277,146 will be issued in phase one, 2026-2028. The selection of ITN type will be guided by local insecticide resistance profiles to optimize vector control effectiveness.

SDM 1.2.1.2: Selective distribution of ITNs in identified sustained transmission hotspots within the low endemicity strata

The current technical consensus recommends implementing targeted ITN distribution in the identified sustained transmission hotspots within the low-endemicity strata as a strategy to reduce malaria risk. This approach is expected to increase access to and coverage of malaria prevention interventions among at risk populations, reduce the instability of malaria transmission strata, and, help to curb and prevent malaria resurgence. Evidence from Malaria Indicator Surveys (MIS), School Malaria Parasitological Surveys (SMPS), and routine Health Management Information System (HMIS) data indicates that household ITN ownership and utilization vary by residence, socioeconomic status, and delivery channel. Consequently, there is a need for improved targeting through data-driven hotspot identification, evidence-based selection of intervention areas, and modular logistics approaches tailored to hotspot zones. Implementation should prioritize targeted ITN catch-up distribution to address coverage gaps and maintain adequate protection among vulnerable populations. According to the 2023 micro-stratification modelling exercise, which utilized routine health facility data aggregated at ward level, a total of 287 sustained transmission hotspots were identified in rural areas within low- and very low-risk councils, representing an estimated population of 4,058,574 people, approximately 20% of the total population living in these strata. Based on these estimates, approximately 1,803,811 ITNs will be required to support mini ITN distribution campaigns in the identified hotspots with 80% of expected coverage.

SDM: 1.2.1.3: Mitigation of malaria incidence rebound in hypo-endemic areas through emergency procurement and distribution of ITN to targeted areas through school outlets

In hypo-endemic areas rebounds can occur due to waning immunity, importation, or gaps in protection. In these areas, only ITN distributions to pregnant women and infant have been carried out in the past 5 years resulting in low access and insufficient ITN coverage. Therefore, emergency procurement or ITN redistribution enables rapid replenishment of ITNs in areas where campaigns were not planned. School outlets, or alternative community-based system, will provide an easy and scalable channel to quickly reach households. Maintaining a contingency buffer stock, and a rapid replenishment mechanism might be an alternative option. It is necessary to strengthen surveillance and data use to detect changing transmission dynamics.

Strategic Intervention (1.2.2): Implement IRS in very low and low malaria transmission strata to interrupt transmission and mitigate epidemics

Within the **very low malaria settings**, foci of residual malaria transmission persist. They are potential risk areas for the spread of the disease across the council and reverse the gains achieved. In these settings, focal IRS is best suited as a response intervention to interrupt transmission. The **unstable transmission low-risk** councils are prone to malaria outbreaks (see SDM 1.2.1.3). Focal/targeted IRS is one of the potential tools to mitigate the progress of the epidemics or to preempt its occurrence in case of an early malaria epidemic warning. The adoption of a community-based approach to IRS implementation through strengthening community engagement enhances acceptance and builds local capacity for sustainability. An intensive surveillance system should be in place to detect conditions that will trigger IRS implementation: a) identification and investigation of transmission foci; b) MEEW alert; and c) MEEDS alert.

Under the Strategic Intervention Implement IRS (1.2.2), the following Service Delivery Mechanisms will be implemented.

SDM	Service Delivery Mechanism
1.2.2.1	Reactive focal IRS in very low malaria strata to interrupt transmission.
1.2.2.2	Targeted IRS to pre-empt or mitigate malaria epidemics.

SDM 1.2.2.1: Reactive focal IRS in very low malaria strata to interrupt transmission

Despite continued implementation of core malaria interventions, such as ITN distribution and prompt case management, localized malaria transmission persists within very low malaria transmission settings. These residual foci are often driven by localized ecological conditions, human movement and operational factors that sustain limited residual transmission. Reactive focal IRS provides a targeted response to rapidly interrupt transmission within these foci and will be implemented in villages meeting the operational threshold for response through malaria case-based surveillance in councils classified as very low transmission. Over the five-year strategic plan, reactive focal IRS is planned for 81 transmission foci (villages), protecting approximately 110,420 household and (474,806) population.

The planned coverage of 81 villages over the five-year strategic plan is based on observed epidemiological trends and represents a conservative planning estimate for focal IRS implementation in very low transmission settings. Analysis of recent (May 2026) case-based surveillance data identified 49 villages across 12 district councils that met the operational threshold for response IRS. The projection is not intended to predict the exact number of villages requiring IRS, but rather to provide a realistic planning assumption based on current surveillance evidence, anticipated expansion of case-based surveillance to additional very low transmission councils and the expected balance between interruption of existing foci and emergence of new foci. Timely implementation of focal IRS, alongside case investigation, case management, reactive case detection and other vector control interventions, is expected to rapidly interrupt residual local transmission within affected villages, thereby limiting the need for repeated IRS in most locations. However, continued importation of malaria infections from neighbouring higher transmission areas is expected to result in occasional indigenous transmission in receptive settings, necessitating targeted response in newly identified foci. In addition, as malaria transmission continues to decline nationally, more councils are expected to transition into the very low transmission stratum, where implementation of case-based surveillance is likely to identify additional foci requiring IRS. Continued routine ITN distribution through reproductive and child health services, biolarviciding where appropriate and sustained social and behaviour change interventions are expected to further reduce receptivity and vulnerability, helping contain the overall number of villages requiring IRS. The projected 81 villages represent an evidence-informed and programmatically cautious planning assumption that ensures operational readiness while avoiding overestimation of resource requirements.

SDM 1.2.2.2: Targeted IRS to pre-empt or mitigate malaria epidemics

Hypo-endemic areas with unstable and/or seasonal transmission might potentially result to malaria epidemics especially in conducive conditions, such as, above normal rainfall data/forecasts. Moreover, existing settlements of displaced populations and/or refugees are at an increased risk of malaria epidemics especially considering that provision of health services as well as environmental and sanitation conditions may be suboptimal. Therefore, it is vital to identify these areas and analyze the data both from the health and climate sectors to detect the variations and to plan for appropriate mitigation measures, which include targeted IRS. An effective MEEWS is essential to trigger targeted IRS to pre-empt the occurrence of abnormal malaria transmission while a functional MEEDS is needed to trigger measures to mitigate the effects of incumbent outbreaks. It is essential to keep a contingency stock of IRS equipment and insecticide that need to be promptly mobilized when an alert is generated by warning and detection systems.

Strategic Intervention (1.2.3): Scale up quality focal LSM interventions to mitigate residual malaria transmission in low transmission risk councils and to interrupt transmission in residual foci in very low transmission risk councils.

Geographic targeting will focus on councils, wards, and communities identified through malaria risk stratification, entomological surveillance, and epidemiological data as having persistent residual transmission or active transmission foci. Priority areas may include flood-prone locations, irrigation schemes, mining and agricultural areas, and other environments with productive mosquito breeding habitats. Focal LSM interventions may include: a) Larviciding of identified breeding habitats; b) Environmental management; and modification to reduce mosquito breeding sites; c) water management interventions; d) community-based source reduction activities; and e) environmental clean-up. The rationale for scaling up focal LSM is that residual malaria transmission often persists in localized breeding habitats that are identifiable, accessible, and manageable. Targeted LSM can significantly reduce vector populations and prevent malaria resurgence in low-endemic settings.

Under the Strategic Intervention Focal and Targeted LSM (1.2.3) the following Service Delivery Mechanisms will be implemented:

SDM	Service Delivery Mechanism
1.2.3.1	Establish a functional LSM in seasonal/unstable transmission areas with malaria low risk.
1.2.3.2	Create a suitable environment for implementation of surveillance and response LSM in hypo endemic areas.

SDM 1.2.3.1: Establish a functional LSM in seasonal/unstable transmission areas with malaria low risk

Experience from a pilot implementation initiative in North East Tanzania indicated that a functional Larval Source Management (LSM) intervention in seasonal or unstable low-malaria-transmission areas, needs several operational, technical, and institutional components to ensure effective and sustainable implementation. A strong policy and strategic framework is in place with national guidelines supporting LSM implementation and clear operational procedures for targeting seasonal and unstable transmission areas. To identify low-risk wards and residual transmission foci robust malaria surveillance data are needed complemented by entomological surveillance and climate and rainfall patterns. Mapping of mosquito breeding habitats, especially temporary and seasonal water bodies, need to be established.

SDM 1.2.3.2: Create a suitable environment for implementation of surveillance and response LSM in residual malaria transmission hypo endemic areas

The objective of this intervention is to interrupt malaria transmission in residual transmission foci through the implementation of targeted Larval Source Management (LSM) interventions. Persistent residual malaria transmission continues to sustain mosquito breeding and malaria transmission in low- and very low-transmission settings. This SDM focuses on identifying, targeting, and eliminating mosquito breeding habitats in residual transmission areas to reduce vector density and interrupt local malaria transmission. Geographic targeting will be guided by malaria surveillance, entomological data, environmental assessments, and risk stratification to identify active transmission foci at ward, village or community level. Key LSM interventions include: a) mapping and regular surveillance of mosquito breeding habitats; b) larviciding using WHO-recommended larvicides in identified breeding sites; c) environmental management and modification to eliminate or reduce aquatic habitats; and d) community-led source reduction and environmental cleanup campaigns. Surveillance data are essential to identify and prioritize residual malaria transmission foci and a functional CBS system should be in place. Effective LSM surveillance and response need to mobilize skilled vector control teams for focal interventions. Reduction or interruption of locally acquired malaria cases in targeted foci. Monitoring and evaluation should be conducted through routine epidemiological and entomological surveillance, larval habitat assessments, intervention coverage reports, and malaria case investigations to assess effectiveness and support progress toward malaria elimination.

Strategic Intervention (1.2.4): Provide appropriate and effective chemo-preventive services to reduce the risk of malaria and its complications and interrupt residual local transmission in hypo endemic areas

Routine chemoprevention is usually **not recommended** in hypo-endemic settings because malaria risk is low, cost-effectiveness decreases, and unnecessary drug exposure may promote resistance. Instead, chemoprevention may be reserved for special situation or high-risk population such as: travelers, outbreaks, epidemic-prone populations, and specific high-risk groups if local epidemiology justifies it.

Under the Strategic Intervention Malaria Chemoprevention for Elimination settings (1.2.4) the following Service Delivery Mechanisms will be implemented:

SDM	Service Delivery Mechanism
1.2.4.1	Provision of IPTp to pregnant women in very low and low transmission risk area.
1.2.4.2	Introduce and scale up provision of focal mass drug administration (MDA) as a response to local residual transmission in a very low transmission risk.
1.2.4.3	Provide targeted drug administration (TDA) as a response to mitigate the effect of malaria outbreaks and upsurges.

SDM 1.2.4.1: Provision of IPTp to pregnant women in very low and low transmission risk area

Provision of IPTp in areas with very low in low malaria transmission settings is not recommended by WHO. Due to existence of focal areas with ongoing transmission within low transmission areas, movement of people between low and high burden areas and weak surveillance response, this Strategic plan maintains provision of IPTp in these very low and low transmission settings.

SDM 1.2.4.2: Introduce and scale up provision of focal mass drug administration (MDA) as a response to local residual transmission in a very low transmission risk

To provide appropriate and effective chemo-preventive services to interrupt residual local transmission in very low endemic areas by targeting remaining pockets of infection with tailored interventions. In such settings, malaria transmission is often focal and driven by asymptomatic carriers or specific high-risk groups. Therefore, strategies such as targeted IPT, reactive case detection, and focused drug administration should be guided by surveillance data to rapidly identify and respond to transmission hotspots. This approach helps to clear residual parasite reservoirs, prevent re-establishment of transmission, and sustain progress toward malaria elimination. The intervention needs to be supported by a functional case-based surveillance.

SDM 1.2.4.3: Provide targeted drug administration as a response to mitigate the effect of malaria outbreaks and upsurges

Targeted drug administration (TDA) is an important emergency response strategy for mitigating malaria outbreaks and transmission upsurges. Temporary administration of antimalarial medicines to selected populations in affected areas will rapidly reduce the

parasite reservoir, interrupt transmission, and prevent severe illness and deaths. This intervention is especially relevant in epidemic-prone, low-transmission, humanitarian, and unstable transmission settings where outbreaks can spread rapidly and overwhelm health systems. Geographic targeting will be guided by surveillance (MEEDS) and outbreak investigation. TDA complements other outbreak control interventions such as insecticide-treated nets (ITNs), indoor residual spraying (IRS), case management, and larval source management.

Strategic Approach 1.3: Promote malaria prevention efforts by protecting the population at risk of infection in urban areas

Situation and rationale: Urban malaria transmission in Tanzania is shaped by concentrated breeding sites in drains, construction zones, informal settlements and poorly managed water systems. Rapid urbanization, population mobility and informal housing interfere with control efforts. Notwithstanding, urban settings offer advantages such as accessible and easily identifiable breeding sites, infrastructure, accessible health services and improved housing. To address these unique dynamics, the NMCP introduced the urban Malaria Surveillance and Response (uMSR) framework in 2024 to support routine, city wide surveillance that integrates ecological, epidemiological, entomological, social and economic data (see Strategic Objective 3 of this MSP). uMSR emphasizes disaggregated case detection with travel history to distinguish local from imported cases, year-round vector monitoring, spatial mapping of vector species, insecticide resistance assessments and micro stratification to guide targeted interventions. Early implementation in Dar es Salaam highlighted gaps in funding continuity and digital data systems, underscoring the need for strengthened urban surveillance, environmental management and targeted vector control.

Strategic direction: Urban malaria control will prioritize scaling up LSM, targeted ITN distribution and, eventually, provision of selective preventive therapies.

Deliverables: a) Scaled up LSM operations in urban councils with functioning electronic reporting systems; coordinated multisectoral environmental management initiatives for larval source reduction; b) targeted ITN distribution reaching biological vulnerable groups and urban hotspots, and c) strengthened urban malaria surveillance and response systems guiding micro stratified chemo-protective interventions.

Under the Strategic Approach Urban Malaria (1.3), the following Strategic Interventions will be implemented:

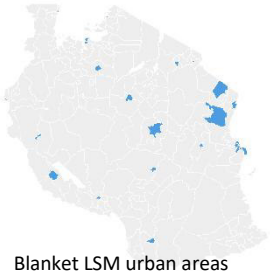
SI	Strategic Intervention
1.3.1	Scale up LSM in urban settings to address concentrated and identifiable mosquito breeding sites.
1.3.2	Provide protection to selected vulnerable population living in urban settings through ITNs targeted distribution.
1.3.3	Provide protection to selected vulnerable population living in urban settings through chemo preventive therapies.

Table 10 shows Strategic Interventions, SDMs and number of councils targeted for implementation:

Table 10: Strategic interventions, Service Delivery Mechanisms in urban areas and number of councils targeted

Stratum	Strategic Interventions	Service Delivery Mechanism	Number of councils	NSP section
Urban	ITN	RCH	26	1.3.2.1
		Selective distribution	TBD (*****)	1.3.2.2
	LSM	Blanket larviciding	26	1.3.1.1
		Environmental management	26	1.3.1.2
	Preventive Therapies	IPTp	26	1.1.4.1
		Selective chemotherapies	TBD (*****)	1.3.3.1
(*****) Selective intervention informed by urban malaria surveillance				

Strategic Intervention (1.3.1): Scale up LSM in urban settings to address concentrated and identifiable mosquito breeding sites.



Blanket LSM urban areas

Figure 14: Eligible urban councils for implementation of blanket LSM

Urban areas present concentrated and easily identifiable mosquito breeding sites such as drains, construction zones, and poorly managed water channels making Larval Source Management (LSM) a highly feasible and impactful intervention. However, effective implementation requires strengthened operational conditions, coordinated environmental management, and reliable digital reporting systems.

The programme will support the expansion of LSM in urban councils (Figure 14), guided by policies that promote enabling operational environments, multisectoral environmental action, and improved accountability and monitoring.

Under the Strategic Intervention Blanket LSM (1.3.1) the following Service Delivery Mechanisms will be implemented:

SDM	Service Delivery Mechanism
1.3.1.1	Create a conducive environment to support the implementation of intensive blanket LSM by using bio-larviciding in urban areas.
1.3.1.2	Promote coordinated multisectoral environmental management for larval source reduction.

SDM 1.3.1.1 Create a conducive environment to support the implementation of intensive blanket LSM by using bio-larviciding in urban areas

The NMSP 2026-2030 will focus on creating conducive conditions for intensive blanket LSM operations, including operational support and resource alignment at council level. Functional electronic data management systems will be established to ensure timely recording, reporting, and use of LSM data for decision making and adaptive management.

SDM 1.3.1.2 Promote coordinated multisectoral environmental management for larval source reduction

Multisectoral collaboration with municipal authorities, sanitation services, and urban planning departments will be strengthened to reduce larval habitats through improved drainage, waste management, and site remediation.

Strategic Intervention (1.3.2): ITNs targeted distribution in urbanized areas

Data from households visited/reached during the 2025 School Malaria Parasitological Survey (SMPS) indicate ITN population access of 59% in urban population. Urban malaria transmission remains concentrated in specific high-risk pockets. Vulnerable groups such as pregnant individuals, infants and residents of persistent transmission hotspots require additional protection. Ensuring reliable access to ITNs through routine RCH services, targeted hotspot coverage and strengthened commercial availability supports sustained protection in these settings.

Under the Strategic Intervention ITN in urban areas (1.3.2) the following Service Delivery Mechanisms will be implemented:

SDM	Service Delivery Mechanism
1.3.2.1	ITNs distribution to biological vulnerable groups, pregnant women and infants, within the RCH clinics (EPI and ANC).
1.3.2.2	Distribution of ITNs in selected and identified sustained transmission hotspots within the urban areas as identified by urban surveillance.
1.3.2.3	Create enabling environment for the commercial sector to sell ITN in urban areas that meets consumer's preference.

SDM 1.3.2.1 ITNs distribution to biological vulnerable groups, pregnant women and infants, within the RCH clinics (EPI and ANC)

Continued distribution of ITNs in all urban settings through ANC and EPI clinics to protect pregnant women and infants. (See SDM 1.1.1.1.) In the 26 urban councils, within the period 2026-2030, a total of 2,635,301 ITNs will be issued through ANC and EPI clinics to infants and pregnant women respectively. Among them 1,529,594 will be issued in phase one, 2026-2028. The type of ITNs will be determined based on the insecticide resistance profile status.

SDM 1.3.2.2: Distribution of ITNs in selected and identified sustained transmission hotspots within the urban areas as identified by urban surveillance

Urban malaria surveillance (uMSR) provides timely, disaggregated data that helps identify these sustained transmission pockets where additional protective measures are required beyond targeted routine ITN distribution to vulnerable population. Selective ITN distribution will be directed to households and populations living in surveillance identified hotspot areas.

SDM 1.3.2.3: Create enabling environment for the commercial sector to sell ITN in urban areas that meets consumer's preference

In urban areas, many households prefer to obtain mosquito nets through retail markets, selecting products based on size, color and design. However, quality assured ITNs are not currently available in most urban commercial outlets, while untreated nets remain common. This limits access to effective protection and highlights the need to strengthen market conditions and regulatory oversight to support future commercial availability of WHO recommended ITNs. The programme will collaborate with regulatory and municipal authorities and private sector actors to create a supportive environment for commercial ITN availability in urban markets.

Strategic Intervention (1.3.3): Provide protection to selected vulnerable population living in urban settings through chemo-preventive therapies

The rationale for introduction of selective urban chemoprevention is that rapid urbanization, population mobility, poor housing, inadequate drainage, and informal settlements can create conditions for hotspots of persistent malaria transmission. Selective chemoprevention can therefore help protect vulnerable populations, reduce parasite reservoirs, and prevent malaria resurgence in urban areas. The strategic interventions need to be triggered by the identification of hotspots or high-risk population through the urban malaria surveillance. Priority groups may include children under five years of age, pregnant women, school-age children, migrant populations, and residents of identified urban hotspots. The intervention needs to be integrated with vector control initiatives.

Under the Strategic Intervention provision of chemo-preventive therapies (1.3.3) the following Service Delivery Mechanisms will be implemented.

SDM	Service Delivery Mechanism
1.3.3.1	Introduction of selective chemo preventive therapies as directed by urban malaria surveillance findings.

SDM 1.3.3.1: Introduction of selective chemo preventive therapies as directed by urban malaria surveillance findings

Urban malaria chemoprevention options include: a) seasonal Malaria Chemoprevention (SMC) in urban settings with seasonal transmission in southern zone (Mtwara and Lindi Municipalities); b) Intermittent Preventive Treatment in Pregnancy (IPTp) through antenatal care services in all municipalities; c) targeted selective Intermittent Preventive Treatment in School age children (IPTsc) in limited high transmission hotspots; d) Perennial Malaria Chemoprevention (PMC) in high-risk municipality such as Kigoma-Ujiji; and targeted drug administration, if required, during outbreaks or in identified transmission hotspots. Implementation should be guided by malaria risk stratification, surveillance data, environmental assessments, and urban transmission patterns. Integration with existing health systems and routine service delivery platforms such as antenatal clinics, RCH services, schools, and community outreach is critical to ensure high coverage and sustainability.

Strategic Approach 1.4: Cross cutting malaria prevention initiatives

Situation and rationale: Tanzania's malaria vector control landscape continues to evolve due to shifting ecological conditions, operational challenges, and emerging opportunities for improved tools and technologies. While insecticide resistance monitoring is well established, with resistance data updated annually, the national insecticide resistance management framework needs updating to reflect the current complexity, evidence base, new insecticide classes, and contemporary operational realities. At the same time, opportunities for innovation in vector control are growing rapidly. These innovations extend beyond new products to include novel operational approaches, delivery technologies, spatial or digital tools, and methods that enhance efficiency, expand coverage, or improve epidemiological impact. However, national processes for evaluating, documenting and adopting such innovations remain limited and fragmented. Strengthening the national resistance management framework and creating a systematic pathway for

adopting new tools and approaches is essential for ensuring a responsive and evidence driven vector control system. A cross cutting policy framework will guide malaria prevention across all transmission strata by integrating two complementary priorities: a) updating and strengthening the national insecticide resistance management framework to ensure resistance evidence is consistently applied in intervention planning; and b) establishing a structured, transparent process for assessing and adopting new vector control tools and approaches based on feasibility, cost effectiveness, and potential public health impact. Importantly, the adoption of innovations will not be limited to contexts of insecticide resistance, recognizing that new tools and improved delivery approaches can contribute to greater efficiency, operational resilience, and accelerated malaria reduction across all settings.

Strategic direction: The programme will strengthen the national resistance management system by updating the insecticide resistance management framework, enhancing analytical capacity, and promoting the consistent use of resistance data in vector control planning. It will also establish a structured national framework for evaluating, piloting, and adopting innovative vector control tools, technologies, and delivery approaches. Through improved evidence generation, documentation, and knowledge management, Tanzania will build a more responsive and innovation-driven vector control system capable of addressing emerging challenges and maximizing malaria control impact.

Deliverables: An updated national insecticide resistance management framework and a fully functional decision support system for evaluating, documenting and guiding the targeted adoption of novel vector control tools and approaches.

Under the Strategic Approach Cross Cutting Interventions to Prevent Malaria (1.4), the following Strategic Interventions will be implemented:

SI	Strategic Intervention
1.4.1	Institutionalize the Insecticide Resistance Management Plan (IRMP).
1.4.2	Support the adoption and documentation of novel vector control tools and approaches.

Strategic Intervention (1.4.1): Institutionalize the Insecticide Resistance Monitoring and Management Plan (IRMMP)

As described in the malaria transmission surveillance section of this MSP (SI 3.1.3 and SDM 3.1.3.2), Tanzania conducts routine insecticide resistance monitoring across 16 sentinel councils for all insecticide classes used in IRS and ITNs, generating annual updates to the national resistance profile. Resistance in major malaria vectors is now widespread, particularly to pyrethroids, with reduced susceptibility to organophosphates in some areas. This threatens the long-term effectiveness of LLINs and IRS. Regularly updating the national insecticide resistance management framework is therefore critical to ensure timely detection of resistance trends and guide informed selection and rotation of insecticides.

Under the Strategic Intervention Insecticide Resistance Management (1.4.1) the following Service Delivery Mechanisms will be implemented:

SDM	Service Delivery Mechanism
1.4.1.1	Develop and implementation of Insecticide Resistance Monitoring and Management plan.

SDM 1.4.1.1: Updating and implementation of Insecticide Resistance Monitoring and Management plan

The implementation of the IRMP will focus on updating the framework, improving analysis and interpretation of insecticides resistance data, and ensuring these findings are systematically incorporated into planning for ITNs, IRS, and larval control. Strengthened coordination between national, regional, and council levels will support timely adjustments in insecticide use and better inform vector control decision-making. The programme will strengthen the national resistance-monitoring and management system by updating the IRMM framework, enhancing analytic capacity, and ensuring resistance data are consistently integrated into planning for ITNs, IRS, and larval control. This will support timely, evidence-driven adjustments to insecticide selection and maintain the effectiveness of vector control interventions.

Strategic Intervention (1.4.2): Support the adoption and documentation of novel vector control tools and approaches

The malaria landscape in mainland Tanzania is increasingly characterized by diverse epidemiological and operational conditions, with pronounced heterogeneity across regions, councils and wards. With the country transitioning from broad, high transmission patterns to more localized and unstable forms of residual transmission, the response environment has become more complex. This complexity

is further intensified by widespread pyrethroid resistance and focal resistance to other insecticide classes, as well as ecological and demographic changes that alter vector habitats and human vulnerability. This changing landscape demands innovation, including both (i) novel products and technologies such as spatial emanators, artificial intelligence (AI), and machine learning, and (ii) innovative delivery models, including combined ITN and IRS implementation as well as drone-based larval source management (LSM), to address diverse epidemiological and operational settings while enhancing access, effectiveness, timeliness, equity, and sustainability of both new and existing interventions.

The response to malaria is no longer homogeneous; as overall burden declines, transmission becomes more focal, less predictable and varied in intensity, creating pockets of persistence where conventional tools no longer sustain the gains. In these settings, vector behavior, insecticide susceptibility, ecological drivers and human population vulnerabilities differ significantly from council to council. These complexities highlight the limitations of relying on the traditional use of ITN, IRS and LSM. The stagnation seen in some high-burden councils and the slower-than-expected decline in others indicate that the existing system is insufficient to accelerate progress. Therefore, the Programme must explore and integrate novel vector control products and innovative approaches to deliver proven interventions to reinvigorate the national trajectory toward malaria elimination. This shift addresses operational bottlenecks and creates resilience within the malaria control system, allowing it to adapt to local needs and sustain impact over time.

The adoption of new vector control tools in Tanzania is guided by global and national frameworks that promote innovation, evidence-based decision-making, and adaptive programming. The WHO Global Technical Strategy for Malaria 2016–2030 and the High Burden to High Impact (HBHI) approach call for integrating new tools and delivery models responsive to local epidemiology. Nationally, Tanzania Development Vision 2050 (DIRA 2050), the National Health Policy, and Health Sector Strategic Plan- V emphasize science, technology, digital transformation, and locally generated evidence, while reinforcing the role of local government authorities in reaching all communities.

This MSP aims to strengthen Tanzania's capacity to identify, assess, adopt and scale up innovative vector control tools and delivery approaches that are safe, effective and operationally appropriate. Through coordinated horizon scanning, evidence generation and implementation research, the programme will evaluate emerging innovations, develop the necessary guidelines and standards, and support their phased introduction in suitable settings based on epidemiological needs and demonstrated effectiveness.

Under the Strategic Intervention adoption of novel vector tools (1.4.2) the following Service Delivery Mechanisms will be implemented:

SDM	Service Delivery Mechanism
1.4.2.1	Adaptation of new vector control innovative tools, products and approaches.
1.4.2.2	Use data-driven Research and Design targeting to optimize deployment (sustain national implementation) of innovative tools and approaches.

SDM 1.4.2.1: Adaptation of new vector control innovative tools, products and approaches.

New vector control tools, products and approaches are rapidly emerging, offering opportunities to improve efficiency, coverage and impact across all malaria transmission settings. However, Tanzania lacks a structured national mechanism to assess, regulate, pilot and document these innovations. This limits the timely introduction of promising tools and hinders the country's ability to adopt evidence-based solutions that can complement or enhance existing interventions. Establish clear, transparent processes for evaluating and adopting new vector control innovations. This includes national guidance to ensure tools and approaches undergo appropriate assessment, regulatory review and documentation before they are introduced or scaled. A national decision framework will be developed to guide the systematic evaluation and documentation of innovative tools and approaches. Regulatory pathways will be strengthened by enhancing the environment and facilitating communication pathways to facilitate in-country approval and access to new technologies. The programme will support piloting, operational research and documentation of promising innovations, while advocating for transformative vector control solutions that can enhance programme effectiveness and resilience.

SDM 1.4.2.2: Use data-driven Research and Design targeting to optimize deployment (sustain national implementation) of innovative tools and approaches

Tanzania generates valuable research, surveillance, and operational data that can inform where new vector control tools and approaches may have the greatest impact. However, this evidence is not yet consistently used to guide the targeted deployment of innovations, limiting the country's ability to optimize performance and sustain national implementation of new technologies. The programme will promote the systematic use of research and operational evidence to guide decisions on evaluating, targeting, and deploying innovative vector control tools and approaches. A clear decision-making process will ensure transparency and consistency.

A data driven Research & Development (R&D) framework will be used to identify where innovations—whether tools, products, or operational approaches—can provide the most benefit. This includes improving evidence generation, strengthening analysis, and supporting targeted piloting and documentation to ensure innovations are deployed where they can enhance efficiency, coverage, or epidemiological impact.

Strategic Objective 2: To prevent the occurrence of mortality related to malaria infection through universal access to appropriate diagnosis and treatment (Malaria Case Management)

According to the WHO World Malaria Reports (2024), the United Republic of Tanzania is among the countries most highly affected by malaria. In 2024, Tanzania ranked fourth among countries with the highest malaria mortality rates per 100,000 population, accounting for 4.3% of global malaria deaths (WMR 2025). The strategic area **Malaria Case Management** and its objective seeks to reduce malaria-related mortality and accelerate progress toward achieving the targets of the Global Technical Strategy (GTS) and the Yaoundé Declaration through the implementation of the following strategic approaches:

SA	Strategic Approaches
2.1	Provide universal access to appropriate, quality and timely malaria diagnosis and treatment to all eligible people at health facilities.
2.2	Provide universal access to appropriate, quality and timely malaria diagnosis and treatment beyond routine health facility services to all eligible people.

Strategic Approach 2.1 Provide universal access to appropriate, quality and timely malaria diagnosis and treatment to all eligible people at health facilities

S**ituation and rationale:** Malaria services in Tanzania are primarily delivered through public and private health facilities, totaling 13,849 in Mainland Tanzania (HFR 2025). Over 90% of these facilities provide malaria diagnosis and treatment. Public facilities account for 60% of all facilities, serving as the main points of care for rural and underserved populations. Their wide coverage ensures timely, affordable care for vulnerable groups such as children under five and pregnant women. Public facilities have been strengthened through provision of quality-assured antimalarials, improved diagnostic tools, and integration into the Health Management Information System (HMIS), making them the backbone of malaria service delivery especially in rural areas. Private facilities, which make up 40%, are concentrated in urban areas and include hospitals, health centers, dispensaries, laboratories, and clinics. Provision of quality and timely malaria diagnosis and treatment services at health facilities serves lives and contributes to reduction of malaria prevalence by preventing those infected to transmit malaria parasites to other individuals. The revised National Guidelines for Malaria Diagnosis, Treatment and Preventive Therapies (NGMDT&PT 2026) provide the standard requirements for the provision of appropriate, quality, and timely malaria diagnosis and define the therapeutics of choice, the recommended clinical procedures, and their application at various levels of the healthcare delivery system in public, and private sectors.

Strategic direction: The focus of the current strategy is to achieve and maintain high coverage of timely parasitological diagnosis and treatment of malaria in both public and private points of care. The principles for this strategy are: a) Adequate sensitive and specific malaria test methods are available; b) Providers skilled in malaria testing are in place; and c) Malaria testing services are of high quality. Behavior change communication (BCC) plays an important role in encouraging patients to seek for a confirmatory diagnostic test before treatment.

Deliverables: At least 85% of individuals with malaria infection are reached with appropriate diagnostic and treatment services

Under the Strategic Approach Malaria diagnosis and treatment at health facilities (2.1), the following Strategic Interventions (SI) will be implemented:

SI	Strategic Intervention
2.1.1	Strengthen malaria diagnosis and treatment in public health facilities.
2.1.2	Strengthen malaria diagnosis and treatment in private health facilities.
2.1.3	Provide high-quality severe malaria management services in public and private health facility settings.
2.1.4	Strengthen malaria diagnosis and treatment for individuals with biological vulnerability.
2.1.5	Adopt and scale up innovative, evidence-based malaria diagnosis and treatment tools and approaches to improve quality, efficiency, and accessibility of malaria case management services.

Strategic Intervention (2.1.1): Strengthen malaria diagnosis and treatment in public health facilities

Public health facilities provide affordable and accessible healthcare to majority of the population, especially in rural and low-income areas where malaria is more prevalent compared to urban areas. Strengthening malaria services in these facilities ensures that patients receive timely and accurate diagnosis through reliable testing methods such as rapid diagnostic tests and microscopy, followed by appropriate treatment with effective antimalarial medicines. Early diagnosis and prompt treatment help prevent severe illness, reduce deaths, and minimize the spread of malaria within communities.

Under the Strategic Intervention malaria diagnosis and treatment in Public Health Facilities (2.1.1) the following Service Delivery Mechanisms will be implemented:

SDM	Service Delivery Mechanism
2.1.1.1	Provide high-standard, accessible, affordable, acceptable, equitable, and quality-assured malaria testing services for people seeking care in public health facilities.
2.1.1.2	Provide high-standard, accessible, affordable, equitable, and quality-assured antimalarials to patients seeking care in public health facilities.

SDM 2.1.1.1: Provide high-standard, accessible, affordable, acceptable, equitable, and quality-assured malaria testing services for people seeking care in public health facilities.

This SDM aims to ensure that all individuals who depend on public health facilities for malaria care receive high-standard, accessible, affordable, acceptable, equitable, and quality-assured malaria testing services. During the strategic plan period, it is estimated that approximately 127,747,662 and 165,876,036 malaria diagnostic tests, including malaria rapid diagnostic tests (mRDTs) and microscopy, will be conducted in public health facilities by 2028 and 2030 respectively. Expanding and strengthening malaria diagnostic capacity will improve timely and accurate detection of malaria cases, ensuring that patients receive appropriate treatment and reducing the burden of severe disease and deaths associated with malaria. Furthermore, strengthening the quality of malaria diagnostic services in public health facilities will improve community trust and confidence in the healthcare system, leading to increased utilization of malaria services at health facilities. Investments in trained healthcare workers, reliable diagnostic equipment, quality assurance systems, and continuous availability of testing supplies will enhance service delivery and support effective malaria case management. Improved diagnostic services will also contribute to stronger disease surveillance and evidence-based decision-making, supporting national efforts toward malaria control and eventual elimination

SDM 2.1.1.2: Provide high-standard, accessible, affordable, equitable, and quality-assured antimalarials to patients seeking care in public health facilities.

Access to high-standard, affordable, and quality-assured antimalarial (QAACTs) is fundamental to reducing malaria morbidity and mortality. Public health facilities maintained uninterrupted supply with minimal stockouts of QAACTs throughout the NMSP 2021-2025 implementation period. For instance; 90% of malaria patients in public facilities received QAACTs in 2025. During this strategic plan implementation period NMCP will continue to ensure uninterrupted availability of QAACTs at all public health facilities. Treatment with ACTs will continue to be at no cost to clients at public health facilities. Cumulatively 9,606,295 and 15,396,046 doses of first line antimalarial will be procured and distributed to public health facilities by 2028 and 2030 respectively. Additionally, Primaquine will be added to ACT in very low strata targeting approximately 50,000 per year. This will guarantee that patients receive timely and effective treatment in line with national guidelines, thereby preventing treatment delays, reducing complications, and lowering case fatality rates.

Strategic Intervention (2.1.2): Strengthen malaria diagnosis and treatment in Private Health Facilities

Significant proportion of malaria cases are treated in private health facilities: out of 99,837,317 malaria tests conducted from 2021-2025, a total of 29,295,325 (29.3%) were from private facilities and 33.7% of dispensed antimalarial treatment doses were by private health facilities (DHIS 2, 2025). These facilities face a number of challenges including poor adherence to malaria case management guidelines such as treatment without testing. Out of 25,938 cases that were diagnosed clinically (2021-2025), 7,413 (28.6%) were from private facilities.

Under the Strategic Intervention malaria diagnosis and treatment in Private Health Facilities (2.1.2) the following Service Delivery Mechanisms will be implemented:

SDM	Service Delivery Mechanism
2.1.2.1	Provide high standard, accessible, acceptable, affordable, equitable, and quality-assured malaria testing services for people seeking care in private health facilities.
2.1.2.2	Provide high-standard, accessible, affordable, equitable, and quality-assured antimalarials for patients seeking malaria treatment in private health facilities.

SDM 2.1.2.1: Provide high standard, accessible, acceptable, affordable, equitable, and quality-assured malaria testing services for people seeking care in private health facilities

According to MSDQI, the quality of malaria diagnosis in the private sector, especially in the non-premium facilities, is generally sub-standard. During the implementation period of the 2021–2025 National Strategic Plan (NSP), a total of 17,625,260 uncomplicated malaria cases were diagnosed through outpatient departments (OPD), of which 2,859,819 (16.2%) were from private health facilities. This SDM will ensure that all individuals seeking care in private facilities receive accurate, affordable, and quality malaria diagnosis, thereby improving treatment outcomes, reducing drug misuse, and supporting overall malaria control.

SDM 2.1.2.2: Provide high-standard, accessible, affordable, equitable, and quality-assured antimalarials for patients seeking malaria treatment in private health facilities

Between 2021 and 2025, a cumulative total of 20,073,743 antimalarial treatment doses were dispensed nationwide, of which 2,668,286 (13.3%) were distributed through private health facilities. This SDM ensures patients in private health facilities receive safe, effective, and affordable antimalarial treatment, thereby reducing malaria morbidity, mortality, and drug resistance while improving equitable access to care.

Strategic Intervention (2.1.3): Provide high-quality severe malaria management services in public and private health facility settings (Severe malaria management).

Severe malaria continues to be a major public health challenge in Tanzania, accounting for 11% of all inpatient cases in 2025, with children under five disproportionately affected accounting for 75 cases per 10,000 population compared to above five age group which had 20 severe malaria cases per 10,000 population (DHIS 2025). Top ten regions with highest severe malaria cases per 10,000 population are Mara, Ruvuma, Kagera, Kigoma, Mtwara, Lindi, Katavi, Tanga, Geita and Morogoro.

Severe malaria can lead to death in a very short time due to multiple organ failure if not promptly and properly managed. Although notable progress has been made in reduce mortality related to malaria, the case fatality rate (CFR) for severe malaria remains high in certain areas due to delays in diagnosis, inconsistent application of treatment protocols, and gaps in the quality of care provided. Strengthening severe malaria services is critical to reducing mortality. This includes timely administration of injectable artesunate, effective supportive care, and reliable referral systems. By enhancing provider skills, enforcing adherence to guidelines, and institutionalizing quality assurance, NMCP aims to further reduce case fatality rates and safeguard vulnerable populations.

Under the Strategic Intervention Severe Malaria Management (2.1.3) the following Service Delivery Mechanisms will be implemented:

SDM	Service Delivery Mechanism
2.1.3.1	Provide high-quality severe malaria management services in public health facility settings.
2.1.3.2	Provide high-quality severe malaria management services in private health facility settings.
2.1.3.3	Strengthen pre-referral services for severe malaria in public health facilities and community settings.

SDM 2.1.3.1: Provide high-quality severe malaria management services in public health facility settings

Public health facilities, which serve as the primary point of care for most of the population, are central to reducing malaria-related deaths. Strengthening severe malaria services in these facilities ensures that patients receive timely, comprehensive management, including prompt administration of injectable artesunate, effective supportive care for complications, and appropriate referral when necessary. By enhancing provider skills, enforcing adherence to national guidelines, and institutionalizing quality assurance mechanisms, NMCP aims to improve the standard of care, reduce CFR, and safeguard vulnerable populations. This integrated

approach combining reliable access to medicines with high-quality service delivery will accelerate progress in reducing severe malaria mortality and reinforce public confidence in the health system's ability to provide effective, life-saving services.

SDM 2.1.3.2: Provide high-quality severe malaria management services in private health facility settings

A significant proportion of patients first seek care in private facilities; strengthening these facilities ensures timely access to life-saving interventions. Improving private sector adherence to national guidelines reduces treatment delays, improves survival rates, and contributes to universal health coverage. To improve the management of severe malaria in private health facilities, the NMCP will pursue strategic direction that ensures both quality and sustainability of services. Capacity building will be prioritized through scaling up training and certification of private health providers, equipping them with the skills and knowledge to deliver quality care in line with national guidelines. Quality assurance will be institutionalized through regular supervision, mentorship, and accreditation mechanisms, ensuring adherence to standards of care. Strong partnerships will be fostered between NMCP, regulatory authorities, and private sector associations to harmonize practices and reinforce accountability.

SDM 2.1.3.3: Strengthen pre-referral services for severe malaria in public health facilities and community settings

Severe malaria progresses quickly and can be fatal without timely treatment. In rural and hard-to-reach areas, patients often first present at lower-level facilities or to community health workers who cannot provide full management of severe malaria cases. Pre-referral interventions such as patient stabilization, and prompt referral—are critical to bridging delays in access to definitive care. Strengthening these services ensures immediate, life-saving treatment while patients are en-route to facilities equipped for comprehensive management. NMCP will strengthen pre-referral services for severe malaria by ensuring that frontline providers at dispensaries and community levels are equipped to deliver immediate, life-saving interventions. This will include guaranteeing the consistent availability of rectal artesunate and injectable artesunate for initial dosing, alongside comprehensive training and mentorship for health workers on patient stabilization and referral protocols. Functional referral linkages will be reinforced through improved communication systems, reliable transport arrangements, and clear referral pathways between dispensaries, health centers, and higher-level hospitals. Monitoring and supervision under the MSDQI framework will track adherence to pre-referral guidelines, commodity use, and referral completion rates. By combining commodity availability, provider capacity building, and strengthened referral systems, NMCP aims to reduce delays in accessing definitive care, lower case fatality rates, and improve survival outcomes for severe malaria patients, particularly in rural and underserved areas.

Strategic Intervention (2.1.4): Strengthen malaria diagnosis and treatment for populations with biological vulnerability

Biological vulnerability to malaria refers to the inherent characteristics of individuals or population groups that increase susceptibility to malaria infection, severe disease, complications, or death following exposure to malaria parasites. This vulnerability is largely associated with inadequate or reduced immunity, underlying health conditions, or physiological states that compromise the body's ability to respond effectively to infection.

Children under five years of age remain highly vulnerable because they have not yet developed partial immunity to malaria. Pregnant women are also at increased risk due to immunological and physiological changes during pregnancy. Elderly individuals may experience reduced immune response, increasing their risk of severe malaria outcomes. Other biologically vulnerable populations include individuals with sickle cell disease (SCD), malnutrition, HIV/AIDS, anemia, cancer and other chronic illnesses, as well as travelers from non-endemic areas who lack acquired immunity. Over the years, the National Malaria Control Programme (NMCP) has implemented targeted interventions to protect pregnant women and children under five through the provision of insecticide-treated nets (ITNs), intermittent preventive treatment for pregnant women (IPTp) and prompt diagnosis and treatment. However, limited attention has been given to other biologically vulnerable groups, resulting in persistent gaps in access to appropriate malaria prevention, diagnosis, and treatment services.

During this strategic plan period, NMCP will strengthen malaria prevention, diagnosis, and treatment services for underserved biologically vulnerable populations, with particular emphasis on individuals living with sickle cell disease (SCD). Given Tanzania's high SCD burden and the increased risk of severe malaria-related complications among affected individuals, the programme will promote routine malaria screening, prompt case management, and integrated prevention services within health facilities and specialized chronic care clinics. This approach aims to improve equitable access to quality malaria services and reduce malaria-related morbidity and mortality among vulnerable populations.

Under the Strategic Intervention management for biological vulnerable populations (2.1.4) the following Service Delivery Mechanism will be implemented:

SDM	Service Delivery Mechanism
2.1.4.1	Integration of malaria services into specialized and chronic care clinics.

SDM 2.1.4.1: Integration of malaria services into specialized and chronic care clinics

NMCP will establish routine malaria screening, testing and treatment into sickle cell, HIV/AIDS (CTC) and oncology clinics and ensure malaria commodities are consistently available in these service delivery points.

Strategic Intervention (2.1.5): Adopt and scale up innovative, evidence-based malaria diagnosis and treatment tools and approaches to improve quality, efficiency, and accessibility of malaria case management services

Malaria case management in Tanzania continues to face several emerging challenges, including partial artemisinin resistance, persistent gaps in surveillance-driven response, delayed diagnosis and treatment in underserved areas, and limited uptake of innovative technologies and service delivery approaches.

During this strategic plan period, the National Malaria Control Programme (NMCP) will strengthen malaria case management through the adoption, introduction, and scale-up of innovative and evidence-based diagnostic tools, treatment regimens, and service delivery approaches aimed at improving the quality, efficiency, equity, and accessibility of malaria services across all levels of the health system. The programme will prioritize timely and accurate parasitological diagnosis through the deployment of improved diagnostic technologies, strengthening quality assurance systems, and enhancing access to diagnostic services. NMCP will also optimize the use of highly effective antimalarial medicines in accordance with national treatment guidelines and emerging global recommendations, while strengthening pharmacovigilance and therapeutic efficacy monitoring to guide policy decisions and safeguard treatment effectiveness.

The adoption and scale-up of proven tools and approaches will contribute to improved treatment outcomes, early detection and management of malaria cases, reduction of malaria-related morbidity and mortality, and accelerated progress toward national malaria control and elimination goals. To sustain these efforts, NMCP will strengthen stakeholder engagement and coordination through inclusive consultative processes involving the Ministry of Health, regulatory authorities, research institutions, professional bodies, implementing partners, private sector actors, and communities. These efforts will support policy alignment, resource mobilization, regulatory preparedness, and timely adoption of new technologies and interventions.

Under the Strategic Intervention innovative malaria management tools (2.1.5) the following Service Delivery Mechanisms will be implemented:

SDM	Service Delivery Mechanism
2.1.5.1	Introduction and adoption of new malaria treatment approaches and tools as guided by scientific evidence.
2.1.5.2	Introduction and adoption of new diagnostic approaches and tools as guided by scientific evidence.

SDM 2.1.5.1: Introduction and adoption of new malaria treatment approaches and tools as guided by scientific evidence

ACTs remain the cornerstone of treatment for uncomplicated malaria; however, emerging APR and early signals of declining AL performance in some settings pose a risk to the long-term effectiveness of current regimens. Proactive deployment of new tools and treatment strategies can slow the emergence and spread of resistance, preserve partner-drug efficacy, and sustain ACT effectiveness. NMCP will introduce and implement a phased transition of first-line antimalarial treatment from Artemether-Lumefantrine (AL) to Multiple First-line Therapies (MFT), to improve malaria treatment effectiveness, mitigate the emergence and spread of antimalarial drug resistance, and strengthen the delivery of quality malaria case management services.

Multiple first line therapy (MFT) consists of deployment of more than one ACT simultaneously in the Country. This approach aims to expose the parasite population to diversified antimalarial drugs thus reducing the possibility of resistance and prolonging the effective lifespan of ACT. The phased MFT roll out in Tanzania will be based on two-year ACT rotation cycles in three different geographical, operational and epidemiological strata.

SDM 2.1.5.2: Introduction and adoption of new diagnostic approaches and tools as guided by scientific evidence

Rapid diagnostic tests (RDTs) remain the cornerstone of case detection and continue to function effectively. Microscopy is also widely used, especially in hospitals and health centers, but both methods face limitations in identifying very low-density or asymptomatic infections. Evidence shows that RDT sensitivity can vary depending on transmission intensity and demographic factors, which poses challenges in regions moving towards elimination where infections are harder to detect. Molecular diagnostics such as PCR and LAMP are available only in limited research or reference laboratories, with no integration into routine health services due to infrastructure and cost constraints. Training gaps among frontline health workers and supply chain weaknesses in rural areas further complicate consistent diagnostic coverage. Given this context, while RDTs remain appropriate and practical for the majority of Tanzania's malaria burden today, the health system must prepare for the future by planning for the introduction and adoption of new diagnostic approaches when they become available. This forward-looking stance ensures that Tanzania can maintain effective case management now while building readiness to integrate more sensitive and innovative tools that will be essential for detecting residual transmission and supporting malaria elimination goals.

Introducing and adopting new malaria diagnostic approaches in Tanzania lies in the need to complement the continued use of RDTs with more advanced tools that address current gaps. While RDTs remain effective and practical in high-transmission settings, they are less reliable in detecting low-density or asymptomatic infections, which are increasingly common as transmission declines. New diagnostic technologies such as highly sensitive RDTs, LAMP assays, and molecular platforms, offer improved accuracy, enabling earlier detection and more precise case management. Their adoption will strengthen surveillance systems, reduce unnecessary use of antimalarial drugs, and help prevent the spread of drug resistance. Moreover, integrating innovative diagnostics ensures equitable access to reliable testing across rural and underserved communities, aligns Tanzania's malaria program with global WHO recommendations, and supports the country's long-term elimination goals. In this way, preparing for the introduction of new tools while maintaining current RDT use positions Tanzania to sustain progress against malaria and build readiness for future elimination efforts.

Strategic Approach 2.2: Provide universal access to appropriate, quality and timely malaria diagnosis and treatment beyond routine health facility services to all eligible people.

Situation and rationale: Geographic inaccessibility, low socioeconomic status, economic activities, poor health-seeking behaviour, and negative attitudes among some health care workers continue to limit equitable access to malaria services in Tanzania, as highlighted in the Tanzania Malaria Matchbox Report (2023). Recent geographical accessibility analysis by MAP-Tanzania (unpublished) indicates that approximately 3.4% of the population (~2.3 million people) cannot reach the nearest primary health care (PHC) facility within one hour using motorized transport, while 19% (~12.8 million people) are unable to access a PHC facility within one hour on foot. Furthermore, findings from the SMPS 2025 reveal that 37% of febrile cases either seek care outside formal health facilities or take no action at all, representing significant missed opportunities for timely malaria diagnosis and treatment. These findings underscore the need for deliberate expansion of malaria service delivery beyond fixed health facilities in order to improve access to diagnosis and treatment, particularly among underserved populations.

In addition, the withdrawal of Targeted Mass Campaign in very low- and low-risk areas has increased vulnerability among communities residing in localized zones with relatively higher malaria transmission, contributing to the emergence of transmission hotspots within otherwise low-burden settings. At the same time, delays and gaps in responding to surveillance alerts through the timely deployment of Malaria Case Management (MCM) interventions, including Mass Drug Administration (MDA), have remained a major implementation challenge during the National Malaria Strategic Plan (NMSP) 2021–2025 period.

Strategic direction: Strengthen and expand non health facility-based malaria service delivery to ensure timely, equitable, and quality-assured access to malaria testing and treatment. Priority will be given to high-risk, hard-to-reach, and underserved populations to address persistent access gaps, while regulatory oversight, monitoring, and accountability mechanisms will be reinforced to ensure adherence to national guidelines and consistent delivery of safe, effective malaria diagnosis and treatment across all service delivery platforms. The program will also deploy malaria case management in response to surveillance alerts in very low and low transmission settings

Deliverables: 1. Communities with limited access to health facility-based malaria testing and treatment services reached with quality malaria services through non health facility platforms. 2. Malaria diagnosis and treatment provided in response to malaria surveillance.

Under the Strategic Approach Malaria case management Beyond Health Facilities (2.2), the following Strategic Interventions will be implemented:

SI	Strategic Intervention
2.2.1	Provide high-standard, accessible, affordable, equitable, and quality-assured malaria testing and treatment services to communities with limited accessibility to operational health facilities.
2.2.2	Deploy malaria case management in response to malaria surveillance initiatives.

Strategic Intervention (2.2.1): Provide high-standard, accessible, affordable, equitable, and quality-assured malaria testing and treatment services to communities with limited accessibility to operational health facilities

Tanzania has demonstrated that community-based malaria testing and treatment are feasible, and impactful for reaching marginalized population groups including those residing in areas with limited accessibility to health facilities, and communities with high occupational and socio-economic exposure. Tanzania's policy direction is to institutionalize community-based malaria testing and treatment as a core pillar of primary healthcare, ensuring that all citizens access accurate, affordable, equitable, and quality-assured services. This is central to the National Malaria Strategic Plan and the country's path toward malaria elimination and Universal Health Coverage (UHC).

Under this Strategic Intervention provision of QA malaria testing and treatment (2.2.1) the following Service Delivery Mechanisms will be implemented:

SDM	Service Delivery Mechanism
2.2.1.1	Scale up integrated Community Case Management (iCCM) services in all eligible villages in high-risk councils.
2.2.1.2	Explore the opportunity to establish malaria testing in pharmaceutical outlets.
2.2.1.3	Provide community-based malaria case management services to marginalized population groups.
2.2.1.4	Provide malaria case management services during natural disasters and other humanitarian emergencies.

SDM 2.2.1.1: Scale up integrated Community Case Management (iCCM) services in all eligible villages in high-risk councils

Scaling up iCCM will ensure that more communities—particularly those with limited access to health facilities—benefit from prompt malaria testing and appropriate treatment. During the implementation period of the 2021–2025 National Strategic Plan (NSP), iCCM was introduced in 41 councils with support from the Global Fund [15]and the USG[16]. Under the next implementation phase, iCCM activities will be sustained in these 41 councils and expanded to an additional 7 high-burden councils[17], bringing the total number of targeted councils to 48. In addition, during this strategic plan pre-referral use of rectal artesunate at community level will be introduced. Strengthening and expanding iCCM implementation will enhance equity in service delivery, reduce delays in access to diagnosis and treatment, and improve malaria-related health outcomes in high-burden and underserved areas. The48 targeted councils and their respective transmission risk (2025 stratification) are listed in Annex 4.

SDM 2.2.1.2: Explore the opportunity to establish malaria testing in pharmaceutical outlets

National surveys show that about 20% of children under five with fever seek care at pharmaceutical outlets, including Accredited Drug Dispensing Outlets (ADDOs) (SMPS 2025). Patients seeking care in pharmaceutical outlets may receive antimalarial without confirmatory testing (presumptive treatment) as these outlets are not allowed to provide diagnostic services. This puts patients at risk of inappropriate treatment and weakens surveillance data. Establishing malaria testing in these outlets offers an opportunity to expand access to timely diagnosis, reduce presumptive treatment, and strengthen malaria case detection outside formal health facilities.

[15] Kakonko, Uvinza, Kibondo, Buhigwe, Geita, Chato, Bukombe, Mbogwe, Rorya, Serengeti, Musoma, Tarime, Butiama, Nsimbo, Tanganyika, Ushetu, District Councils

[16] Lindi, Kilwa, Liwale, Nachingwea, Ruangwa, Mtama, Masasi, Mtwara, Nanyumbu, Newala, Tandahimba, Madaba, Namtumbo, Nyasa, Tunduru, Songea, Kibiti, Kisarawe, Karagwe, Kyerwa, Biharamulo, Ngara District Councils; Mtwara MC, Nanyamba TC, Lindi MC

[17] Kasulu, Nyang'hwale, Buchosa, Misungwi, Handeni, Morogoro, Ulanga District Councils

Malaria testing in pharmaceutical outlets can significantly increase coverage of diagnostic services, especially in areas where health facilities are distant or overstretched. By enabling ADDOs and pharmacies to provide rapid diagnostic tests (RDTs), patients can receive prompt and accurate diagnosis before treatment, reducing misuse of antimalarials and improving rational drug use. This intervention also supports national malaria elimination goals by expanding surveillance data capture and ensuring that treatment aligns with national guidelines. Engaging pharmaceutical outlets leverages their accessibility and trust within communities, making them a strategic partner in malaria control.

SDM 2.2.1.3: Provide community-based malaria case management services to marginalized population groups

The epidemiology of malaria in Tanzania presents several scenarios that increase vulnerability among specific population groups. Certain segments of the population experience heightened occupational and socioeconomic exposure to malaria, including seasonal labourers engaged in large construction and road projects, small-scale miners, refugees, fishermen, security guards, nomadic communities, and other mobile or hard-to-reach populations. These groups often live or work temporarily or permanently in areas far from operational health facilities, limiting timely access to malaria prevention, diagnosis, and treatment services. As a result, conventional facility-based malaria case management approaches may not adequately address their needs. Tailored and targeted malaria case management and preventive therapy strategies, delivered through differentiated service delivery modalities, may therefore be necessary to improve access and ensure continuity of services for these high-risk and mobile populations. Such approaches could include outreach services, mobile clinics, workplace-based interventions, community-based service delivery, and targeted preventive interventions adapted to the specific contexts and mobility patterns of these groups.

SDM 2.2.1.4: Provide malaria case management services during natural disasters and other humanitarian emergencies

Natural disasters and humanitarian emergencies tend to disrupt routine malaria case management services by affecting health facility functionality, supply chains, health worker availability, and community access to care. These disruptions increase the risk of delayed diagnosis and treatment, particularly among vulnerable populations in high-burden, hard-to-reach, and disaster-prone areas. Ensuring continuity of malaria case management during emergencies is critical to promoting prompt testing and appropriate treatment of malaria among affected communities, preventing avoidable morbidity, mortality, and malaria resurgence.

Strategic Intervention (2.2.2): Deploy malaria case management in response to malaria surveillance initiatives

In Tanzania's malaria control and elimination strategy, focal and targeted case management interventions should be introduced as a direct response to surveillance findings, ensuring resources are deployed where they are most needed. When cases are detected in areas of very low transmission, focal interventions involve testing and treating household members and close contacts to quickly contain transmission, while targeted approaches concentrate efforts in high-risk areas with persistent transmission in very low and low strata councils. These measures must be closely linked to surveillance systems so that every confirmed case triggers a rapid response, supported by trained frontline health workers and regional laboratories equipped with advanced diagnostics. Embedding these interventions into national policy and monitoring frameworks will enable Tanzania to move from passive diagnosis to proactive containment, accelerating progress toward malaria elimination.

Under the Strategic Intervention malaria case management in response to malaria surveillance initiatives (2.2.2) the following Service Delivery Mechanisms will be implemented:

SDM	Service Delivery Mechanism
2.2.2.1	Deploy malaria case management as principal intervention for epidemic containment.
2.2.2.2	Introduce focal and targeted case management interventions to respond to malaria Case Based Surveillance findings.
2.2.2.3	Introduce focal and targeted malaria case management interventions to respond to urban Surveillance findings.

SDM 2.2.2.1: Deploy malaria case management as principal intervention for epidemic containment.

Malaria continues to pose a significant public health threat in Tanzania, with transmission intensity varying across regions and periodic outbreaks occurring in high-risk zones, border councils, and areas with weak surveillance coverage. While RDTs and microscopy remain the backbone of malaria diagnosis, gaps in rapid containment measures often allow localized outbreaks to escalate before being controlled. Current surveillance systems detect increases in malaria cases, but responses are sometimes delayed, fragmented, or inadequately resourced. Limited coordination between surveillance data and case management

interventions, coupled with supply chain weaknesses and workforce training gaps, undermines epidemic preparedness. These challenges highlight the need to position malaria case management (MCM) as the principal intervention for epidemic containment, ensuring that surveillance findings directly trigger rapid, targeted responses.

Deploying malaria case management as the primary intervention for epidemic containment ensures that every confirmed malaria case becomes a trigger for immediate testing, treatment, and follow-up within affected households and communities. This approach enables swift interruption of transmission chains, reduces the risk of widespread outbreaks, and prevents excess morbidity and mortality. By linking surveillance data directly to case management, Tanzania can move from reactive to proactive epidemic control. MCM also minimizes unnecessary use of antimalarial drugs by focusing interventions where they are most needed, strengthens community trust in health services, and aligns with WHO recommendations and Tanzania's malaria control and elimination roadmap. Furthermore, embedding MCM into epidemic preparedness frameworks enhances coordination between health facilities, regional laboratories, and mobile response teams, while reinforcing supply chain readiness for diagnostics and medicines.

SDM 2.2.2.2: Introduce focal and targeted case management interventions to respond to malaria Case Based Surveillance findings

Malaria Case-Based Surveillance (CBS) is currently implemented in 29 councils classified as having very low malaria transmission risk. Surveillance data from these councils continue to identify localized pockets of ongoing transmission; however, corresponding case management response interventions are not being consistently implemented. Strengthening the implementation of Malaria Case Management (MCM) as a surveillance response strategy will be critical to interrupting residual transmission, containing emerging hotspots, and accelerating progress towards malaria elimination.

SDM 2.2.2.3: Introduce focal and targeted malaria case management interventions to respond to urban Surveillance findings

Urban malaria in Tanzania presents distinct challenges compared to rural transmission, shaped by rapid urbanization, high population density, informal settlements, poor drainage, and increased mobility. Surveillance data increasingly highlight pockets of transmission in urban centers, yet case management services have not been sufficiently adapted to the urban context. Unlike rural areas, urban settings are characterized by a diverse mix of health service providers including pharmaceutical outlets, private laboratories, clinics, and hospitals that often operate at sub-optimal capacity.

Many of these facilities face gaps in diagnostic accuracy, inconsistent availability of quality-assured tools, and weak adherence to national treatment guidelines. The fragmented nature of urban health services, combined with limited integration of surveillance findings into case management, reduces the effectiveness of malaria control in cities and undermines epidemic preparedness. Addressing these challenges requires tailored strategies that strengthen diagnostic and treatment capacity across both public and private sectors, while ensuring alignment with national malaria elimination goals.

Adapting malaria case management services to the urban context is critical for Tanzania's roadmap because urban malaria presents unique transmission dynamics and service delivery challenges. Unlike rural areas, urban centers have a diverse mix of health providers including pharmaceutical outlets, private laboratories, clinics, and hospitals that often operate at sub-optimal capacity, with weak diagnostic accuracy and poor adherence to national treatment guidelines. This fragmentation undermines the effectiveness of malaria control and creates gaps in epidemic preparedness.

By tailoring MCM to urban populations and linking it directly to surveillance findings, Tanzania can ensure rapid identification and containment of transmission pockets, improve diagnostic and treatment quality across both public and private sectors, and strengthen referral systems for timely case management. Urban-focused strategies also promote equity by reaching vulnerable populations in informal settlements and high-density neighborhoods, while reinforcing national elimination goals. Ultimately, adapting MCM for urban settings ensures that surveillance data drive targeted, effective interventions, reducing transmission in cities and accelerating progress toward malaria elimination.

Strategic Objective 3: To provide timely and reliable information on malaria and its control needed to take appropriate actions in different transmission risk and ensure resources are used in the most cost-effective manner (Malaria Surveillance, Monitoring, Evaluation, and Learning)

Strategic Objective 3 focuses on strengthening the strategic area **Malaria Surveillance, Monitoring, Evaluation, and Learning** (SME&L) to ensure timely and reliable information is available for decision-making and for the efficient use of limited resources. In line with the World Health Organization Global Technical Strategy for Malaria 2016 -2030, surveillance is recognized as a core malaria intervention that saves lives through early detection of cases, outbreaks, and transmission upsurges, enabling rapid response and timely treatment to prevent severe disease, deaths, and further transmission.

In the context of constrained funding, SME&L supports evidence-based prioritization by identifying high-risk populations and geographic areas where interventions will have the greatest impact. Strong surveillance systems also enable continuous assessment of program performance, monitoring of changing malaria trends, and adaptation of strategies in response to climate variability, humanitarian emergencies, and service disruptions.

Through timely data generation, analysis, and learning, SME&L strengthens accountability, improves targeting of interventions, protects previous gains in malaria control, and maximizes the impact of available resources in reducing malaria morbidity and mortality.

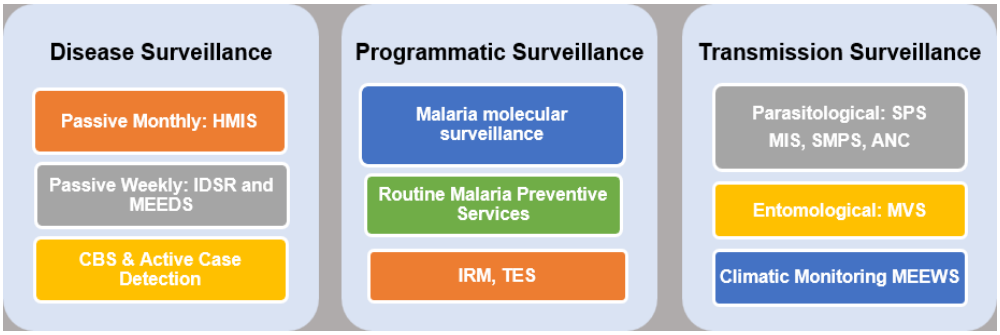
To achieve this Strategic Objective on Malaria Surveillance, Monitoring, Evaluation and Learning (SME&L), three strategic approaches will be implemented as follows:

SA	Strategic Approaches
3.1	Implement a comprehensive malaria surveillance and response system to inform stakeholders and respond to the emerging needs through an evidence-based platform.
3.2	Institutionalize the continuum of monitoring and evaluation process during the implementation of malaria strategic plan.
3.3	Strengthen a learning process based on comprehensive malaria strategic information system and operational research to generate knowledge for evidence-based planning and decision making at all levels.

Strategic Approach 3.1: Implement a comprehensive malaria surveillance and response system to inform stakeholders and respond to the emerging needs through an evidence-based platform.

Situation and rationale: The complex nature of malaria transmission driven by dynamic interactions between the vector, parasite, human host, and environment, necessitates continuous monitoring of disease trends, transmission patterns, program performance, and the coverage and effectiveness of interventions. Since 2017, Tanzania adopted a malaria surveillance system that has been structured around three interconnected pillars, each directly linked to response mechanisms Figure 15. To strengthen malaria surveillance, Tanzania has established and operationalized multiple electronic data systems, including HMIS-DHIS2, eIDSR, MSDQI, and the Composite Management Information System (CMIS). Since 2017, the country has further advanced targeted and data-driven malaria control through enhanced epidemiological stratification at council and ward levels, utilizing routine health facility and periodic surveys data. The National Malaria Control Programme (NMCP) has improved stratification and intervention targeting across diverse transmission settings, enabling more efficient allocation of resources. In addition, programmatic and transmission surveillance have expanded, with the SMPS emerging as a cost-effective complement to the less frequently conducted Malaria Indicator Survey (MIS). Despite these achievements, several challenges persist, including incomplete reporting, inconsistent data quality, and limited availability of digital tools at community level, weak integration across malaria information systems, and inadequate data governance and harmonized data quality assurance processes.

Figure 15: Framework for malaria surveillance (modified 2017 Malaria Surveillance guidelines NMCP)



Key: **MEEDS:** Malaria Epidemic Early Detection System; **MEEWS:** Malaria Epidemic Early Warning System; **HMIS:** Health Management Information system; **IDSR** Integrated Disease Surveillance and Response; **IRM:** Insecticide Resistance Monitoring; **TES:** Therapeutic Efficiency Studies; **MVS:** Malaria Vector Surveillance; **MIS:** Malaria Indicator Survey; **SMPS:** School Malaria Parasitological Survey; **SPS:** Sentinel Population Surveillance; **ANC:** Ante Natal Clinic; **QAQC:** Quality Assurance and Quality Control.

As malaria transmission becomes increasingly heterogeneous across councils and wards, a robust Surveillance and response framework is essential for timely detection of changes in transmission patterns, informed decision-making, targeted implementation of interventions, and efficient allocation and utilization of available resources. Strengthening Surveillance systems will enhance data-driven planning, improve programme responsiveness, and support progress toward malaria control and elimination goals.

Strategic direction: Surveillance, Monitoring, Evaluation, and Learning (SMEL) activities continue to be guided by the National Guidelines for Malaria Surveillance and Response (2017), the WHO Global Technical Strategy (GTS) for Malaria 2016–2030, and the High Burden to High Impact (HBHI) framework. These frameworks emphasize surveillance as a core malaria intervention and promote evidence-based, stratified programming to improve the effectiveness, efficiency, and impact of malaria control interventions. The Surveillance and response strategic approach will support the National Malaria Control Programme (NMCP) in developing an integrated, resilient, and digitally enabled malaria surveillance system capable of timely detection, reporting, and response to changes in malaria transmission. The strategy emphasizes strengthening data quality assurance and governance systems, enhancing the national malaria information system, promoting real-time utilization of epidemiological and entomological data, expanding community-based surveillance, and improving feedback mechanisms across all levels of the health system. These interventions are intended to improve data quality, interoperability, and evidence-based decision-making to support more targeted and efficient malaria interventions.

Deliverables: Evidence based targeted malaria interventions, functional and integrated malaria surveillance systems (HMIS-DHIS2, eIDSR, and CMIS), and real-time data flow across facility and community levels, updated council and ward-level malaria stratification maps.

Under this Strategic Approach, 3.1 the following strategic Interventions will be implemented:

SI	Strategic Interventions
3.1.1	Strengthen malaria disease surveillance and response on routine detection, recording, reporting and analysis of malaria related data across all epidemiological strata.
3.1.2	Enhance malaria programmatic surveillance and response for improved performance.
3.1.3	Strengthen malaria transmission surveillance and response.

Strategic Intervention (3.1.1): Strengthen malaria disease surveillance and response on routine detection, recording, reporting and analysis of malaria related data across all epidemiological strata (Malaria disease surveillance).

Malaria disease surveillance in Tanzania is primarily passive and relies on health facility- and community-based reporting systems. Routine malaria data are collected through HMIS/DHIS2, which captures both disease and programmatic information. Most health facilities enter data directly into DHIS2 on a daily basis, while a few submit aggregated monthly reports through Council levels for data entry. This enables timely access, analysis, and interpretation of malaria data at health facility, Council, Regional, and National levels to monitor disease trends and detect outbreaks, particularly in moderate- and high-transmission areas. In addition, the

electronic Integrated Disease Surveillance and Response (eIDSR) system provides weekly aggregated reporting of notifiable diseases, including malaria, supporting outbreak detection and response in low- and very low-transmission settings. The Global Technical Strategy for Malaria 2016 - 2030 emphasizes strengthening surveillance systems to monitor disease trends, detect and prevent outbreaks, guide investigations and responses, and support malaria elimination in low-transmission areas. National guidance is provided through key documents including the Malaria Case-Based Surveillance Reference Manual (2020), Surveillance, Monitoring and Evaluation Plan (2021), Malaria Surveillance and Response Guidelines (2017), Malaria Epidemic Preparedness and Response Operational Manual (2023), and Urban Malaria Surveillance and Response Operational Manual (2024).

Under the Strategic Intervention Malaria Disease Surveillance, (3.1.1) four service delivery mechanisms (SDM) will be implemented:

SDM	Service Delivery Mechanisms
3.1.1.1	Institutionalize routine health facility malaria surveillance and response across all epidemiological risk strata.
3.1.1.2	Strengthen capacity for Malaria epidemics detection, investigation and containment at Council and health facility level in epidemic prone areas.
3.1.1.3	Strengthen malaria Case Based Surveillance and response to support malaria elimination in very low transmission risk councils.
3.1.1.4	Implement malaria urban surveillance and response to support elimination interventions in urban councils.

SDM 3.1.1.1 Institutionalize routine health facility malaria surveillance and response across all epidemiological risk strata.

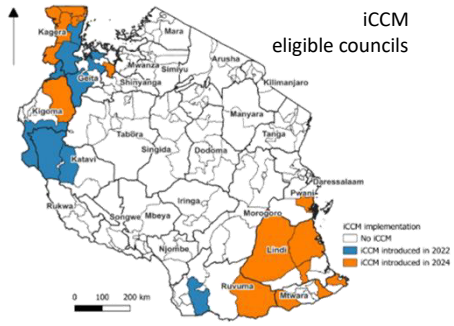


Figure 16: Councils implementing iCCM

Monthly health facility-based malaria surveillance and response across all epidemiological strata: Public and private health facilities in Tanzania routinely report malaria data through DHIS2 to support monitoring of disease trends, outbreak detection, stratification, and evidence-based decision-making. Additional systems such as GoTHOMIS contribute hospital-level data, although interoperability with DHIS2, eIDSR, and CMIS remains limited, prompting ongoing efforts to improve system integration, data governance, and coordination in line with national surveillance guidelines that emphasize continuous facility-level reporting as the foundation for effective malaria surveillance and response. Weaknesses persist in community-level reporting, particularly for integrated community case management (Figure 16), where the lack of a standardized data collection and integration mechanism between HMIS/DHIS2 and the Unified Community System (UCS), combined with staggered implementation across councils, results in inconsistent and incomplete data, limiting the ability to assess iCCM contribution, monitor coverage, and compare program performance over time.

SDM 3.1.1.2 Strengthen capacity for malaria epidemics detection, investigation and containment at Council and health facility level in epidemic prone areas

All councils in very low and low malaria transmission areas are considered epidemic-prone due to climatic suitability and historical patterns, although reported outbreaks are rare, raising concerns about potential under-detection and under-reporting. To address this, the National Malaria Control Programme has established an epidemic detection system within the malaria dashboard that uses weekly IDSR data and defined thresholds, with a focus on low and very low transmission areas. The system was piloted in seven councils in Singida Region and will be expanded to other similar settings to ensure timely outbreak detection and response within two weeks of onset to reduce morbidity, mortality, and transmission. This initiative aligns with International Health Regulations (IHR) requirements to strengthen outbreak investigation and response capacities, especially as malaria epidemiological transition increases the risk of unstable transmission in more areas, making strengthened early detection and rapid response systems essential for effective containment.

SDM 3.1.1.3: Strengthening malaria Case Based Surveillance and response to support malaria elimination in very low transmission risk councils

Malaria case-Based Surveillance (mCBS) aims to determine whether infections are locally acquired, identify transmission foci, and guide targeted elimination interventions such as focal case management, vector control, and, where appropriate, mass drug

administration in very low transmission settings. Guided by the Global Technical Strategy for Malaria 2016–2030 and national guidelines, it supports detailed case and cluster investigations to understand transmission risks and eliminate residual foci, making its scale-up across eligible councils critical to prevent malaria resurgence amid increasing population exposure and reintroduction risks in very low transmission areas. According to the 2025 malaria stratification, 54 councils (29.3%) in Mainland Tanzania are classified as very low transmission areas with less than 1% prevalence and fewer than 15 cases per 1,000 population per year, making them eligible for mCBS. Implementation has expanded from 17 councils in 2021 to 29 councils across 5 regions by 2023; (17 councils in Arusha, Manyara, and Kilimanjaro in 2021; 7 councils in Njombe and 2 councils in Kilimanjaro in 2022, and 5 Iringa in 2023, reaching a total of 29 councils). Supported by national tools such as the mCBS reference manual, training materials, and an electronic notification system, alongside capacity building at all health system levels. Key activities include immediate case notification, active household follow-up, testing of all contacts, treatment of positives, and intensified investigation in areas with persistent transmission.

SDM 3.1.1.4 Implement malaria urban surveillance and response to support elimination interventions in urban councils

Urban malaria transmission in Tanzania is generally lower than in rural areas, where the risk is 3–15 times higher; however, urban settings remain vulnerable due to rapid urbanization, expansion of informal settlements, poor drainage, environmental degradation, and high population mobility. With 47 urban councils hosting over one-third of the population (25.5%), these areas face unique ecological and demographic conditions that support focal transmission, including peri-urban zones, construction sites, and poorly planned neighborhoods that serve as mosquito breeding sites, alongside frequent imported cases from rural-to-urban movement. Although urban areas have relatively better access to health services, inconsistent adherence to diagnostic and treatment standards, low population immunity, and rapid environmental change increase epidemic risk. To address this, urban malaria surveillance was piloted in five councils in Dar es Salaam and will be expanded nationally, guided by national surveillance guidelines and the WHO Urban Malaria Framework, with emphasis on stratified, data-driven surveillance, environmental management, multisectoral collaboration, and strengthened case-based surveillance for early detection and response to malaria foci and outbreaks.

Strategic Intervention (3.1.2): Enhance malaria programmatic surveillance and response for improved performance

NMCP, in collaboration with stakeholders conducts programmatic surveillance including: Molecular surveillance, Therapeutic Efficacy Studies (TES) and Insecticide Resistance Monitoring (IRM) to monitor parasites and vector dynamics and assess the effectiveness of antimalarial medicines, ITNs, and IRS insecticides. A major challenge has been the lack of a centralized system for managing reports, as studies are often implemented by research institutions and partners, resulting in delayed and incomplete reporting.

To address this, NMCP established the Composite Management Information System (CMIS) to collect, analyze, and generate outputs for non-health facility-based data, with plans to expand access from national to council level. Programmatic surveillance is essential for detecting reduced efficacy of medicines and insecticides, informing timely policy changes, and monitoring interventions not captured in routine surveillance systems. The National Guidelines for Malaria Surveillance and Response (2017) emphasize continued TES and IRM implementation, timely availability of surveillance reports, and monitoring the proportion of planned surveillance activities conducted.

Under the Strategic Delivery Intervention: Malaria Programmatic Surveillance (3.1.2) the following four Service Delivery Mechanisms will be implemented:

SDM	Service Delivery Mechanisms
3.1.2.1	Implement routine Therapeutic Efficacy Studies (TES) of drug of choice and alternative antimalarial drugs and other drugs that will be adopted by MoH for the treatment of uncomplicated malaria.
3.1.2.2	Strengthen malaria related molecular surveillance for programmatic monitoring of parasites and vector dynamics.
3.1.2.3	Document and coordinate response to mitigate Artemisinin Partial Resistance - APR.
3.1.2.4	Conduct longitudinal monitoring of efficacy and effectiveness of insecticides.

SDM 3.1.2.1: Implement routine Therapeutic Efficacy Studies (TES) of drug of choice and alternative antimalarial drugs and other drugs that will be adopted by MoH for the treatment of uncomplicated malaria.

Since 1997, NMCP and partners have conducted uninterrupted routine Therapeutic Efficacy Studies (TES) across eight sentinel sites to monitor the safety and efficacy of first-line and alternative antimalarial drugs among children, except in 2025 due to funding constraints. TES assesses treatment efficacy, adverse effects, and resistance markers, and has informed major malaria treatment

policy changes, including shifts from chloroquine to SP, SP to ACTs, and recent recommendations for AL replacement and future TACT/MFT strategies. In line with WHO recommendations, the strategy aims to strengthen and expand TES surveillance and use findings to guide case management and resistance mitigation. Key indicators include the number of TES conducted annually and routine reporting from four sentinel sites against the WHO 90% efficacy threshold.

SDM 3.1.2.2: Strengthen malaria related molecular surveillance for programmatic monitoring of parasites and vector dynamics

Malaria molecular surveillance in Tanzania is still emerging and largely driven by research and partner-supported projects, with fragmented implementation, limited laboratory capacity, and weak integration into routine surveillance systems. Current efforts focus on monitoring antimalarial drug resistance, pfhrp2/3 gene deletions, and insecticide resistance. Strengthening molecular surveillance is critical for early detection of parasite and vector resistance, protecting the effectiveness of ACTs, RDTs, and vector control interventions, and supporting evidence-based malaria control and elimination. In line with WHO Global Technical Strategy and the HBHI approach, NMCP will institutionalize and scale up molecular surveillance by expanding laboratory and genomic capacity, establishing sentinel sites, integrating molecular data into CMIS, strengthening data use for policy decisions, and enhancing collaboration with research institutions. Expected outputs include a functional national molecular surveillance system, strengthened laboratory and bioinformatics capacity, routine surveillance reporting, and integration of molecular data into programmatic decision-making.

SDM 3.1.2.3: Document and coordinate response to mitigate Artemisinin Partial Resistance - APR

Artemether-Lumefantrine (AL) has remained Tanzania's first-line treatment for uncomplicated malaria since 2006, with routine Therapeutic Efficacy Studies (TES) conducted to monitor its safety and efficacy. Although full Artemisinin Partial Resistance (APR) has not been confirmed, early signs of delayed parasite clearance and kelch13 mutations have been detected in parts of Kagera Region. APR poses a significant threat to ACT effectiveness and malaria control gains, highlighting the need for strengthened surveillance, documentation, and response systems. In line with WHO recommendations, NMCP will continue TES and molecular surveillance while establishing a national APR monitoring and response framework, including mitigation plans and coordination mechanisms to guide timely action.

SDM 3.1.2.4: Conduct longitudinal monitoring of efficacy and effectiveness of insecticides

Tanzania has established 22 sentinel sites for Insecticide Susceptibility Testing (IST), conducted by NIMR to monitor the efficacy of insecticides used in ITNs and IRS. Tanzania's malaria vector control efforts, particularly ITNs and IRS, are increasingly challenged by the rapid spread of insecticide resistance in major vectors such as *Anopheles gambiae s.l*., with pyrethroid resistance expanding from none detected in 2004 to over 80% of monitored sites by 2020, alongside emerging resistance to DDT and bendiocarb, although pirimiphos-methyl remains largely effective for IRS; in response, the country has introduced next-generation ITN and alternative IRS products such as Clothianidin product with brand name Sumi Shield and Clothianidin and deltamethrin combination formulation with brand name Fludora Fusion while strengthening routine resistance monitoring to guide evidence-based insecticide selection, rotation, and deployment.

In line with WHO guidance and the national Insecticide Resistance Monitoring and Management Plan (IRMMP), the National Malaria Control Programme (NMCP) will continue collaborating with partner institutions to routinely monitor insecticides resistance across all transmission settings. Findings from national sentinel sites will guide insecticide selection for IRS and types of ITN and support implementation of the national insecticide resistance mitigation plan. NMCP will also institutionalize a coordinated national insecticide resistance surveillance system by expanding sentinel sites, strengthening entomological and laboratory capacity, harmonizing protocols, improving data systems, and ensuring routine use of resistance data in decision-making, while promoting integrated vector management and next-generation tools to reduce reliance on single insecticide classes and safeguard long-term malaria control effectiveness, with key outputs including routine data on susceptibility status, resistance frequency, intensity, and mechanisms across major vector species.

Strategic Intervention (3.1.3): Strengthen malaria transmission surveillance and response

NMCP, in collaboration with stakeholders, monitors malaria transmission through surveillance among under-fives, school children, and pregnant women using MIS, SMPS, and ANC-based screening platforms. School Malaria Parasitological Surveys (SMPS) are now also used to assess malaria prevalence among under-fives and measure intervention impact. Since 2015, the National Malaria Vector Entomological Surveillance (MVES) system has monitored vector dynamics through sentinel sites, although the number of sites was

reduced from 62 to 32 after 2021. Climatic factors and extreme weather events continue to influence malaria transmission, prompting plans to establish a Malaria Epidemic Early Warning System (MEEWS) for early detection and preparedness. In line with the WHO Global Technical Strategy, NMCP will continue strengthening epidemiological and entomological surveillance, including routine implementation of SMPS, ANC surveillance, and sustained MVES sentinel site monitoring to guide evidence-based malaria interventions.

Under the Strategic Intervention: Malaria Programmatic Surveillance (3.1.3) the three service delivery mechanisms will be implemented as follows:

SDM	Service Delivery Mechanisms
3.1.3.1	Strengthen longitudinal vigilance of malaria parasitaemia in sentinel population: under five, school children and pregnant women.
3.1.3.2	Strengthen longitudinal monitoring of mosquito population dynamics in sentinel sites (MVS).
3.1.3.3	Operationalization of a climate change–sensitive Meteorological Early Warning and Surveillance System to detect early changes in climate variables that may increase malaria transmission.

SDM 3.1.3.1: Strengthen longitudinal vigilance of malaria parasitaemia in sentinel population: under five, school children and pregnant women at ANC

Demographic and Health Surveys with Malaria Indicator Survey modules (TDHS-MIS), stand-alone MIS, School Malaria Parasitological Surveys (SMPS), and ANC surveillance are key platforms used by NMCP to monitor malaria prevalence, anemia, and program outcomes. While TDHS-MIS and MIS provide national progress indicators, financial constraints following the withdrawal of USAID-PMI support threaten future MIS implementation. SMPS, conducted biennially and coordinated by NMCP, provides council and sub-council level malaria prevalence data and is increasingly being expanded to capture MIS indicators for programmatic decision-making and malaria stratification.

Geocoded survey data are integrated into the national parasite prevalence database to generate high-resolution malaria risk maps and support ward-level micro-stratification. Routine ANC malaria surveillance through HMIS/DHIS2 also provides important indicators for monitoring transmission trends and guiding targeted interventions. NMCP will continue collaborating with NBS on DHS-MIS, sustain SMPS implementation every two years, and strengthen surveillance among pregnant women to support evidence-based malaria control and elimination efforts.

SDM 3.1.3.2: Strengthen longitudinal monitoring of mosquito population dynamics in the sentinel sites

The National Malaria Vector Entomological Surveillance (MVES), established in 2016, is a longitudinal system coordinated by NMCP and PMO-RALG with technical support from research institutions and academia that was supported by the Global Fund to monitor malaria vector species composition, abundance, seasonality, and feeding and resting behavior. Initially implemented in 62 councils across 26 regions, the system was reduced to 34 councils in 23 regions in 2021 due to financial constraints and implementation challenges, though continued broad coverage remains critical. MVES is the backbone for understanding the dynamic of the local mosquito population, their behavior, infectivity, and how these vectors respond to the interventions. With the changing malaria situation, ecology, and biology of mosquitoes as well as new insecticide formulations, become available for mosquito control, it is essential to monitor, adapt, and respond to changes in mosquito populations. The MVES is used to inform NMCP on the progress towards reduction of the entomological inoculation rate (EIR) as an impact indicator for assessing the effectiveness of malaria vector control interventions generates standardized entomological indicators to support evidence-based planning, stratification, and Integrated Vector Management in line with WHO Global Technical Strategy (2016–2030). Data are collected monthly and submitted electronically, with samples analyzed at reference laboratories, and are used to assess both malaria burden reduction in moderate-to-high transmission areas and progress toward elimination in low-transmission settings. NMCP will strengthen the existing malaria vector entomological surveillance sentinel sites to enhance the quality and timeliness of entomological data for evidence-based vector control decision-making.

SDM 3.1.3.3: Operationalization of a climate informed Malaria Epidemic Early Warning and Response System to detect early changes in climate variables that may increase malaria transmission

Tanzania has limited baseline information on the impact of climate variability and extreme weather on malaria, despite growing evidence that climate change increases transmission risk, disrupts services, and contributes to outbreaks. To address this, the NMCP will establish a Climate Informed Malaria Epidemic Early Warning System (CI-MEEWS) to integrate climate-sensitive indicators into

malaria surveillance, improve outbreak forecasting, and strengthen preparedness and timely response, including identification of vulnerable populations and early warning alerts. Aligned with the National Adaptation Plan (NAP 2025–2035), WHO, WMO, and IPCC guidance, the system will be implemented in phases covering indicator development, strengthening DHIS2 climate-health integration, and modelling and risk forecasting, with coordination between NMCP, the Tanzania Meteorological Authority (TMA), and partners. Key deliverables include NMCP–TMA collaboration, vulnerability and risk assessments, climate monitoring systems, alert and trigger frameworks, user guidelines, capacity building, and operational research to support climate-resilient malaria control.

Strategic Approach 3.2: Institutionalize the continuum of monitoring and evaluation process during the implementation of malaria strategic plan.

Situation and rationale: Tanzania has made significant progress in strengthening malaria monitoring and evaluation systems, particularly through the rollout of the Malaria Services and Data Quality Improvement (MSDQI) framework. Health facilities routine malaria data is collected through eIDSR and HMIS and aggregated reported weekly and monthly respectively in DHIS2. Digital platforms and dashboards have enhanced data visualization and prioritization of supportive supervision. Quarterly supervision and monthly virtual data review meetings have been usually conducted. Despite progress made in improving monitoring and evaluation of the malaria control interventions, there are some challenges that persist, including data inconsistencies, gaps in data use at service delivery points, irregular review meetings, and lack of standardized tools for some interventions. A strong and institutionalized M&E system is essential to ensure high-quality malaria services and reliable data for decision-making. Strengthening routine data systems will improve data accuracy, completeness, and timeliness.

Strategic direction: This strategic approach is guided by the National Malaria Surveillance and Response Guidelines (2017) It is also aligned with the WHO Global Technical Strategy for Malaria and the High Burden to High Impact (HBHI) approach which promote data driven decision making.

Deliverable: The program will institutionalize a comprehensive, data-driven M&E system by strengthening routine data collection, analysis, interpretation, and use. It will scale up MSDQI implementation, conduct regular supportive supervision and data quality assessments. Under the Strategic Approach: Malaria Monitoring and Evaluation (3.2), the following two strategic interventions will be implemented:

SI	Strategic Interventions
3.2.1	Strengthen the availability and quality of routine data collection, analysis and use at service delivery points.
3.2.2	Evaluation of malaria strategic plan implementation.

Strategic Intervention (3.2.1): Strengthen the availability and quality of routine data collection, analysis and use at service delivery points.

The Malaria Services and Data Quality Improvement (MSDQI) tool is used to assess and strengthen the quality of malaria services at health facilities across Tanzania, having evolved from paper-based reporting to a fully electronic system implemented in all councils. Regional and Council Health Management Teams (RHMTs and CHMTs), supported by national, regional, and council supervision teams, ensure adherence to national malaria service guidelines using standardized checklists covering OPD, diagnostics, ANC, logistics, severe malaria, and data quality assurance, while the NMCP malaria dashboard is used to prioritize facility supervision based on performance gaps. Integrated within DHIS2 and aligned with national Quality Improvement, Supportive Supervision, and Data Quality Assurance frameworks, MSDQI promotes unified reporting, real-time performance monitoring, and data-driven decision-making across all 26 regions, supported by training on dashboard use and interpretation.

Overall, MSDQI institutionalizes routine, structured, and digital supportive supervision to improve malaria service delivery, strengthen accountability and transparency through systems such as DHIS2, eLMIS, and Epicor 10, and guide targeted mentorship and facility-level Quality Improvement Plans to enhance both service quality and malaria data for timely response.

Under the Strategic Intervention Routine Data Collection (3.2.1) the three following service delivery mechanisms will be implemented:

SDM	Service Delivery Mechanisms
3.2.1.1	Implement quality improvement of malaria services provision.
3.2.1.2	Enhance malaria services data quality through DQA, monthly, Regional and Zonal Data Review meetings.
3.2.1.3	Collection, analysis, interpretation and use of the programmatic monitoring of vector control and preventive therapies initiatives (including ITNs, IRS, LSM, IPTsc, and IPTp) data.

SDM 3.2.1.1: Implement quality improvement of malaria services provision

Introduced in 2018, the Malaria Services and Data Quality Improvement (MSDQI) system is a comprehensive approach for assessing health facility readiness to deliver quality malaria services, including diagnosis, case management, logistics, data management, and adherence to national guidelines across all key service delivery areas such as OPD, IPD, laboratory, pharmacy, stores, and RCH clinics. The system identifies service and data quality gaps and supports development of facility-specific Quality Improvement Plans (QIPs). Aligned with national Quality Improvement, Supportive Supervision, and Data Quality Assurance frameworks, MSDQI is integrated with digital platforms including DHIS2, eLMIS, Epicor 10, and malaria dashboards to strengthen accountability and data-driven decision-making. Strategically, MSDQI institutionalizes routine, structured, and data-driven supportive supervision using digital tools to improve transparency, mentorship, corrective actions, service quality, and the availability of reliable malaria data for timely response and program improvement

SDM 3.2.1.2: Enhance malaria services data quality through DQA, monthly, Regional and Zonal Data Review meetings

Routine malaria data is essential for the National Malaria Control Programme (NMCP) to monitor malaria burden and intervention coverage at national and sub-national levels through the Health Management Information System (HMIS) and the electronic DHIS2 platform introduced nationwide in 2013. By 2024, outpatient reporting completeness had reached a national average of 99%, although regional variations persist.

Despite strong reporting performance, data quality challenges remain across the documentation and reporting process, including errors during patient recording, transcription from registers to summary forms, data entry mistakes, and inadequate routine data review meetings at facility level. Recognizing that high-quality data must be accurate, complete, timely, consistent, and relevant, the NMCP conducts monthly virtual data quality review meetings with regions and councils to identify outliers and address reporting issues, alongside annual regional and zonal review meetings, although the latter have faced financial constraints since 2024. Strengthening health facility-based malaria data quality remains critical for evidence-based planning, monitoring, and decision-making.

SDM 3.2.1.3: Coordinate the collection, analysis, interpretation and use of the programmatic monitoring of vector control and preventive therapies initiatives

Monitoring of malaria vector control and preventive therapy interventions is essential for assessing effectiveness and guiding program planning. In Tanzania, data on distribution of long-lasting insecticidal nets (LLINs) to pregnant women and children under five, as well as provision of sulfadoxine-pyrimethamine (SP) for pregnant women, is collected through HMIS/DHIS2, while implementation data for School Net Programme (SNP) and Targeted Mass Campaign (TMC) is captured through the ITN application. However, indoor residual spraying (IRS), larval source management (LSM), and IPTsc implementation data are mainly obtained through implementation reports, with no standardized manual or electronic data collection tools currently in place, leading to unreliable data availability for these interventions. In line with the National Guidelines for Malaria Surveillance and Response (2017), the National Malaria Control Programme (NMCP) will continue strengthening the collection, analysis, and utilization of vector control and preventive therapy data to support evidence-based decision-making and improve implementation monitoring.

Strategic Intervention (3.2.2): Evaluation of malaria strategic plan implementation

Malaria Program Reviews (MPR) and Mid-Term Reviews (MTR) are conducted periodically by the National Malaria Control Programme (NMCP) to assess implementation performance, identify challenges, and generate recommendations for improving malaria strategies and policies. Findings from these reviews have been instrumental in guiding revisions of NMCP strategic objectives

and priorities during development of malaria strategic plans, with the last MPR conducted in February 2020. In line with WHO recommendations on routine malaria program reviews and trend analysis, NMCP will continue conducting MPRs and MTRs to support evidence-based policy and strategic decision-making, including mid-term and end-term evaluations of malaria strategic plan implementation.

Under the Strategic Intervention Evaluation (3.2.2) the following two service delivery mechanisms will be implemented:

SDM	Service Delivery Mechanisms
3.2.2.1	Conduct Mid-term and End term Evaluation of Malaria Programs.

SDM 3.2.2.1: Conduct Midterm and End term Evaluation of Malaria Programs

Malaria Program Reviews (MPR) and Mid-Term Reviews (MTR) are periodically conducted by the National Malaria Control Programme (NMCP) to assess program performance, identify challenges, and generate recommendations for improving malaria strategies and objectives within the Strategic Plan cycle. Findings from these reviews have informed updates to NMCP strategic priorities, with the last MPR conducted from August to October 2025. In line with WHO recommendations on routine malaria program reviews and trend analysis, NMCP will continue the MTR and MPR of the NMSP 2026 – 2030 in 2028 and 2030 respectively.

Strategic Approach 3.3: Strengthen a learning process based on comprehensive malaria strategic information system and operational research to generate knowledge for evidence-based planning and decision making at all levels (Learning)

Situation and rationale: Malaria data in mainland Tanzania is obtained from routine and non-routine systems, with routine data collected monthly through HMIS/DHIS2 and presented via an interactive malaria dashboard that provides standardized outputs such as charts, graphs, tables, and maps across all service areas. Non-routine data from surveys (SMPS, TES, IST, MVS) and programmatic activities (SNP, MRC, IRS, CBS, LSM, and supportive supervision) is compiled through a composite database that is currently offline, though efforts are underway to host it on the national server.

To address fragmentation and improve data use, NMCP developed the Composite Management Information System (CMIS) to integrate non-routine data and generate standardized outputs, but it remains limited to national-level access with plans for expansion to council level. Despite progress, challenges persist in ensuring completeness and timely reporting due to reliance on implementing partners and fragmented data ownership, making strengthening CMIS functionality, system integration, and accessibility critical for improved coordination and evidence-based decision-making. Managing and use of routine and non-routine information for evidence-based decision making requires strong system to facilitate efficient allocation of resources at all health care delivery levels.

Strategic direction: WHO and consultative expert meeting recommends triangulation of all available malaria information to facilitate analysis of trends, stratification, allocation of resources allocation and informed decisions. Availability of reliable data triangulated from repository database and the national DHIS2. The two systems are expected to have an interface so that data can be triangulated for micro-planning, micro-stratification and facilitation of other informed decisions.

Deliverables: The malaria strategic information system to generate knowledge for evidence-based planning and decision making will be strengthened by using interactive web-based platforms.

Under the Strategic Approach Learning (3.3), the two following Strategic Interventions will be implemented:

SI	Strategic Interventions
3.3.1	Strengthening the systematic analysis and use of quality data to inform evidence-based decision-making.
3.3.2	Develop and implement prioritized operational research agenda to generate context-specific evidence that informs policy and improves service delivery effectiveness.

Strategic Intervention (3.3.1): Strengthening the systematic analysis and use of quality data to inform evidence-based decision-making (Systematic analysis and use of quality data)

Malaria data in Tanzania is increasingly available through HMIS/DHIS2 and CMIS, but its use remains limited, especially at sub-national levels, due to weak analytical capacity, poor integration of data sources, and insufficient feedback for decision-making. Strengthening

the systematic use of integrated, high-quality malaria data is essential to improve intervention targeting, program performance, stratification, and accountability.

Guided by WHO and national M&E frameworks, NMCP will promote integration of routine and non-routine data to support evidence-based planning, with key outputs including DHIS2–CMIS interoperability, routine dashboards and reports, and strengthened data use capacity at all levels.

Under the Strategic Intervention Systematic Analysis and Use of Data (3.3.1) the three following service delivery mechanisms will be implemented:

SDM	Service Delivery Mechanisms
3.3.1.1	Conduct a comprehensive periodic stratification of malaria transmission risk in all councils for improved targeting of interventions.
3.3.1.2	Strengthen malaria data management capacity and the national repository arrangements to enable evidence-based decision making at all levels.
3.3.1.3	Implement an integrated malaria modelling initiative within the CMIS that routinely consolidates MIS, SMPS, HMIS and global datasets to generate calibrated forecasts and intervention-impact estimates that inform targeted planning.

SDM 3.3.1.1: Conduct a comprehensive periodic stratification of malaria transmission risk in all councils for improved targeting of interventions

Since 2021, Tanzania has advanced toward a more targeted, data-driven malaria response by strengthening epidemiological and operational stratification at council and ward levels using HMIS/DHIS2, community reporting, and survey data, with 2022 and 2024 updates incorporating key indicators such as OPD incidence, ANC positivity, API, SMPS prevalence, and TPR trends. These efforts are supported by expanded surveillance systems including eIDSR, MSDQI, and CMIS, alongside increasing use of SMPS as a cost-effective alternative to MIS; however, challenges remain in data completeness, consistency, system integration, and limited community-level digital tools, underscoring the need for stronger data governance and harmonized quality assurance. Guided by the WHO Global Technical Strategy and HBHI framework, NMCP will strengthen an integrated, digitally enabled surveillance system for 2026–2030 focused on improved data quality, real-time analysis of epidemiological and entomological data, enhanced community surveillance, and stronger feedback mechanisms, enabling all councils to generate and use micro-stratification maps for evidence-based malaria control and accelerating progress toward elimination by 2030.

SDM 3.3.1.2: Strengthen malaria data management capacity and the national repository arrangements to enable evidence-based decision making at all levels

NMCP has faced persistent challenges in accessing and consolidating non-routine malaria data due to fragmented storage, data ownership constraints, and delayed sharing. To address this, a Composite Malaria Information System (CMIS) was developed to collect aggregated data from implementing institutions, but it remains offline due to infrastructure limitations currently being addressed with MoH M&E and ICT teams. The programme aims to establish a fully functional, web-based malaria data repository with interactive dashboards to integrate routine and non-routine data, improve analysis, and support evidence-based decision-making through standardized outputs and strengthened M&E systems.

SDM 3.3.1.3: Implement an integrated malaria modelling initiative within the CMIS that routinely consolidates MIS, SMPS, HMIS and global datasets to generate calibrated forecasts and intervention-impact estimates that inform targeted planning

Malaria data from multiple sources in Tanzania, including HMIS, surveys such as MIS and SMPS, and global datasets, are currently available but not routinely integrated or used for predictive analytics, limiting the programme's ability to forecast malaria trends and estimate intervention impact for proactive and targeted planning. Strengthening integrated modelling is therefore essential to enable data-driven forecasting, scenario analysis, and improved understanding of transmission dynamics, supporting more efficient intervention targeting and resource allocation. Aligned with WHO guidance and national priorities on data integration and advanced

analytics, this approach will enhance the shift from reactive to predictive and strategic malaria control by enabling evidence-based planning through improved use of malaria information systems.

Strategic Intervention (3.3.2): Develop and implement prioritized operational research agenda to generate context-specific evidence that informs policy and improves service delivery effectiveness (Operational research agenda)

Coordination between NMCP and research institutions in implementing the malaria research agenda is limited, leading to weak engagement of key experts and low use of evidence at regional and council levels, where operational research is also insufficient to explain malaria burden trends. Establishing a dedicated coordination focal point is therefore needed to align research priorities, strengthen collaboration with partners, and improve the use of operational research findings. Guided by WHO recommendations, improved coordination and prioritization of malaria research will enhance evidence generation, dissemination, and use for informed decision-making at all levels.

Under the Strategic Intervention, Operational Research Agenda (3.3.2) two service delivery mechanisms will be implemented:

SDM	Service Delivery Mechanisms
3.3.2.1	Create conducive environment for continuous collaboration with research, academia institutions and research capacities at subnational levels to facilitate evidence-based decision making at all levels.
3.3.2.2	Conduct operational research on new tools and interventions to protect ACTs.

SDM 3.3.2.1: Create conducive environment for continuous collaboration with research, academia institutions and research capacities at subnational levels to facilitate evidence-based decision making at all levels.

The effectiveness of malaria control depends not only on available tools but also on the quality of antimalarial medicines and services, correct case management, and real-world health system performance, with ongoing gaps in diagnosis, treatment, supply chains, drug quality, and post-marketing surveillance across public and private sectors. Operational and implementation research is therefore critical to identify bottlenecks, improve case management, ensure commodity quality, and generate evidence on existing and new tools such as MFTs, Triple ACTs, and novel diagnostics and drugs. Guided by WHO and national recommendations, NMCP will institutionalize a coordinated operational research agenda to strengthen service delivery, regulatory oversight, and evidence-based decision-making for malaria interventions.

SDM 3.3.2.2: Conduct Operational research on new tools and interventions to protect ACTs

Artemisinin-based combination therapies (ACTs) remain the cornerstone of treatment for uncomplicated malaria, but emerging artemisinin partial resistance (APR) and early signals of reduced efficacy of Artemether-Lumefantrine (AL) in some settings threaten their long-term effectiveness. Proactive introduction of alternative treatment strategies is therefore essential to slow resistance development and preserve partner drug efficacy, including recommended ACT diversification options such as multiple first-line therapies (MFT), triple ACTs (TACT), preventive therapies, and new antimalarial drugs and diagnostics. Guided by WHO recommendations, NMCP will support evidence-based, phased implementation and pilot testing of innovative treatment approaches using clinical, molecular, and programmatic data to inform decisions and sustain effective malaria case management.

Strategic Objective 4: Ensure timely availability of safe, efficacious and quality malaria commodities and supplies at the service delivery points (Malaria Commodities and Logistic Management)

Through the Ministry of Health and its partners, the Government of Tanzania has strengthened public health supply chains to ensure the availability of safe, quality malaria commodities. Between 2021 and 2025, this initiative facilitated the procurement and distribution of 36,811,440 Artemether-Lumefantrine (AL) treatments, 118.7 million RDTs, and 13.6 million vials of Artesunate injection maintaining availability of commodities at health facilities consistently above 93% (eLMIS). While performance is high being contributed by regular quantification/ reviews and monitoring, some facilities still experience occasional shortages or oversupply due to operational challenges. Prevention efforts were equally robust, delivering 25.9 million ITNs to pregnant women and infants. The government also distributed a significant volume of ITNs for mass campaigns and school programs, alongside several liters of

biolarvicides to enhance malaria control across the country Insecticides for IRS were not procured due to resource constraints. All procured commodities, whether through donors or public systems, are quality-assured and monitored by regulatory authorities. Consistent access to safe, effective, and quality-assured malaria commodities at all service delivery points is critical for quality health services. This requires: a) Accurate selection, quantification, and procurement; b) Strong inventory and logistics management; c) Reliable data for decision-making; d) Trained workforce and adequate infrastructure; e) Robust regulatory oversight for quality and safety; f) Sufficient financing. The strategic area **Malaria Commodities and Logistic Management** and its objective will be implemented through collaboration with relevant institutions including the Medical Stores Department (MSD) to coordinate supply planning and distribution and by strengthening the collaboration with regulatory authorities including the Tanzania Medicines and Medical Devices Authority (TMDA), and Tanzania Plant Health and Pesticides Authority (TPHPA). The partners are expected to support routine quality testing of malaria commodities before distribution and during post-market surveillance. The following principles will be followed: a) Use data from health facilities and surveillance systems to forecast malaria commodity needs accurately; b) Strengthen logistics and inventory management to ensure timely delivery to all service points; and c) Conduct joint supervision and monitoring to identify and resolve stock gaps quickly; d) Promote communication and coordination between national, regional, and local health authorities to maintain continuous availability. NMCP will ensure continuous availability of safe, effective, and quality-assured malaria commodities through strengthened supply chain management, including forecasting, planning, procurement, inventory management, and monitoring.

Under the strategic area Commodities and Logistic Management (4), the following Strategic Approaches will be implemented:

SA	Strategic Approaches
4.1	Promote partnership to ensure malaria commodities are available in all service delivery points in the right quantity and when needed.
4.2	Promote partnership with regulatory authorities to ensure all malaria commodities used at service delivery points are quality assured and safe.

Strategic Approach 4.1 Promote partnership to ensure malaria commodities are available in all service delivery points in the right quantity and when needed

Situation and rationale: The government, through the Ministry of Health and partners, has strengthened public health supply chains to improve availability of malaria commodities. Between 2021 and 2025, commodity availability remained above 93%, supported by timely procurement, distribution, regular quantification, reviews, and monitoring. However, some facilities still face occasional shortages or oversupply due to operational challenges. Medical Stores Department (MSD) manages the supply chain for malaria case management commodities, including clearance, receiving, quality checks, storage, and distribution to health facilities. Tanzania uses a pull delivery system, where facilities request commodities through eLMIS every two months. Monitoring ensures accurate reconciliation at each supply chain level. Biolarvicides, IRS insecticides and other commodities, which are not used in health facility settings, are distributed through different channels including pick up from the supplier.

Strategic direction: Implementation of Strategic will focus on approach 4.1 strengthening collaboration with MSD and relevant institutions to improve supply planning, forecasting, distribution, and stock management. Emphasis will be placed on using facility and surveillance data, improving logistics and inventory systems, conducting joint supervision, and enhancing coordination across national, regional, and local levels.

Deliverables: The deliverables will include strengthening accurate forecasting of malaria commodity needs using health facility and surveillance data, improving logistics and inventory management to ensure timely distribution to service delivery points, enhancing supervision and monitoring systems to quickly identify and address stock gaps, and promoting better coordination and communication among supply chain actors to maintain continuous availability of malaria commodities.

Under the Strategic Approach Procurement and Supply Management (4.1), the following Strategic Intervention will be implemented:

SI	Strategic Interventions
4.1.1	Facilitate timely availability of malaria commodities and supplies at service delivery points.

Strategic Intervention (4.1.1): Facilitate timely availability of malaria commodities and supplies at service delivery points.

From 2021 to 2025, malaria commodities for diagnosis, treatment and chemo prevention—including ACTs, mRDTs, SP and Artesunate—were available in health facilities at over 93% according (eLMIS). This high performance is due to regular quantification,

timely procurement, and effective logistics at MSD and service delivery points. DHIS2 and eLMIS support monitoring, accountability, and reporting of commodity use across the supply chain. NMCP will **e**nsure commodities are properly quantified, ordered, distributed, stored, and used according to SOPs and guidelines.

The following service delivery mechanisms (SDM) have been developed to implement the above strategic intervention:

SDM	Service delivery mechanisms
4.1.1.1	Carry out quantification using data and advanced techniques, identify discrepancies between current and desired states (gap analysis), and plan and monitor the flow (supply planning and pipeline review) for all malaria commodities and supplies.
4.1.1.2	Manage procurement of malaria commodities and supplies by promoting conducive partnership.
4.1.1.3	Enhance supply chain of malaria commodities from point of entry/suppliers to service delivery points.
4.1.1.4	Enhance logistic management, use and reporting of malaria commodities within service delivery points.

SDM 4.1.1.1: Carry out quantification, gap analysis, supply planning and pipeline review for all malaria commodities and supplies

Annual quantification and gap analysis for malaria commodities is a multi-partner exercise led by the National Malaria Control Program, involving PSU, MSD, PMO-RALG, NBS, TMA, implementing partners, and development partners. The exercise uses top-down and bottom-up approaches to project national needs of malaria commodities for health facilities, community services, surveys, operational research, and resistance monitoring. It also determines procurement costs, funding sources, financial gaps, and supply planning, with quarterly reviews to adjust plans based on actual data. Accurate forecasting and supply planning are essential for uninterrupted availability of malaria commodities. Integration and validation of multiple data sources ensure realistic projections, while financial planning ensures efficient procurement and logistics.

SDM 4.1.1.2: Manage procurement of malaria commodities and supplies through effective partnerships and coordination mechanisms

The National Malaria Control Program (NMCP) has established an effective procurement system that ensures a continuous supply of safe, quality-assured products to service delivery points. Procurement ensures that the right malaria products are available and ready for distribution. It can be sourced locally or internationally, while adhering to national procurement regulations for transparency and accountability. It is the backbone of malaria control, ensuring the right products are continuously available for testing, treatment, for protecting vulnerable groups through preventive therapies and vector control interventions. Effective procurement mechanisms are required to maintain universal access of malaria services, respond to epidemics, and prevent a rebound of malaria transmission.

Deliverables: a) Annual supply and shipment plans; b) Timely submission of procurement orders; and c) Procured malaria commodities as per the quantification and supply plan (see Annex 5 for annual needs and specific items):

- Procurement of 15,420,831 ACTs doses (AL/ ASAQ) and 860,817 Primaquine tablets for facilities, ACD and studies
- Procurement of 121,395,506 mRDTs for malaria testing in public facilities and community
- Procurement of 15,591,833 Artesunate injectable vials for treatment of severe malaria in public health facilities
- Procurement of 185,058,985 SP tablets, 7,790,837 Dihydroartemisinin Piperaquine and SPAQ doses and 10,503,628 ASAQ doses of for preventive therapy interventions
- Procurement of 86,695,236 ITNs needed for distribution through different channels for malaria vector control
- Procurement of 4,780,500 litres of biolarvicides for malaria vector control
- Procurement of 220,109 liters/ sachets of IRS insecticides and 11,440 Personal Protective Gears (PPE) for malaria vector control

SDM 4.1.1.3: Enhance supply chain of malaria commodities from point of entry/suppliers to service delivery points

Medical Stores Department (MSD) manages the supply chain for malaria case management commodities, including clearance, receiving, quality checks, storage, and distribution to health facilities. Tanzania uses a pull delivery system, where facilities request commodities through eLMIS every two months. Monitoring ensures accurate reconciliation at each supply chain level. Biolarvicides,

IRS insecticides and other commodities, which are not used in health facility settings, are distributed through different channels including pick up from the supplier.

Strong systems for clearance, quality checks, storage and distribution are essential to maintain commodity availability and quality. Close follow-up ensures that procured malaria commodities reach the service delivery points and are accessible for the intended use.

SDM 4.1.1.4: Enhance the management, use and reporting of malaria commodities within service delivery points.

Health facilities are monitored using tools like the Malaria Services and Data Quality Improvement (MSDQI) checklists to assess inventory, ordering and dispensing practices, data quality, storage, and commodity availability. Tracking and auditing also trace commodity movement and ensure consumption aligns with services provided. Proper logistics, storage, and dispensing practices are essential to maintain the quality of malaria diagnostics and medicines. Medicines must be dispensed accurately, in the correct dosage, quantity, and packaging, with clear instructions to users. Accurate record-keeping ensures accountability and supports monitoring.

Strategic Approach 4.2: Promote partnership with regulatory authorities to ensure all malaria commodities used at service delivery points are quality assured and safe

Situation and rationale: Regulatory authorities in Tanzania play a key role in protecting the public from counterfeit, falsified, and substandard health products. The Tanzania Medicines and Medical Devices Authority (TMDA), regulates the quality, safety, and efficacy of medicines, diagnostics, and medical devices, supported by its WHO-prequalified and ISO-accredited quality control laboratory. TPHPA on other side oversees insecticides used for vector control, including evaluation, local bio-efficacy testing, and approval. Between 2021 and 2025, all tested malaria commodity batches met quality standards and were approved for distribution and use. Quality assurance is strengthened through routine sampling, pre-shipment inspections, port-of-entry checks, post-market surveillance, and pharmacovigilance by MSD and the National Public Health Laboratory (NPHL). Reporting of adverse drug reactions has improved through public awareness facility-based reporting systems, and enhanced laboratory services, with malaria medicines accounting for a small proportion of reported ADRs.

Strategic direction: Strengthen regulatory systems and quality assurance mechanisms to sustain the safety, quality, and effectiveness of malaria commodities and vector control products. This will include continued collaboration with TMDA, TPHPA, MSD, and NPHL to enhance product testing, registration, surveillance, and safety monitoring across the supply chain. Focus will be placed on maintaining routine pre- and post-market quality testing, strengthening pharmacovigilance and ADR reporting, improving public and health worker awareness, and ensuring evidence-based regulatory decisions to protect public health. MSD regularly submits malaria commodity samples to TMDA and NPHL for quality testing, with additional samples collected from public and private outlets.

TMDA oversees quality assurance during registration, importation, and throughout the supply chain through pre-distribution checks and post-market surveillance. Between 2021 and 2025, all tested antimalarial commodity batches met quality standards and were approved for use. Safety monitoring also includes insecticide quality assessment through TPHPA. Tanzania's quality assurance and pharmacovigilance systems help protect the public from counterfeit, falsified, and substandard products. Measures such as product registration, inspections, surveillance, and ADR monitoring have strengthened medicine safety. In 2024, only 0.86% of reported ADRs were linked to malaria medicines, with TMDA continuing to monitor and share safety findings nationally and internationally.

Deliverables: a) Malaria commodities at service delivery points are quality assured; and b) All adverse reactions related to malaria commodities are reported, monitored, analyzed, and addressed.

Under the Strategic Approach of Quality and Safety Management (4.2), the following Strategic Intervention will be implemented:

SI	Strategic Interventions
4.2.1	Facilitate quality assurance of malaria commodities.
4.2.2	Facilitate assessment of safety for malaria commodities.

Strategic Intervention (4.2.1): Facilitate quality assurance of malaria commodities

This will be implemented by strengthening the collaboration with regulatory authorities including the Tanzania Medicines and Medical Devices Authority (TMDA), and Tanzania Plant Health and Pesticides Authority (TPHPA). The partners are expected to support routine quality testing of malaria commodities before distribution and during post-market surveillance.

The Tanzania Medicines and Medical Devices Authority (TMDA) evaluate the quality of malaria commodities both during the pre-registration phase and upon importation. Between 2021 and 2025, all tested commodity batches successfully met the required quality standards and received approval for distribution and use. To ensure continued efficacy, routine quality testing is maintained throughout the supply chain, covering both pre-distribution checks and post-market surveillance.

Under the Strategic Intervention Quality Assurance (4.2.1) the following Service Delivery Mechanisms will be implemented:

SDM	Service Delivery Mechanisms
4.2.1.1	Strengthen quality check of malaria commodities for vector control and case management for public and private sectors.
4.2.1.2	Post Market surveillance (PMS) for antimalarial medicines and malaria testing devices.
4.2.1.3	Post Market surveillance for vector control commodities.

SDM 4.2.1.1: Strengthen quality check of malaria commodities for vector control and case management for public and private sectors

The Tanzania Medicines and Medical Devices Authority (TMDA), under the Ministry of Health, regulates the quality and efficacy of medicines, medical devices, and diagnostics. The Tanzania Plant Health regulates insecticides used for vector control and Pesticides Authority (TPHPA), which evaluates product information, coordinates bio-efficacy testing under local conditions, and approves pesticides for use. Porous borders increase the risk of falsified and substandard health products entering the country. This highlights the need for a strong and sustainable quality control system before and after product registration. Strengthened quality checks for malaria commodities used in vector control and case management.

SDM 4.2.1.2: Post Market surveillance for antimalarial medicines and malaria testing devices

Strengthen quality control system for malaria commodities in the markets for evidence-based regulatory decisions.

SDM 4.2.1.3: Post Market surveillance for vector commodities

Monitoring and post-distribution surveillance of ITNs to assess physical durability while insecticidal and larvicides bio-efficacy remains inconsistent. Post-market surveillance ensures ITNs remain effective in malaria protection by monitoring durability. Findings will guide future ITNs selection and help identify factors affecting net durability in Tanzania. It will also guide on technology improvement in the production of vector control commodities

Strategic Intervention (4.2.2): Facilitate assessment of safety for malaria commodities

Assessment of safety for malaria commodities involves checking whether malaria prevention and treatment products are safe for people, animals, and the environment during and after their use. Reporting of adverse drug reactions (ADRs) has improved through public awareness, facility-level reporting systems, and improved TMDA laboratory services. Safety assessments involve monitoring adverse effects in people and checking the chemical safety of insecticides through TPHPA. Regulations require the reporting of ADRs by manufacturers, suppliers, health programs, healthcare workers, and consumers. Healthcare providers are mandated to report ADRs related to medicines or medical devices to TMDA according to national guidelines for surveillance of adverse events. Increase ADR awareness among healthcare workers and communities through various approaches, including health facility visits. All adverse reactions related to malaria commodities are reported, monitored, analyzed, and addressed. Under the Strategic Intervention Product Safety (4.2.2) the following Service Delivery Mechanisms will be implemented:

SDM	Service Delivery Mechanisms
4.2.2.1	Facilitate the relevant regulatory authorities to conduct passive pharmacovigilance for malaria commodities.

SDM 4.2.2.1: Facilitate the relevant regulatory authorities to conduct passive pharmacovigilance for malaria commodities.

The ADR monitoring through TMDA involves collecting, evaluating, and sharing adverse drug reaction findings with healthcare professionals, the public, and international entities including WHO. All suspected ADRs including serious or minor, known or unknown should be reported. Reports on the new drugs are of great interest to monitor the performance of these drugs in the country

Strategic Objective 5: To strengthen an enabling environment that empowers individuals and communities at risk of malaria to constituently protect themselves and their families and seek timely and appropriate malaria care (Social Behavior Change, Advocacy and Community Engagement)

The strategic area **Social Behavior Change, Advocacy and Community Engagement** (SBCA&CE) is key supportive strategies under the National Malaria Strategic Plan and play a critical role in promoting positive health behaviors and increasing the uptake of malaria interventions. The SBCA&CE strategic objective aims at sustain the population high knowledge of malaria interventions while expanding the coverage and intensity of multichannel approaches and community sensitization and Engagement. This will be achieved through targeted multi-media approaches with special emphasis on community-based approaches so as to bring about the desired behavior change in the uptake of malaria interventions. Emphasis will be placed on inclusive Community engagement, ensuring that all vulnerable and high-risk population groups are effectively reached and involved. Advocacy for gender inclusiveness and gender responsive approach in the implementation of malaria interventions will be emphasized. Community feedback to improve the quality of malaria services will be collected using Community-Led Monitoring (CLM). Under the Strategic Objective 5; Social Behavioral Change, Advocacy, and Community Engagement, the following Strategic Approaches will be implemented:

SA	Strategic Approaches
5.1	Promote social and behaviour change among communities and strengthen advocacy initiatives among leaders through effective risk reduction communication.
5.2	Promote community engagement and active participation in malaria control and elimination interventions within their respective settings.

Strategic Approach 5.1: Promote social and behaviour change among communities and strengthen advocacy initiatives among leaders through effective risk reduction communication (Social Behaviour Change and Advocacy)

Situation and rationale: The implementation of SBCA interventions through multiple approaches and communication channels has contributed to sustained levels of malaria knowledge and awareness nationwide, currently estimated at 78% according to the 2025 SMPS. Exposure to malaria messages remains high, particularly through mass media - especially radio - that continues to effectively reach both urban and rural populations. In addition, a range of advocacy initiatives and events has been conducted at both national and subnational levels, targeting high-level political leaders and decision-makers. These efforts have been instrumental in maintaining political commitment, mobilizing resources, and ensuring that malaria remains a priority on both national and subnational agendas. The implementation of SBC&A is essential for sustaining knowledge and translating it into consistent and sustained behavior change. It addresses behavioral, social, and structural barriers that limit the uptake and effective use of malaria interventions, thereby enhancing community participation, improving health outcomes, and ensuring long-term, sustainable impact.

Strategic direction: SBC&A focuses on transitioning from knowledge and awareness creation to sustained behavior change through integrated, multi-channel communication, complemented by robust advocacy to secure political commitment, strengthen coordination, and elevate the malaria agenda at all levels

Deliverables: 85% of the targeted audience will be reached through the SBC channel/activities.

Under the Strategic Approach Malaria Social Behaviour Change and Advocacy (5.1), the following Strategic Interventions will be implemented:

SI	Strategic Intervention
5.1.1	Strengthen knowledge, attitude and practices among community members on positive uptake of malaria interventions.

5.1.2	Enhance malaria advocacy to political leaders and decision makers to strengthen commitment, and increased malaria visibility.
5.1.3	Strengthen the quality, coverage, and effectiveness of interpersonal communication (IPC) to increase uptake of key malaria interventions.

Strategic Intervention (5.1.1): Strengthen knowledge, attitude and practices among community members on positive uptake of malaria interventions

General Knowledge about malaria is high and almost universal in Mainland Tanzania. The SMPS 2025 shows that knowledge of malaria prevention is 94%. This high level of knowledge is due to increasing exposure to malaria messages through different approaches and channels, especially mass media (radio, 78% as per MIS 2022). The effect of this high level oof knowledge on malaria prevention is reflected in the high utilization of ITNS (given access) where ITN access is 68.8% and use is at 62.1%, making a ratio of 0.9 (SMPS 2025). However, apart from this high knowledge, other behaviour-related indicators such as treatment seeking and uptake of IPT3+ to pregnant women have not met a target.

The focus of the SBC will build on pre-existing high knowledge, reinforce understanding of desired behaviors, and promote action through different approaches and channels including mass media (radio, print materials, and digital/social media) mid media, increased community engagement, use of healthcare providers and malaria message delivery through school health programs to promote uptake of malaria interventions including ITN utilization.

Under this Strategic Intervention strengthen KAP among community members (5.1.1) the following Service Delivery Mechanisms will be implemented:

SDM	Service Delivery Mechanisms
5.1.1.1	Implement Mass media campaigns to key target audiences.
5.1.1.2	Strengthen the implementation of malaria SBC programs through the school platforms.
5.1.1.3	Integrate Artificial Intelligence (AI) tools to enhance adoption of SBC activities.

SDM 5.1.1.1: Implement Mass media campaigns to key target audiences

Mass media has the ability to reach a large audience quickly and consistently, hence helps to increase knowledge and awareness, reinforcing key messages, builds public support and trust, supporting behavior change, and promoting social norms that favor malaria prevention and treatment seeking. E.g. radio has a wide coverage, and is accessible to the majority of people both in rural and urban Tanzania. Television and print materials are also the fastest channels that reach many at a time and they capture audience attention and interests. Furthermore, social media and digital platforms are increasingly reaching a wide number of people (especially youth) and has a big influence in messaging and information transfer

The focus will be continuing with a mass media approach to sustain the level of knowledge and visibility of malaria interventions. NMCP will leverage the widespread popularity of radio in Mainland Tanzania, across national, regional, and community stations, to disseminate malaria messages and information. In addition, AI tools will be integrated into the development and production and dissemination of SBC messages and materials. Malaria messages will also be shared through social media platforms, which are rapidly expanding and have the potential to reach a large portion of the population, thereby increasing overall reach and exposure."

SDM 5.1.1.2: Strengthen the implementation of malaria SBC programs through the school platforms in all malaria transmission strata

Data from the School Malaria Parasitological Surveys (SMPS) indicate a shift in the burden of malaria transmission from children under five to school-aged children, with prevalence higher among older children than younger ones, and higher among boys than girls. This highlights the need to implement malaria SBC programs in schools, as school-aged children often share what they learn with their families and communities, thereby influencing parents, siblings, and others.

Strategic direction will be to implement school-based SBC interventions targeting school children and their teachers so that they can understand the importance of protecting themselves from malaria and also become a medium of delivering messages to their parents/guardians and siblings.

SDM 5.1.1.3: Integrate Artificial Intelligence (AI) tools to enhance adoption of SBC activities

There is a strong need to utilize Artificial Intelligence (AI) in the design, development, and production and dissemination of malaria messages and SBC materials. This is driven by the rapid advancement of technology, which, when applied strategically can significantly improve efficiency, creativity, targeting, and cost-effectiveness. However, the use of AI in malaria SBC is currently limited due to inadequate technical capacity, limited awareness of AI applications, and a lack of clear guidance on integrating AI tools into campaign and routine SBC activities. Integrating AI in message and SBC materials designing, development, and production and dissemination will enhance creativity, content production, efficiency, and relevance, such as in rapid drafting of scripts, print materials, TV and radio spots, social media content, and other visual designs to reduce production time while expanding creative options. Strategic direction will be to adopt AI gradually through a structured, ethical, and capacity-driven approach, and integrate it into existing SBC systems based on evidence of added value.

Strategic Intervention (5.1.2): Enhance malaria advocacy to political leaders and decision makers to strengthen commitment, and increased malaria visibility (Malaria Advocacy)

Malaria advocacy is essential for maintaining sustained political commitment, mobilizing resources, and engaging communities' key elements for controlling and ultimately eliminating malaria in the country. By informing leaders and decision-makers about the malaria burden and the impact of interventions, advocacy helps ensure that malaria remains a priority on both national and local agendas.

The strategic approach will be to strengthen malaria advocacy among political leaders, policy and decision makers so as to increase their support for malaria visibility and resource mobilization, especially in this era where malaria resources from external sources are declining.

This strategic intervention Malaria advocacy to political leaders and policy makers (5.1.2) will be implemented through two service delivery mechanisms (SDM):

SDM	Service Delivery Mechanisms
5.1.2.1	Enhance engagement with political leaders and key stakeholders at all levels.
5.1.2.2	Leverage SBC activities through the End Malaria Council of Tanzania (EMCT).

SDM 5.1.2.1: Enhance engagement with political leaders and key stakeholders at all levels

Malaria SBC & Advocacy Guide instructs the importance of advocacy activities to create awareness, influence malaria policies, improve malaria funding, malaria resource mobilization and prioritization of malaria fund allocations at different levels of implementation and increased political will to raise malaria profile.

Advocacy activities will continue to be implemented in collaboration with relevant partners such as ALMA/TAPAMA, EMCT, and other implementing partners.

SDM 5.1.2.2: Leverage SBCA activities through the End Malaria Council of Tanzania (EMCT)

The End Malaria Council of Tanzania (EMCT), among other functions, is responsible for advocating for malaria control and increasing message visibility through various communication platforms. Launched in April 2023, EMCT brings together the government, private sector, civil society, religious and faith leaders, youth, and artists to drive the country's goal of malaria elimination by 2030.

EMCT directly supports the National Malaria Strategic Plan (NMSP) through resource mobilization, advocacy, message dissemination, and community sensitization. It focuses on raising domestic funding, engaging the private sector, promoting behavior change, and mobilizing communities by leveraging influential platforms such as religious/faith groups, private sector networks, and artist- or sports-led events. Malaria messaging through EMCT has been disseminated via religious leaders, the private sector, artists, and football via electronic billboards during CHAN competition.

NMCP will continue to utilize and engage EMCT platforms for resource mobilization and reaching wider audience with malaria messages.

Strategic Intervention (5.1.3): Strengthen the quality, coverage, and effectiveness of interpersonal communication (IPC) to increase uptake of key malaria interventions (Interpersonal Communication)

Interpersonal communication (IPC) is a key approach currently used to promote uptake of malaria interventions. It is mainly implemented through community-based structures and health facilities as part of Social and Behaviour Change (SBC) strategies. IPC for malaria is largely conducted by community health workers (CHWs), who engage communities directly, and by Health care Workers when attending their clients at health facilities. It is a critical SBCA&CE approach for improving uptake of malaria prevention and treatment interventions in Tanzania and enables personalized, trusted communication, unlike mass media. It also provides two-way communication, allowing individuals to ask questions and receive tailored information. Messages delivered by trusted sources, such as community health workers and health providers, are often trusted and have greater influence on behavior change.

The strategic direction will be to strengthen interpersonal communication (IPC) for malaria in focusing on improving the quality, reach, and effectiveness of it through IPC skills and capacity of frontline IPC communicators so as to increase uptake of malaria interventions.

The strategic intrvention strengthen effective IPC (5.1.3) will have one strategic intervention:

SDM	Service Delivery Mechanisms
5.1.3.1	Strengthen the capacity of healthcare workers to effectively provide accurate and relevant malaria messages to clients.

SDM 5.1.3.1: Strengthen the capacity of healthcare workers to effectively provide accurate and relevant malaria messages to clients

Healthcare workers serve as a vital source of malaria information during their routine interactions with clients. According to the 2025 MSDQI report, 89% of the health facilities assessed provide malaria messages through healthcare workers. Furthermore, findings from NMCP SBC verification and supportive supervision show that most household members identify health facilities or healthcare providers as their main source of malaria-related information.

Improved Interpersonal Communication of healthcare providers will facilitate friendly service provision and delivery of malaria messages to clients, hence improve uptake of malaria interventions. Providers are highly trusted by their clients, and hence the messages they provide are highly credible and influential for behaviour change.

Strategic direction will be to strengthen the capacity and interpersonal communication skills of healthcare providers, and promote provider behavior change to ensure they deliver relevant malaria messages and effectively encourage clients to adopt positive malaria prevention and treatment practices.

Strategic Approach 5.2 Promote community engagement and active participation in malaria control and elimination interventions within their respective settings (Malaria Community Engagement)

Situation and rationale: Malaria community sensitization and engagement in Tanzania are implemented through multiple community-based approaches, including the use of Community Health Workers (CHWs), Civil Society Organizations (CSOs), and mid-media communication platforms, particularly in high- and moderate-malaria transmission regions. Community-Led Monitoring (CLM) was piloted in Nzega DC and Kaliua DC in Tabora Region to strengthen community participation, accountability, and feedback collection on malaria services and interventions. These efforts have contributed to improved community awareness and increased reach of malaria messages. However, persistent gaps in coverage, inconsistent adoption of preventive behaviors, and limited sustainable support continue to reduce the overall impact of community engagement interventions. These challenges highlight the need for more integrated, targeted, and evidence-based approaches to community sensitization and engagement.

Strategic direction: The strategic direction for malaria community sensitization and engagement focuses on strengthening behavior change and promoting sustained adoption of malaria prevention and treatment practices through integrated and multi-channel community approaches. Emphasis will be placed on enhancing community ownership and participation, engaging local leaders and stakeholders, strengthening the role of CHWs, and implementing targeted interventions for vulnerable, high-risk, and hard-to-reach

populations. In addition, the programme will promote evidence-based planning, coordinated implementation, and community accountability mechanisms to improve equitable access to malaria interventions and accelerate progress toward malaria control and elimination goals.

Deliverables: The programme is expected to achieve improved community awareness and uptake of malaria prevention and treatment interventions through strengthened community engagement platforms and behavior change strategies. It will also enhance community ownership, accountability, and participation in malaria interventions through expanded Community-Led Monitoring and strengthened collaboration with CHWs, CSOs, and local leaders. Furthermore, the programme will support the implementation of targeted and data-driven community engagement interventions that improve equitable access to malaria services among vulnerable and hard-to-reach populations while promoting sustainable malaria prevention behaviours.

Under the Strategic Approach Malaria Community engagement (5.2), the following Strategic Interventions will be implemented:

SI	Strategic Intervention
5.2.1	Enhance malaria knowledge and practices among malaria-vulnerable groups to raise awareness of their risks and enable effective uptake of preventive and curative services available.
5.2.2	Strengthen community engagement and participation to promote and implement malaria control and elimination initiatives.
5.2.3	Strengthen verification and quality control mechanisms of SBCA&CE for malaria intervention and activities across all levels of implementation.

Strategic Intervention 5.2.1: Enhance malaria knowledge and practices among malaria-vulnerable groups to raise awareness of their risks and enable effective uptake of preventive and curative services available (Promote Malaria Services for Vulnerable groups)

Vulnerable groups to malaria are categorized based on biological vulnerability and other vulnerabilities, such as socioeconomic, geographical, and occupational factors. Malaria messages targeting vulnerable groups have been delivered to communicate the importance of protecting pregnant women and children under-five using ITNs, ITNs delivery through RCH, prevention of malaria in pregnancy, and the benefits of pregnant women to complete the dose of IPTp3+ and importance of early treatment seeking for children under five. NMCP also developed and disseminated SBC materials for hard-to-reach groups, including miners, pastoralists and nomads. Again, the Malaria matchbox assessment was conducted to understand equity and vulnerability for the malaria at-risk population to improve in reaching the most vulnerable and at-risk populations with malaria interventions. The assessment also indicates barriers to malaria service uptake and considerations in reaching the most vulnerable groups, people at risk of malaria, and Persons with Disability (PWDs).

The national malaria SBC&A guide recommends that vulnerable groups be reached with targeted messages and channels available in their areas to address their vulnerabilities and enable them to take appropriate actions.

NMCP will continue with the provision of malaria messages to vulnerable groups through relevant channels, including healthcare providers and SBC outreach programs, while addressing considerations from the malaria matchbox assessment.

The strategic Intervention enhance malaria knowledge and practice (5.2.1) have two Service Delivery Mechanisms:

SDM	Service Delivery Mechanisms
5.2.1.1	Develop and implement SBC& CE outreach programs for disadvantaged vulnerable groups and marginalized Population in all malaria transmission strata.
5.2.1.2	Promote integration of gender inclusive and responsive approaches in the implementation of malaria interventions.

SDM 5.2.1.1: Develop and implement SBC& CE outreach programs for disadvantaged vulnerable groups, high risk and marginalized population in all malaria transmission strata

SBC outreach programs are implemented in a form of mid media activities like community wide events, road shows, Public Spot Announcement (PSA) and edutainment. Although the coverage of mid- media is still low, its importance lies in complementing messages that are delivered through the mass media and trigger conversation around key behavior in a way that makes sense to the audiences. Groups in the lowest economic quintile and with the lowest education generally are more likely to face barriers to

behavior change, including lower availability, accessibility and affordability of services and products, and less exposure to media. The same barriers apply to marginalized and mobile populations such as nomadic groups and migrants, Persons with Disability (PWDs) and displaced populations, including refugees. In some circumstances, there is also a social barrier in terms of acceptability of getting and using services or products, or practicing the desired behaviour.

SBC&A guide for malaria interventions 2021- 2025 insist on targeting vulnerable groups with specific messages regarding their vulnerability using relevant channels to them such as interpersonal communication through health providers, print materials and targeted mid media. Furthermore, the malaria matchbox assessment has indicated barriers to malaria service uptake and considerations in reaching most vulnerable groups, people at risk of malaria and community Engagement, Gender and Persons with Disability (PWDs). NMCP will strengthen SBC outreach programs and community engagement to biological, socio-economic and other most vulnerable groups such marginalized population, hard-to-reach, mobile populations, refugees and persons with disability in high and moderate -transmission areas.

SDM 5.2.1.2: Promote the integration of gender inclusive and responsive approaches in the implementation of malaria interventions

Malaria Matchbox assessment of 2023 has outlined gender consideration areas in the implementation of malaria interventions. These include different gender roles which may influence health-seeking behavior, with women often initiating care-seeking but facing delays due to household responsibilities and financial constraints. Other gender considerations are around social-economic and occupation factors where both men and women can be exposed to mosquito bites (due to their occupations) and socially constructed gender norms and cultural barriers which. All this can have effects on proper utilization of malaria services. The strategic direction will be to include gender considerations in relation to access and utilization of malaria interventions in the implementation of malaria interventions, including developing and dissemination of messages that address gender norms in malaria interventions and using targeted communication approaches.

Strategic Intervention (5.2.2): Strengthen community engagement and participation to promote and implement malaria control and elimination initiatives (Community engagement in Malaria prevention and care)

Community-based malaria initiatives are implemented through a combination of approaches; mainly through community health workers (CHWs), who are sensitizing community members to utilize malaria interventions using different interpersonal communication approaches like household visits, group discussions and dialogues, meetings, and clinic talks.

During the implementation of NMSP 2021-2025, NMCP oriented 4,655 CHWs on malaria SBC and communication skills across 16 regions in high and moderate prevalence regions (Lindi, Mtwara, Kagera, Tabora, Ruvuma, Katavi, Rukwa, Kigoma, Mwanza, Arusha, Singida, Iringa, Njombe, Mara, Shinyanga, Geita) and supplied them with the malaria SBC CHW tool. Furthermore, the Integrated and Coordinated Community Health Workers program plays a pivotal role in delivering community-level health interventions, including malaria prevention, community sensitization and & behavior change activities. In this strategic plan period, Community-led approaches will be used, including use of Community Health Workers for Interpersonal communication and interaction with individuals and community members, engagement of CSOs, engagement of village/community and religious leaders.

This Strategic Intervention strengthen community engagement (5.2.2) will be implemented through following Service Delivery Mechanisms:

SDM	Service Delivery Mechanisms
5.2.2.1	Strengthen the capacity of local authorities including village and Mtaa leaders to effectively conduct malaria community sensitization and engagement.
5.2.2.2	Facilitate the adoption of malaria community mobilization and engagement activities through CHWs/CORPs.
5.2.2.3	Engage CSOs, religious leaders, Faith leaders, and faith-based organizations in malaria community sensitization and engagement.

SDM 5.2.2.1 Strengthen the capacity of local authorities including village/Mtaa leaders to effectively conduct malaria community sensitization and engagement

Village/community leaders are engaged in awareness creation and sensitization of ITNs distribution through Targeted Mass Campaign, and they have played a very crucial role in giving information about the campaign including dates for household

registrations, and when to collect ITNs. Engaging village and community leaders in malaria awareness and sensitization is one of the most effective ways to increase community participation, engagement, trust, and behavior change. Community leaders, when fully involved/engaged and sensitized, are able to carry the malaria agenda with promised accountability.

NMCP, in collaboration with PMO-RALG/LGAs, will strengthen the environment to enable village/community leaders to get fully engaged in the malaria agenda and sensitize their community members

SDM 5.2.2.2: Facilitate the adoption of malaria community mobilization and engagement activities through CHWs/CORPs

CHWs/CORPs are actively engaged in SBC and community sensitization on malaria in regions with high and moderate malaria transmission: they conduct household visits, group discussions (e.g., with women and youth), clinic talks, and other interpersonal communication to encourage the use of malaria interventions. A total of 4,655 CHWs were oriented on malaria SBC across 16 regions in high and moderate prevalence regions (Lindi, Mtwara, Kagera, Tabora, Ruvuma, Katavi, Rukwa, Kigoma, Mwanza, Arusha, Singida, Iringa, Njombe, Mara, Shinyanga, Geita) and supplied with the SBC CHW tool. The Ministry of Health, through the Health Promotion section, has established the Integrated and Coordinated Community Health Workers program where CHWs have been trained (and is continuing to be trained in phases) in 11 regions (two councils per region) of Kagera, Geita, Mbeya, Njombe, Kigoma, Tabora, Tanga, Lindi, Songwe, Pwani and Ruvuma.

NMCP, in collaboration with PMO-RALG and partners, will continue to engage CHWs in promotion and community sensitization of malaria intervention for optimal community engagement and uptake of malaria intervention at the grassroots levels and will leverage the CHWs trained under the Integrated and Coordinated Community Health Workers program.

SDM 5.2.2.3: Engage CSOs, religious leaders, Faith leaders, and faith-based organizations in malaria community sensitization and engagement

The NMCP, in collaboration with PMO-RALG, is working with civil society organizations (CSOs) to reach communities and raise awareness about malaria interventions. In partnership with CONAMET, a total of 15 organizations were involved in 2023 across 15 regions: Tabora, Kagera, Kigoma, Lindi, Mtwara, Ruvuma, Shinyanga, Mara, Simiyu, Tanga, Morogoro, Katavi, Rukwa, Pwani, and Mara. Additionally, five CSOs were active in the Mara, Shinyanga, Geita, Simiyu, and Kigoma regions. These CSOs have been engaging communities through various approaches and channels, including community meetings, edutainment activities, and through CHWs. Also, the NMCP, in collaboration with partners, has engaged religious and faith leaders to sensitize communities about malaria. This involved equipping religious leaders with malaria messages to deliver to their congregations through sermons and other gatherings. Through the EMCT, the NMCP and partners developed these religious/faith leaders' malaria messages, which were officially launched in April 2024 by high-level religious leaders who are also EMCT members. Since then, both Muslim and Christian leaders have used various forums to raise awareness and encourage the uptake of malaria interventions.

NMCP, in collaboration with PMO-RALG and malaria Community Networks, will continue to engage CSOs to implement community sensitization and engagement to reach the grassroots population with messages on uptake of malaria interventions. Again, the SBC & Advocacy guide recognized religious/faith leaders as important channels of message delivery to the intended audience.

Strategic Intervention (5.2.3): Strengthen verification and quality control mechanisms of SBCA&CE for malaria intervention and activities across all levels of implementation (SBCA&CE monitoring)

Monitoring of malaria SBCA& CE activities ensures that the strategies and approaches designed to influence people's behaviors are actually working and contributing to the malaria prevention and elimination goal. NMCP has been monitoring SBCA&CE activities at the national, regional, and council levels, including activities implemented by partners.

will continue to monitor SBCA&CE activities at different levels. At the community level, NMCP, in collaboration with malaria community and partners, will scale up collection of community feedback.

This strategic intervention strengthen verification and quality control of SBCA&CE (5.2.3) has the following service delivery mechanisms (SDM):

SDM	Service Delivery Mechanisms
5.2.3.1	Monitor SBCA&CE activities to track progress of implementation.
5.2.3.2	Implement, coordinate and oversee the implementation and scale-up of malaria Community Led Monitoring (CLM) in high and moderate malaria transmission.

SDM 5.2.3.1: Monitor SBCA&CE activities to track progress of implementation

The NMCP, in collaboration with PMO-RALG, regional authorities, and councils, has been conducting verification and supportive supervision of SBCA&CE activities at national, regional, council, and community levels. The purpose of these exercises is to assess and ensure that those activities are being implemented as planned and in accordance with established guidelines. These exercises were conducted quarterly over the past four years and biannually during the final year of the Malaria Strategic Plan (2025). Findings from these exercises have been used to track implementation progress, identify operational challenges, and inform appropriate corrective actions and solutions.

Verification and supportive supervision of SBCA&CE activities will continue to be implemented in collaboration with PMO-RALG, regional authorities, and councils to ensure quality implementation and adherence to established standards.

SDM 5.2.3.2: Implement, coordinate and oversee the implementation and scale-up of malaria Community Led Monitoring (CLM) in high and moderate malaria transmission

Community-Led Monitoring (CLM) is an accountability mechanism in which trained and equipped community members systematically collect and analyze quantitative and qualitative data on health service delivery—both facility-based and community-based. Working through community-led organizations, CLM provides routine feedback on the availability, accessibility, quality, and responsiveness of malaria services. It also enables communities to identify service delivery gaps, track bottlenecks, and provide evidence-based feedback to improve malaria services and enhances accountability between communities and health systems, and ensures service delivery challenges are detected early and addressed promptly. Tanzania has already developed a full package of CLM tools and systems—including a national malaria CLM framework, work-plan and roadmap for 2025, SOPs, curriculum and training materials, and data-collection tools. Malaria CLM has been piloted in two councils in Tabora Region (Nzega DC and Kaliua DC), demonstrating feasibility for scale-up. The resources and systems already developed by NMCP, Malaria Community Networks, PMO-RALG and partners provide a solid foundation for expansion.

CLM will be scaled as a structured community feedback mechanism to monitor malaria service quality, identify gaps, and propose actionable solutions. The approach will enable routine reporting from communities and support continuous improvement in malaria prevention, diagnosis, treatment, and outreach services. Expansion will focus on high-burden councils where community oversight can accelerate results and will be integrated under a broader health programme framework, including malaria, HIV, TB, and other relevant health priorities, to maximize synergies, strengthen community voice, and improve the use of community-generated data for programme improvement

Strategic Objective 6: To strengthen efficient and effective implementation of malaria strategies through accountable leadership and partnership.

The National Malaria Control Programme (NMCP) serves as the national focal point for leadership, partnership coordination, and resource mobilization for malaria control and elimination in Tanzania. In collaboration with Prime Minister's Office – Regional Administration and Local Government (PMO-RALG), regional and council health teams, development partners, research institutions, civil society, and the private sector, the programme coordinates implementation of malaria interventions nationwide. Despite notable achievements, declining external support and ongoing resource constraints continue to threaten the sustainability of malaria control and elimination efforts. Policy guidance from the Tanzania National Health Policy and the Health Sector Strategic Plan V emphasizes strong disease control programmes, multisectoral collaboration, and improved health system governance. The NMSP 2026–2030 prioritizes strong leadership, coordinated partnerships, and sustainable resource mobilization to ensure effective implementation of malaria interventions across all levels of the health system. The **Leadership Partnership and Resource Mobilization** strategic area places particular emphasis on strengthening domestic financing, enhancing stakeholder coordination, and promoting community engagement to sustain progress toward malaria elimination. Expected outcomes include strengthened

coordination mechanisms between NMCP, PMO-RALG, and partners, as well as increased domestic and external resource mobilization to improve the effectiveness, efficiency, and sustainability of malaria interventions.

The Strategic Objective; Leadership, Partnership and Resource Mobilization (6), will be implemented through three strategic approaches:

SA	Strategic Approaches
6.1	Provide effective leadership to ensure program's objectives are met.
6.2	Promote harmonized partnership for malaria control and elimination.
6.3	Establish a sustainable environment for resource mobilization.

Strategic Approach 6.1: Provide effective leadership to ensure program's objectives are met.

Situation and rationale: Despite progress in malaria control, Tanzania continues to face challenges in ensuring sustainable financing, strong governance, and effective implementation of malaria interventions. Malaria activities remain highly dependent on external funding, while integration of malaria priorities into government financial and planning systems is still limited. In addition, changing malaria epidemiology requires more targeted, evidence-based interventions, yet implementation capacity, use of data, and integration of innovations remain uneven across levels of the health system.

Strategic direction: The Ministry of Health (MoH) through the National Malaria Control Programme (NMCP) will strengthen leadership and governance to ensure malaria elimination is integrated into government planning, financing, and implementation systems. NMCP will advocate for increased domestic financing, strengthen technical oversight of malaria interventions, guide evidence-based resource allocation, build capacity of health teams and partners, and promote the use of research, innovations, and operational evidence to improve programme impact.

Deliverables: Implementation of leadership and governance functions will result in improved integration of malaria priorities into government systems, increased domestic financing, and stronger coordination and accountability for malaria programmes. It will also lead to updated strategies and guidelines, strengthened technical and managerial capacity, improved use of data and innovations, and more effective implementation of targeted malaria interventions to accelerate progress toward elimination in Tanzania.

Under the Strategic Approach Leadership (6.1), the following two strategic Interventions will be implemented:

SI	Strategic Interventions
6.1.1	Strengthen governance, advocacy, and coordination.
6.1.2	Enhance appropriate strategies and technical capacity for implementation of malaria interventions.

Strategic Intervention 6.1.1: Strengthen governance, advocacy, and coordination

The aim of this strategic intervention is to strengthen governance and advocacy by integrating malaria control and elimination priorities into national policies, strategies, and regulatory frameworks, while enhancing leadership, accountability, and compliance with national standards across all levels of the health system. The programme will also promote sustainable domestic financing, strengthen community awareness and participation, and mobilize support from government, partners, NGOs, and the private sector using evidence-based advocacy approaches.

Strengthen coordination and collaboration through multisectoral partnerships and improved alignment among government agencies, development partners, NGOs, and community organizations to maximize efficiency and intervention coverage. The programme will further strengthen monitoring, information sharing, and operational coordination to support timely delivery of malaria commodities, synchronized implementation of interventions, and effective surveillance and research activities.

Under the Strategic Intervention governance, advocacy, and coordination (6.1.1) five service delivery mechanisms will be implemented:

SDM	Service Delivery Mechanisms:
6.1.1.1	Advocate for the inclusion of malaria control and elimination objectives in government financial regulations and guidelines.
6.1.1.2	Raise the profile of malaria amongst policymakers and decision makers at all levels to ensure adequate integration of interventions and sufficient budget allocation in national, regional, and council plans aligned to the malaria strategic plan.
6.1.1.3	Strengthen governance structures at all levels to improve coordination, communication, and follow up of all malaria related interventions.
6.1.1.4	Enhance well-structured, coordinated and harmonized supervision and verification system involving all implementing entities across all levels.
6.1.1.5	Strengthen the integration and prioritization of malaria interventions within Annual Comprehensive Council Health Plans (CCHPs).

SDM 6.1.1.1: Advocate for inclusion of malaria control and elimination objective into the financial regulations and guidelines.

The absence of explicit malaria elimination objective in financial regulations has led to weak prioritization and unclear accountability for malaria funding within national and council budgets, as allocations are often embedded in broader health financing. In response, and in line with national health and malaria strategic frameworks, the Ministry of Health through the Department of Policy and Planning will strengthen advocacy and coordination with the Ministry of Finance to integrate malaria elimination into financial regulations and the Medium-Term Expenditure Framework, improving alignment of budgeting processes with national malaria targets and strengthening accountability for malaria financing.

SDM 6.1.1.2: Raise the profile of malaria amongst policy and decision makers at all levels so that national, regional and council plans include appropriate interventions and sufficient budget to implement the malaria strategic plan

Malaria interventions in Tanzania are largely funded by development partners, while government contributions are limited to selected activities such as IPTp commodities, diagnostics, and larviciding. However, low prioritization among some policymakers has led to weak integration of malaria activities into development plans and insufficient domestic financing. Guided by the WHO Global Technical Strategy for Malaria (2016–2030) and RBM framework, the National Malaria Strategic Plan 2026–2030 will strengthen advocacy and stakeholder engagement to position malaria as a development priority, increase domestic resource allocation, and improve financial sustainability for effective malaria control and elimination.

SDM 6.1.1.3: Strengthen governance structures at all levels to strengthen coordination, communication, and close follow up of all malaria related interventions

Over the past five years, limited resources have reduced the frequency of Integrated Malaria Vector Control and Diagnosis, Treatment and Preventive Therapies technical working group meetings, with only 42% of planned quarterly sessions conducted, although annual malaria meetings have supported progress review and decision-making. Guided by national health and malaria strategic frameworks, NMCP will strengthen coordination of these TWGs with key stakeholders, ensuring quarterly meetings (including virtual sessions where needed) and annual reviews are consistently held during the 2026–2030 period to address gaps, agree on corrective actions, and improve governance for malaria control and elimination.

SDM 6.1.1.4: Enhance well-structured, coordinated and harmonized supervision and verification system involving implementing entities at various levels.

Effective supervision and verification are critical for ensuring quality, efficiency, and accountability of malaria interventions at all levels. NMCP, in collaboration with PMO-RALG and partners, has established supportive supervision guidelines, tools, and the MSDQI framework to strengthen service delivery and data quality monitoring from national to community levels. In line with HSSP V, NMCP will continue to coordinate supervision through regional and council health teams to ensure accurate and timely reporting. The NMSP

2026–2030 will further harmonize supervision approaches, improve documentation and follow-up of findings, sustain joint supervision for data and financial verification, and strengthen capacity building at the council level.

SDM 6.1.1.5: Strengthen the malaria component of annual comprehensive council health plans.

Malaria planning and budgeting are conducted at national and subnational levels, but integration into Comprehensive Council Health Plans remains inconsistent due to competing priorities, limited capacity, and weak use of epidemiological data. This has led to gaps between national malaria priorities and local implementation. In response, the Ministry of Health through NMCP, with PMO-RALG and partners, will strengthen engagement in CCHP planning, provide technical support, and improve oversight to ensure malaria interventions are adequately prioritized and funded at council level, enabling more effective local implementation.

Strategic Intervention 6.1.2: Enhance appropriate strategies and technical capacity for implementation of malaria interventions.

Two technical working groups for malaria burden reduction and malaria elimination will provide technical guidance to NMCP on malaria interventions in collaboration with regional and local authorities and implementing partners, reporting through the Head of Programs to senior Ministry of Health leadership under the Chief Medical Officer. In line with the National Health Policy (2007) and HSSP V, which promote thematic disease committees for improved coordination and problem-solving, the Ministry of Health through NMCP will strengthen technical oversight, coordination, and alignment of malaria activities across all levels. This will ensure effective leadership, transparent governance, and strong technical support for malaria control and elimination nationwide. Under the Strategic Intervention, appropriate strategies and technical capacity (6.1.2) three service delivery mechanisms will be implemented as follows:

SDM	Service Delivery Mechanisms
6.1.2.1	Develop and sustain evidence-based malaria control and elimination strategies to guide stakeholders and implementers toward achievement of national strategic goals.
6.1.2.2	Strengthen the capacity of NMCP and PMO-RALG to effectively implement planned malaria interventions at all levels of the health system.
6.1.2.3	Enhance human resource capacity at national and LGA levels to ensure effective implementation of the strategic plan.

SDM 6.1.2.1: Develop and sustain appropriate evidence-based malaria control and elimination strategies that will guide stakeholders and implementers towards the achievement of the strategic goal

Over time, NMCP has developed and disseminated guidelines and SOPs to support malaria control and elimination at all levels. To respond to changing malaria patterns and support more targeted, data-driven interventions, the NMSP will prioritize updating and strengthening evidence-based policies and guidelines aligned with Tanzania's stratified malaria context. In line with HSSP V, NMCP, with PMO-RALG and partners, will enhance technical guidance, training, and sensitization for regional and council health teams to ensure effective and standardized implementation.

SDM 6.1.2.2: Strengthen NMCP and PMO-RALG capacity to successful implement planned malaria interventions at all levels

The Effective implementation of the NMSP 2026–2030 requires strong institutional capacity and coordinated partner support. The strategy will strengthen operational capacity through timely provision of essential equipment, technical skills, and logistical support to enhance malaria control and elimination interventions.

SDM 6.1.2.3: Strengthen human resources capacity for effective strategic plan implementation at national and LGA levels

Successful implementation of malaria interventions depends on having sufficient, skilled, and well-distributed human resources at all levels. The NMSP 2026–2030 will strengthen workforce capacity through targeted recruitment, continuous training, and deployment of malaria focal persons in collaboration with PMO-RALG. It will also support staff development and education to ensure a competent workforce for effective malaria control and elimination.

Strategic Approach 6.2: Promote harmonized partnership for malaria control and elimination

Situation and rationale: Malaria control and elimination in Tanzania require strong collaboration among multiple stakeholders, including government agencies, development partners, NGOs, the private sector, research institutions, and communities. However, coordination challenges, duplication of efforts, weak alignment of interventions, and inconsistent resource use continue to limit programme efficiency and impact. In addition, fragmented planning, reporting systems, and limited integration of community feedback and research evidence reduce the effectiveness of malaria interventions. This strategic approach is guided by national malaria strategic frameworks and standards, which require all stakeholders to align with national priorities, guidelines, and quality standards. It emphasizes transparency, accountability, and evidence-based decision-making in resource allocation and programme implementation. It also promotes harmonized monitoring and evaluation systems, coordinated donor support, and the integration of community perspectives and innovation into malaria programming.

Strategic direction: The strategy will strengthen multi-stakeholder coordination by improving collaboration among government institutions and partners through joint planning, implementation, and monitoring at all levels. It will enhance resource mobilization and efficiency by pooling financial, technical, and institutional support while ensuring alignment of donor funding with national priorities. It will also promote standardized approaches through unified guidelines and M&E systems, foster innovation and knowledge sharing, and strengthen community engagement to improve uptake of malaria services and ensure inclusive decision-making.

Deliverables: Implementation of this approach will result in improved coordination and reduced duplication among malaria stakeholders, increased efficiency in resource use, and better alignment of partner support with national priorities. It will also produce harmonized implementation of malaria guidelines, strengthened monitoring and reporting systems, increased use of evidence and innovation, and improved community participation in malaria control and elimination efforts.

Under the Strategic Approach Partnership (6.2), the following strategic interventions will be implemented:

SI	Strategic Interventions
6.2.1	Institutionalize multi-sectoral collaboration for malaria control and elimination.
6.2.2	Enhance implementation of effective cross-border initiatives.

Strategic Intervention (6.2.1): Institutionalize multi-sectoral collaboration for malaria control and elimination

The Ministry of Health, through the National Malaria Control Programme (NMCP), collaborates with government institutions, local authorities, development partners, civil society, and the private sector to support malaria prevention, control, and elimination efforts across Tanzania. These partnerships contribute to coordination, advocacy, resource mobilization, and implementation at national and sub-national levels. However, challenges in coordination, alignment, accountability, and sustained multisectoral engagement continue to limit progress toward malaria elimination. Policy guidance from the Health Sector Strategic Plan V, the Malaria Multisectoral Collaboration Framework, and the Public-Private Partnership Policy emphasizes collaborative planning and strong partnerships to improve health outcomes. The NMSP 2026–2030 prioritizes strengthening partnerships to mobilize, coordinate, and sustain multisectoral and multi-stakeholder collaboration for accelerated malaria elimination. The strategy focuses on improving coordination, accountability, joint planning, and resource mobilization while promoting shared ownership of malaria targets and integrating malaria interventions into broader development agendas. Through innovative and effective partnerships, the strategy aims to strengthen governance, coordination, accountability, and sustainability of malaria elimination efforts.

Under the Strategic intervention; Multi Sectoral Engagement (6.2.1) the following three service delivery mechanisms will be implemented:

SDM	Service Delivery Mechanisms
6.2.1.1	Advocate for implementation of malaria SMART Actions within multisectoral engagement framework[18].
6.2.1.2	Promote Public Private Partnership.
6.2.1.3	Sustain the function of End Malaria Council and Fund.

[18] List of malaria SMART actions is attached as Annex 3

SDM 6.2.1.1: Advocate for implementation of malaria SMART Actions within multisectoral engagement framework

Recognizing the multisectoral determinants of malaria, Tanzania developed the Malaria Multisectoral Collaboration Framework, which defines sector-specific roles and SMART actions to guide coordinated implementation of evidence-based interventions across different sectors. Aligned with this framework, the National Malaria Strategic Plan (NMSP) 2026–2030 will focus on advocating for, supporting, and monitoring the implementation of malaria SMART actions across sectors to ensure effective operationalization of multisectoral engagement, resulting in an increased proportion of sectors actively implementing malaria interventions as outlined in the national framework.

SDM 6.2.1.2: Promote Public Private Partnership

Collaboration between the public and private sectors in malaria control currently includes support for interventions such as malaria case management in health facilities, while the End Malaria Council (EMC) provides an additional platform for private sector engagement, although contributions remain limited. Guided by the Health Sector Strategic Plan V (HSSP V) and the Public-Private Partnership Policy, the National Malaria Strategic Plan (NMSP) 2026–2030 will focus on strengthening public-private partnerships through stakeholder engagement and sensitization initiatives to promote collaboration, innovation, and resource mobilization, with the aim of increasing private sector financial and in-kind contributions to malaria prevention, control, and elimination efforts.

SDM 6.2.1.3: Sustain the function of End Malaria Council

The End Malaria Council serves as a high-level multisectoral platform for coordinating and advocating malaria control and elimination efforts by mobilizing political commitment, promoting cross-sector collaboration, and advocating for sustainable domestic and external financing. Guided by the National Malaria Strategic Plan (NMSP) and the National Health Policy 2007, the focus will be on sustaining the Council's governance, coordination, and accountability functions through regular meetings to review progress and guide strategic decisions, thereby strengthening advocacy for malaria resources.

Strategic Intervention (6.2.2): Enhance implementation of effective cross-border initiatives

Tanzania has made significant progress in reducing malaria burden, but transmission remains high in border areas due to population mobility and imported malaria cases. Despite existing political commitment and regional collaboration efforts, cross-border coordination remains weak because of fragmented implementation, limited data sharing, and the absence of a fully operational cross-border malaria framework. Regional and international frameworks, including those of the East African Community, provide guidance for harmonized malaria strategies, joint planning, surveillance, and coordinated interventions among neighboring countries. The NMSP 2026–2030 aims to establish a coordinated, evidence-based, and sustainable cross-border malaria approach through strengthened regional coordination, joint action plans, multisectoral collaboration, and improved surveillance and real-time data sharing. The strategy also promotes joint monitoring, coordinated response activities, and collaborative research to support targeted interventions in high-risk border areas. Expected outcomes include functional and sustainable cross-border coordination platforms, harmonized surveillance systems, regular joint engagements, and coordinated malaria response interventions to accelerate malaria control and elimination efforts.

Under the Strategic Intervention cross -border initiatives, (6.2.2) the following service delivery mechanisms will be implemented:

SDM	Service Delivery Mechanisms
6.2.2.1	Operationalize GLMI/EAC and SADC strategic frameworks to strengthen cross-border collaboration for malaria control.

SDM 6.2.2.1: Operationalize EAC- GLMI and SADC strategic framework for cross border collaboration on malaria control

Tanzania, through the National Malaria Control Programme (NMCP) in collaboration with PMO-RALG, LGAs, and implementing partners, has strengthened cross-border malaria control through operational plans for border councils and participation in regional coordination initiatives with neighboring East African countries. Guided by regional frameworks including the GLMI Malaria Strategic Plan 2021–2025 and SADC malaria elimination commitments, the National Malaria Strategic Plan (NMSP) 2026–2030 will focus on adapting regional strategies to the Tanzanian context and strengthening cross-border surveillance, harmonized interventions, and regional data and resource sharing to improve collaboration and reduce malaria transmission in border areas.

Strategic Approach 6.3: Establish a sustainable environment for resource mobilization

Situation and rationale: Sustainable financing remains essential for achieving malaria control and elimination goals in Tanzania. Although malaria interventions have benefited from both domestic and external support, funding gaps, dependence on donor financing, and limited diversification of resources continue to threaten the sustainability and scale-up of key interventions. Strengthening governance, accountability, partnership engagement, and community participation is therefore critical to ensure predictable financing and efficient implementation of malaria programmes. National health and development frameworks emphasize the integration of malaria financing into government planning, budgeting, and financial regulations to ensure long-term sustainability. The resource mobilization approach also promotes transparency, accountability, multisectoral collaboration, and alignment of financing priorities with the National Malaria Strategic Plan (NMSP) 2026 - 2030.

Strategic Direction: The strategy focuses on strengthening sustainable and diversified financing through increased domestic investment, enhanced donor engagement, innovative financing mechanisms, and stronger partnerships with the private sector, civil society, and development partners. It also prioritizes multi-year resource mobilization planning, financial tracking and reporting, advocacy, and capacity building in proposal development, financial management, and donor coordination to improve efficiency, accountability, and long-term programme sustainability.

Deliverables: Sustainable and diversified financing mechanisms established, with strengthened governance, accountability, partnerships, financial tracking systems, and resource mobilization capacity to ensure adequate and efficient funding of malaria control and elimination interventions. Under the Strategic Approach Resource Mobilization (6.3), the following strategic interventions will be implemented:

SI	Strategic Intervention
6.3.1	Strengthen the resource mobilization mechanisms for sustainable implementation of malaria interventions.

Strategic Intervention (6.3.1): Strengthen the resource mobilization mechanisms for sustainable implementation of malaria interventions

Sustained financing remains essential for effective malaria prevention, diagnosis, treatment, surveillance, and elimination in Tanzania. While domestic and international investments have contributed to major reductions in malaria burden, significant funding gaps remain, particularly for high-cost interventions such as Indoor Residual Spraying (IRS). Continued dependence on external funding also threatens long-term programme sustainability, underscoring the need for increased domestic investment and diversified financing mechanisms.

To address this, the National Malaria Control Programme has developed a malaria resource mobilization plan aligned with the NMSP 2026 - 2030 to guide sustainable financing and efficient resource management. The NMSP 2026–2030 prioritizes strengthening sustainable and diversified financing through increased domestic resource allocation, stronger government commitment at national and local levels, and continued engagement with international financing partners.

The strategy also emphasizes advocacy for increased funding of priority interventions such as ITNs and IRS, while mobilizing additional support from development partners, the private sector, and innovative financing platforms. Strengthened financial tracking, accountability, and resource mobilization capacity are expected to improve efficient resource utilization, enhance donor confidence, and ensure sustainable implementation of evidence-based malaria control and elimination interventions.

Under the Strategic Intervention; Resource mobilization for sustainable implementation (6.3.1) the three service delivery mechanisms will be implemented as follows:

SDM	Service Delivery Mechanism
6.3.1.1	Develop comprehensive business and operational plans for malaria control interventions.
6.3.1.2	Advocate for increased domestic resources allocation to support malaria control and elimination.
6.3.1.3	Secure additional financial resources from global financing mechanisms to support malaria control and elimination efforts.

SDM 6.3.1.1: Develop comprehensive business and operational plans for malaria control interventions

Malaria control and elimination interventions will be guided by the National Malaria Strategic Plan (NMSP) 2026–2030, operational plans, and the malaria business plan, which together define priority interventions, implementation timelines, resource requirements, and financing needs. The business plan will provide a clear investment case to support resource mobilization, address funding gaps, and strengthen monitoring of implementation in line with allocated resources and timelines, thereby enhancing sustainable financing for malaria interventions.

SDM 6.3.1.2: Advocate for increased domestic resources allocation to support malaria control and elimination

The National Malaria Control Programme (NMCP) currently implements a resource mobilization plan aimed at strengthening fundraising, advocacy, and financial sustainability, particularly through increased domestic financing. In line with the Health Sector Strategic Plan V (HSSP V), which prioritizes sustainable health financing for priority health programs, the Government of Tanzania established the Tanzania End Malaria Council to enhance national ownership, political commitment, multisectoral collaboration, and domestic resource mobilization involving government, private sector, civil society, and other stakeholders.

The National Malaria Strategic Plan (NMSP) 2026-2030 further emphasizes strengthened advocacy and fundraising efforts to mobilize additional domestic resources for sustaining malaria control and elimination interventions and preserving the gains achieved. This approach is expected to improve domestic resource mobilization for malaria interventions.

SDM 6.3.1.3: Secure additional financial resources from global financing mechanisms to support malaria control and elimination efforts.

Sustained financing remains essential for the effective implementation of malaria control and elimination strategies in Tanzania. Through the National Malaria Control Programme (NMCP), the Ministry of Health coordinates the mobilization and allocation of resources for malaria interventions, with a substantial share of funding currently provided by global financing mechanisms and bilateral partners. These partnerships have supported the nationwide scale-up of key malaria interventions and strengthened health system capacity to respond to malaria.

In line with the Health Sector Strategic Plan V (HSSP V), which encourages alignment of external funding with national priorities, the National Malaria Strategic Plan (NMSP) 2026–2030 will focus on strengthening the capacity of NMCP and PMO-RALG structures to access and effectively utilize funding from global financing mechanisms through the development of high-quality, evidence-based funding proposals aligned with national priorities.

5. Cost of the strategy

The expected full resource envelope to implement the NSP

Direct malaria related costs by Strategic Objectives.

The NMSP 2026-2030 intends to mobilize financial resources to provide a) universal malaria vector protection with at least one measure in high and moderate transmission risk areas (mainly ITN), complemented by a secondary vector initiative (mainly targeted LSM); b) targeted vector control interventions in low and very low transmission to protect vulnerable population (mainly ITN for RCG clinic) complemented by complementary surveillance and response initiatives (IRS and LSM); c) targeted chemo-preventive therapies mainly in higher risk strata; d) universal malaria test and treatment for people attending public health facilities; and e) malaria surveillance and response initiatives especially in hypo-endemic and urban areas. (see Annex 7 for more details).

Table 11: Strategic Objective (SO) Costing in Tanzanian Million Shillings

SO	SO/SA/SI/SDM	Total	2026	2027	2028	2029	2030
1	Reduce malaria parasite transmission by accelerating the implementation of targeted, recommended, evidence-based, integrated malaria preventive interventions (IMVC and PT)	59,083 M	2,578 M	15,672 M	12,269 M	13,762 M	14,802 M
2	Prevent the occurrence of mortality related to malaria infection through universal access to appropriate diagnosis and treatment (MCM)	22,287 M	5,337 M	6,496 M	3,631 M	3,515 M	3,308 M
3	Provide timely and reliable information on malaria and its control needed to take appropriate actions in different transmission risk and ensure resources are used in the most cost-effective manner (SMEL)	74,610 M	14,300 M	15,628 M	15,520 M	11,387 M	17,775 M
4	Ensure timely availability of safe, efficacious and quality malaria commodities and supplies at the service delivery points (C&LM)	1,352,120 M	233,808 M	305,375 M	231,006 M	264,940 M	316,992 M
5	Strengthen an enabling environment that empowers individuals and communities at risk of malaria to constituently protect themselves and their families and seek timely and appropriate malaria care (SBCA&CE)	58,325 M	10,312 M	14,133 M	12,422 M	11,834 M	9,625 M
6	Strengthen efficient and effective implementation of malaria strategies through accountable leadership and partnership (PM)	26,856 M	5,561 M	7,183 M	4,201 M	5,401 M	4,511 M
	Total Amount (TZS)	1,593,281 M	271,896 M	364,487 M	279,049 M	310,839 M	367,013 M
	USD ($) exchange rate = 1:2,500	$637,312,766	$108,758,065	$145,794,624	$ 111,619,889	$124,335,300	$146,804,889

Indirect malaria control costs

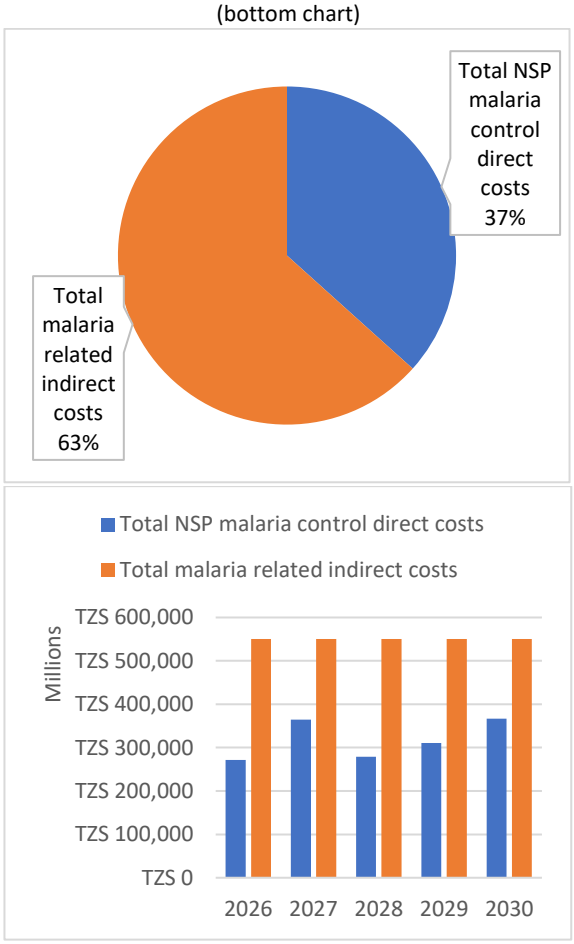
The indirect costs of malaria control interventions are calculated from the current national health account (NHA) figures and are proportionally reflecting the malaria burden related expenses in the public health sector. The indirect costs breakdown and the projected costs for the year 2026-2030 are illustrated in Table 12. The proportion of direct and indirect costs (left charts) and direct costs breakdown (right charts), total (upper charts) and annual (lower charts) are represented in Figure 17. Almost ¾ of malaria expenditures are covered by indirect health system expenditure. Among the direct malaria control interventions 85% is allocated for commodities procurement (ITN, insecticides, larvicides, medicine and diagnostics).

Table 12: Indirect costs breakdown (in TZ Shillings)

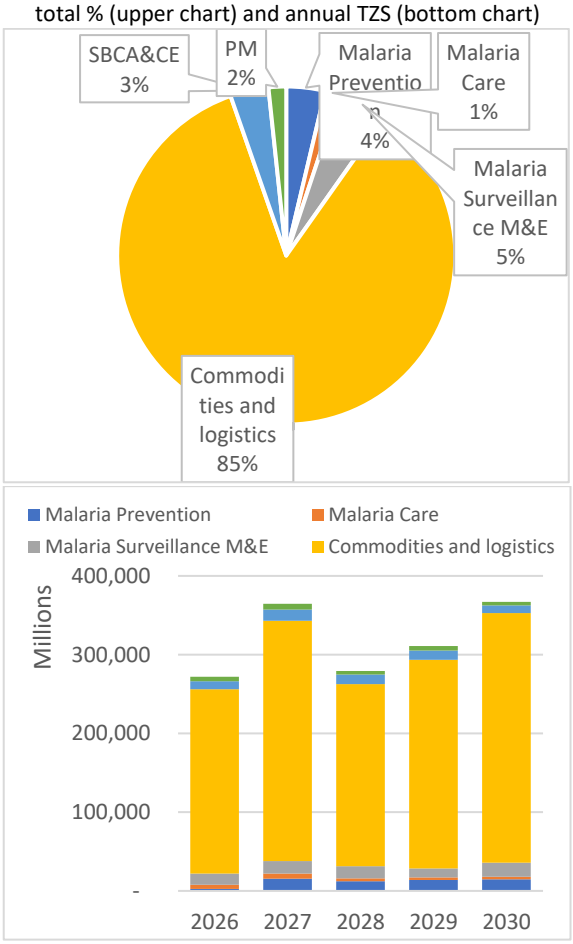
Cost category	NSP 2026-2030 projected costs	Source 2025
Own Source-Malaria Specific Activities	TZS 167,377,429,936,750	TZS 33,475,485,987,350
Personal Emoluments (PE)	TZS 2,842,953,663,058,320	TZS 568,590,732,611,665
Working Tools and Other Infrastructure	TZS 596,966,597,414,667	TZS 119,393,319,482,933
Other operational running costs	TZS 3,275,030,465,845,570	TZS 655,006,093,169,114
Total	TZS 6,882,328,156,255,310	TZS 1,376,465,631,251,060

Figure 17: Proportion of direct and indirect costs

Direct and indirect malaria costs total % (upper chart) and annual TZS (bottom chart)



Direct malaria control costs: malaria interventions and commodities total % (upper chart) and annual TZS (bottom chart)



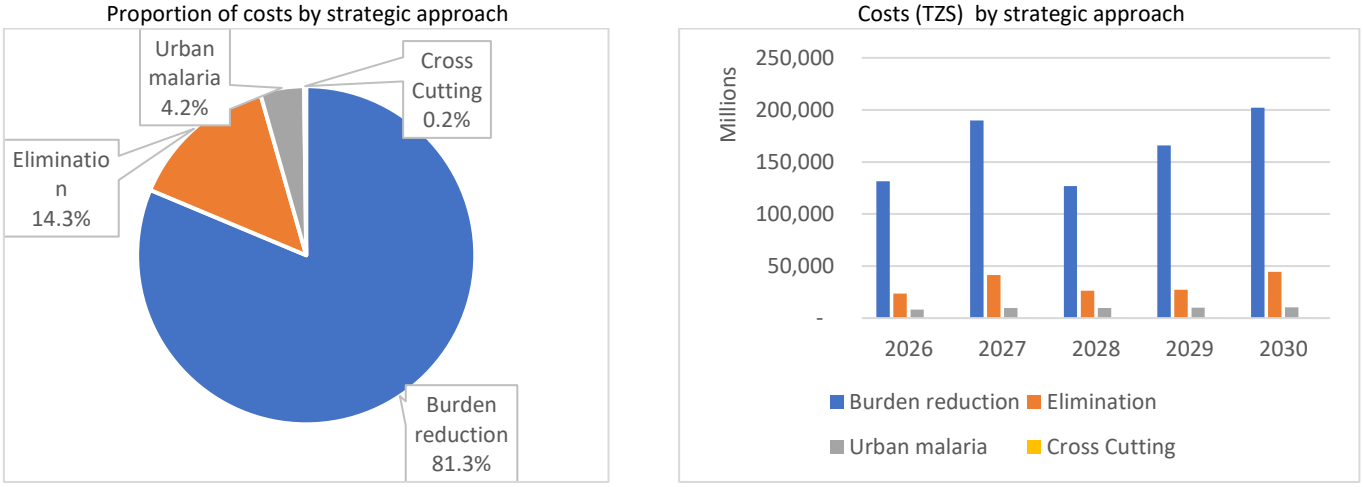
PM: Programme Management; SBCA&CE: Social Behavioral Change Advocacy and Community Engagement; M&E; Monitoring and Evaluation

Malaria direct costs analysis by strategic approach and strategic intervention

Burden reduction vs elimination tailored interventions for malaria prevention

Under the strategic objective 1, malaria prevention, three strategic approaches are defined: malaria burden reduction in high and moderate transmission risk councils, malaria elimination in low and very low transmission risk councils, and urban malaria initiatives in city and municipal councils. The highest proportion of budget allocation is dedicated to burden reduction (81%). Figure 18.

Figure 18: Costs of malaria prevention by strategic approach

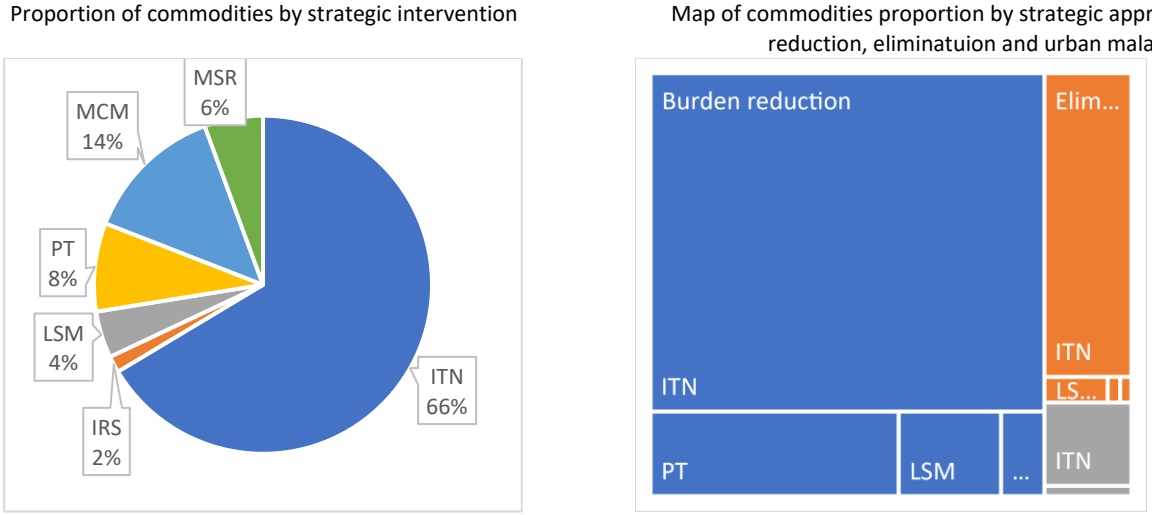


Malaria Commodities

Malaria commodities vs operational support by type of intervention

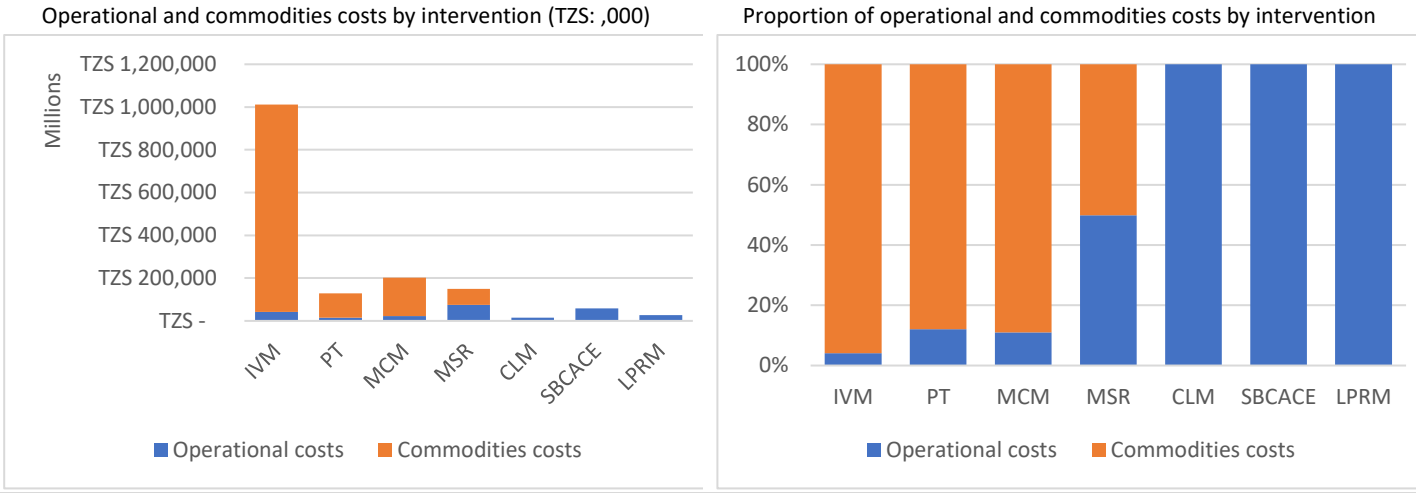
As anticipated in the previous section, the large majority of funding required for the MSP implementation are expected to cover the costs of procurement of malaria commodities. The actual and proportional contributions of operational and procurement costs are quite diverse according to the different core interventions. The highest commodities budget, by far, is required by vector control measures and for burden reduction strategic approaches. (Figure 19 and Figure 20).

Figure 19: Commodities procurement by strategic intervention



MSR: Malaria Surveillance and Response; ITN: Insecticide Treated Nets; IRS Indoor Residual Spray; LSM: Larval Source Management; PT: Preventive Therapies; MCM: Malaria Case Management.

Figure 20: Operational vs commodities costs by intervention

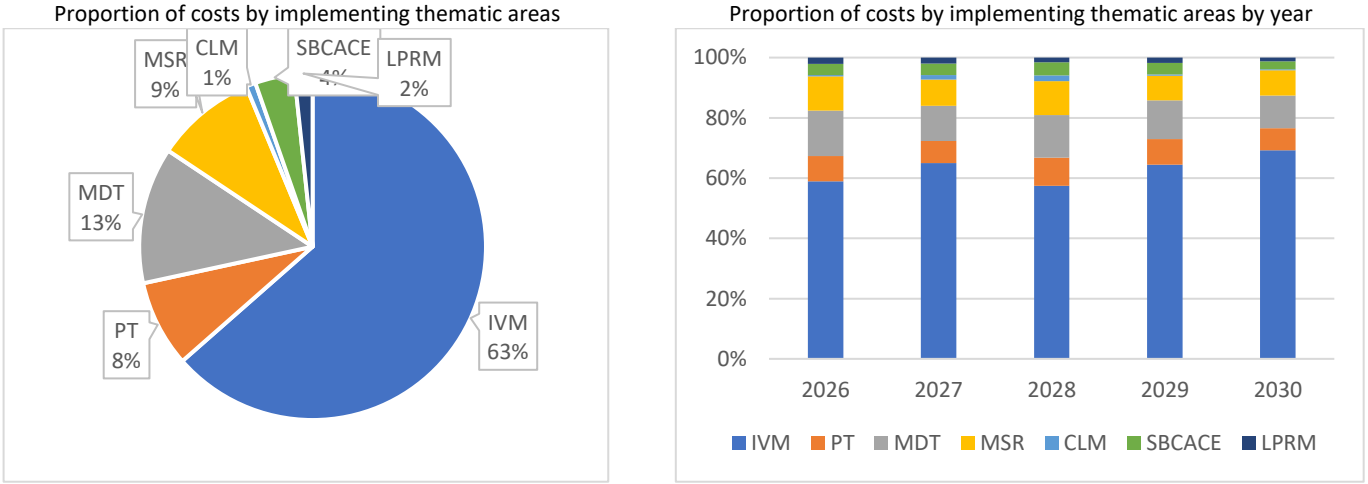


IVM: Integrated Vector Management; CLM: Commodities and Logistic Management; LPRM: Leadership Partnership Resources Mobilization; SBCA&CE: Social Behavioral Change Advocacy and Community Engagement; Malaria Surveillance and Response; PT: Preventive Therapies; MCM: Malaria Case Management.

Malaria costs by thematic areas

Integrated malaria vector management (IVM) requires almost 2/3 (63%) of the calculated budget for implementation of this MSP. Malaria diagnosis and treatment (MDT) and preventive therapies (PT) represent the following spending categories (13% and 8% respectively). (Figure 21).

Figure 21: MSP costs by implementing thematic areas



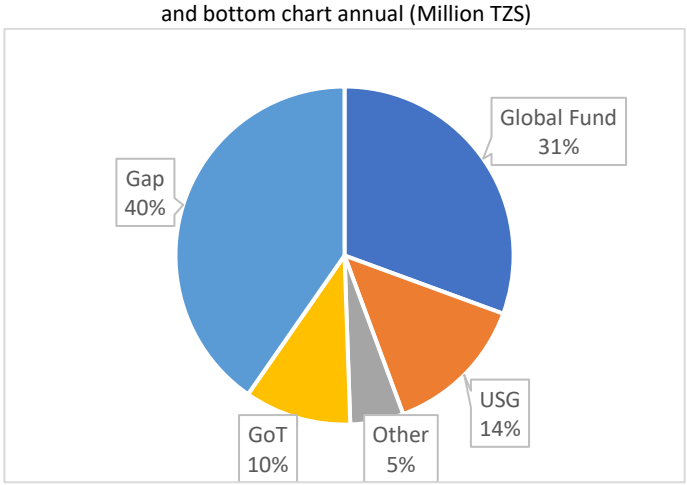
Available vs anticipated funding and gaps

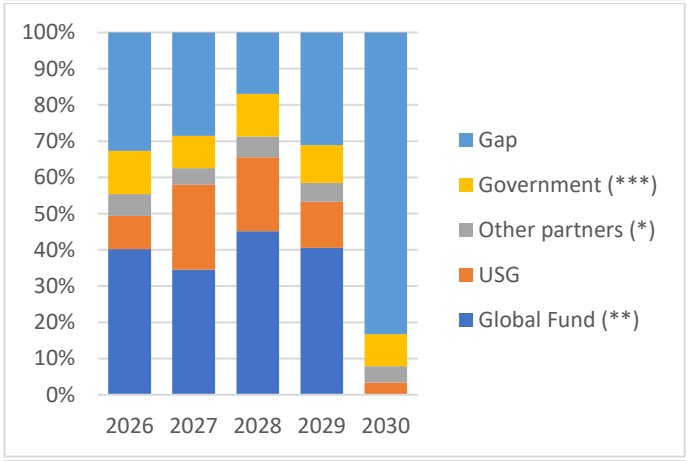
Around 40% of the expected MSP costs are not covered through the traditional funding mechanisms and represent a massive financial gap to achieve the MSP goals. More than half of the anticipated funds are expected to be covered by the Global Fund. The Government of Tanzania is covering the costs of about 17% of the expected direct expenditures and the entire indirect malaria related costs (see above). US government funding initiatives are still expected to continue but with a reduced input reaching 23% of the anticipated contributions. Other bilateral (e.g. Swiss government), multilateral (WHO, RBM, ALMA) and private foundations (e.g. Gates) will also contribute to the MSP budget. (See Figure 22).

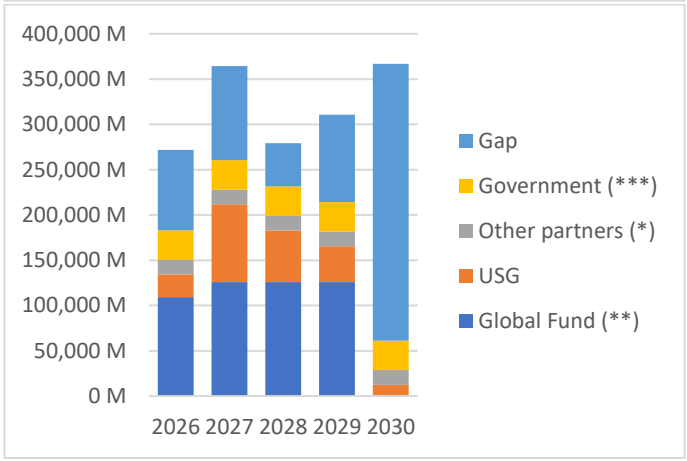
Due to the insufficient anticipated resource envelop, it is necessary to develop a prioritized intervention package taking into account its potential impact and cost effectiveness. This is well documented in the next section of the MSP.

Figure 22: Anticipated funds by source and expected gaps

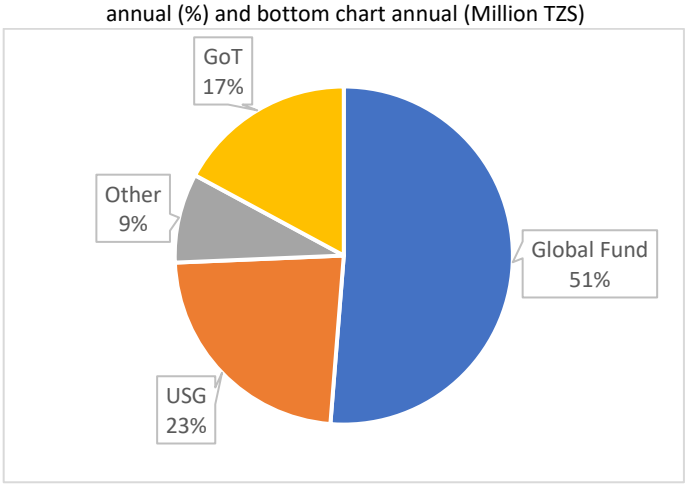
Gav vs anticipated funding: upper chart total (%),mid chart annual (%) and bottom chart annual (Million TZS)

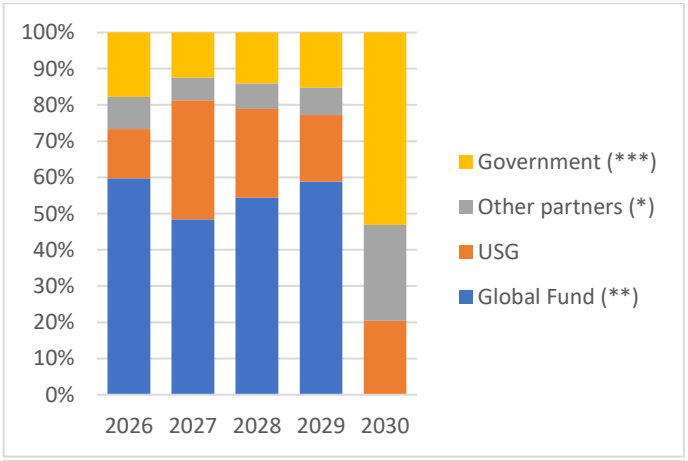


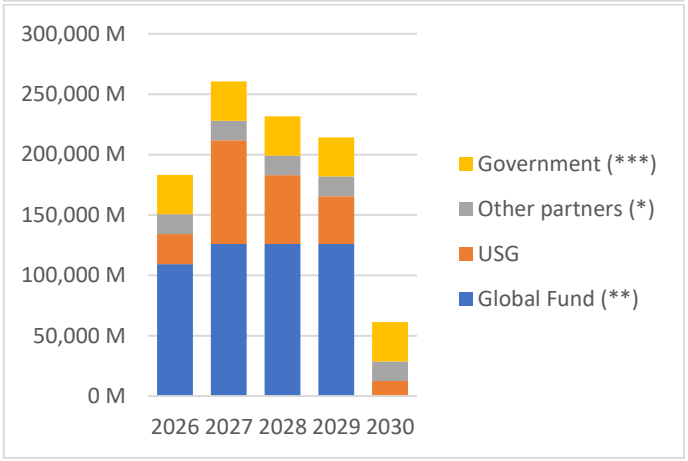




Anticipated funding breakdown: upper chart total (%),mid chart annual (%) and bottom chart annual (Million TZS)







(*) Gates; Swiss gov; WHO; RBM, others;
(**) total allocation for GC8 (net of RSSH) USD 151,258,148 (annual average 50,419,383;
(***) 2027-2030 figures extrapolated from 2025/26 government contribution

6. Implementation framework

A vision of a Tanzania where every person lives free from malaria requires robust leadership across the health sector, strengthened multisectoral partnerships, evidence-based planning, inclusive community engagement and sustainable financing. Stratification will continue to guide equitable resource allocation to geographical areas and population groups including women, children, and other vulnerable demographics that stand to benefit, accelerating cost-effective reductions in malaria burden towards elimination.

Stratification and targeting of Interventions

This strategic plan will continue target interventions based on the most recent 2025 malaria stratification outputs, classifying 54, 40, 63, 27 councils as very low, low, moderate and high transmission risk respectively (Annex 4: List of councils by epidemiological strata). Burden reduction interventions such as targeted mass campaigns (TMC), selective IRS, larviciding, IPTsc and PMC will be prioritized in moderate-and high-burden councils. In contrast, elimination focused strategies, including case-based surveillance, will be implemented in councils with low and very low malaria transmission to accelerate progress toward interruption of transmission.

Sub-council targeting will be used to identify persistent hotspots (areas with transmission levels above the respective strata average) within high-and moderate councils, where a comprehensive package of preventive interventions will be implemented. In parallel, surveillance and response efforts will be intensified in very low and low transmission councils to sustain gains and accelerate further reduction in malaria burden. A detailed workplan is presented in Annex 6.

Implementation arrangements

This strategic plan will be implemented across all levels of health system, from national to community. In addition, non-health sectors will be actively engaged to adopt malaria-relevant interventions, thereby expanding coverage, enhancing multisectoral collaboration, and accelerating progress toward malaria elimination.

National level

National Malaria Control Program

The **National Malaria Control Program** (NMCP) is responsible to define strategic decisions and develop strategic plans concerning malaria control and elimination, based on recommendations from technical working groups and development partners' technical teams. However, majority of the issues are multi-sectoral and involve a range of stakeholders, including other vertical programs within the Ministry of Health, other ministries and government statutory bodies, regulatory authorities, and development partners (Figure 23). Malaria Technical working groups, are the major consultative bodies that will provide the NMCP and the MoH the recommendations for malaria control and elimination interventions. The NMCP governance structure is depicted by in Figure 23 and the NMCP organogram is represented in (Figure 24).

The NMCP is guided by six (6) core values:

1. **Compassion** – Centering the program on saving lives and improving Tanzanians well-being.
2. **Resilience** – Building adaptive systems to challenges like climate change, migration, or drug resistance.
3. **Transparency & Accountability** – Ensuring clear communication and responsible resources use.
4. **Equity** – Ensuring access to malaria prevention and treatment for all, especially vulnerable groups like children and pregnant women.
5. **Evidence-Based Action** – Guiding strategies with research, surveillance data, and proven interventions.
6. **Sustainability** – Promoting long-term solutions that reduce external aid dependency and strengthen local capacity.

These values underpin every decision, partnership, and action, fostering truthful conduct, equitable access, accountability, stakeholders' recognition, and transparent operations that build trust.

Figure 23: NMCP governance structure

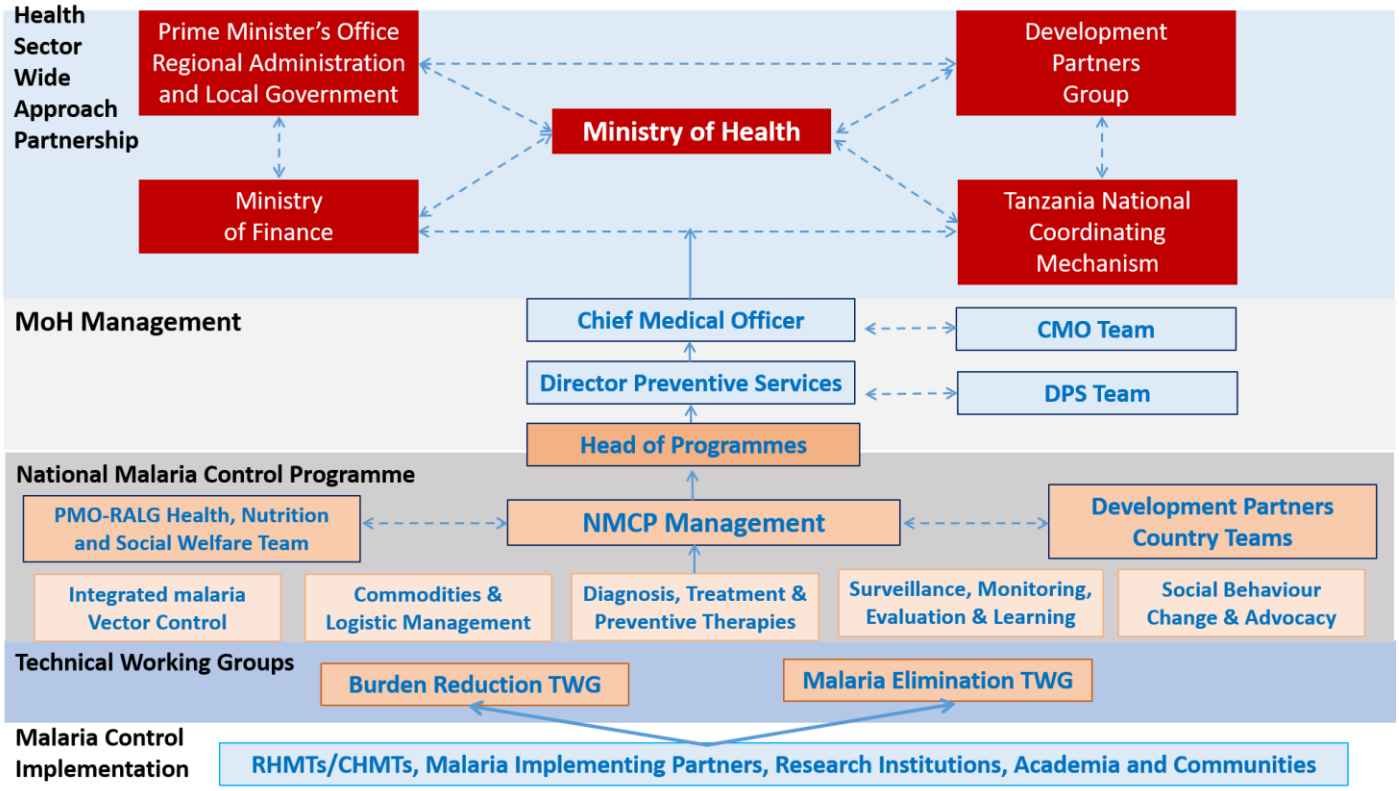
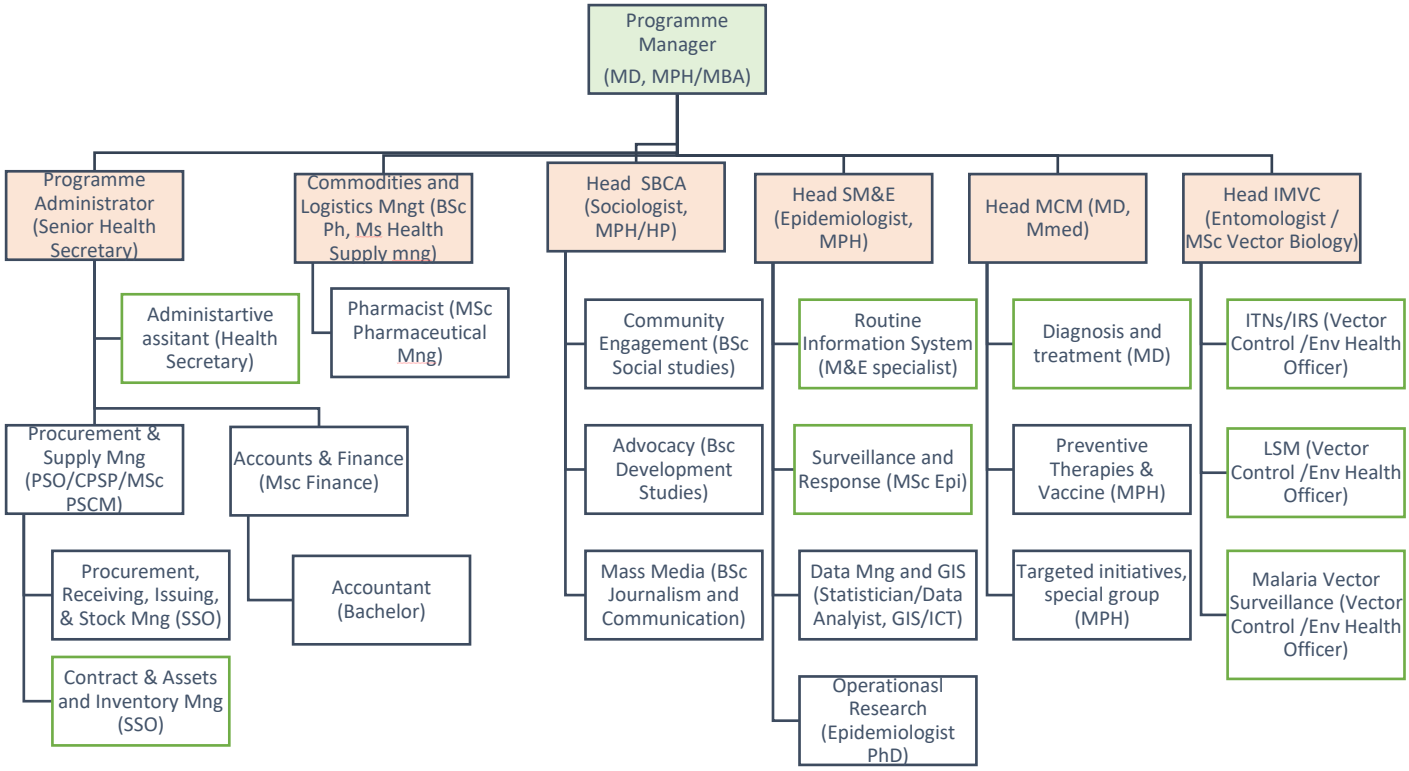


Figure 24: NMCP Organogram



The NMCP mobilizes resources by developing operational plans for submission to development partners and the Government of Tanzania while fast-tracking malaria control to scale interventions and meet strategic plan targets. Key roles include:

- Advise MoH on national malaria control and elimination policies/strategies.
- Reviewing technical working groups' reports and approving recommendations on policies, strategies and interventions.
- Building partner consensus on strategic implementation issues.
- Developing scientifically sound guidelines for malaria control and elimination.
- Providing supervision/support framework to PMO-RALG, RHMT, CHMT, partners and communities.
- Offering technical guidance for monitoring, evaluation and impact assessment.
- Identifying strategic/programmatic issues and assigning working group follow up.
- Highlighting emerging research questions for partners.
- Supporting PMO-RALG/ partners to address capacity gaps for interventions scaling up.
- Advocating for increased resources; and
- Multisectoral partnership for malaria control/elimination.

Prime Minister's Office - Regional Administrations and Local Government (PMO-RALG)

Tanzania's decentralized public health system operates at National (policy/strategy), regional (technical advice/capacity building) and council (implementation coordination/supervision) levels, with services delivery shared between MoH and PMO-RALG.

Since 1990s decentralization reforms, primary healthcare decision-making has been devolved to regional/council levels, with the system organized in a pyramidal structure from village and dispensary services at the community level, through health centers to district hospitals at higher levels of care.

Health Facility Management Teams, CHMTs and RHMTs are responsible for developing annual health plans and budgets aligned with MoH guidelines, although implementation is often constrained by insufficient resources. CHMTs play a central role in supporting health facilities and communities in the implementation of malaria control activities, as well as in the supervision and M&E of council health plan.

The Regional and District Malaria and IMCI Focal Persons (RMFPs/DMFPs), together with RHMT and CHMT members, coordinate day-to-day malaria activities at regional and council levels. NMCP maintains technical linkages with regions and councils through RMFPs and the DMFPs to ensure alignment and consistency in the implementation of malaria interventions.

The District Primary Healthcare Committee, chaired by the District Commissioner and comprising key stakeholders, including partners, private sector, NGOs and development agencies, ensures that malaria control remains a permanent agenda item.

Roles of PMO-RALG: Health, Social Welfare and Nutrition Directorate

- Coordinate implementation of malaria control and elimination interventions at RS and LGAs levels.
- Oversee planning and budgeting process at RS and LGA levels, ensuring malaria interventions are integrated into CCHP to support sustainability.
- Monitor and reinforce adherence to national policies, regulations and guidelines related to malaria control and elimination.
- Facilitate the use of national malaria data and statistics for planning and decision-making at subnational levels.
- Provide technical guidance to RHMTs and CHMTs to strengthen community engagement and ownership of malaria service delivery.
- Coordinate capacity building and provide governance support at RS and LGAs.
- Conduct cascade supportive supervision and programme evaluations to strengthen governance and improve malaria service delivery.
- Ensure adherence to ethical standards among vector control officers and Malaria Focal Persons in RS and LGA levels.

Other ministries

NMCP will work closely with other ministries and agencies whose mandates influence malaria prevention and control. These include the Office of the Vice President, the National Environment Management Council (NEMC), and key sectoral ministries such as Lands, Housing and Urban Development; Agriculture; Education, Science and Technology; Industry and Trade; Natural Resources and Tourism; Water; Livestock Development; and Ministry of Works.

Collaboration will focus on complementarity, effectiveness and sustainability, leveraging synergies to accelerate both social-economic development and malaria control. Where relevant and feasible, NMCP will support these sectors to jointly develop and implement inter-sectoral malaria action plans that integrate malaria into agricultural extension, environmental management, school health, urban planning, and water and sanitation programmes.

NMCP will coordinate design and monitoring of the multisector framework while each ministry leads implementation within its remit.

Regional Level:

Roles of the Regional Malaria IMCI Focal Persons

The RMFP is a health professional appointed by the RHMT and trained by NMCP. Key roles include:

- Coordinating malaria interventions across the region;
- Liaising with NGOs and partners on malaria control activities across the region;
- Consolidating council quarterly malaria implementation reports into a regional and submit it to NMCP on time;
- Advising the RHMT on improved implementation strategies for malaria control/elimination activities;
- Reviewing regional malaria data in DHIS2/Malaria dashboards, sharing findings with RHMT and providing feedback to councils;
- Acting as a technical link between PMO-RALG, NMCP and RHMT on malaria policy and guidelines dissemination; and
- Undertaking additional assignments from Regional Medical Officer (RMO) and RHMT.

Council Level – District Malaria/IMCI Focal Persons (DMIFPs):

The councils are responsible for implementing malaria guidelines, supporting health facilities to apply them, ensuring data quality, and updating malaria indicators in DHIS2.

Roles of the District Malaria IMCI Focal Persons

The DMIFP, appointed by the CHMT and trained by NMCP:

- Coordinates malaria interventions in the Council;
- Ensure that NGOs and partners adhere to national malaria policy guidelines;
- Prepare and submit annual technical implementation report to RMIFP;
- Advises the CHMT on the implementation strategies;
- Reviews council malaria data in DHIS dashboards and share feedback with relevant authorities;
- Acts as the liaison between the PMO-RALG, NMCP and RHMT and CHMT on malaria issues,
- Undertake assignments from District Medical Officer (DMO)/CHMT

Community Level:

At community and household level, citizens are central to malaria prevention, diagnosis, treatment, and surveillance. Cultural and religious institutions will complement compliment formal services by mobilizing communities, shaping behavior change, and sustaining local ownership of malaria interventions.

Malaria Technical Working Groups:

Two malaria Technical Working Groups (TWGs) will operate during this NMSP period:

- Malaria burden reduction - TWG
- Malaria elimination and surveillance - TWG

They will track implementation progress in burden reduction and pre-elimination councils, advise NMCP to ensure NMSP targets are met, and absorb functions of the former Vector control, Case management, Surveillance, Monitoring, and Evaluation (SME), Commodities Logistics Management and Social Behaviour Change & Advocacy TWGs.

Membership will be drawn from institutions based on expertise, malaria programme experience, and commitment

Each TWG will meet twice a year with ad hoc meetings as needed. NMCP thematic Heads will serve as a Secretariat. All major technical and programmatic matters will be deliberated in the TWGs, with recommendations submitted to NMCP management and then to the Chief Medical Officer (CMO).

Malaria burden reduction TWG

Malaria burden reduction TWG, main terms of reference TOR:

- Monitor implementation of burden reduction interventions (TMC, Selective IRS, preventive therapies, community Malaria Case Management (cMCM), vaccines) in the 90 moderate and high-risk councils.
- Review and advise on implementation plans, progress reports and stakeholders activities related to burden reduction.
- Review relevant policies, legislation, regulations and procedures and advise NMCP on enforcement.
- Develop/review clinical and laboratory guidelines for case management;
- Review operational research on burden-reduction interventions, identify priority research questions, and recommend solutions.
- Advise on IEC/SBC policies, materials, and channels, and on tracking progress of programme interventions.
- Etablish task forces and define their TOR and membership as needed.

Composition of the TWG

Members are selected by the respective institutions based on their expected contribution to the TWG within their areas of expertise. The TWG membership includes the following:

- Chairperson - To be selected by members of the TWG
- Secretary - Heads of NMCP IMVC and MCM units
- Secretariat - Heads of NMCP SME, CLM and SBC&A units

Members:

- Program Manager, NMCP
- Representative from research institutions
- Representative from training institutions
- Representative of Therapeutic Efficacy Testing Network
- Representative from Tanzania Plant Health and Pesticides Authority (TPHPA)
- Representative from the National Environmental Management Council (NEMC)
- Chairpersons of formed task force groups
- Representative from Vice President's Office- Division of Environment
- Representative from the Ministry of Agriculture
- Representative from PMO-RALG
- Donor Partner Group representative (Malaria Technical Advisor)
- NMCP Technical Advisor
- WHO representative
- Representative from partners implementing malaria vector control initiatives in the 90 high and moderate risk councils
- Representative from partners implementing malaria case management initiatives in the 90 high and moderate risk councils

Should it be deemed necessary the TWG will co-opt members in accordance to subject matter.

Malaria elimination and Surveillance TWG

Malaria elimination and Surveillance TWG will work based on the following TOR:

- Monitor implementation of pre-elimination interventions (mCBS, Urban surveillance, epidemic preparedness, focal IRS, MDA) in the 94 very-low and low-risk councils
- Revise and advise on implementation plans, elimination activities, and stakeholder interventions.
- Review policies and guidelines for case-based surveillance, epidemic preparedness and urban surveillance and advise on enforcement.
- Review operational research on malaria elimination interventions, identify research gaps and suggest solutions
- Review drug resistance, as well as molecular, entomological and epidemiological surveillance findings, and make recommendations;
- Advise on IEC/SBC strategies, materials, and communication channels for elimination settings.
- Define mechanisms for tracking progress and establish time bound task forces required.

Composition of the TWG

Members are selected by the respective institutions based on their expected contribution to the TWG within their areas of expertise. The TWG membership includes the following:

- Chairperson -To be selected by members of the TWG
- Secretary - Head of NMCP SME unit / Head of NMCP MCM unit
- Secretariat - Heads of NMCP IMVC, CLM and SBC&A units (Secretariat)

Members:

- Program Manager, NMCP
- Representative from research institutions
- Representative from training institutions
- Representative of Therapeutic Efficacy Testing Network
- Representative from Tanzania Plant Health and Pesticides Authority (TPHPA)
- Representative from the National Environmental Management Council (NEMC)
- Chairpersons of task force groups that will be established
- Representative from Vice President's Office- Division of Environment
- Representative from the Ministry of Agriculture
- Representative from PMO-RALG
- Donor Partner Group representative (Malaria Technical Advisor)
- NMCP Technical Advisor
- WHO representative
- Representative from partners implementing malaria vector control initiatives in the 94 very low and low risk councils
- Representative from partners implementing malaria case management initiatives in the 94 very low and low risk councils

The Technical Working Group (TWG) will co-opt additional members, as necessary, based on the specific subject matter under consideration to ensure the availability of relevant expertise.

Specific Task Forces

Thematic programmatic areas that require competent and dedicated technical time bound contributions will be addressed by specific task forces. For specialized, time-bound technical issues (e.g., selection of first line antimalarial, malaria in pregnancy, regimens, private sector access to treatment), TWGs may establish task forces with defined TORs, membership and timelines. Task forces report to the relevant TWG.

Multisectoral collaboration

Multisectoral collaboration will be operationalized through the NMCP led multisector framework and sector specific joint action plans, integrating malaria into policies and programmes of environment, agriculture, water, education, urban development and others to address upstream determinants of transmission.

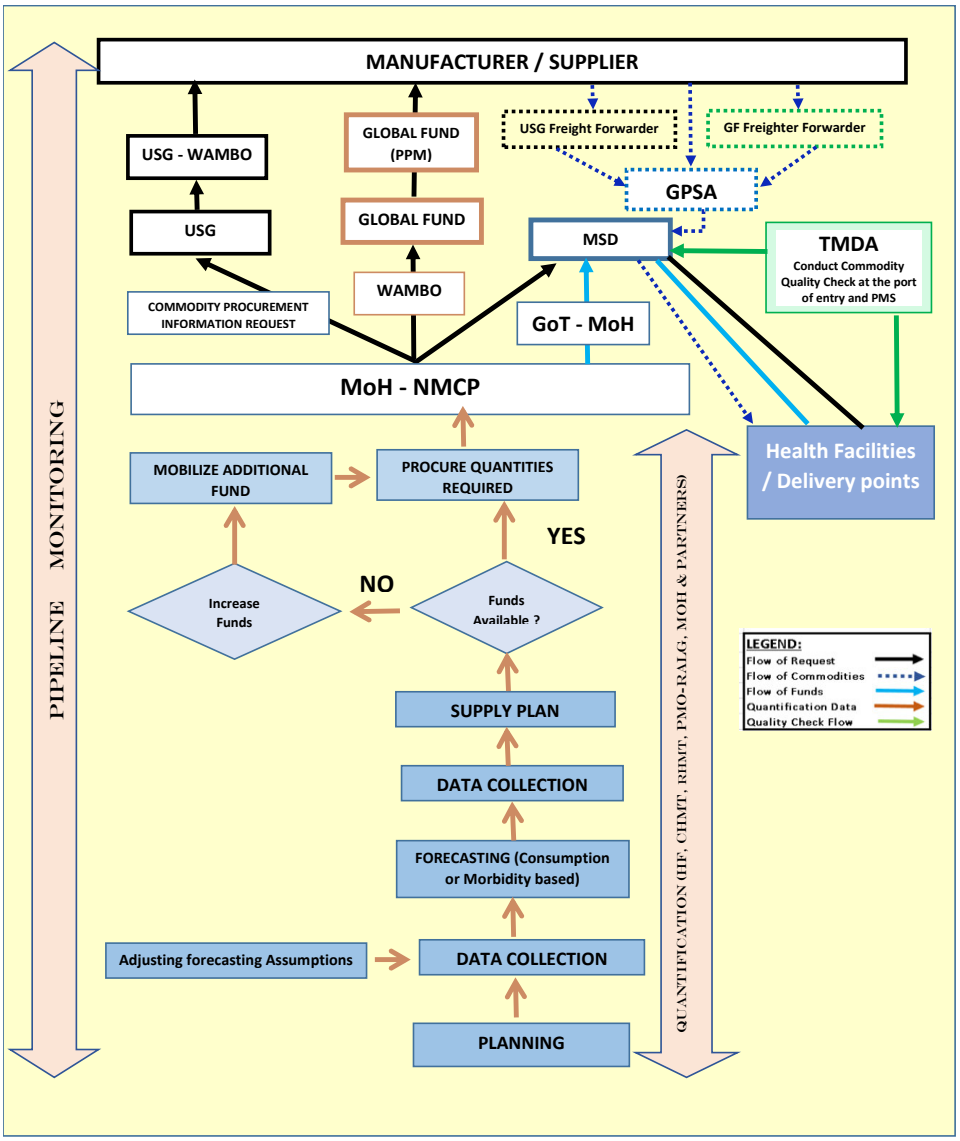
Private sector and non-state actors

Private and non-state actors remain key partners. Registered private facilities, pharmacies, and drug outlets will expand access to quality testing, treatment and surveillance data. Corporate partners will support resource mobilization and workplace programmes. Civil Society Organizations (CSOs) will drive community mobilization, accountability, advocacy, and independent monitoring while academia and research institutions will conduct operational research and support independent evaluations.

Procurement and supply management systems

Procurement and management of malaria commodities are led by MoH through NMCP, in collaboration with MSD, TMDA, PMO-RALG and partners (see Figure 25)

Figure 25: Procurement and Supply management systems



Roles and Responsibilities for Commodities and Logistic Management

- NMCP provides technical support for: a) Quantification; b) Supply planning; c) Gap analysis; d) Product specifications; e) Procurement initiation f) Pipeline monitoring; and g) schedule adjustments.
- PMO-RALG-HQ is responsible for a) Supports quantification; b) Oversee RHMT/CHMT and Facility supply chain activities, and c) Provide technical support.
- RHMT is responsible for a) Consolidate and review council quantification b) Approve council orders; c) Oversee council level supply chains and d) Support councils.
- CHMT is responsible for a) Consolidate facility quantification; b) Review facility orders; c) Oversee delivery point supply chains and d) Support facilities.
- Delivery points (facilities) are responsible for a) Quantify needs; b) Prepare supply plan; c) Request commodities; d) Manage inventories; and e) Dispensing products.
- MSD is responsible for a) Procurement of GoT funded commodities; b) Receive product (this includes physical quality check and storing) c) distribute products to delivery points and d) Manage recalls as needed.
- PPM partners are responsible for procuring commodities funded by GF.
- Approved Prime Vendors (PV) are responsible to supply commodities to delivery points when MSD is stocked out.
- GPSA is responsible for clearing malaria commodities at ports of entry.
- TMDA ensures quality and regulatory compliance for medicines and medicinal devises throughout the supply chain, including product evaluation, registration and monitoring.

- TPRI ensures quality of all insecticides-based commodities throughout the supply chain.
- TBS ensures denier quality specifications for LLINs throughout the supply chain.
- Pharmaceutical Services Unit of MoH and implementing partners provide technical backstopping across the malaria commodity supply chain.

Financial resources management and audits

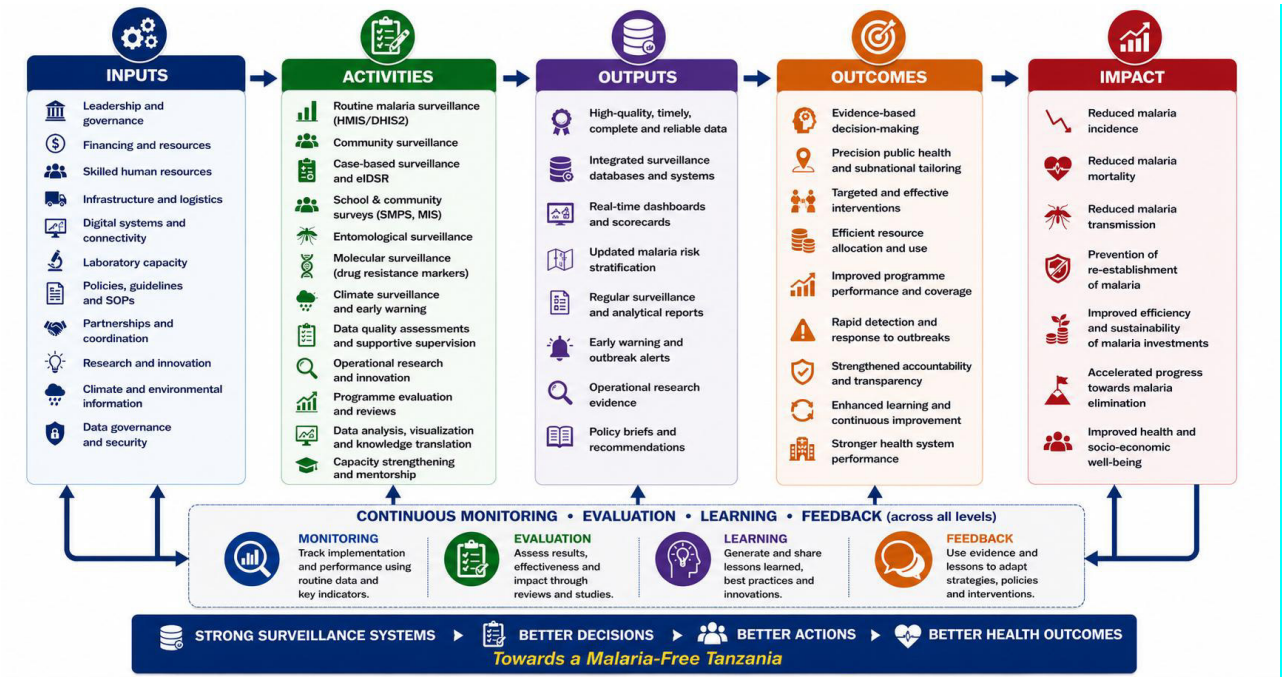
Effective financial management ensures funds are used efficiently to meet programme goals and mitigate risk. NMCP manages malaria fund through Internal/External audits, and quarterly review of implementing partners activities. All partners receiving donor funds via NMCP must submit annual audited financial statements and project implementation status report, signed by government authorities. Financial resources received are reported to MoH through Director of Policy and Planning (DPP) for inclusion in the National Heath Account (NHA), with implementers required to provide the accurate data upon request.

Malaria surveillance monitoring and evaluation and strategic data repository system

Theory of Change for surveillance monitoring and evaluation (SMEL Plan 2026–2030)

Investments in surveillance systems and strategic information generate evidence that informs programme decisions, improves intervention targeting and performance, and ultimately contributes to reducing malaria burden and accelerating progress towards malaria elimination. Continuous monitoring, evaluation, learning, and feedback strengthen adaptive programme management across all levels of the health system (Figure 26). A detailed Performance framework is included in Annex 8 of this MSP.

Figure 26: surveillance monitoring and evaluation theory of change

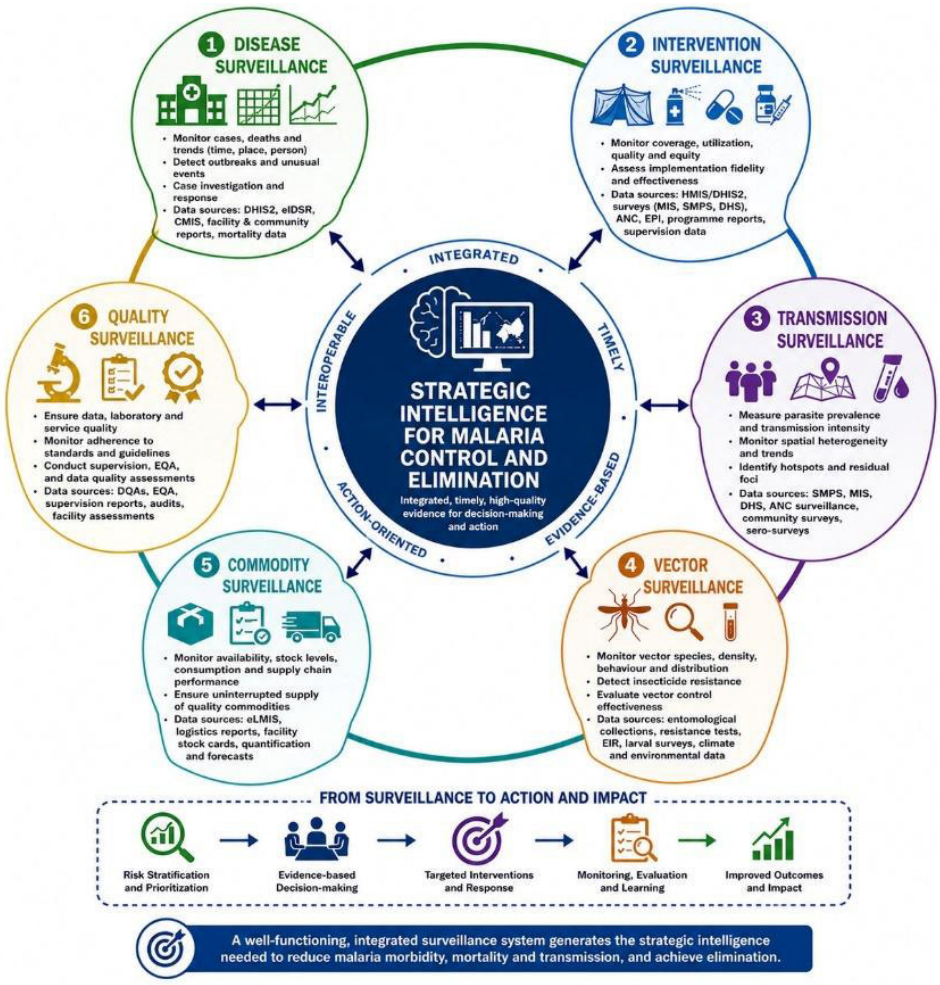


Source NMCP (generated with AI assistance

Outline of Strategic Malaria Surveillance for control and elimination

Malaria surveillance data is a very important monitoring malaria burden and intervention coverage at national and sub-national levels to make evidence-based programmatic decisions. Tanzania malaria surveillance is organized and implemented under key three pillars that have been designed to capture all aspect of malaria transmission and control; disease surveillance, Programmatic surveillance, Transmission surveillance and Quality of services surveillance (Figure 27).

Figure 27: Strategic intelligence for malaria control and elimination



Source NMCP (generated with AI assistance)

Disease surveillance:

Data for disease surveillance is generated by public and private health facilities capturing routine cases, testing, treatment data and HF based intervention data. At health facility level service data is filled on daily basis using HMIS books, most health facilities have capacity to enter data direct into the HMIS-DHIS2 system while few facilities aggregate and submit to Council level for entry on monthly basis. Analysis and interpretation of the data enable all levels (Health facility, Council, Regional and National) to assess disease burden trends. eIDSR system reports aggregated weekly data of all notifiable diseases including malaria. This facilitates detection of malaria outbreaks and response in low and very low malaria transmission risk areas (MEEDS). eIDSR also hosts a mCBS dash board for elimination settings. Unified Community System (UCS) records community-level malaria cases and treatment though often irregular and partner dependent.

The NMCP intends to introduce eIDSR / MEEDS to all the malaria unstable transmission areas across Tanzania. These areas are considered to be epidemic prone because malaria transmission is less likely to occur making the population less immune to the disease and more susceptible to severe disease.

Programmatic Surveillance:

Logistics Management Information System (eLMIS) and MSD supply chain information system (Epicor 10): There are two major initiatives to report malaria commodities logistic management: Logistic Management Information System (eLMIS) overseen by the Pharmaceutical Services Section (PSS) of the MoH, and Supply Chain Information System run (Epicor 10) by MSD.

eLMIS tracks malaria commodities availability, consumption, and distribution while MSD information system generates stock and commodities movement information including issuing records of all malaria commodities to public health facilities including batch numbers.

NMCP is actively involved in the delivery and utilization of the services provided by the two systems and is committed to promote and sustain a more integrated and efficient platform by a) improving the currently adopted technical solutions; b) establish an effective commodities surveillance linked with rapid stock outs response; and c) establishing an interface with the DHIS2.

Malaria preventive services: Malaria preventive services data will be captured by (a) HMIS/DHIS2 for preventive services offered at health facilities (e.g. provision of LLINs to pregnant women and infants at RCH clinics) (b) Activity reports or mobile data collection applications for Community level interventions (e.g. Number of LLINs distributed through TMC or SNP)

Insecticide Resistance Monitoring (IRM) and Therapeutical Efficacy Studies (TES) Systematic national representative Insecticide Resistance Monitoring (IRM) was introduced in 2009 in 12 sentinel sites and is currently conducted in 28 sentinel sites. Tests are conducted by NMCP partner research institutions, coordinated by NIMR, in each sentinel site every alternate year. IRM follows standard WHO testing protocol. NMCP and its partners monitors the efficacy and safety of recommended antimalarial drugs among children of 6 months to 10 years at 8 country representative sentinel sites (Mtwara, Mbeya, Pwani, Tabora, Mwanza, Kigoma, Tanga, and Morogoro regions). TES is coordinated by NMCP and implemented by five partner institutions namely; MUHAS, IHI, KCMC, CUHAS and NIMR.

Molecular surveillance: Molecular surveillance of parasites and malaria vector will be conducted in collaboration with research institutions

Transmission Surveillance:

Epidemiological surveillance: Tanzania set up three sentinel surveillance populations to monitor trends of transmission: a) children under the age of five years, b) pregnant women attending ANC for the first time, and c) school going age children.

Entomological surveillance: Entomological Surveillance is conducted in 32 sentinel councils to monitor malaria vectors basic indicators; Entomological Inoculation Rate, species density and composition. Additional bionomics parameters such as indoor vs outdoor biting, early vs late biting and human blood index will be added.

Data is collected monthly and reported quarterly. The sites used within each council are the same sites as the school's malaria parasitemia survey. This allows NMCP to gather surveillance and parasitological data from same site.

Climatic monitoring (MEEWS): Malaria transmission is highly sensitive to climatic conditions because both the mosquito vector and the malaria parasite depend on environmental factors for survival and development. Temperature influences mosquito longevity, biting frequency, and the duration of the parasite's extrinsic incubation period, while rainfall creates breeding habitats for mosquito larvae. Humidity affects mosquito survival and flight activity. Small changes in these climatic variables can therefore substantially influence malaria transmission dynamics, particularly in epidemic-prone and highland areas where transmission is normally limited by environmental conditions. Integrating climate information into surveillance and programme planning has become increasingly important. Climate-informed malaria surveillance, coupled with geographic information systems (GIS), remote sensing, and subnational risk stratification, enables programmes to identify areas at increased risk of transmission, anticipate seasonal outbreaks, and optimize the timing and targeting of interventions.

Composite Management Information Systems (CMIS): CMIS operates as a data repository system capturing and storing specific non-routine data captured outside DHIS2 platform.

Risk Management

A dynamic risk management framework will be established to identify, document, and mitigate risks. Table 13 summarizes the key risks and mitigation measures for the NMSP.

Table 13: Key program risks for the NMSP (2026-2030) and Risk Mitigation Strategy

Risk	Mitigation strategy
Program Implementation, coordination, performance monitoring, and risk management	Implementation of the NMSP will be closely aligned with the development and execution of a business plan and Annual Operational Plan (AOP). The AOP will be developed annually to: (a) assess the status of intervention implementation, (b) review financial inputs and identify funding gaps and (c) monitor progress against planned activities and timelines. The AOP serves as a key mechanism for ensuring that prioritized, high-impact, and cost-effective interventions are implemented in a coordinated and integrated manner to achieve GC8 targets. The AOP will be developed through a joint planning process involving key malaria stakeholders and partners. It will clearly define roles and responsibilities based on the comparative advantages for each partner, providing a structured framework for coordination and accountability. The AOP will also outline programmatic expectations for all implementing stakeholders, thereby promoting alignment, efficiency, and effective delivery of malaria interventions.
Funding gaps and resource constraints limiting the effective and sustainable implementation of malaria interventions	To mitigate risks associated with funding gaps and potential donor withdrawal, the program will strengthen domestic resource mobilization through sustained advocacy at national and subnational levels, including increased integration of malaria interventions into Council Comprehensive Health Plans (CCHPs). Efforts will also focus on expanding private sector engagement and promoting co-investment mechanisms to diversify funding sources and reduce reliance on external financing. In addition, NMCP will explore innovative financing mechanisms, including the End Malaria Council and Fund, health levies and malaria bonds, to enhance long-term financial sustainability. Strengthening alignment between government and partner financing cycles, will further support continuity and effective implementation of malaria interventions.
Emergence and spread of antimalarial drug and insecticide resistance	The country will prioritize investments in robust entomological, molecular, and genomic surveillance systems to enable timely detection and monitoring of insecticide and antimalarial drug resistance. Implement the national resistance management plan, will be strengthened, including rotation of insecticide classes for IRS, scaling up next generation vector control tools such as dual active – ingredient (e.g., Dual-AIs) insecticide treated nets, and promotion of the rational use of antimalarial medicines. These efforts will be supported by existing therapeutic drug efficacy studies (TES) sites, use of routine programmatic data from the District Health Information Software 2 such as (DHIS2) and targeted surveillance platforms, including the School Malaria Parasitological Survey (SMPS). Together, these systems will provide the evidence needed to guide timely decision-making, optimize intervention strategies, and sustain the effectiveness of malaria prevention and treatment tools.
Stock outs of essential malaria commodities.	To reduce the risk of stock outs of essential malaria commodities, the country will strengthen supply chain management through improved quantification, forecasting, procurement planning, and distribution systems to services delivery points. Digital logistics platforms, including the electronic logistics management information systems (eLMIS), will be leveraged to enhance real-time visibility and monitoring of stock levels across the supply chain. National and subnational buffer stocks will be maintained for key malaria commodities to ensure continuity of services during supply disruptions. In addition, procurement mechanisms will be diversified to reduce dependency on single supplier, improve supply chain resilience and mitigate risks associated with global market fluctuations, procurement delays, and other supply disruptions.
Climate variability & increased risk of malaria epidemics	In the context of increasing climate variability, and the growing risk of malaria epidemics, the programme will operationalize will operationalize the Malaria Early Warning System (MEEWS) through the integration of meteorological, environmental, and epidemiological data. This will enable timely identification of epidemic risks, facilitate predictive analysis and early evidence-based response actions. Preparedness measures will include pre-positioning of essential malaria commodities in high-risk areas, establishment and capacity strengthening of Rapid Response Teams and development of contingency plans for outbreak response. The programme will also strengthen cross-border surveillance, information sharing and coordination with neighboring countries to detect and respond to transboundary malaria transmission. These measures will enhance the country's resilience to climate-related malaria risks and support timely containment of outbreaks, thereby minimizing their impact on malaria morbidity and mortality
Unsatisfactory community uptake and utilization of malaria interventions.	To address suboptimal community uptake of malaria interventions, the program will implement culturally appropriate, gender-responsive, and evidence-based social and behavior change (SBC) strategies. These will include targeted communication campaigns, community dialogue platforms, engagement of trusted local leaders and influencers and strengthening of community feedback mechanisms to promote responsiveness and accountability. All interventions will be guided by the principles of equity, human rights, gender equality, and inclusion to ensure that services and messages effectively reach underserved and vulnerable populations. Through enhanced community engagement and participation, the programme aims to foster community ownership, increase demand for and uptake of malaria interventions, and sustaining long-term behavioural change and programme impact.

Annexes

Annex 1: Modelling results to support national malaria strategic plan (2026 -2030)

Background Context

Following the national malaria strategic planning workshop conducted between February and March 2026, focused on the development of Tanzania's National Malaria Strategic Plan (NMSP) for 2026–2030, the Swiss TPH was requested by the Tanzanian National Malaria Control Programme (NMCP) to support the planning process by providing analytical evidence to inform the selection of an optimal intervention strategy.

The modelling work was designed to complement analyses of routine surveillance and programmatic data by enabling explicit comparison of potential impact of alternative intervention strategies. In particular, it aimed to support the programme in understanding how to best deploy available tools to maximize impact, identify gaps in the current intervention mix, and prioritize councils for intensified or additional interventions. This approach recognizes the strong value of epidemiological, clinical, and routine health information systems, while also highlighted the added benefit of complementary tools to inform strategic decision-making, particularly when long-term outcomes, geographically heterogeneous effects, and hypothetical implementation scenarios must be considered.

Within this strategic context, the Analytics and Interventions Modelling group at Swiss TPH applied the OpenMalaria transmission modelling platform (Smith et al., 2006) to assess the expected impact of malaria control interventions over the duration of the strategic plan. OpenMalaria is a well-established simulation platform that model malaria transmission dynamics, incorporating human infection processes, mosquito vector behaviour, and health system delivery. It enables the evaluation of how malaria burden responds to different combinations of interventions, including vector control, preventive therapies, and case management, under varying programmatic scenarios.

For the 2026–2030 NMSP period, the model was used as a decision-support tool to address three key policy questions posed by the NMCP:

- What is the expected impact of the currently funded strategies being implemented in the country?
- What additional impact could be achieved through implementation of strategies included in the NMSP 2026-2030 that are currently not funded?
- How do different combinations of interventions compare in their ability to reduce national malaria burden by 2030?

Together, these analyses provide an evidence base to support prioritization of interventions and inform strategic investment decisions for the upcoming planning period.

Implementing the malaria strategic plan

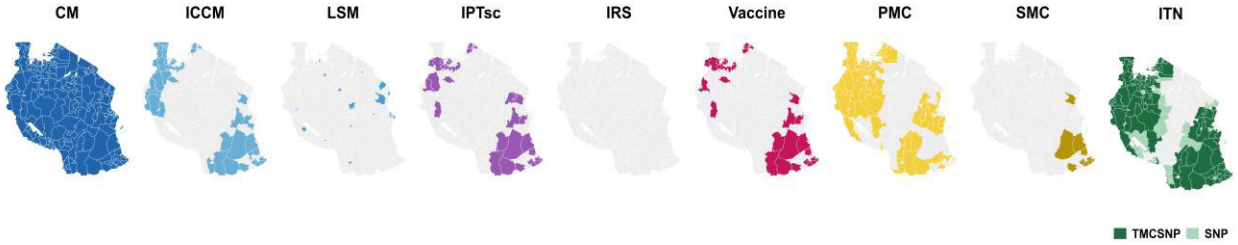
Two plans were considered in this modelling report, the 2021-2025 funded plan (Figure A1a) and the ideal plan (NMSP 2026-2030) discussed in the workshop held in February 2026 (Figure A1b). The modelling assumptions considered for each intervention in the plans is presented in Table A1.

A1: (a) Current funded plan; (b) Ideal NMSP 2026-2030 plan.

(a) Current funded plan:



(b) Ideal NMSP 2026-2030 plan:



CM: Case Management; ICCM: Integrated Community Case Management; LSM: Larval Source Management; IPTsc: Intermittent Preventative Therapy in School Children; IRS: Indoor Residual spray; PMC: Perennial Malaria Chemoprevention; SMC: Seasonal Malaria Chemoprevention; ITN: Insecticide Treated Nets; TMC-SNP: Targeted Mass Campaign followed by School Net Program; SNP: School Net Program.

Table A1: Model assumptions per intervention

Intervention	Target population	Coverage	Deployment strategy	Targeted areas	Cost assumptions (unit costs)
Insecticide Treated Nets (ITNs) – IG2	Whole population	Maintaining ITN access at 80%	Targeted mass campaigns (TMCs) every 3 years followed by the School Net programme (SNP) in between the 3 years.	• TMC + SNP in high and moderate (90 councils) • SNP in low rural (27 councils)	2.4
LSM	Whole population	Habitat detection level at 53%	Blanket larviciding for 24 weeks timed during the council peak seasons	24 urban and in low. very low risk councils	0.66
SMC	Children under 5	80%	3 doses, once per month during the peak rainy season in February – April every year	9 seasonal councils in the high and moderate strata	8.1
PMC	Children under 2	80%	Continuous under the EPI schedule with 3 doses, every year	81 perennial seasonal high and moderate strata councils	0.1
Vaccine	Children from 5 months to 3 years	50%	R21/Matrix-M vaccine under the continuous deployment of the primary and secondary doses, every year	27 high risk strata councils	30.8
IPTsc	School going children 5 to 15 years	80%	3 doses every year based on the seasonality of the council	27 high risk strata councils	9.6
ICCM	Whole population	3% increased case management	Increased testing and coverage of case management in the targeted councils	40 high and moderate risk strata councils	Uncomplicated cases= 1.12 Severe cases=27.63 Operational cost= 0.9
IRS	We don't include it because our model assumes blanket IRS				

Modelling the impact of malaria interventions

In the analyses that follow, estimates of malaria transmission changes for the different intervention scenario questions are analyzed by looking at changes in prevalence trends, malaria cases, cases averted and cost per case averted over the period of 2026-2030.

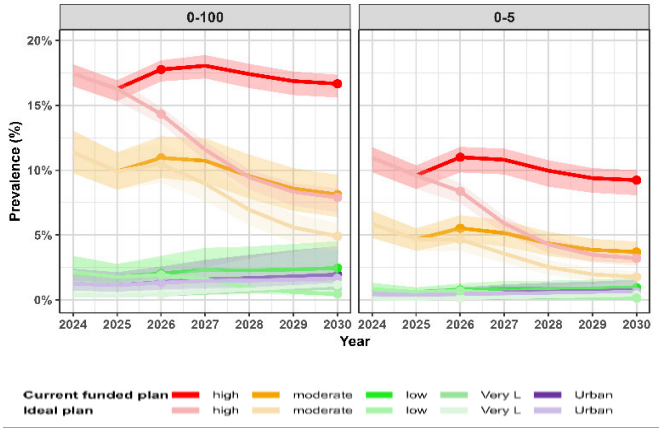
Comparative impact of current funded {Business as usual (BAU)} plan with the ideal NMSP 2026-2030 strategy

The modelling analysis compared the 2021-2025 NMSP funded intervention package (BAU) with the ideal NMSP 2026–2030 strategy to assess whether the planned intervention mix is sufficient to achieve strategic goals, including progress toward elimination. Results (Figure A2a) indicate that the current funded package alone is unlikely to achieve elimination by 2030. Under BAU, only modest reductions are projected in high- and moderate-transmission settings (approximately 6–33%), while prevalence is expected to increase in low, very low, and urban strata, reflecting a rebound in *Pf*PR due to limited intervention coverage in these areas.

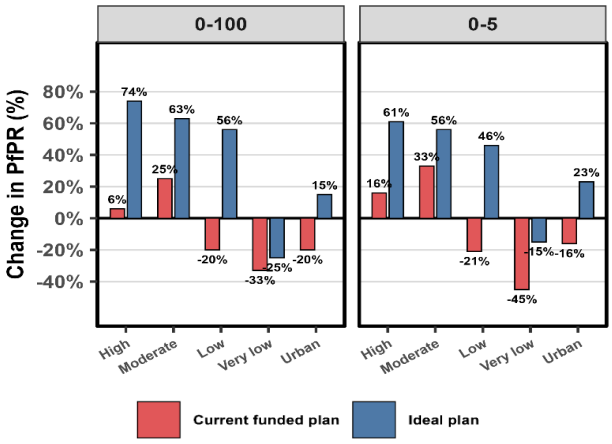
In contrast, full implementation of the ideal NMSP 2026–2030 strategy is projected to substantially reduce malaria prevalence across most transmission settings by 2030 (Figure A2b). The greatest impact is observed in high and moderate strata, with reductions of up to approximately 63–74% in the general population and around 60% among children under five. In low-transmission settings, reductions of up to ~55% are projected, driven by the implementation of larval source management (LSM) in urban areas and school net programmes (SNP) in rural areas.

A2: Estimated impact of the ideal plan (NMSP 2026 -2030) vs the current funded

(a) malaria prevalence disaggregated by strata



(b) prevalence reduction between 2026 and 2030 in the whole population and under 5 years old

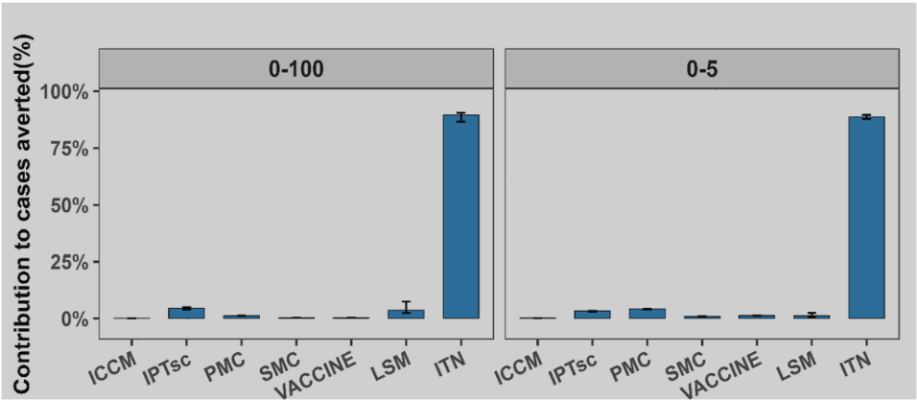


Impact of the different intervention strategies under the ideal NMSP 2026-2030 plan

Contribution of each intervention in the ideal plan (NMSP 2026-2030) towards reducing cases

If fully implemented, the ideal NMSP 2026–2030 shows that ITNs are the primary drivers of impact, accounting for over 80% of cases averted across all age groups (Figure A3). This is followed by IPTsc in the overall population. In children under five, its impact is comparable to that of PMC. Although IPTsc is targeted to school-aged children (5–15 years), it also has a positive indirect effect on under-fives, likely through reducing transmission in the community.

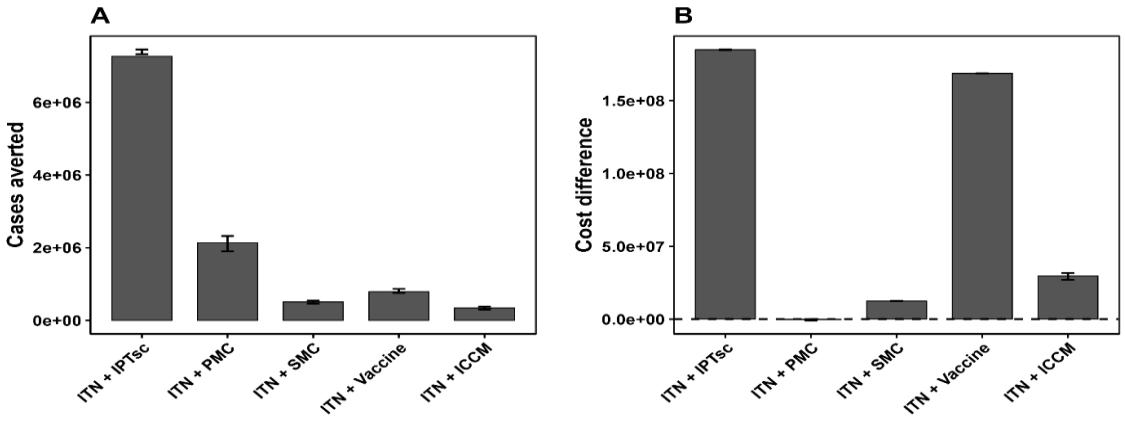
A3: Relative contribution of interventions to cases averted under the ideal plan by age group.



Impact of adding single intervention to ITNs in high and moderate risk strata

Building on Section 3.2.1, which identified ITNs as the primary drivers of case reduction under the ideal plan, we further assess the incremental impact and cost of adding additional interventions to ITNs (with case management assumed everywhere) in moderate and high-risk strata (Figure A4). Among the combinations evaluated, ITNs + IPTsc yield the greatest impact but also with the most additional cost to ITNs. This is followed by ITN + PMC which has the least additional cost to ITN.

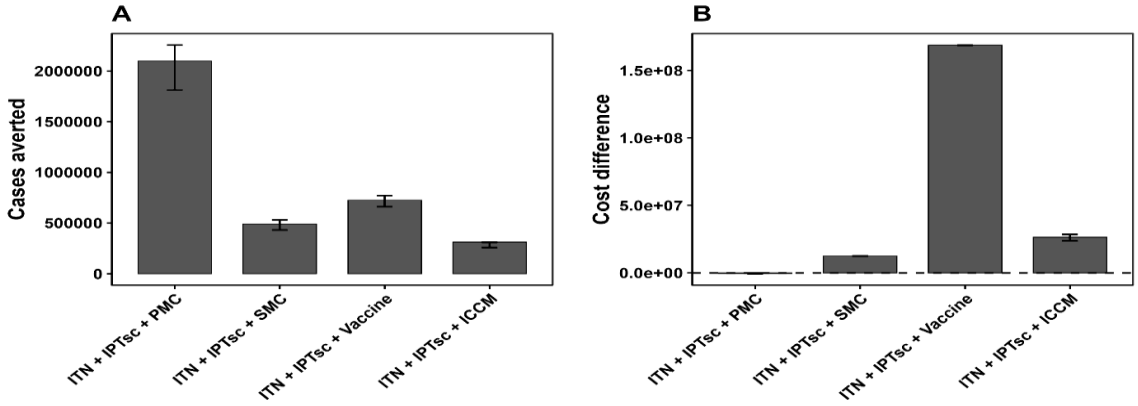
A4: Trade-offs between impact and cost when adding a single intervention to ITNs.



Impact of layering additional interventions onto ITN + IPTsc in high and moderate transmission areas

Since IPTsc is the most impactful additional intervention to ITNs when compared to other single interventions, we take it as our baseline and evaluate the additional benefit of introducing a third intervention alongside this combination (with case management assumed everywhere) (Figure A5). The results suggest that adding PMC to the mix of ITNs and IPTsc yields the largest additional reduction in malaria cases at minimal extra cost, making it the most efficient intervention package. While vaccination also achieves additional impact, it's very high cost limits its cost-effectiveness. SMC provides moderate gains at a moderate cost, whereas iCCM contributes relatively limited additional impact for the resources required.

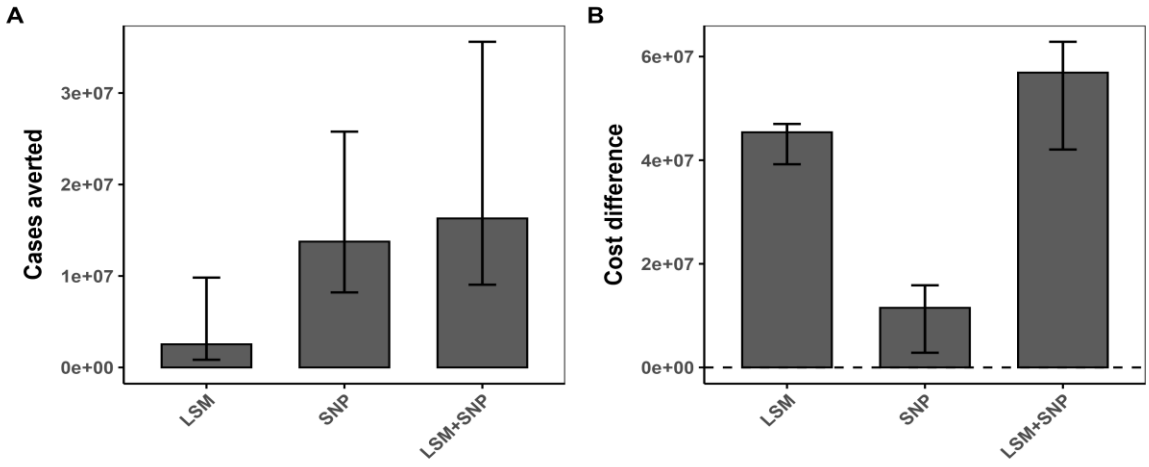
A5: Trade-offs in impact and cost when adding a third intervention to ITN + IPTsc.



Impact of layering additional interventions onto CM and routine ITNs (RCH and EPI) in low and very low transmission areas

In this section, we assess the incremental impact and cost of adding additional interventions to CM in low and very low risk strata (Figure A6). Among the combinations evaluated, LSM combined with SNP yield the greatest impact but also with the most additional cost to CM. This is followed by SNP which has the least additional cost to CM in the low-risk areas.

A6: Trade-offs in impact and cost when adding interventions onto CM in low and very low councils



Prioritization of interventions per council

Given constrained funding for full implementation of the NMSP 2026–2030 plan, we ranked each intervention across eligible councils to identify priority areas for implementation under budget limitations.

The figures 33 and 34 compare rankings of intervention performance using two different metrics: impact, measured as cases averted per 1000, and cost-effectiveness measured using the incremental cost-effectiveness ratio (ICER) in eligible councils. The ICER is defined as the difference in cost between two comparative plans divided by the difference in cases averted, representing the cost per additional malaria case averted; lower ICER values indicate more cost-effective interventions. Across interventions (PMC, vaccination, IPTsc, ICCM, SMC, ITN, and LSM), the maps and bar plots show that areas ranked as highest impact are not always the same as those ranked as most cost-effective. See council ranking (A7, A8 and A9).

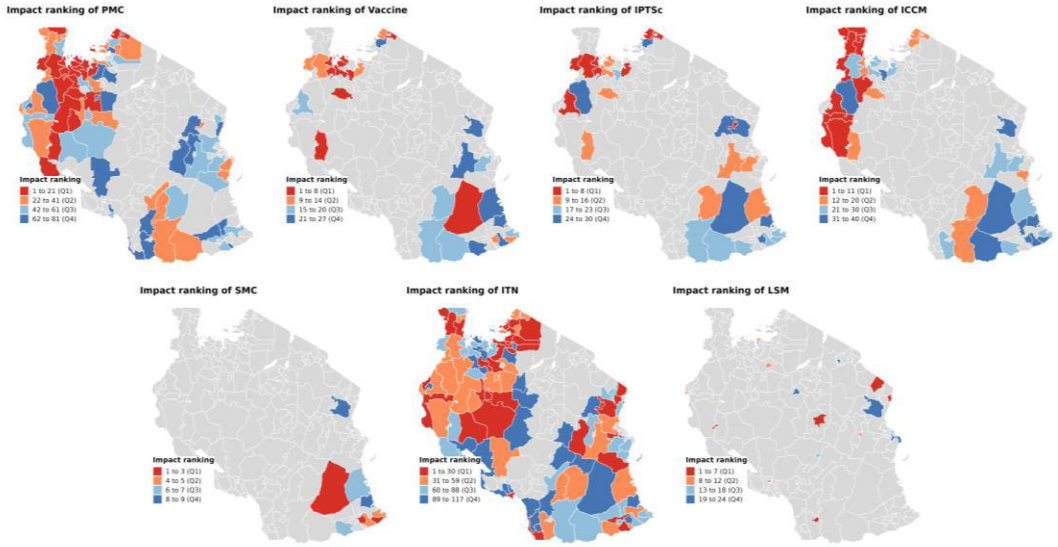
This divergence arises because the two metrics capture different dimensions of performance. Ranking by cases averted reflects the absolute epidemiological benefit of an intervention i.e., where an intervention prevents the largest number of cases. In contrast, ICER accounts for both health outcomes and costs, estimating the additional cost required to avert one additional case.

Because ICER incorporates variation in delivery costs, intervention efficacy, baseline transmission intensity, and diminishing returns, an intervention may avert many cases in a given area but still be less cost-effective there if it is relatively expensive or if additional gains come at higher marginal cost. Conversely, some areas may show moderate impact but high cost-effectiveness if interventions can be delivered efficiently or yield large health gains per unit cost.

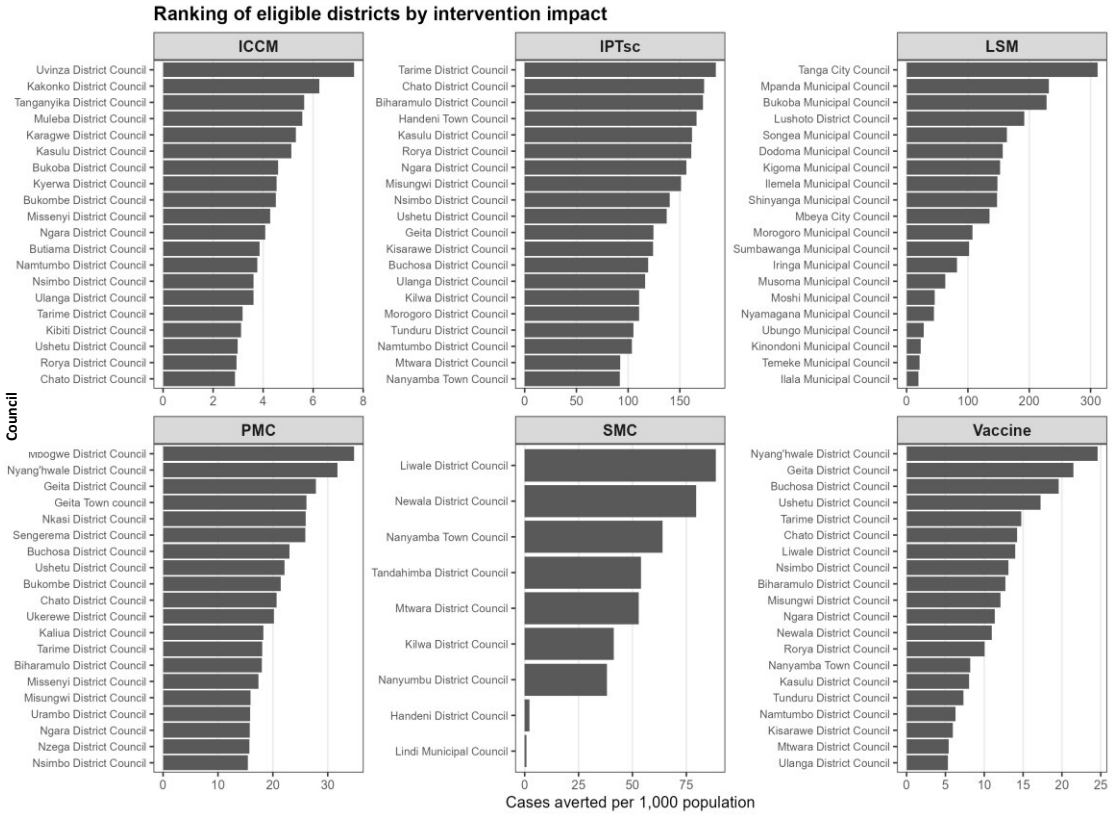
Overall, these findings highlight that prioritization based solely on impact may lead to different geographic targeting than prioritization based on cost-effectiveness. This underscores the importance of jointly considering both metrics when allocating limited resources, and supports the need for sub-nationally tailored intervention strategies rather than a uniform national approach.

Ranking by cases averted

A7: Ranking of interventions by cases averted/1000 population

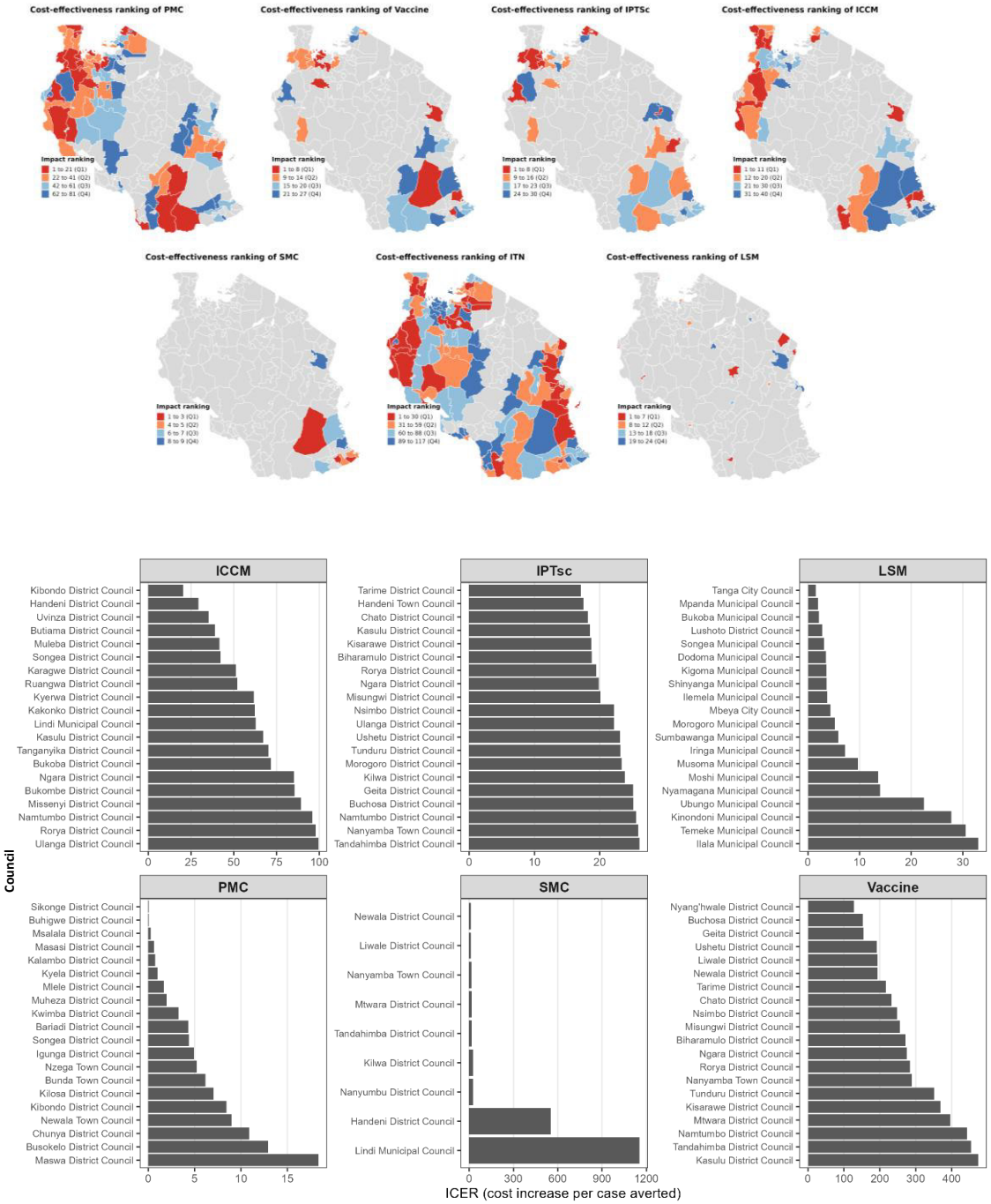


Prioritization of councils per intervention



Ranking by cost per cases averted (ICER)

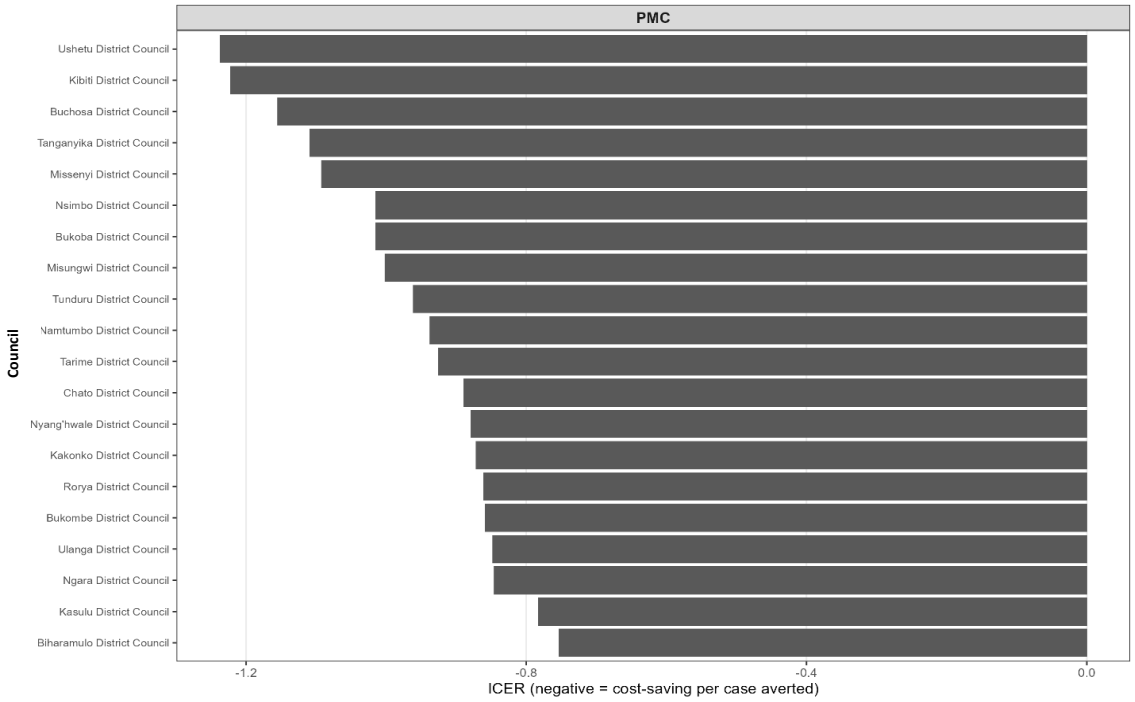
A8: Ranking of interventions by cost effectiveness



Ranking of interventions by cost-effectiveness, where a lower ICER indicates a more cost-effective intervention.

The ICER values in Figure 35 are negative across all councils, indicating that the intervention is cost-saving in all settings. This means that the intervention not only averts malaria cases but also reduces overall costs compared to the comparator plan. Councils with more negative ICER values (e.g., Ushetu and Kibiti) achieve greater cost savings per case averted and therefore represent the most economically efficient locations for implementation.

A9: Ranking of PMC councils by cost savings



Ranking of interventions by cases averted per 1,000 population, where higher values indicate greater epidemiological impact.

Conclusions

The current funded intervention package is insufficient to achieve malaria reduction targets and may lead to increasing transmission in low and urban settings. Recommendation: Scale up implementation of the NMSP 2026–2030 strategy to achieve substantial reductions in malaria burden and avoid resurgence.

While ITNs are the primary drivers of impact, relying on a single intervention is suboptimal; combining ITNs with IPTSc and PMC delivers greater and more efficient reductions in malaria cases. Recommendation: Prioritize ITNs as the foundation of control, while strategically layering IPTSc and PMC to maximize impact and cost-effectiveness.

Prioritization based on impact (cases averted) does not always align with prioritization based on cost-effectiveness, leading to different geographic targeting decisions. Recommendation: Use both impact and cost-effectiveness metrics jointly to guide subnational prioritization and ensure efficient allocation of limited resources.

Annex 2: Summary of MPR Identified Challenges and Recommended Strategic Directions

Strategic Area	Challenge	Recommended strategic directions
Epidemiology	Targets not met; crude incidence data, stratification has limited attributes, limited expand school surveys	• As a HBHI country, improve documentation, monitoring national and sub-national estimation of malaria mortality to track progress on malaria deaths. These include but not limited to severe malaria, tracking case fatality, understand inpatient admissions, hospital quality of care. • Targeting high burden areas: Focus interventions on regions with high malaria burden to address local transmission effectively. • Enhancing CMIS and other data systems: Improve data consistency and timeliness across reporting systems for informed decision-making. • Consider other tailored surveys to assess care-seeking rates, leverage the SMPS, or council-level surveys • Continuous/refresher training of staff on malaria epidemiology, in view of high staff turnover.
Financing	Budget shortfall; partner withdrawal; improved domestic funding not covering the whole gap	• Increase domestic funding: There is a need for a national strategy & an updated business plan for domestic resource mobilization including support for subnational areas. The End Malaria Council and Fund should be used more in resource mobilization activities. • Cost effective interventions: Continuously prioritize interventions based on cost-effectiveness to maximize impact within limited resources. Modeling can be used to support the analysis. • Strengthen financial planning: Effective & careful service integration leveraging on other financed programs. • Existing financial sustainability plans developed by the Government should be reflected in the MPR report and the new NSP.
Implementation	Low activity completion-63%; funding shortages	• Analyze fund absorption by source over time and compare with thematic area implementation performance. • Analyze the impact of funding cuts in the context of the 5-year NSP
Vector Control	IRS withdrawn, ITN, partial funding of LSM; vector control targets not achieved	• Scale up IRS and ITN distribution in targeted areas to increase malaria prevention coverage effectively. • Continue to prioritize ITN targeted mass campaign in high and moderate burden strata. • Evaluate Focal IRS to validate its usefulness of its establishment in very low malaria risk strata for elimination (eligible areas for Case Based Surveillance). • Scale up beyond pilot LSM larval density monitoring to increase its efficiency. Collect data at subnational level, use of GIS to guide larviciding and demonstrate impact of investments.
Case Management	Low testing/treatment rates; gaps in low-risk areas APR in some parts of the country	• Revisit national guidelines to strengthen the use of microscopy OR highly sensitive rapid diagnostic test (RDT) kits in all low and very-low-transmission strata for malaria diagnosis. Current application is only use of conventional mRDTs. Improved case identification and surveillance are core in this setting. • Dry blood spot (DBS) samples for molecular species identification and characterization are also advised. • Expedite and prioritize implementation of the strategy to switch from AL to ASAQ. Also consider diverse use of ACTs countrywide to address confirmed APR. • TES and Genomic surveillance integrated into the programmatic activities, in partnership with academia, should continue & expand sites. Prioritize and expedite drug switch in Kagera & other vulnerable regions.
Chemoprevention	Low IPTp coverage despite satisfactory ANC first visits; limited implementation	• Include a comparison of ANC1 and IPTp1 in the analysis of coverage harmonizing denominator use for each variable. • Improve documentation or routine delivery through MCH and ANC. • Consider scaling up of intermittent preventive treatment for schoolchildren (IPTsc) intervention to school-going children in high-burden councils. • Consider inclusion of WHO-recommended Post Malaria Discharge Chemoprevention (PMDC) in high burden councils to move towards Abuja targets.

Strategic Area	Challenge	Recommended strategic directions
Commodities	Stock outs and distribution issues during COVID period	• Triangulation of data from routine, logistic systems and commodity stock outs and distribution to enhance quantification and forecasting. Consider quantification module in CMIS.
SBCC	Poor funding of SBCC activities	• Strengthen SBCC initiatives through integrated approach. • The End Malaria Council to translate awareness into sustained positive health behaviours. Example through multi-sectoral approaches.
Surveillance	Unsatisfactory data quality at subnational level	• Amend the denominator for malaria testing from OPD and community health workers (at the community level) attendances to suspected malaria-fever case in DHIS2. OPD visits include a broad range of non-malaria suspected visits – can consider a pilot study in one council. • Harmonizing indicators and tools improves accountability and strategic alignment in programmes. • Revisit Composite Management Information System (CMIS) development including unified repository of key data, logistics, HR data, financing, epidemiological campaigns and commodities etc. These mini-data modules should be interoperable and effectively used in decision making. • Enable both online and offline operations in areas with poor internet. • Rapid surveillance system assessment to identify areas for strengthening and improvement. • Need to assess high-risk areas susceptible to epidemics. Produce risk maps for epidemic-prone areas for prioritization. • Address the implications of the prevalence of mixed infections diagnosis and treatment nationally. This includes estimation of national prevalence, strengthening surveillance of these infections, and treatment. • Ensure continued and expanded surveillance of all biological and non-biological threats to malaria control, including for the invasive vector species (An. stephensi), impact of climate, poverty etc. • DQA's to be regular, and reported. • Rationale for case classification emphasized, and HWs/CHWs motivated to report case classification. • Data use culture at all levels including subnational levels is encouraged: for CBS – characterize the cases for response.
Program Management	Uncoordinated partner activities including trainings; incomplete multi-sectoral plans	• Enhance coordination among stakeholders to ensure efficient execution and strategic alignment. • Enhance multi-sectoral collaboration and engagement. • Identify areas of integration within the NSP for strengthening implementation. • Increasing virtual meetings enhances coordination and oversight within programme management. Explore ways to improve participation, as this will add up to a new modality. • Subnational planning, budgeting and resource mobilization to be encouraged in all councils. NMCP should consult councils about subnational plans for budgeting, resource mobilization and advocacy. • Document best practices for experience sharing and learning e.g. cascade training. • Strengthening cross-border and multi-sectoral collaboration addresses regional challenges effectively.

Annex 3: Overview of Malaria Multisectoral Collaboration Framework

The Malaria Multisectoral Collaboration Framework (MCF) is a Government of Tanzania initiative led by the Ministry of Health through the National Malaria Control Programme (NMCP), in collaboration with multiple government ministries, departments, agencies, private sector actors, civil society organizations, and development partners. The initiative recognizes that malaria transmission and control are influenced not only by the health sector, but also by broader social, environmental, economic, infrastructure, education, agriculture, mining, tourism, and community development factors. The framework promotes a coordinated "whole-of-government" and "whole-of-society" approach to malaria prevention and elimination. Its overall goal is to strengthen multisectoral collaboration and implement malaria-smart actions that reduce malaria transmission, improve prevention and treatment, address environmental and social determinants of malaria, and contribute to Tanzania's target of malaria elimination by 2030.

Priority Sectors Involved in the Multisectoral Framework

The following sectors are prioritized within the Malaria Multisectoral Collaboration Framework:

1. Health Sector (MoH/NMCP)
2. Prime Minister's Office – Regional Administration and Local Government (PMO-RALG)
3. Environment and Climate Sector (VPO/Environment, NEMC)
4. Agriculture and Livestock Sector
5. Mining, Extractive Industries and Energy Sector
6. Transport and Infrastructure Sector
7. Water Sector
8. Education Sector
9. Tourism and Natural Resources Sector
10. Defense and Security Sector
11. Industry and Trade Sector
12. Community Development and Social Welfare Sector
13. Information, Communication and ICT Sector
14. Local Government Authorities (LGAs)
15. Private Sector and Employers
16. Faith-Based Organizations (FBOs) and Civil Society Organizations Development Partners and International Agencies
17. Research and Academic Institutions

SMART Actions to be implemented within the Initiative

Key malaria-smart actions proposed under the framework include:

- Strengthening healthcare systems for malaria diagnosis, treatment, prevention, surveillance, and response.
- Expanding access to malaria commodities including LLINs, diagnostics, medicines, and vector control tools.
- Implementing integrated vector control measures such as larval source management and indoor residual spraying.
- Conducting Environmental and Health Impact Assessments for mining, infrastructure, energy, and construction projects.
- Promoting malaria-smart infrastructure designs that reduce mosquito-breeding sites.
- Integrating malaria prevention into occupational health and workplace safety programmes.
- Strengthening school malaria programmes and integrating malaria education into school curricula.
- Conducting community awareness campaigns and social behaviour change interventions.
- Enhancing malaria surveillance, monitoring, evaluation, and cross-sectoral data sharing.
- Supporting research, innovation, and operational studies for malaria control.
- Improving environmental sanitation and water management to eliminate mosquito-breeding habitats.
- Promoting public-private partnerships to mobilize domestic resources for malaria control.
- Strengthening cross-border and regional collaboration for malaria prevention and control.
- Mainstreaming malaria prevention into tourism, agriculture, transport, mining, and energy sector operations.
- Establishing regular multisectoral coordination, review, and accountability mechanism

Annex 4: List of Councils by malaria transmission risk as per 2025 stratification and interventions

Region	Council	Strata	ITNs	IRS	LSM	MCM	Preventive Therapies	Malaria Surveillance and Response
Arusha	Arusha City Council	Very L*	RCH; Proactive ITN	Focal response	Blanket	HFs-CM	IPTp	CBS; rfDA; tTaT; fTaT
Arusha	Arusha District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; tTaT; fTaT
Arusha	Karatu District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; tTaT; fTaT
Arusha	Longido District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; tTaT; fTaT
Arusha	Meru District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; tTaT; fTaT
Arusha	Monduli District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; tTaT; fTaT
Arusha	Ngorongoro District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; tTaT; fTaT
Dar Es Salaam	Ilala Municipal Council	Low*	RCH; Proactive ITN	Epidemic Response	Blanket	HFs-CM	IPTp	MEEDS; tTaT
Dar Es Salaam	Kigamboni Municipal Council	Low*	RCH; Proactive ITN	Epidemic Response	Blanket	HFs-CM	IPTp	MEEDS; tTaT
Dar Es Salaam	Kinondoni Municipal Council	Very L*	RCH; Proactive ITN	Focal response	Blanket	HFs-CM	IPTp	uMSR; RDA; tTaT
Dar Es Salaam	Temeke Municipal Council	Low*	RCH; Proactive ITN	Epidemic Response	Blanket	HFs-CM	IPTp	MEEDS; tTaT
Dar Es Salaam	Ubungo Municipal Council	Very L*	RCH; Proactive ITN	Focal response	Blanket	HFs-CM	IPTp	uMSR; RDA; tTaT
Dodoma	Bahi District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Dodoma	Chamwino District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Dodoma	Chemba District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Dodoma	Dodoma City Council	Very L*	RCH; Proactive ITN	Focal response	Blanket	HFs-CM	IPTp	uMSR; RDA; tTaT
Dodoma	Kondoa District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Dodoma	Kondoa Town Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Dodoma	Kongwa District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Dodoma	Mpwapwa District Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Geita	Bukombe District Council	Moderate	MRC; SNP+RCH		Targeted	HF-CM; iCCM	IPTp; PDMC; PMC	
Geita	Chato District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; PMC; MV	
Geita	Geita District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; PMC; MV	
Geita	Geita Town council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Geita	Mbogwe District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Geita	Nyang'hwale District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; PMC; MV	
Iringa	Iringa District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Iringa	Iringa Municipal Council	Very L*	RCH; Proactive ITN	Focal response	Blanket	HFs-CM	IPTp	CBS; rfDA; fTaT
Iringa	Kilolo District Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	CBS; fTaT
Iringa	Mafinga Town Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT

Region	Council	Strata	ITNs	IRS	LSM	MCM	Preventive Therapies	Malaria Surveillance and Response
Iringa	Mufindi District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Kagera	Biharamulo District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; PMC; MV	
Kagera	Bukoba District Council	Moderate	MRC; SNP; RCH		Targeted	HF-CM; iCCM	IPTp; PDMC; PMC	
Kagera	Bukoba Municipal Council	Low*	RCH; Proactive ITN	Epidemic Response	Blanket	HFs-CM	IPTp	MEEDS; tTaT
Kagera	Karagwe District Council	Moderate	MRC; SNP; RCH		Targeted	HF-CM; iCCM	IPTp; PDMC; PMC	
Kagera	Kyerwa District Council	Moderate	MRC; SNP; RCH		Targeted	HF-CM; iCCM	IPTp; PDMC; PMC	
Kagera	Missenyi District Council	Moderate	MRC; SNP; RCH		Targeted	HF-CM; iCCM	IPTp; PDMC; PMC	
Kagera	Muleba District Council	Moderate	MRC; SNP; RCH		Targeted	HF-CM; iCCM	IPTp; PDMC; PMC	
Kagera	Ngara District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; PMC; MV	
Katavi	Mlele District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Katavi	Mpanda Municipal Council	Low*	RCH; Proactive ITN	Epidemic Response	Blanket	HFs-CM	IPTp	MEEDS; tTaT
Katavi	Mpimbwe District Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Katavi	Nsimbo District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; PMC; MV	
Katavi	Tanganyika District Council	Moderate	MRC; SNP; RCH		Targeted	HF-CM; iCCM	IPTp; PDMC; PMC	
Kigoma	Buhigwe District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Kigoma	Kakonko District Council	Moderate	MRC; SNP; RCH		Targeted	HF-CM; iCCM	IPTp; PDMC; PMC	
Kigoma	Kasulu District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; PMC; MV	
Kigoma	Kasulu Town Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Kigoma	Kibondo District Council	Moderate	MRC; SNP; RCH		Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; PMC	
Kigoma	Kigoma District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Kigoma	Kigoma Ujiji Municipal Council	Low*	RCH; Proactive ITN	Epidemic Response	Blanket	HFs-CM	IPTp	MEEDS; tTaT
Kigoma	Uvinza District Council	Moderate	MRC; SNP; RCH		Targeted	HF-CM; iCCM	IPTp; PDMC; PMC	
Kilimanjaro	Hai District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; tTaT; fTaT
Kilimanjaro	Moshi District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; tTaT; fTaT
Kilimanjaro	Moshi Municipal Council	Very L*	RCH; Proactive ITN	Focal response	Blanket	HFs-CM	IPTp	CBS; rfDA; tTaT; fTaT
Kilimanjaro	Mwanga District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; tTaT; fTaT
Kilimanjaro	Rombo District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; tTaT; fTaT
Kilimanjaro	Same District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; tTaT; fTaT
Kilimanjaro	Siha District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; tTaT; fTaT
Lindi	Kilwa District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; SMC; MV	
Lindi	Lindi Municipal Council	High*	MRC; SNP; RCH	Targeted	Blanket	HF-CM; iCCM	IPTp; IPTSc; PDMC; SMC; MV	uMSR
Lindi	Liwale District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; SMC; MV	
Lindi	Mtama District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	

Region	Council	Strata	ITNs	IRS	LSM	MCM	Preventive Therapies	Malaria Surveillance and Response
Lindi	Nachingwea District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Lindi	Ruangwa District Council	Moderate	MRC; SNP; RCH		Targeted	HF-CM; iCCM	IPTp; PDMC; PMC	
Manyara	Babati District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Manyara	Babati Town Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Manyara	Hanang District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Manyara	Kiteto District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Manyara	Mbulu District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Manyara	Mbulu Town Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Manyara	Simanjiro District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Mara	Bunda District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Mara	Bunda Town Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Mara	Butiama District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; PMC; MV	
Mara	Musoma District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Mara	Musoma Municipal Council	Low*	RCH; Proactive ITN	Epidemic Response	Blanket	HFs-CM	IPTp	MEEDS; tTaT
Mara	Rorya District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; PMC; MV	
Mara	Serengeti District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Mara	Tarime District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; PMC; MV	
Mara	Tarime Town Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Mbeya	Busokelo District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Mbeya	Chunya District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Mbeya	Kyela District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Mbeya	Mbarali District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Mbeya	Mbeya City Council	Very L*	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	uMSR; RDA; tTaT
Mbeya	Mbeya District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Mbeya	Rungwe District Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Morogoro	Gairo District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Morogoro	Ifakara Town Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Morogoro	Kilosa District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Morogoro	Malinyi District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Morogoro	Mlimba District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Morogoro	Morogoro District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; PMC; MV	
Morogoro	Morogoro Municipal Council	Low*	RCH; Proactive ITN	Epidemic Response	Blanket	HFs-CM	IPTp	MEEDS; tTaT
Morogoro	Mvomero District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	

Region	Council	Strata	ITNs	IRS	LSM	MCM	Preventive Therapies	Malaria Surveillance and Response
Morogoro	Ulanga District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; PMC; MV	
Mtwara	Masasi District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Mtwara	Masasi Town Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Mtwara	Mtwara District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; SMC; MV	
Mtwara	Mtwara Municipal Council	Moderate*	MRC; SNP; RCH		Blanket	HFs-CM	IPTp; PDMC; PMC	uMSR
Mtwara	Nanyamba Town Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; SMC; MV	
Mtwara	Nanyumbu District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; SMC; MV	
Mtwara	Newala District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; SMC; MV	
Mtwara	Newala Town Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Mtwara	Tandahimba District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; SMC; MV	
Mwanza	Buchosa District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; PMC; MV	
Mwanza	Ilemela Municipal Council	Low*	RCH; Proactive ITN	Epidemic Response	Blanket	HFs-CM	IPTp	MEEDS; tTaT
Mwanza	Kwimba District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Mwanza	Magu District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Mwanza	Misungwi District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; PMC; MV	
Mwanza	Nyamagana Municipal Council	Low*	RCH; Proactive ITN	Epidemic Response	Blanket	HFs-CM	IPTp	MEEDS; tTaT
Mwanza	Sengerema District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Mwanza	Ukerewe District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Njombe	Ludewa District Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Njombe	Makambako Town Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Njombe	Makete District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Njombe	Njombe District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Njombe	Njombe Town Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Njombe	Wanging'ombe District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Pwani	Bagamoyo District Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Pwani	Chalinze District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Pwani	Kibaha District Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Pwani	Kibaha Town Council	Very L	RCH; Proactive ITN	Focal response	Surv & Response	HFs-CM	IPTp	CBS; rfDA; fTaT
Pwani	Kibiti District Council	Moderate	MRC; SNP; RCH		Targeted	HF-CM; iCCM	IPTp; PDMC; PMC	
Pwani	Kisarawe District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; PMC; MV	
Pwani	Mafia District Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Pwani	Mkuranga District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Pwani	Rufiji District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	

Region	Council	Strata	ITNs	IRS	LSM	MCM	Preventive Therapies	Malaria Surveillance and Response
Rukwa	Kalambo District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Rukwa	Nkasi District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Rukwa	Sumbawanga District Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Rukwa	Sumbawanga Municipal Council	Very L*	RCH; Proactive ITN	Focal response	Blanket	HFs-CM	IPTp	uMSR; RDA; tTaT
Ruvuma	Madaba District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Ruvuma	Mbinga District Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Ruvuma	Mbinga Town Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Ruvuma	Namtumbo District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; PMC; MV	
Ruvuma	Nyasa District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Ruvuma	Songea District Council	Moderate	MRC; SNP; RCH		Targeted	HF-CM; iCCM	IPTp; PDMC; PMC	
Ruvuma	Songea Municipal Council	Low*	RCH; Proactive ITN	Epidemic Response	Blanket	HFs-CM	IPTp	MEEDS; tTaT
Ruvuma	Tunduru District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; PMC; MV	
Shinyanga	Kahama Municipal Council	Low*	RCH; Proactive ITN	Epidemic Response	Blanket	HFs-CM	IPTp	MEEDS; tTaT
Shinyanga	Kishapu District Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Shinyanga	Msalala District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Shinyanga	Shinyanga District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Shinyanga	Shinyanga Municipal Council	Low*	RCH; Proactive ITN	Epidemic Response	Blanket	HFs-CM	IPTp	MEEDS; tTaT
Shinyanga	Ushetu District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; PMC; MV	
Simiyu	Bariadi District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Simiyu	Bariadi Town Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Simiyu	Busega District Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Simiyu	Itilima District Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Simiyu	Maswa District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Simiyu	Meatu District Council	Very L	RCH; Proactive ITN	Focal response	LSM surveillance & response	HFs-CM	IPTp	CBS; rfDA; fTaT
Singida	Ikungi District Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Singida	Iramba District Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Singida	Itigi District Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Singida	Manyoni District Council	Very L	RCH; Proactive ITN	Focal response	LSM surveillance & response	HFs-CM	IPTp	CBS; rfDA; fTaT
Singida	Mkalama District Council	Very L	RCH; Proactive ITN	Focal response	LSM surveillance & response	HFs-CM	IPTp	CBS; rfDA; fTaT
Singida	Singida District Council	Very L	RCH; Proactive ITN	Focal response	LSM surveillance & response	HFs-CM	IPTp	CBS; rfDA; fTaT
Singida	Singida Municipal Council	Very L*	RCH; Proactive ITN	Focal response	Blanket	HFs-CM	IPTp	uMSR; RDA; tTaT

Region	Council	Strata	ITNs	IRS	LSM	MCM	Preventive Therapies	Malaria Surveillance and Response
Songwe	Ileje District Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Songwe	Mbozi District Council	Very L	RCH; Proactive ITN	Focal response	LSM surveillance & response	HFs-CM	IPTp	CBS; rfDA; fTaT
Songwe	Momba District Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Songwe	Songwe District Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Songwe	Tunduma Town Council	Very L	RCH; Proactive ITN	Focal response	LSM surveillance & response	HFs-CM	IPTp	CBS; rfDA; fTaT
Tabora	Igunga District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Tabora	Kaliua District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Tabora	Nzega District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Tabora	Nzega Town Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Tabora	Sikonge District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Tabora	Tabora Municipal Council	Moderate*	MRC; SNP; RCH		Blanket	HFs-CM	IPTp; PDMC; PMC	uMSR
Tabora	Urambo District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Tabora	Uyui District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; PDMC; PMC	
Tanga	Bumbuli District Council	Low	RCH; Proactive ITN	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Tanga	Handeni District Council	High	MRC; SNP; RCH	Targeted	Targeted	HF-CM; iCCM	IPTp; IPTSc; PDMC; SMC; MV	
Tanga	Handeni Town Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; IPTSc; PDMC; PMC	
Tanga	Kilindi District Council	Moderate	MRC; SNP; RCH		Targeted	HFs-CM	IPTp; IPTSc; PDMC; PMC	
Tanga	Korogwe District Council	Low	HFs	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Tanga	Korogwe Town Council	Low	CM	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Tanga	Lushoto District Council	Very L	iCCM	Focal response	LSM surveillance & response	HFs-CM	IPTp	CBS; rfDA; fTaT
Tanga	Mkinga District Council	Low	PDMC	Epidemic Response		HFs-CM	IPTp	MEEDS; tTaT
Tanga	Muheza District Council	Moderate	PMC		Targeted	HFs-CM	IPTp; PDMC; PMC	
Tanga	Pangani District Council	Moderate	SMC		Targeted	HFs-CM	IPTp; PDMC; PMC	
Tanga	Tanga City Council	Low*	RCH; Proactive ITN	Epidemic Response	Blanket	HFs-CM	IPTp	MEEDS; tTaT

Key:

IPTp	**Intermitted preventive therapies pregnant women**	iCCM	integrated community case management
IPTsc	**Intermitted preventive therapies school children**	fTAT	Focal test and treatment
MRC	**Mass replacement campaign**	tTAT	Targeted test and treatment
SNP	**School net program**	PMC	Perennial malaria chemoprevention
RCH	**Reproductive and child health**	SMC	Seasonal malaria chemoprevention
HF	**Health Facility**	PDMC	Post discharge malaria chemoprevention
CM	**Case management**		

Annex 5: Annual quantification of malaria commodities

Procurement of 15,420,831 ACTs doses (AL/ ASAQ) and 860,817 Primaquine tablets for facilities, ACD and studies

Antimalarial medicines	Needs 2026	Needs 2027	Needs 2028	Needs 2029	Needs 2030
AL/ASAQ in public facilities	3,322,552	3,250,888	3,032,855	2,979,701	2,810,050
AL/ASAQ for TES and SMPS	352	6,352	352	6,352	352
AL/ASAQ for ACD	2,084	2,136	2,189	2,266	2,350
Primaquine doses for fDA	50,130	51,467	52,843	54,259	55,717
Primaquine Tablets in public HFs	109,981	113,094	116,308	119,627	123,056
Primaquine doses for ACD	2,712	2,779	2,848	2,946	3,050

Procurement of 121,395,506 mRDTs for malaria testing in public facilities and community

mRDT	Needs 2026	Needs 2027	Needs 2028	Needs 2029	Needs 2030
mRDT for routine testing in public sector health facilities	23,613,245	23,941,659	24,229,326	24,485,201	24,715,595
mRDT for TES and SMPS	6,000	86,000	6,000	86,000	6,000
mRDT for ACD	41,675	42,710	43,773	45,330	46,992

Procurement of 15,591,833 Artesunate injectable vials for treatment of severe malaria in public health facilities

Item	Needs 2026	Needs 2027	Needs 2028	Needs 2029	Needs 2030
Total Artesunate inj. Vials	3,481,628	3,364,305	3,246,982	2,903,165	2,595,753

Procurement of 185,058,985 SP tablets, 7,790,837 Dihydroartemisinin Piperaquine (DP) and SPAQ doses and 10,503,628 ASAQ doses of for preventive therapy interventions

Item	Needs 2026	Needs 2027	Needs 2028	Needs 2029	Needs 2030
SP Tablets for IPTp	31,680,465	32,535,838	33,381,770	34,249,696	35,105,938
SP Tablets for PMC	3,376,768	3,494,136	3,616,174	3,743,092	3,875,108
SPAQ doses for IPTsc	1,269,962	1,300,527	1,331,976	1,364,343	1,397,661
DP doses for fDA	50,130	51,467	52,843	54,259	55,717
DP doses for SCD	10,415	10,754	11,105	11,467	11,841
DP doses for Epidemic control	151,592	156,232	161,139	166,221	171,186
ASAQ doses for PDMC	324,944	298,958	309,091	319,616	330,549
ASAQ doses for SMC	-	2,140,933	2,199,306	2,259,292	2,320,939

Procurement of 86,695,236 ITNs needed for distribution through different channels for malaria vector control

Item	Needs 2026	Needs 2027	Needs 2028	Needs 2029	Needs 2030
ITNs for RCH	5,431,461	5,610,291	5,795,823	5,988,343	6,188,147
ITNs for TRC	8,459,509	10,363,404	3,631,313	7,688,419	11,438,831
ITNs for SNP (continuous)	261,937	2,290,224	3,904,997	3,195,829	2,559,732
ITNs for SNP in rebound mitigation	214,600	-	227,691	234,544	-
ITNs in hotspots	-	1,525,100	-	-	1,683,041

Procurement of 4,780,500 liters of biolarvicides for malaria vector control

Biolarvicides (in liters)	Needs 2026	Needs 2027	Needs 2028	Needs 2029	Needs 2030
Targeted LSM	739,500	739,500	739,500	739,500	739,500
LSM Surveillance &Response	118,040	118,040	118,040	118,040	118,040
Focal response LSM	20,430	20,430	20,430	20,430	20,430
Blanket LSM in urban areas	78,130	78,130	78,130	78,130	78,130

Procurement of 220,109 liters/ sachets of IRS insecticides and 11,440 Personal Protective Gears (PPE) for malaria vector control

Item	Needs 2026	Needs 2027	Needs 2028	Needs 2029	Needs 2030
Insecticides for targeted selective IRS	37,818	39,029	40,278	41,566	42,897
PPE for targeted selective IRS	2,160	2,160	2,160	2,160	2,160
Insecticides for focal IRS	630	-	630	-	630
PPE for focal IRS	80	-	80	-	80
IRS insecticides for outbreak mitigation	3,120	3,220	3,323	3,429	3,539
PPE for IRS in outbreak mitigation	80	80	80	80	80

Annex 6: NMSP Work Plan

SO/SA/SI/SDM		SO, SA, SI, SDM and Activity description	Year													
			2026				2027				2028				2029	2030
			Quarter													
			1	2	3	4	1	2	3	4	1	2	3	4		
SO	1	**Reduce malaria parasite transmission by accelerating the implementation of targeted, recommended, evidence-based, integrated malaria preventive interventions.**														
SA	1.1	Accelerate the reduction of malaria burden in high and moderate transmission risk areas														
SI	1.1.1	Provide universal ITN coverage through mass and continuous distribution to ensure optimal population ITN access (80%) in high and moderate malaria transmission risk strata														
SDM	1.1.1.1	Implement targeted mass campaign to achieve optimal ITN access in high and moderate malaria transmission strata				x	x	x	x	x	x	x	x			
		Convene a planning and coordination meeting with implementing partners to agree on the processes and procedures for the mass campaigns														
		Facilitate the microplanning process with the council health management teams (CHMTs)				x		x		x		x		x		
		Conduct advocacy meetings with the Regional and Council Health Management and Security teams				x		x		x		x		x		
		Train Council Teams on the campaign processes, including household registration and ITNs issuing				x	x		x	x	x		x	x		
		Train Registration Assistants, WEOs, and VEOs on the campaign processes including household registration and ITNs issuing					x		x							
		Household registration and data entry into TMC-MIS for the micro-quantification of ITN needs				x	x	x	x	x	x	x	x	x		
		Conduct a data review and validation process to get the actual number of nets required				x		x		x		x		x		
		Conduct pre-alert meetings at the council level				x		x		x		x		x		
		Facilitate ITNs issuing to the community				x	x		x	x	x		x	x		
		Monitoring the implementation of TMC (during household registration and ITNs issuing) at the councils implementing the campaign					x		x							
		Report writing and dissemination of the optimized TMC implementation process														
		Printing of campaign materials				x	x	x	x	x	x	x	x	x		
		Conduct post TMC evaluation campaign to assess ITNs distributed to the household level (assuming 1 ITN is used by 2 people)				x	x	x	x	x	x	x	x	x		
	1.1.1.2	Implement annually ITN distribution in between targeted mass campaigns to maintain optimal coverage through School programme				x		x		x		x		x		
		Review of the school enrollment data to confirm the number of enrolled pupils supposed to receive ITNs														
		Facilitate an annual review meeting to agree on the implementation processes and address past challenges and agree on the way forward				x		x		x		x		x		
		Conduct advocacy meetings at the regional and council levels				x	x		x	x	x		x	x		
		Update and review the TMC implementation guide					x		x							
		Facilitate refresher training to SLOs				x	x	x	x	x	x	x	x	x		
		Conduct pre-alert meetings at the council level				x		x		x		x		x		
		Monitoring and supervision of ITNs issuing to school pupils				x		x		x		x		x		
		Data entry into the School Information System (SIS)				x	x		x	x	x		x	x		
	1.1.1.3	Distribute ITNs to biological vulnerable groups pregnant women and infants through ANC and EPI clinics in all malaria epidemiological strata					x		x							
		Monitoring and follow up of the ANC and EPI mosquito nets distribution to biologically vulnerable groups (pregnant women and infant children) quarterly to assess its performance														
		Meeting with stakeholders (NMCP, PORALG, MSD & LMU) to share and reconciliate number of ITNs distributed to the health facilities through ANC and EPI clinics.				x	x	x	x	x	x	x	x	x		

SO/SA/SI/SDM		SO, SA, SI, SDM and Activity description	Year													
			2026				2027				2028				2029	2030
			Quarter													
			1	2	3	4	1	2	3	4	1	2	3	4		
		Update and review ITN implementation guide i.e., ANC, EPI and TMC				x		x		x		x		x		
		Facilitate monthly transportation and provision of ITNs distribution to infants at their MR1 vaccination during outreach services in hard-to-reach areas				x		x		x		x		x		
SI	1.1.2	Targeted IRS to reduce malaria burden in prioritized areas of extremely high transmission and high population vulnerability				x	x		x	x	x		x	x		
SDM	1.1.2.1	Apply selective IRS in areas with extremely high infection rate (residual hyper and holo-endemic areas)					x		x							
		Develop criteria for selection of areas to be targeted by selective IRS using existing information (ANC, SMPS, micro-stratification))														
		Procure insecticides for IRS application				x	x	x	x	x	x	x	x	x		
		Orient the council team (CHMTs) for application of IRS				x		x		x		x		x		
		Conduct spray operations				x		x		x		x		x		
	1.1.2.2	Response to alarming emergency and special situation in high/moderate transmission areas				x	x		x	x	x		x	x		
		Sensitize the private sector to support the implementation of targeted IRS as part of their corporate social responsibility.														
		Response to climatic driven emergencies														
SI	1.1.3	Support targeted Larval Source Management (LSM) as part of integrated vector management in suitable epidemiological and operational settings				x		x		x		x		x		
SDM	1.1.3.1	Implement integrated Environment management interventions through coordinated partnership with local councils, private sector and community and engagement to reduce mosquito breeding sites														
		Facilitate resource mobilization for procurement of biolarvicides and operational costs for LSM														
		Develop annual LSM operational plans and costed budgets for targeted councils,				x	x		x	x	x		x	x		
		Advocate for allocation of LSM resources in national and council health plans and budgets (CCHPs),					x		x							
		Mobilize domestic and partner funding to support procurement of biolarvicides and operational costs				x	x	x	x	x	x	x	x	x		
		Strengthen capacity of regions, councils and stakeholders for planning, implementation and evaluation of LSM														
		Train regional and council-level vector control teams on LSM planning, implementation and monitoring				x		x		x		x		x		
		Conduct supportive supervision and mentorship visits to regions and councils implementing LSM				x		x		x		x		x		
		Promote community engagement and social mobilization for effective LSM														
		Develop and disseminate IEC/BCC materials on mosquito breeding site management and LSM,														
		Conduct community sensitization campaigns on environmental management and breeding site elimination					x		x							
		Support community-led clean-up campaigns and environmental management initiatives				x	x	x	x	x	x	x	x	x		
		Promote coordinated multisectoral environmental management for larval source reduction														
		Establish and strengthen multisectoral coordination platforms for LSM at national and sub-national levels				x	x	x	x	x	x	x	x	x		
		Facilitate collaboration with local government authorities, stakeholders and private sector to support environmental management				x		x		x		x		x		
		Facilitate joint planning and review meetings with relevant sectors				x		x		x		x		x		
		Support documentation and dissemination of best practices and lessons learned from multisectoral LSM and environmental management initiatives				x	x		x	x	x		x	x		
	1.1.3.2	Ensure quality-assured application of biolarvicides using appropriate tools and innovative technologies where feasible (e.g. drones)														
		Develop or update national LSM guidelines and SOPs,				x		x		x		x		x		
		Conduct supportive supervision and periodic quality assurance assessments of larviciding implementation in targeted councils				x		x		x		x		x		
		Guide adoption of innovative technologies (e.g., drones, digital habitat mapping) for LSM where feasible				x	x		x	x	x		x	x		

SO/SA/SI/SDM		SO, SA, SI, SDM and Activity description	Year													
			2026				2027				2028				2029	2030
			Quarter													
			1	2	3	4	1	2	3	4	1	2	3	4		
		Facilitate periodic review of LSM implementation performance through national and sub-national review meetings					x		x							
		Establish functional electronic data management and reporting systems for LSM														
		Develop/adapt electronic LSM data collection and reporting tools,					x		x							
		Train regional and council teams on LSM data recording, reporting, and analysis,				x	x	x	x	x	x	x	x	x		
		Integrate LSM indicators into routine malaria surveillance and reporting systems,				x		x		x		x		x		
		Conduct routine data quality assessments and validation of LSM data				x		x		x		x		x		
SI	1.1.4	Provide appropriate and effective chemo-preventive services to reduce the risk of malaria and its complications among populations biologically and socioeconomic vulnerable to malaria.	x	x	x	x	x	x	x	x	x	x	x	x		
SDM	1.1.4.1	Increase the uptake of IPTp3+ among pregnant women at the health facilities to reduce vulnerability in pregnancy.		x		x		x		x		x		x		
		Conduct supportive supervision using MSDQI eds														
		Conduct mentorship sessions to facilities with low IPTp3+ performance		x		x		x		x		x		x		
	1.1.4.2	Strengthen the implementation of IPTsc in current implementing areas and scale up in selective high and moderate transmission areas to reduce the risk of malaria in school-aged children and to mitigate malaria transmission	x	x	x	x	x		x	x	x		x	x		
		Maintain the IPTSC intervention to the existing implementing council until reach Low and very low strata														
		Development of Digital data collection tool to feed CMIS					x		x							
		Medicine dispensing	x	x	x	x	x		x	x	x		x	x		
		Conduct supportive supervision during each IPTsc round	x		x		x		x		x		x			
		Scale up the implementation of IPTSc in selective high and moderate transmission risk areas and where there is confirmed APR to mitigate malaria transmission among school-aged children														
		Mapping of new eligible councils		x	x											
		Advocacy meetings (R/CHMT)	x	x	x	x	x		x	x	x		x	x		
		Training (Tot & Teachers)														
		Medicine dispensing			x		x		x		x		x			
		Conduct supportive supervision during each IPTsc round			x		x		x		x		x			
	1.1.4.3	Introduce and scale up provision of perennial malaria chemoprevention (PMC) in high burdened councils.														
		Develop SOPs and job aids for PMC Implementation														
		Mapping of eligible council			x											
		Advocacy meetings (R/CHMT)				x										
		Training (ToT &provider)					5									
		Updating ANC checklist in MSDQI EDs to include PMC					5									
	1.1.4.4	Introduce and scale up provision of SMC in selected epidemiological suitable council with high transmission risk				x										
		Mapping of eligible councils														
		Advocacy meetings (R/CHMT)					x									
		Development of Digital data collection tool to feed CMIS			x											
		Training (ToT & provider/ CHW)						x								
		Develop SMC supervision checklist			x											
		Medicine dispensing at community														
	1.1.4.5	Introduce and scale up provision of Post Discharge Malaria Chemoprevention (**PDMC**) among under five children admitted with severe malaria			x											
		Develop PDMC implementation manual and job aids														
		Advocacy meetings (R/CHMT)				x										
		Training (ToT & provider)					x	x								

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		Updating IPD checklist on MSDQI-EDs to include PDMC				x										
	1.1.4.6	Introduction and scale-up of **malaria vaccination** within the country's existing immunization program in high transmission area														
		Mapping of new eligible councils														
		Advocacy meetings (R/CHMT),														
		Training (Tot & provider)	x			x			x			x		x		
SA	1.2	**Promote malaria elimination efforts by protecting the population at risk of infection in areas with extremely low malaria endemicity**														
SI	1.2.2	Provide protection to selected vulnerable population living in low and very low transmission risk areas through ITNs targeted distribution				x	x	x	x	x	x	x	x	x		
SDM	1.2.2.1	ITNs distribution to biological vulnerable groups, pregnant women and infants, within the RCH clinics (EPI and ANC)					x		x							
		Monitoring and follow up of the ANC and EPI mosquito nets distribution to biologically vulnerable groups (pregnant women and infant children) quarterly to assess its performance														
		Meeting with stakeholders (NMCP, PORALG, MSD & LMU) to share and reconciliate number of ITNs distributed to the health facilities through ANC and EPI clinics.				x	x	x	x	x	x	x	x	x		
	1.2.2.2	Distribute ITNs selectively in identified sustained transmission hotspots within the low endemicity strat				x	x		x	x	x		x	x		
		Facilitate the microplanning process with the council health management teams (CHMTs)				x		x		x		x		x		
		Conduct advocacy meetings with the Regional and Council Health Management and Security teams				x		x		x		x		x		
		Train Council Teams on the campaign processes, including household registration and ITNs issuing				x	x		x	x	x		x	x		
		Train Registration Assistants, WEOs, and VEOs on the campaign processes including household registration and ITNs issuing					x		x							
		Household registration and data entry into TMC-MIS for the micro-quantification of ITN needs				x	x	x	x	x	x	x	x	x		
		Conduct a data review and validation process to get the actual number of nets required				x		x		x		x		x		
		Facilitate ITNs issuing to the community				x	x		x	x	x		x	x		
		Monitoring the implementation of TMC (during household registration and ITNs issuing) at the councils implementing the campaign					x		x							
	1.2.2.3	Mitigation of malaria incidence rebound in hypoendemic areas through emergency procurement and distribution of ITN to targeted areas through school outlets														
SI	1.2.3	Implement IRS in very low malaria transmission strata to interrupt transmission and mitigate epidemics														
SDM	1.2.3.1	Reactive focal IRS in very low malaria strata to interrupt transmission				x	x	x	x	x	x	x	x	x		
		Procurement of insecticides and protective equipment for focal IRS in wards with hot transmission														
		Conduct advocacy and sensitization meeting for the LGAs at subnational levels on the foci IRS implementation				x		x		x		x		x		
		Train CHMT-specialized team for the foci IRS response following the CBS				x		x		x		x		x		
		Application of focal IRS in response to foci investigation in wards with very low malaria transmission strata														
SO	2	**To prevent the occurrence of mortality related to malaria infection through universal access to appropriate diagnosis and treatment**														
SA	2.1	Provide universal access to appropriate, quality and timely malaria diagnosis and treatment to all eligible people at health facilities.														
SDI	2.1.1	Strengthen malaria case management in Public Health Facilities														
SDM	2.1.1.1	Provide high-standard, accessible, affordable, acceptable, equitable, and quality-assured malaria testing services for people seeking treatment in public health facilities.							X	X						
		Train health workers on updated malaria testing protocols and proper use of RDTs/Microscopy														
		Implement external quality assurance (EQA) programs for microscopy and RDTs.			X				X				X			

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		Conduct regular supervisory visits and on-site mentoring for laboratory staff		X				X				X				
		Strengthening of Malaria Microscopy slide bank		X				X				X				
		Conduct Malaria re-certification of trained laboratory professional			X				X							
SDM	2.1.1.2	Provide high-standard, accessible, affordable, equitable, and quality-assured antimalarials to patients seeking treatment in public health facilities.						X	X							
		Update Malaria Case management training materials														
		Train health workers on updated treatment guidelines (including ACTs and severe malaria management)							X	X						
		Conduct supportive supervision using MSDQI-eds tool		x				X				X				
SDI	2.1.2	Strengthen malaria diagnosis and treatment in Private Health Facilities														
SDM	2.1.2.1	Provide high standard, accessible, acceptable, affordable, equitable, and quality-assured malaria testing services for people seeking treatment in private health facilities		x				X				X				
		Enforce national standards and guidelines for malaria testing in private facilities.														
		Improve compliance with quality standards by requiring licensing and accreditation of private labs and clinics.		x				X				X				
		Implement external quality assurance (EQA) programs for microscopy and RDTs.		X				X				X				
		Conduct trainings on Malaria microscopy QAQC			x		x		x		x					
		Training Health care providers on updated NMDTPV guideline							X	X						
		Improve services in stand alone laboratories							X	X				X		
		Establish an accreditation guide of laboratory services for malaria								X						
		Capacity building on primaquine dispensing in very low transmission areas in private sector				x	x	x	x		x			x	x	x
		Orient on DOT primaquine dispensing in private sector														
		Provide Primaquine in very low transmission areas in private sector				x	x	x	x		x			x	x	x
		Dispense direct observation treatment to confirmed cases														
SDM	2.1.2.2	Provide high-standard, accessible, affordable, equitable, and quality-assured antimalarials for patients seeking malaria treatment in private health facilities		x				x				x				
		Conduct supportive supervision using MSDQI-eds tool														
		Conduct mentorship on Malaria case Management		x				x				x				
SI	2.1.3	Provide high-quality severe malaria management services by skilled providers in public and private health facility settings														
SDM	2.1.3.1	Provide high-quality severe malaria management services by skilled providers in public health facility settings.			x				X				X			
		Conduct clinical and death audit in selective public Health facilities														
		Conduct basic and advance MMQAQC to Lab personal in high and moderate transmission strata			X	X			X	x			X	X		
		Conduct re-certification to well performed Lab personal			x	X				x	X					
		Capacity building on emergency care and pre-referral management to Nurses (develop e-learning materials on management of severe malaria)					x	X			x	x				x
SDM	2.1.3.2	Provide high-quality severe malaria management services by skilled providers in private health facility settings.			x	X			x	x			x	x		
		Conduct death audit in selective public Health facilities														
		Integrate IMCI, ETAT+, and emergency care approaches into facility workflows for early identification and rapid management														

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		Conduct basic and advance MMQAQC to Lab personal in high and moderate transmission strata (support to strengthen diagnostic quality assurance for microscopy and RDT performance)					x	x				x	x			
		Conduct re-certification to well performed Lab personal					x	x			x	x			x	
		Track counter-referrals to improve continuity of care and feedback loops			x				x				x			
		Train CHWs to recognize danger signs and refer severe cases early.			x				x				x			
		Capacity building on emergency care and pre-referral management to Nurses (Conduct regular training and certification for clinicians and nurses on severe malaria case management, including diagnosis, triage, treatment protocols, and complications management)			x				x				x			
SDM	2.1.3.3	Strengthen pre-referral services for severe malaria in public health facilities and community settings														
		Improve pre referral use of rectal artesunate use in community level		x		x				x				x		
		Administer rectal artesunate to referred under 5 children														
		Conduct supportive supervision			x	x			x	x			x	x		
SI	2.1.4	Strengthen malaria diagnosis and treatment for populations with biological vulnerability														
SDM	2.1.4.1	Integration of malaria services into specialized and chronic care clinics		x		x		x		x			x			x
		conduct supportive supervision														
SI	2.1.5	Adopt and scale up innovative, evidence-based malaria diagnosis and treatment tools and approaches to improve quality, efficiency and accessibility of malaria case management services														
SDM	2.1.5.1	Introduction and adoption of new malaria treatment approaches and tools as guided by scientific evidence														
		Introduce triple ACTs (TACTs) in pilot programs where resistance is emerging.														
		Update national malaria treatment guidelines to include APR mitigation strategies.														
SDM	2.1.5.2	Introduction and adoption of new diagnostic approaches and tools as guided by scientific evidence														
		Conduct task force meeting														
		Update national malaria guidelines to incorporate innovative diagnostics alongside standard RDTs and microscopy.			x				x				x			
		Train health workers and CHWs on the use and interpretation of new diagnostic tools.								x	x					
		Integrate new diagnostics into routine ANC, pediatric, and outpatient services.							x	x						
		Ensure linkage to treatment protocols							x	x						
		Establish external quality assurance (EQA) programs for new diagnostic tools.							x				x			
		Monitor diagnostic accuracy through periodic proficiency testing.			x				x				x			
SA	2.2	Provide universal access to appropriate, quality and timely malaria diagnosis and treatment beyond routine health facility services to all eligible people														
SI	2.2.1	Provide high standard, accessible, affordable, equitable and quality assured malaria testing and treatment services to communities with limited accessibility to operational health facilities														
SDM	2.2.1.1	Scale up integrated Community Case Management (iCCM) services in all eligible villages in high-risk councils														
		Conduct advocacy meetings to the village leaders			x				x				x			
		Mapping of eligible villages for iCCM														
		Cascade training of iCCM package			x				x				x			
		Procure working tools to iCCM providers (tablet, bicycles)				x				x	x					
		Provide stipends to iCCM providers/ICCHWs.	x	x	x	x	x	x	x	x	x	x	x	x	x	x
SDM	2.2.1.2	Explore the opportunity to re-establish malaria testing in pharmaceutical outlets														
		Promote consultative process among MoH and regulatory boards														
		Advocacy to the national level leaders							x	x						
		Mapping ADDO and pharmaceutical services							x	x						

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		Prioritize intervention areas to be targeted							x	x						
SDM	2.2.1.3	Provide community-based malaria case management services to marginalized population groups					x			x					x	x
		Providing outreach services to the communities														
		Mapping the special populations					x				x					
		Conduct Advocacy to Region and Council leaders around the special population					x				x					
		Conduct training to R/CHMT					x	x								
		Conduct training to CHW							x	x						
		Conduct supportive supervision to facilities serving special group population							x	x						
SDM	2.2.1.4	Provide malaria case management services during natural disasters and other humanitarian emergencies								x	x					
		Capacity building to R/CHMT														
		Capacity building to CHW						x				x				
		Malaria testing and treatment														
		Organize referral for severe malaria cases	x	x	x	x	x	x	x	x	x	x	x	x		
		Follow up implementation and reporting.	x			x			x			x				
SDA	2.3	Promote cross cutting initiatives to improve malaria case management interventions														
SI	2.3.1	Operationalize new tools and interventions to protect ACTs as indicated by the TES and MMS														
SDM	2.3.1.1	Providing APR mitigation strategies			x				x			x			x	
		Conduct regular task force meetings (two virtual meetings and two physical meetings)														
		Introduce triple ACTs (TACTs) in pilot programs where resistance is emerging.						x			x		x			
		Update national malaria treatment guidelines to include APR mitigation strategies.								x	x					
SI	2.3.2	Adoption and documentation of novel malaria case management tools and approaches														
SDM	2.3.2.1	ensure introduction and adoption of new diagnostic approaches and tools when available			x				x			x			x	
		Conduct task force meeting														
		Update national malaria guidelines to incorporate innovative diagnostics alongside standard RDTs and microscopy.			x				x				x			
		Train health workers and CHWs on the use and interpretation of new diagnostic tools.								x	x					
		Integrate new diagnostics into routine ANC, pediatric, and outpatient services.							x	x						
		Ensure linkage to treatment protocols							x	x						
		Establish external quality assurance (EQA) programs for new diagnostic tools.							x				x			
		Monitor diagnostic accuracy through periodic proficiency testing.			x				x				x			
SI	2.2.2	Deploy malaria case management in response to malaria surveillance initiatives														
SDM	2.3.3.1	MCM deployed as principal intervention for epidemic containment.						x				x				
		Mapping														
		Capacity building to R/CHMT						x				x				
		Capacity building to CHW						x				x				
		Malaria testing and treatment						x				x				
		Organize referral for severe malaria cases						x				x				
		Monitor the implementation and reporting						x				x				
SDM	2.2.2.2	Introduce focal and targeted case management interventions to respond to malaria Case Based Surveillance findings						x				x				
		Mapping														
		Capacity building to R/CHMT						x				x				

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		Capacity building to CHW														
		Malaria testing and treatment	x	x	x	x	x	x	x	x	x	x	x	x		
		Organize referral for severe malaria cases	x			x			x			x				
		Monitor the implementation and reporting														
	2.3.3.3	Establish or adapt improved malaria case management services targeting specific urban population in the context of urban malaria surveillance					x	x				x	x			
		Mapping														
		Capacity building to R/CHMT						x				x				
		Capacity building to CHW						x				x				
		Malaria testing and treatment						x				x				
		Organize referral for severe malaria cases						x				x				
		Monitor the implementation and reporting						x				x				
SO	3	**To provide timely and reliable information on malaria and its control needed to take appropriate actions in different transmission risk and ensure resources are used in the most cost-effective manner**														
SA	3.1	Establish a comprehensive malaria surveillance and response system to inform stakeholders and respond to the emerging needs through an evidence-based platform														
SI	3.1.1	Strengthen malaria **disease surveillance** and response on routine detection, recording, reporting and analysis of malaria related data across all epidemiological strata														
SDM	3.1.1.1	Institutionalize routine HF malaria surveillance and response across all epi risk strata														
		Institutionalization of monthly health facility-based malaria surveillance and response across all epidemiological strata														
		Conduct monthly health facility-based malaria surveillance and response across all epidemiological strata														
		Conduct quarterly supervisory visits to region/council/HFs focusing on timely recording and reporting malaria cases and death for decision making			X	X	X	X	X	X	X	X	X	X		
		Conduct meetings to review malaria indicators (reporting, analysis and use).			X		X				X					
		Develop and disseminate malaria annual bulletins				X				X				X		
		Conduct semiannual Malaria surveillance assessment meeting with regional and council malaria focal person			X				X				X			
		Institutionalization of monthly malaria surveillance and response across all councils implementing malaria community case management			X	X										
		Integrate iCCM reported data into the composite management information system (CMIS).			X	X										
		Capacity building at council level on reporting, analysis and use of community generated malaria information for council planning and decision making in ICCM Implementing Councils							X	X						
		Strengthen epidemic preparedness & MEEDS and emergency situation in low transmission areas														
		Scale up implementation of MEEDS to all eligible councils in low strata			X	X										
		Develop and digitize epidemic investigation tool to enable generation of epidemic alerts investigated				X			X							
		Capacitate councils on malaria epidemics detection, investigation and containment at Council and health facility level in epidemic prone areas.			X	X							X	X		
		MCM deployed as principal intervention for epidemic containment				X				X				X		
		Ensure malaria case management services are maintained during natural disasters, or other humanitarian emergencies				X				X				X		
		Emergency VC measures to preempt or mitigate epidemic events				X				X				X		
SDM	3.1.1.3	Strengthening malaria Case Based Surveillance and response to support malaria elimination in very low transmission risk councils														
		Revisit the current CBS design and related protocol					X									

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		Scale up CBS implementation in new councils within very low risk strata						X	X							
		Conduct focus investigation in councils implementing case-based surveillance			X	X			X	X			X	X		
		Conduct a spot check and data validation visits to councils implementing malaria case-based surveillance		X		X		X		X		X		X		
		Conduct index local case follow up and re-active case detection to detect other asymptomatic cases at household level to interrupt transmission		x	x	x	x	x	x	x	x	x	x	x		
		Conduct primaquine distribution to council implementing malaria case-based surveillance			x				x				x			
		Conduct annual CBS implementation evaluation meeting to address CBS implementation gaps				x				x				x		
		Implement reactive focal responses to identified foci to interrupt local residual malaria transmission				x								x		
		Conduct reactive focal IRS as a surveillance targeted response to interrupt local residual malaria transmission				x								x		
SDM	3.1.1.4	Implement malaria Urban Surveillance and response to support elimination interventions in urban councils														
		Revise and update Urban Malaria surveillance Protocol						x								
		Scale up urban malaria surveillance implementation in new municipalities					x	x								
		Conduct focus mapping and investigation to identify potential risk factors to trigger response			x	x	x	x	x	x	x	x	x	x		
		Capacitating the municipal councils' teams to identify and investigate hotspots or high risk population and to address appropriate response			x	x							x	x		
SI	3.1.2	Enhance malaria **programmatic surveillance** and response for improved performance														
SDM	3.1.2.1	Implement routine Therapeutic Efficacy Studies (TES) of drug of choice and alternative antimalarial drugs as well as other drugs that will be adopted by MoH for the treatment of uncomplicated malaria.		**x**				**x**				**x**				
		Conduct routine Therapeutic Efficacy Studies (TES) of drug of choice and alternative antimalarial drugs as well as other drugs that will be adopted by MoH for the treatment of uncomplicated malaria.														
		Conduct special Therapeutic Efficacy Studies (TES) in areas with potential AMDR signals.						x								
SDM	3.1.2.2	Strengthen malaria related molecular surveillance for programmatic monitoring of parasites and vector dynamics			**x**	**x**			**x**	**x**			**x**	**x**		
		Conduct malaria related molecular surveillance for programmatic monitoring of parasites and vector dynamics														
SDM	3.1.2.3	Document and coordinate response to mitigate APR				**x**				**x**				**x**		
		Coordinate and document response to mitigate APR														
SDM	3.1.2.4	Conduct longitudinal monitoring of efficacy and effectiveness of insecticides				**x**				**x**				**x**		
		Conduct longitudinal monitoring of efficacy and effectiveness of insecticides														
SI	3.1.3	Strengthen malaria **transmission surveillance** and response														
SDM	3.1.3.1	Conduct longitudinal vigilance of malaria parasitaemia in sentinel population: under five, school children and pregnant women														
		SMPS: preparation, implementation travel and staff costs, supervision, data management										**x**	**x**	**x**		
		SMPS Dissemination				**x**										
SDM	3.1.3.2	Strengthen and entomological monitoring to guide deployment of malaria vector control interventions.														
		Strengthening the existing malaria vector entomological surveillance sentinel sites														
		Conduct monitoring of trapping and collection of mosquito samples in 32 district sentinel sites				x	x		x	x	x		x	x		
		Trapping and collection of mosquito samples in 32 district sentinel sites					x		x							
		Support transportation of mosquito samples from the sentinel sites to reference laboratory				x	x	x	x	x	x	x	x	x		
		Procurement of Entomological Equipment				x		x		x		x		x		
		Perform molecular analysis for malaria vector species collected from 32 sentinel sites for species identification and sporozoites detection using PCR and ELISA				x		x		x		x		x		
		Increase the number of actively functional IRM sentinel sites				x	x		x	x	x		x	x		

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		Conduct post-market follow up of ITNs in order to determine insecticidal bio-efficacy and chemical contents (bioavailability) of the PBO nets and new generation nets.					x			X				X		
SDM	3.1.3.3	Operationalization of a climate informed Malaria Epidemic Early Warning and Response System to detect early changes in climate variables that may increase malaria transmission				X										
		Establish threshold values and alert triggers for malaria risk linked to climate variability.														
		Establish automated early warning alerts when climate thresholds linked to malaria risk are exceeded.					X	X	X							
		Train malaria program staff and surveillance officers on interpretation of climate data and early warning signals.									X					
		Implement a preparedness and response plan to climate changes alerts									X	X	X	X		
SA	3.2	**Institutionalize the continuum of monitoring and evaluation process during the implementation of malaria strategic plan**														
SI	3.2.1	Strengthen the availability and quality of routine malaria – related data at service delivery points														
SDM	3.2.1.1	Implement quality improvement of malaria services provision				X	X	X	X	X	X	X	X	X		
		Conduct MSDQI supportive supervision to health facilities to improve the quality-of-service provision														
		Conduct data quality Assessment (DQA) to all health facilities across all epidemiological strata		X	X	X	X	X	X	X	X	X	X	X		
		Conduct annual targeted Region/Zonal data review meetings														
SDM	3.2.1.2	Strengthen Collection of the vector control and preventive therapies programmatic monitoring data (including ITNs, IRS, LSM, IPTsc, IPTp) to inform decision making						X								
		Establish and digitize a standardized tool to support the collection of vector control and preventive therapies intervention to ensure data reliability and accessibility														
SI	3.2.2	Evaluation of malaria strategic plan implementation														
SDM	3.2.2.1	Conduct national representative programmatic surveys														
		The activity is carried out within the SI 3.1.3. (SDM 3.1.3.1)														
SDM	3.2.2.2	Conduct Mid-term and End term Evaluation of Malaria Programs												X		
SA	3.3	Strengthen a learning process based on comprehensive malaria strategic information system and operational research to generate knowledge for evidence-based planning and decision making at all levels														
SI	3.3.1	Strengthening the systematic analysis and use of quality data to inform evidence-based decision-makin														
SDM	3.3.1.1	Conduct a comprehensive periodic stratification of malaria transmission risk in all councils for improved targeting of interventions									X					
SDM	3.3.1.2	Strengthen malaria data management capacity and the national repository arrangements to enable evidence-based decision making at all levels				X				X				X		
SDM	3.3.1.3	Implement an integrated malaria modelling initiative within the CMIS that routinely consolidates MIS, SMPS, HMIS and global datasets to generate calibrated forecasts and intervention-impact estimates that inform targeted planning.						X								
		Establish a national malaria-modelling unit within the CMIS structure.														
		Develop and maintain a framework for integrating modelling outputs into routine surveillance and program planning.				X								X		
		Train malaria program staff, surveillance officers, and data scientists on modelling and interpretation of results							X							
SI	3.3.2	Develop and implement prioritized operational research agenda to generate context-specific evidence that informs policy and improves service delivery effectiveness														
SDM	3.3.2.1	Create conducive environment to facilitate evidence-based decision making at all levels.														
		Promote continuous collaboration with research, academia institutions and improved research capacities at subnational levels														
		Implement comprehensive operational and implementation research framework to optimize MCM		X					X							
		Implement comprehensive operational and implementation research framework to optimize malaria vector control			X	X			X	X			X	X		

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SO	4	Ensure timely availability of safe, efficacious and quality malaria commodities and supplies at the service delivery points.														
SA	4.1	Promote partnership to ensure malaria commodities are **available** in all service delivery points in the right quantity and when needed														
SI	4.1.1	Facilitate timely availability of malaria commodities and supplies at the service delivery points														
SDM	4.1.1.1	Carry out quantification, gap analysis, supply planning and pipeline review for all malaria commodities and supplies				x				x				x		
		Conduct quantification of malaria commodities for prevention and Case Management														
		Conduct quantification review of malaria commodities for prevention and Case Management		x				x				x				x
		Prepare gap analysis for quantification/quantification review, and dissemination of findings to relevant stakeholders	x					x		x		x		x		x
		Conduct quarterly supply plan review and PIPELINE update to track trends in overall consumption and adjust national-level procurements as needed by identifying overstocks, high risk of product expiry and then initiate action to prevent a recurrence.	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	4.1.1.2	Manage procurement of malaria commodities and supplies by promoting conducive partnership	x	x	x	x	x	x	x	x	x	x	x	x	x	x
		Timely initiate procurement by placing orders in specific platforms														
		Commodities procurement														
	4.1.1.3	Enhance supply chain of malaria commodities from point of entry/suppliers to service delivery points.	x	x	x	x	x	x	x	x	x	x	x	x	x	x
		Facilitate availability of import permits and VAT exemption from relevant authorities during malaria commodities														
		Monitor and review performance to ensure timely clearing and avoid port extra charges	x	x	x	x	x	x	x	x	x	x	x	x	x	x
		Reconciliation of malaria commodities procured from supplier and the in-country receiving point	x	x	x	x	x	x	x	x	x	x	x	x	x	x
		Reconciliation of distributed commodities to estimate PSM costs	x	x	x	x	x	x	x	x	x	x	x	x	x	x
		Monitoring operationalization of ordering control measures for Malaria commodities in eLMIS through system performance and data review and analysis	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	4.1.1.4	Enhance the management, use and reporting of malaria commodities within service delivery points				x				x				x		
		Conduct targeted audits of existing malaria commodities supply chains to identify opportunities for improvement and providing guidance regarding inventory management.														
		Closely follow up on the performance of updated validation controls in eLMIS to identify the supply chain gap and update control measures according to the needs arise, based on the bimonthly analysis of the performance and physical verification follow up.	x		x		x		x		x		x		x	
		Assessment of stock availability at MSD and HF levels by using the systems in place	x	x	x	x	x	x	x	x	x	x	x	x	x	x
SA	4.2	Promote partnership with regulatory authorities to ensure all malaria commodities used at service delivery points are **quality assured and safe**														
SI	4.2.1	Facilitate quality assurance of malaria commodities														
SDM	4.2.1.1	To strengthen quality check of malaria commodities for prevention and case management for public and private sector		x	x	x	x	x	x	x	x	x	x	x	x	x
		Collaborate with TMDA, TBS and TPRI to ensure malaria commodities batches are tested for quality, safety and efficacy before distribution.														
		Facilitate scientific evidence-based transition of health commodities for malaria prevention and case management (ACTs to ASAQ)		x	x	x	x	x	x	x	x	x	x	x	x	x
	4.2.1.2	Post Market surveillance (PMS) for antimalarial medicines and malaria testing devices		x	x	x	x	x	x	x	x	x	x	x	x	x
		Follow up, review shared report of the quarterly Post Market Surveillance and advise on the finding														
	4.2.1.3	Post Market surveillance for vector control commodities														
		Facilitate authorities to conduct ITNs durability monitoring, technical testing of pesticides and insecticide efficacy														
SI	4.2.2	Facilitate assessment of safety for malaria commodities														

SO/SA/SI/SDM		SO, SA, SI, SDM and Activity description	Year													
			2026				2027				2028				2029	2030
			Quarter													
			1	2	3	4	1	2	3	4	1	2	3	4		
SDM	4.2.2.1	Facilitate the relevant regulatory authorities to conduct passive pharmacovigilance for malaria commodities.		x	x	x	x	x	x	x	x	x	x	x	x	x
		Facilitate TMDA to conduct passive pharmacovigilance for malaria commodities.														
		Conduct field visits to assess ADR reporting and raise awareness on ADR		x		x		x		x		x		x		x
		Review received antimalarial reported ADR data		x	x	x	x	x	x	x	x	x	x	x	x	x
SO	5	**To strengthen an enabling environment that empowers individuals and communities at risk of malaria to constituently protect themselves and their families and seek timely and appropriate malaria care**														
SA	5.1	Promote social and behavior change among communities and strengthen advocacy efforts among leaders through effective risk reduction communication														
SI	5.1.1	Strengthen knowledge, attitude and practices among community members on positive uptake of malaria interventions														
SDM	5.1.1.1	Implement Mass media campaigns to key target audiences		X			X			X						
		Review, develop and disseminate New SBCA & CE guide														
		Message development and pretesting							X							
		Conduct co-design workshop for multimedia contents production and SBC material development					X	X								
		Printing of posters and distribution/dissemination						X	X						X	
		Airing radio, TV spots, Social Media placement and dissemination						X	X			X		X	X	X
		Wall drawing/rural min- billboard placement								x					x	
		Engage Influencers media houses and journalists to support malaria mass media campaign						X	X			X	X		X	X
		Conduct regular update of NMCP Website and social media accounts	X	X	X	X	X	X	X	X	X	X	X	X	X	X
		Conduct media monitoring and tracking							X					X	X	X
		Conduct malaria behaviour and social driver assessment to inform SBC&CE						X								
	5.1.1.2	Strengthen the implementation of malaria SBC programs through the school platforms			X	X		X	X			X		X	X	X
		Review, develop print and disseminate student-friendly malaria SBC materials (story comic books, visual aids, posters).														
		Utilize school health programs platforms to lead malaria awareness activities				X			X				X		X	X
		Orient and equip school teachers with malaria messages							X				X		X	X
	5.1.1.3	Integrate Artificial Intelligence (AI) tools into SBC activities								X						
		Develop the AI integration guideline and SoP for AI use in SBC interventions														
		Conduct capacity building to SBC team (National, Regional and Council level) on practical use of AI									X		X			
		Conduct AI- assisted SBC materials development, production and dissemination									X			X	X	
		Pilot AI-Assisted Message Development, materials production and dissemination							X							
		Conduct the integration of AI into existing SBC workflows and scale up												X	X	X
SIi	5.1.2	Enhance malaria advocacy to political leaders and decision makers to strengthen commitment														
SDM	5.1.2.1	Enhance/increase engagement with political leaders and key stakeholders at all levels					X									
		Review, update, develop and print malaria advocacy guide														
		Prepare high level advocacy materials and dissemination						X								
		Conduct high level advocacy meeting with leaders, Member of Parliaments (TAPAMA, Health and AIDS Parliamentary Committee)	X				X		X				X		X	X
		To conduct the advocacy meeting with Regional and Council level leaders		X							X			X	X	X
		Commemorate word malaria day		X				X				X			X	X
		Attend different exhibitions			X				X				X		X	X
	5.1.2.2	Leverage SBC activities through the End Malaria Council of Tanzania (EMCT)				X										
		Develop joint annual SBC and Advocacy plan with the EMCT														

SO/SA/SI/SDM		SO, SA, SI, SDM and Activity description	Year													
			2026				2027				2028				2029	2030
			Quarter													
			1	2	3	4	1	2	3	4	1	2	3	4		
		Harmonize key SBC malaria messages with EMCT				X									X	
		Conduct capacity building to EMCT members on the key malaria SBC messages					X									
		Utilize EMCT platforms to deliver malaria Messages		X				X				X				
		Conduct EMCT advocacy trip to high burden regions								X					X	
SI	5.1.3	Strengthen the quality, coverage, and effectiveness of interpersonal communication (IPC) to increase uptake of key malaria interventions														
SDM	5.1.3.1	Strengthens the capacity of healthcare workers to effectively provide accurate and relevant malaria messages to clients					X									
		Develop provider behaviour change IPC job Aid														
		Printing and dissemination of provider behaviour change (PBC) IPC job Aid									X					
		Integrate provider behaviour change job Aid into Digital Artificial Intelligence (AI)							X							
		Conduct capacity building of Health Care Providers on IPC and provider behaver change											X		X	
		Support healthcare workers to conduct routine health education sessions for clients in waiting areas at health facilities								X			X		X	X
		Conduct supportive supervision and on job mentorship								X			X		X	X
SA	5.2	**Promote community engagement and active participation in malaria control and elimination interventions within their respective settings**														
SI	5.2.1	Enhance malaria knowledge and practices among malaria-vulnerable groups to raise awareness of their risks and enable effective uptake of preventive and curative services available.														
SDM	5.2.1.1	Develop and implement SBCA & CE outreach programs for disadvantaged, vulnerable groups, and the marginalized population in all malaria transmission strata				X		X								
		Identify and map vulnerable and high-risk group and marginalized population across all malaria transmission strata														
		Review, update and develop and disseminate message and materials for disadvantaged vulnerable and high-risk groups and marginalized population								X						
		implement targeted mid media outreach activities				X			X				X		X	X
		Capacitate and engage CHWs to deliver messages vulnerable and high-risk group			X				X					X	X	X
	5.2.1.2	Promote integration of gender inclusive and responsive approaches in the implementation of malaria interventions					X		X							
		Develop and disseminate guidelines on integrating gender considerations in malaria interventions.														
		Develop and disseminate gender sensitive and responsive malaria SBC messages and materials						X								
		Advocate and capacitate for Gender-Responsive malaria Service Delivery								X				X	X	X
		Integrating gender-sensitive indicators into malaria program monitoring systems.													X	X
		Document best practices and lessons learned on gender integration in malaria interventions.														
		Implement targeted community sensitization and engagement for ICCM, CBS and malaria chemoprevention				X			X				X		X	X
SI	5.2.2	Strengthen community engagement and participation to promote and implement malaria control and elimination initiatives.														
SDM	5.2.2.1	Strengthen the capacity of local authorities including village and /Mtaa leaders to effectively conduct malaria community sensitization and engagement					X				X					
		Develop and Disseminate materials, job aids and talking points to support Village leaders during community sensitization meetings.														
		Orient and build capacity of local authorities on malaria messages, community mobilization and advocacy skills and community engagement approaches							X				X		X	X
		Facilitate malaria community dialogue sessions and village meetings								X			X		X	X
		Conduct supportive supervision visits to mentor local leaders in implementing community sensitization activities and engagement activities								X				X	X	X

SO/SA/SI/SDM		SO, SA, SI, SDM and Activity description	Year													
			2026				2027				2028				2029	2030
			Quarter													
			1	2	3	4	1	2	3	4	1	2	3	4		
		Establish mechanisms for local authorities to report community sensitization activities conducted at village/Mtaa level								X				X		
		Document community engagement outcomes and best practices.									X			X	X	X
		Implement community sensitization and engagement for ITN distribution mechanism (TMC, SNP, Health Facility)			X				X				X		X	X
	5.2.2.2	Support/facilitate the adoption of malaria community mobilization and engagement activities through CHWs/CORPs						X								
		Update and disseminate Malaria community Sensitization and engagement tool														
		Support and facilitate CHWs/CORPs to conduct community sensitization and engagement sessions							X				X		X	X
	5.2.2.3	Engage CSOs, religious/Faith leaders, and faith-based organizations in malaria community sensitization and engagement					X								X	
		Identify and map CSOs, religious institutions, and faith-based organizations (FBOs) involved in community health activities														
		Select and engage CSOs					X								X	
		conduct capacity building to CSOs						X							X	
		Support and facilitate and engage CSOs to conduct community outreach sessions, dialogues, and sensitization meetings on malaria						X			X				X	
		conduct capacity building to religious/faith leaders				X				X					X	
		develop and disseminate religious leaders sensitization materials such as sermon guides				X				X					X	
		Facilitate and support religious leaders to disseminate malaria messages during sermons and religious gatherings			X					X				X	X	X
		Conduct monitoring, supportive supervision and documentation of SCOs/FBOs and religious leaders community activities						X				X			X	X
SI	5.2.3	Strengthen verification and quality control mechanisms of SBCA&CE for malaria interventions and activities across all levels of implementation														
SDM		Monitor SBCA&CE activities to track progress of implementation		X			X				X				X	X
		Review and Update SBCA & CE verification tool and reporting template														
	5.2.3.1	Conduct technical verification of SBCA&CE activities at Regional and District Level and document			X		X			X	X			X	X	X
		Review and validate SBCA&CE implementation reports from the partners					X		X				X		X	X
		Analyses the SBCA&CE reports to track behavioral outcomes related to malaria interventions							X				X		X	X
		Provide the feedbacks to regional and Council implementing partners to improve quality of SBCA&CE activities							X				X		X	X
		Implement, Coordinate and oversee the implementation and scale up of malaria Community Led Monitoring (CLM) in high and moderate malaria transmission					X									
		Review and update Malaria CLM framework, technical guidelines, Training Manuals, and data collection tools.														
	5.2.3.2	Scale-up the CLM in high and moderate transmission districts						X			X				X	
		Train community representative, Civil society Organizations and CHWs/CORPs on CLM.							X			X			X	
		Conduct CLM Supportive Supervision and mentorship							X				X		X	
		Conduct technical meeting at Council, Regional and National Level to discuss the CLM findings								X			X		X	
SO	6	**To strengthen efficient and effective implementation of malaria strategies through accountable leadership and partnership**														
SA	6.1	**Provide effective leadership to ensure program's objectives are met**														
SI	6.1.1	**Strengthen governance, advocacy, and coordination**														
SDM	6.1.1.1	Advocate for inclusion of malaria elimination objective into the government financial regulations and guidelines		x		x										
		Conduct meetings with DPP and MOF														
		Conduct annual review meeting for implementation of malaria control activities in workplaces and surrounding communities				x				x				x	x	x

SO/SA/SI/SDM		SO, SA, SI, SDM and Activity description	Year													
			2026				2027				2028				2029	2030
			Quarter													
			1	2	3	4	1	2	3	4	1	2	3	4		
	6.1.1.2	Raise the profile of malaria amongst policy and decision makers at all levels so that national, regional and district plans include appropriate interventions and sufficient budget to implement the malaria strategic plan				x	x	x	x							
		Dissemination meetings of New Malaria Strategic Plan 2026 - 2026														
		Conduct advocacy meeting with policy and decision makers for seeking political commitment to tangible action plans and budgets (Parliamentarians (Social Service Committee and special Committee for Malaria), DED and RAS			x	x										
	6.1.1.3	Improve governance structures at all levels to strengthen coordination, communication, and close follow up of all malaria related interventions	x	x	x	x	x	x	x	x	x	x	x	x	x	x
		Conducting quarterly TWG meetings and Annual Malaria Meetings														
	6.1.1.4	Enhance well-structured, coordinated and harmonized supervision and verification system involving implementing entities at various levels.	x	x	x	x	x	x	x	x	x	x	x	x	x	x
		Conducting oversight meeting and general supervision for monitoring implementation of malaria interventions														
	6.1.1.5	Strengthen the malaria component of annual comprehensive council health plans			x	x			x	x				x	x	x
		Participation on CCHP planning sessions and advocate for malaria interventions														
		Conduct oversight meeting to review CCHPS.			x				x				x		x	x
SI	6.1.2	**Enhance appropriate strategies and technical capacity for implementation of malaria interventions**														
SDM	6.1.2.1	Develop and sustain appropriate evidence-based malaria control and elimination strategies that will guide stakeholders and implementers towards the achievement of the strategic goal	x				x	x								
		Develop strategic plan and review technical documents.														
	6.1.2.2	Strengthen NMCP and PORALG capacity to successful implement planned malaria interventions at all level	x	x	x	x	x	x	x	x	x	x	x	x	x	x
		Training of New malaria focal persons in all new interventions.														
	6.1.2.3	Strengthen human resources capacity for effective strategic plan implementation at national and LGA levels								x						
		Recruit and sustain qualified staff at Programme and LGA levels														
SA	6.2	**Promote harmonized partnership** for malaria control and elimination														
SI	6.2.1	**Institutionalize multi-sectoral collaboration for malaria control and elimination**														
SDM	6.2.1.1	Advocate for implementation of malaria Smart actions within multisectoral engagement framework				x				x				x	x	x
		Support sector-led implementation of priority multisectoral interventions														
	6.2.1.2	Promote Public Private Partnership								x				x	x	x
		Conduct stakeholder engagement meetings and sensitization workshops														
	6.2.1.3	Sustain the function of End Malaria Council	x	x	x	x	x	x	x	x	x	x	x	x	x	x
		Support End Malaria Council quarterly meeting and facilitate functionality of End Malaria Council														
SI	6.2.2	**Enhance implementation of effective cross-border initiatives**														
SDM	6.2.2.1	Operationalize GLMI/EAC and SADC strategic frameworks to strengthen cross-border collaboration for malaria control.				x				x				x	x	x
		Implement cross-border malaria control activities in Tanzania in line with regional frameworks, including surveillance and response, harmonized intervention packages, and data and resource sharing with neighboring countries.														
SA	6.3															
SI	6.3.1	**Strengthen the resource mobilization mechanisms for sustainable implementation of malaria strategies**														
SDM	6.3.1.1	Develop comprehensive business and operational plans for malaria control interventions					x	x	x	x	x	x	x	x	x	x
		Advocate the business plan to development partners														
	6.3.1.2	Advocate for increment of domestic resources dedicated to malaria control and elimination				x								x		
		Conduct advocacy fundraising events for malaria resource mobilization														
	6.3.1.3	Attract additional resources from global financing mechanisms														
		Prepare and submit funding proposals to global financing institutions														

Annex 7: NMSP Budget

Budget breakdown by Strategic Approach (Million TZS)

Strategic Approach (SA) Costing in Tanzanian Million Shillings									
SA	**STA #**	**SO/SA/SI/SDM**	**STA**	**TOTAL**	**2026**	**2027**	**2028**	**2029**	**2030**
SA	**1.1**	Accelerate the reduction of malaria burden in high and moderate transmission risk areas	**IMVC**	41,238 M	2,098 M	10,503 M	8,487 M	10,042 M	10,107 M
SA	**1.2**	Promote malaria elimination efforts by protecting the population at risk of infection in areas with extremely low malaria endemicity	**IMVC**	10,797 M	480 M	3,188 M	2,052 M	2,138 M	2,938 M
SA	**1.3**	Promote malaria prevention efforts by protecting the population at risk of infection in urban areas	**IMVC**	4,785 M	0 M	1,445 M	1,212 M	1,022 M	1,105 M
SA	**1.4**	Establish cross cutting-malaria prevention initiatives across all malaria strata	**IMVC**	2,264 M	0 M	535 M	518 M	559 M	652 M
SA	**2.1**	Provide universal access to appropriate, quality and timely malaria diagnosis and treatment to all eligible people at health facilities.	**MCM**	15,415 M	3,808 M	5,083 M	2,410 M	2,046 M	1,088 M
SA	**2.2**	Provide universal access to appropriate, quality and timely malaria diagnosis and treatment to all eligible people beyond health facilities.	**MCM**	6,872 M	1,529 M	1,413 M	1,230 M	1,469 M	2,220 M
SA	**3.1**	Establish a comprehensive malaria surveillance and response system to inform stakeholders and respond to the emerging needs through an evidence-based platform	**SMEL**	51,448 M	9,700 M	11,116 M	10,645 M	7,000 M	12,988 M
SA	**3.2**	Institutionalize the continuum of monitoring and evaluation process during the implementation of malaria strategic plan	**SMEL**	13,150 M	2,525 M	2,525 M	2,825 M	2,450 M	2,825 M
SA	**3.3**	Strengthen a learning process based on comprehensive malaria strategic information system and operational research to generate knowledge for evidence-based planning and decision making at all levels	**SMEL**	10,013 M	2,075 M	1,988 M	2,050 M	1,938 M	1,963 M
SA	**4.1**	Promote partnership to ensure malaria commodities are available in all service delivery points in the right quantity and when needed	**C&LM**	1,343,900 M	233,808 M	301,265 M	226,896 M	264,940 M	316,992 M
SA	**4.2**	Promote partnership with regulatory authorities to ensure all malaria commodities used at service delivery points are quality assured and safe	**C&LM**	8,220 M	0 M	4,110 M	4,110 M	0 M	0 M
SA	**5.1**	Promote social and behavior change among communities and strengthen advocacy efforts among leaders through effective risk reduction communication	**SBCA**	31,455 M	5,588 M	7,990 M	6,382 M	6,750 M	4,745 M
SA	**5.2**	Promote community engagement and active participation in malaria control and elimination interventions within their respective settings.	**SBCA**	26,870 M	4,724 M	6,143 M	6,040 M	5,084 M	4,880 M
SA	**6.1**	Provide effective leadership to ensure program's objectives are met	**PMGT**	17,176 M	3,561 M	3,963 M	2,981 M	2,981 M	3,691 M
SA	**6.2**	Promote harmonized partnership for malaria control and elimination	**PMGT**	6,880 M	1,400 M	2,020 M	1,020 M	1,620 M	820 M
SA	**6.3**	Establish a sustainable environment for resource mobilization	**PMGT**	2,800 M	600 M	1,200 M	200 M	800 M	0 M
Total				**1,593,282 M**	**271,895 M**	**364,487 M**	**279,050 M**	**310,838 M**	**367,012 M**

Budget breakdown by Intervention (Million TZS)

Strategic Objective (SO), Strategic Approach (SA) and Strategic Interventions (SI) Costing in Tanzanian Million Shillings									
SA	STA #	SO/SA/SI/SDM	STA	Total	2026	2027	2028	2029	2030
SO	1	**Reduce malaria parasite transmission by accelerating the implementation of targeted, recommended, evidence-based, integrated malaria preventive interventions.**	IMVC	59,083 M	2,578 M	15,672 M	12,269 M	13,762 M	14,802 M
SA	1.1	Accelerate the reduction of malaria burden in high and moderate transmission risk areas	IMVC	41,238 M	2,098 M	10,503 M	8,487 M	10,042 M	10,107 M
SI	1.1.1	Provide universal ITN coverage through mass and continuous distribution to ensure optimal population ITN access (90%) in high and moderate malaria transmission risk strata	IMVC	21,268 M	135 M	5,520 M	4,342 M	5,993 M	5,278 M
SI	1.1.2	Targeted IRS to reduce malaria burden in prioritized areas of extremely high transmission and high population vulnerability	IMVC	2,814 M	0 M	675 M	539 M	893 M	707 M
SI	1.1.3	Support targeted Larval Source Management (LSM) as part of integrated vector management in suitable epidemiological and operational settings	IMVC	4,350 M	0 M	1,160 M	1,000 M	550 M	1,640 M
SI	1.1.4	Provide appropriate and effective chemo-preventive services to reduce the risk of malaria and its complications among populations biologically and socioeconomic vulnerable to malaria.	IMVC	12,805 M	1,963 M	3,148 M	2,606 M	2,606 M	2,481 M
SA	1.2	Promote malaria elimination efforts by protecting the population at risk of infection in areas with extremely low malaria endemicity	IMVC	10,797 M	480 M	3,188 M	2,052 M	2,138 M	2,938 M
SI	1.2.1	Provide protection to selected vulnerable population living in low and very low transmission risk areas through ITNs targeted distribution	IMVC	2,868 M	0 M	411 M	361 M	653 M	1,443 M
SI	1.2.2	Implement IRS in very low malaria transmission strata to interrupt transmission and mitigate epidemics	IMVC	2,232 M	0 M	491 M	431 M	650 M	660 M
SI	1.2.3	Scale up targeted quality LSM interventions to address (interrupt or mitigate) residual malaria transmission in low and very low endemicity councils	IMVC	3,010 M	0 M	1,160 M	900 M	475 M	475 M
SI	1.2.4	Provide appropriate and effective chemo-preventive services to interrupt residual local transmission in very low endemic areas.	IMVC	2,686 M	480 M	1,125 M	360 M	360 M	360 M
SA	1.3	Promote malaria prevention efforts by protecting the population at risk of infection in urban areas	IMVC	4,785 M	0 M	1,445 M	1,212 M	1,022 M	1,105 M
SI	1.3.1	Scale up LSM in urban settings to address concentrated and identifiable mosquito breeding sites.	IMVC	2,910 M	0 M	1,060 M	900 M	475 M	475 M
SI	1.3.2	Provide protection to selected vulnerable population living in urban setting through ITNs targeted distribution	IMVC	1,875 M	0 M	385 M	312 M	547 M	630 M
SA	1.4	Establish cross cutting-malaria prevention initiatives across all malaria strata	IMVC	2,264 M	0 M	535 M	518 M	559 M	652 M
SI	1.4.1	Institutionalize the Insecticide Resistance Management Plan (IRMP)	IMVC	1,556 M	0 M	405 M	371 M	390 M	390 M
SI	1.4.2	Support the adoption and documentation of novel vector control tools and approaches	IMVC	708 M	0 M	130 M	147 M	169 M	262 M
SO	2	**To prevent the occurrence of mortality related to malaria infection through universal access to appropriate diagnosis and treatment**	MCM	22,287 M	5,337 M	6,496 M	3,631 M	3,515 M	3,308 M
SA	2.1	Provide universal access to appropriate, quality and timely malaria diagnosis and treatment to all eligible people at health facilities.	MCM	13,155 M	3,088 M	4,523 M	2,410 M	2,046 M	1,088 M
SI	2.1.1	Strengthen malaria case management in Public Health Facilities	MCM	3,862 M	856 M	1,656 M	438 M	558 M	354 M
SI	2.1.2	Strengthen malaria case management in Private Health Facilities	MCM	3,893 M	632 M	1,607 M	632 M	888 M	134 M
SI	2.1.3	Provide high-quality severe malaria management services by skilled providers in public and private health facility settings	MCM	5,400 M	1,600 M	1,260 M	1,340 M	600 M	600 M

Strategic Objective (SO), Strategic Approach (SA) and Strategic Interventions (SI) Costing in Tanzanian Million Shillings									
SA	STA #	SO/SA/SI/SDM	STA	Total	2026	2027	2028	2029	2030
SI	2.1.4	Strengthen malaria diagnosis and treatment for individuals with biological vulnerability	MCM	2,260 M	720 M	560 M	465 M	50 M	465 M
SI	2.1.5	Adopt and scale up innovative, evidence-based malaria diagnosis and treatment tools and approaches	MCM	1,730 M	700 M	160 M	410 M	50 M	410 M
SA	2.2	Provide universal access to appropriate, quality and timely malaria diagnosis and treatment to all eligible people beyond health facilities.	MCM	6,872 M	1,529 M	1,413 M	756 M	1,419 M	1,755 M
SI	2.2.1	Provide high-standard, accessible, affordable, equitable, and quality-assured malaria testing services to communities with limited accessibility to operational health facilities	MCM	6,872 M	1,529 M	1,413 M	756 M	1,419 M	1,755 M
SA	2.3	Promote cross cutting initiatives to improve malaria case management interventions	MCM	2,260 M	720 M	560 M	465 M	50 M	465 M
SI	2.3.1	Introduce focal and targeted case management interventions to respond to malaria surveillance findings	MCM	530 M	20 M	400 M	55 M	0 M	55 M
SO	3	**To provide timely and reliable information on malaria and its control needed to take appropriate actions in different transmission risk and ensure resources are used in the most cost-effective manner**	SMEL	74,610 M	14,300 M	15,628 M	15,520 M	11,387 M	17,775 M
SA	3.1	Establish a comprehensive malaria surveillance and response system to inform stakeholders and respond to the emerging needs through an evidence-based platform	SMEL	51,448 M	9,700 M	11,116 M	10,645 M	7,000 M	12,988 M
SI	3.1.1	Strengthen malaria **disease surveillance** and response on routine detection, recording, reporting and analysis of malaria related data across all epidemiological strata	SMEL	29,175 M	6,863 M	6,688 M	5,150 M	3,400 M	7,075 M
SI	3.1.2	Enhance malaria **programmatic surveillance** and response for improved performance	SMEL	14,125 M	2,375 M	3,500 M	2,375 M	2,375 M	3,500 M
SI	3.1.3	Strengthen malaria **transmission surveillance** and response	SMEL	8,148 M	463 M	928 M	3,120 M	1,225 M	2,413 M
SA	3.2	Institutionalize the continuum of monitoring and evaluation process during the implementation of malaria strategic plan	SMEL	13,150 M	2,525 M	2,525 M	2,825 M	2,450 M	2,825 M
SI	3.2.1	Strengthen the availability and quality of routine malaria – related data at service delivery points	SMEL	12,400 M	2,525 M	2,525 M	2,450 M	2,450 M	2,450 M
SI	3.2.2	Evaluation of malaria strategic plan implementation	SMEL	750 M	0 M	0 M	375 M	0 M	375 M
SA	3.3	Strengthen a learning process based on comprehensive malaria strategic information system and operational research to generate knowledge for evidence-based planning and decision making at all levels	SMEL	10,013 M	2,075 M	1,988 M	2,050 M	1,938 M	1,963 M
SI	3.3.1	Strengthening the systematic analysis and use of quality data to inform evidence-based decision-making	SMEL	4,963 M	1,050 M	963 M	1,050 M	938 M	963 M
SI	3.3.2	Develop and implement prioritized operational research agenda to generate context-specific evidence that informs policy and improves service delivery effectiveness	SMEL	5,050 M	1,025 M	1,025 M	1,000 M	1,000 M	1,000 M
SO	4	**Ensure timely availability of safe, efficacious and quality malaria commodities and supplies at the service delivery points.**	C&LM	1,352,120 M	233,808 M	305,375 M	231,006 M	264,940 M	316,992 M
SA	4.1	Promote partnership to ensure malaria commodities are available in all service delivery points in the right quantity and when needed	C&LM	1,343,900 M	233,808 M	301,265 M	226,896 M	264,940 M	316,992 M
SI	4.1.1	Facilitate timely availability of malaria commodities and supplies at the service delivery points	C&LM	1,343,900 M	233,808 M	301,265 M	226,896 M	264,940 M	316,992 M
SA	4.2	Promote partnership with regulatory authorities to ensure all malaria commodities used at service delivery points are quality assured and safe	C&LM	8,220 M	0 M	4,110 M	4,110 M	0 M	0 M
SI	4.2.1	Facilitate quality assurance of malaria commodities	C&LM	8,220 M	0 M	4,110 M	4,110 M	0 M	0 M
SI	4.2.2	Facilitate assessment of safety for malaria commodities	C&LM	0 M	0 M	0 M	0 M	0 M	0 M

Strategic Objective (SO), Strategic Approach (SA) and Strategic Interventions (SI) Costing in Tanzanian Million Shillings									
SA	STA #	SO/SA/SI/SDM	STA	Total	2026	2027	2028	2029	2030
SO	5	To strengthen an enabling environment that empowers individuals and communities at risk of malaria to constituently protect themselves and their families and seek timely and appropriate malaria care	SBCA&CE	58,325 M	10,312 M	14,133 M	12,422 M	11,834 M	9,625 M
SA	5.1	Promote social and behavior change among communities and strengthen advocacy efforts among leaders through effective risk reduction communication	SBCA&CE	31,455 M	5,588 M	7,990 M	6,382 M	6,750 M	4,745 M
SI	5.1.1	Strengthen knowledge, attitude and practices among community members on positive uptake of malaria interventions	SBCA&CE	19,900 M	3,236 M	5,445 M	3,768 M	4,465 M	2,986 M
SI	5.1.2	Enhance malaria advocacy to political leaders and decision makers to strengthen commitment, and increased malaria visibility	SBCA&CE	9,548 M	2,059 M	2,059 M	2,059 M	1,829 M	1,543 M
SI	5.1.3	Strengthen the quality, coverage, and effectiveness of interpersonal communication (IPC) to increase uptake of key malaria interventions	SBCA&CE	2,008 M	293 M	486 M	555 M	456 M	216 M
SA	5.2	Promote community engagement and active participation in malaria control and elimination interventions within their respective settings	SBCA&CE	26,870 M	4,724 M	6,143 M	6,040 M	5,084 M	4,880 M
SI	5.2.1	Enhance malaria knowledge and practices among malaria-vulnerable groups to raise awareness of their risks and enable effective uptake of preventive and curative services available.	SBCA&CE	7,247 M	1,170 M	1,709 M	1,709 M	1,320 M	1,339 M
SI	5.2.2	Strengthen community engagement and participation to promote and implement malaria control and elimination initiatives.	SBCA&CE	14,535 M	2,512 M	3,393 M	3,290 M	2,722 M	2,619 M
SI	5.2.3	Strengthen verification and quality control mechanisms of SBCA&CE for malaria interventions and activities across all levels of implementation	SBCA&CE	5,088 M	1,042 M	1,042 M	1,042 M	1,042 M	922 M
SO	6	To strengthen efficient and effective implementation of malaria strategies through accountable leadership and partnership	PMGT	26,856 M	5,561 M	7,183 M	4,201 M	5,401 M	4,511 M
SA	6.1	Provide effective leadership to ensure program's objectives are met	PMGT	17,176 M	3,561 M	3,963 M	2,981 M	2,981 M	3,691 M
SI	6.1.1	Strengthen governance, advocacy, and coordination	PMGT	11,802 M	2,454 M	2,346 M	2,334 M	2,334 M	2,334 M
SI	6.1.2	Enhance appropriate strategies and technical capacity for implementation of malaria interventions	PMGT	5,374 M	1,107 M	1,617 M	647 M	647 M	1,357 M
SA	6.2	Promote harmonized partnership for malaria control and elimination	PMGT	6,880 M	1,400 M	2,020 M	1,020 M	1,620 M	820 M
SI	6.2.1	Institutionalize multi-sectoral collaboration for malaria control and elimination	PMGT	2,830 M	550 M	570 M	570 M	570 M	570 M
SI	6.2.2	Enhance implementation of effective cross-border initiatives	PMGT	1,250 M	250 M	250 M	250 M	250 M	250 M
SA	6.3	Establish a sustainable environment for resource mobilization	PMGT	2,800 M	600 M	1,200 M	200 M	800 M	0 M
SI	6.3.1	Strengthen the resource mobilization mechanisms for sustainable implementation of malaria strategies	PMGT	2,800 M	600 M	1,200 M	200 M	800 M	0 M

Annex 8: Performance framework 2026 – 2030

		SO/SA/SI	Indicator	Definition	Risk	Baseline	Target		Source
						2025	2028	2030	
Goal	1	Reduce malaria prevalence rate in children under the age of five years by at least 90% from 2015 levels	Malaria parasite prevalence rate in children under the age of five years	**Numerator**: Children under the age of five tested positive for malaria parasites **Denominator**: Children under the age of five tested		5.7%	3.5%	1.4%	MIS/SMPS
						0.1%	0.0%	0.0%	
						0.4%	0.2%	0.1%	
						7.1%	3.5%	1.5%	
						11.3%	6.0%	3.0%	
	2	Reduce malaria mortality rates per 100,000 population by at least 90% compared with 2015	Malaria deaths reported in health care facilities	**Numerator**: Total number of malaria deaths **Denominator**: Risk population (x 100,000)		1.9	1.5	1.0	DHIS2
						0.3	0.1	0.0	
						1.0	0.6	0.3	
						2.3	1.5	1.0	
						3.1	2.0	1.5	
	3	Reduce malaria case incidence by at least 90% compared to 2015	Confirmed malaria cases reported in health care facilities	**Numerator**: Total number of malaria cases reported in HFs **Denominator**: Risk population (x 1,000)		43.3	29.2	15.0	DHIS2
						4.0	2.0	1.0	
						12.2	8.0	4.0	
						42.3	30.0	20.0	
						90.1	60.0	30.0	
	4	Increase the proportion of Councils with very low malaria transmission	Councils classified at very low risk of malaria	Number of councils by stratum		29%	38%	43%	Stratification
SO	1	Accelerate implementation of integrated, evidence-based vector control interventions to reduce malaria transmission	Malaria parasite prevalence among children under five years (%)	Malaria parasite prevalence among children under five years is the percentage of children under five years of age who test positive for malaria parasites during a nationally representative malaria survey, irrespective of the presence of fever or other clinical symptoms. The numerator is the number of children under five testing positives for malaria by quality-assured microscopy and/or rapid diagnostic test (RDT), while the denominator is the total number of children under five tested during the survey.		5.70%	3.50%	2.53%	SMPS
SA	**1.1**	Accelerate the reduction of malaria burden in high and moderate transmission risk areas	Number of councils categorized as high- and moderate malaria risks transmission during stratification	Number of Council with high- and moderate malaria transmission risks		63	40	29	Annual Malaria Report
						27	17	13	
SI	**1.1.1**	Provide universal ITN coverage through mass and continuous distribution to ensure optimal population ITN access (80%) in high and moderate malaria transmission risk strata	Proportion of the population with access to an ITN (assuming one ITN covers two persons)	**Numerator**: population with access to an ITN (assuming one ITN covers two persons) **Denominator**: Total population		59%	80%	80%	SMPS/ Modelling Reports
						66%	80%	80%	SMPS/ Modelling Reports
SI	**1.1.2**	Increase and sustain ITN utilization	Proportion of population that slept under an insecticide-treated net the previous night in areas targeted for ITNs	**Numerator**: Number of people living in ITN-targeted areas who slept under an ITN the previous night. **Denominator**: Total number of people surveyed in ITN-targeted areas.		54.4%	75%	85%	SMPS

		SO/SA/SI	Indicator	Definition	Risk	Baseline	Target		Source
						2025	2028	2030	
SI	1.1.3	Targeted IRS to reduce malaria burden in prioritized areas of extremely high transmission and high population vulnerability	Number of councils in high malaria transmission risk strata implemented targeted IRS	District councils in high malaria transmission risk strata implemented targeted IRS		0	5	10	SMPS/IRS Implementation Report
SI	1.1.4	Support targeted Larval Source Management (LSM) as part of integrated vector management in suitable epidemiological and operational settings	Number of councils in high and moderate malaria transmission risks capacitated to implement quality LSM	Councils in high and moderate malaria transmission areas capacitated to implement quality LSM		34	129	184	SMPS/LSM Implementation Report
SI	1.1.5	Provide appropriate and effective chemo preventive services to reduce the risk of malaria and its complications among populations biologically and socioeconomic vulnerable to malaria	Proportion of eligible populations receiving malaria chemoprevention interventions according to national guidelines	**Numerator**: Number of eligible populations who received malaria chemoprevention interventions according to national guidelines **Denominator**: All eligible populations targeted for malaria chemoprevention interventions according to national guidelines		27%	50%	80%	Implementation report
SA	1.2	Promote malaria elimination efforts by protecting the population at risk of infection in areas with residual malaria transmission	Number of councils categorized as very low malaria transmission risk areas during stratification	Number of councils categorized as very low malaria transmission risk areas during stratification		54	73	90	Malaria Annual Report
SI	1.2.1	Provide protection to selected vulnerable population living in low and very low transmission risk areas through ITNs targeted distribution	Proportion of the population with access to an ITN (assuming one ITN covers two persons)	**Numerator**: Number of people with access to an ITN in the household (assuming one ITN covers two persons). Denominator: Total population surveyed		40%	45%	55%	SMPS/Annual ITN Access Modeling Report
						48%	53%	60%	SMPS/Annual ITN Access Modeling Report
SI	1.2.2	Implement focal IRS in very low malaria transmission risk strata to interrupt transmission and mitigate epidemics	Proportion of identified malaria foci that are investigated and responded to in malaria elimination councils	**Numerator**: Number of identified malaria foci that received the complete recommended response. Denominator: Total number of malaria foci identified in targeted malaria elimination councils		0	TBD	TBD	Implementation Report
SI	1.2.3	Scale up high-quality focal larval source management (LSM) interventions to reduce residual malaria transmission in low-transmission councils and interrupt transmission in residual foci within very low-transmission councils.	Number of councils with identified and mapped mosquito breeding sites	Number of councils with identified and mapped mosquito breeding sites		NA	20	**40**	CMIS/LSM Implementation Report
			Number of councils implementing biolarvicide treatment	Number of councils implementing biolarvicide treatment		NA	20	**40**	CMIS/LSM Implementation Report
SI	1.2.4	Provide appropriate and effective chemo-preventive services to mitigate malaria outbreaks and interrupt residual local transmission in very low endemic areas	Percentage of eligible population in very low endemic areas receiving chemoprevention (e.g., fMDA or IPT where applicable	**Numerator**: Number of eligible populations in very low endemic areas who received chemoprevention (e.g., fMDA or IPT where applicable) **Denominator**: All eligible population targeted for chemoprevention in very low endemic areas		NA	30%	65%	Implementation Report
SA	1.3	Promote malaria prevention efforts by protecting the population at risk of infection in urban areas	Number of urban councils implementing targeted	Number of urban councils implementing targeted malaria prevention interventions.		NA	15	**26**	Implementation Report

		SO/SA/SI	Indicator	Definition	Risk	Baseline	Target		Source
						2025	2028	2030	
			malaria prevention interventions.						
SI	1.3.1	Implement blanket LSM in urban settings to address concentrated and identifiable mosquito breeding sites	Number of urban councils implementing quality biolarviciding	Number of urban councils implementing quality biolarviciding		1	13	26	CMIS/Implementation Report
SI	1.3.2	Accelerate targeted ITN distribution in urban areas to achieve and sustain high access to and utilization of ITNs among populations at risk	Number of ITNs distributed in urban settings	Number of ITNs distributed in urban settings		345,000	436,000	490,550	CMIS/Implementation Report
SI	1.3.3	Provide protection to selected vulnerable population living in urban settings through chemo preventive therapies	Percentage population in urban settings receiving chemoprevention (e.g., fMDA or IPT) in implementing councils	**Numerator**: Number of populations in urban settings who received chemoprevention interventions (e.g., fMDA or IPT) in implementing councils **Denominator**: Total population targeted for chemoprevention interventions in urban implementing councils		NA	20%	35%	CMIS/Implementation Report
SA	1.4	Establish cross cutting-malaria prevention initiatives across all malaria strata	Proportion of malaria vector control deployment decisions guided by insecticide resistance, surveillance, and operational research evidence.	**Numerator:** Number of malaria vector control deployment decisions guided by insecticide resistance, surveillance, and operational research evidence **Denominator**: All malaria vector control deployment decisions made during the reporting period		NA	50%	100%	CMIS/Implementation Report
SI	1.4.1	Operationalize and implement the National Insecticide Resistance Management Plan (IRMP) to preserve the effectiveness of vector control interventions	National IRMP reviewed, updated and operationalized to guide evidence-based selection and deployment of vector control interventions.	The National IRMP is reviewed, updated, o fficially endorsed, and implemented to guide the evidence-based selection, deployment, and rotation of vector control interventions		NA	YES	YES	CMIS/Implementation Report
SI	1.4.2	Support the adoption and documentation of novel vector control tools and approaches	Number of new products & approaches adopted and documented	Number of new products & approaches adopted and documented		2	4	6	CMIS/Implementation Report
SO	2	To prevent the occurrence of mortality related to malaria infection through universal access to appropriate diagnosis and treatment	Malaria inpatient mortality rate per 100,000 population	**Numerator**: Number of deaths due to malaria being an underlying cause during the reporting period **Denominator**: Total population during the reporting period expressed per 100,000 population		1.9	0.9604	0.61	HMIS/DHIS2
						0.3	0.2	0.1	HMIS/DHIS2
						1.0	0.7	0.4	HMIS/DHIS2
						2.3	1.7	1.1	HMIS/DHIS2
						3.1	2.4	1.7	HMIS/DHIS2
SA	2.1	Provide universal access to appropriate, quality and timely malaria diagnosis and treatment to all eligible people at health facilities.	Proportion of children under five with fever who had a malaria test the same or next day after onset of symptoms	**Numerator:** Number of children under five who had fever and received malaria tests within 24 hours of illness. **Denominator:** Total number of children under five year who reported to have fever on the day of the survey		50%	65%	85%	SMPS Report
			Proportion of children under five with fever who received treatment the same or next day after onset of symptoms	**Numerator:** Number of children under five who had fever, confirmed to have malaria and received malaria treatment within 24 hours of illness.		41.6%	65.0%	85.0%	SMPS Report

		SO/SA/SI	Indicator	Definition	Risk	Baseline	Target		Source
						2025	2028	2030	
				Denominator: Total number of children under five year who reported to have fever on the day of the survey					
SI	**2.1.1**	Strengthen malaria case management in Public Health Facilities	Proportion of confirmed malaria cases that received first-line antimalarial treatment at public sector health facilities	**Numerator:** Number of patients dispensed with ACTs in public health facilities. **Denominator:** Total number of malaria cases in public health facilities.		95.36%	97%	98%	HMIS/DHIS2
SI	**2.1.2**	Strengthen malaria case management in Private Health Facilities	Proportion of confirmed malaria cases that received first-line antimalarial treatment at private sector health facilities	**Numerator:** Number of ACTs dispensed in private health facilities **Denominator:** Total number of malaria cases in private health facilities.		86%	90%	95%	HMIS/DHIS2
SI	2.1.3	Provide high-quality severe malaria management services by skilled providers in public and private health facility settings.	Proportion of severe malaria cases managed according to national treatment guidelines by skilled providers in public and private health facilities	**Numerator**: Number of severe malaria cases in public and private health facilities that managed as per treatment guideline. **Denominator**: total number of severe malaria cases seen in public and private health facilities regardless of whether they received correct treatment or not.		75%	85%	95%	HMIS/DHIS2
SI	2.1.4	Strengthen malaria diagnosis and treatment for individuals with biological vulnerability	TBD	**TBD**		**TBD**	**TBD**	**TBD**	
SI	2.1.5	Adopt and scaleup innovative, evidence-based malaria diagnosis and treatment tools and approaches	Number of new or alternative ACTs introduced according to TES recommendations	This indicator measures how many new artemisinin-based combination therapies (ACTs) or alternative ACT regimens have been adopted or introduced into national treatment policy in a given period, specifically in response to or in line with recommendations from Therapeutic Efficacy Studies (TES) and MFT		0	2	3	HMIS/DHIS2
SDA	2.2	Provide universal access to appropriate, quality and timely malaria diagnosis and treatment to all eligible people beyond health facilities.	Proportion of suspected malaria cases in hard-to-reach areas who received quality-assured malaria diagnosis and appropriate treatment through community-based services.	**Numerator**: Number of suspected malaria cases in hard-to-reach areas tested for malaria and, if confirmed positive, treated with first-line antimalarial medicines through community-based services. **Denominator**: Total number of suspected malaria cases managed through community-based services in hard-to-reach areas.		80%	90%	100%	CMIS iCCM registers HMIS/DHIS2
SI	2.2.1	Provide high-standard, accessible, affordable, equitable, and quality-assured malaria testing services to communities with limited accessibility to operational health facilities	Proportion of suspected malaria cases in hard-to-reach areas tested for malaria through integrated community case management (iCCM)	The percentage of suspected malaria cases in hard-to-reach areas that receive a quality-assured malaria test. **Numerator:** Number of suspected malaria cases in hard-to-reach areas tested for malaria through iCCM. **Denominator:** Total number of suspected malaria cases managed through iCCM in hard-to-reach areas.		15%	25%	30%	CMIS iCCM registers HMIS/DHIS2

		SO/SA/SI	Indicator	Definition	Risk	Baseline	Target		Source
						2025	2028	2030	
SI	2.2.2	Deploy malaria case management in response to malaria surveillance initiatives	Proportion of malaria surveillance alerts responded to with case management actions.	**Numerator**: Number of malaria surveillance alerts responded to with case management actions **Denominator**: All malaria surveillance alerts generated during the reporting period		NA	20%	50%	CMIS/eIDSR
SDA	2.3	Promote cross cutting initiatives to improve malaria case management interventions	Proportion of planned cross-cutting initiatives for malaria case management implemented.	This indicator measures the extent to which multisectoral and cross-cutting actions that support malaria case management are carried out as planned, including activities that improve access, quality, coordination, and timely delivery of services.		0	1	2	Implementation Report
SI	2.3.1	Operationalize new tools and interventions to protect ACTs	Number of new or alternative ACTs introduced according to TES recommendations	This indicator measures how many new artemisinin-based combination therapies (ACTs) or alternative ACT regimens have been adopted or introduced into national treatment policy in a given period, specifically in response to or in line with recommendations from Therapeutic Efficacy Studies (TES)		0	1	2	HMIS/DHIS2
SI	2.3.2	Introduce novel malaria case management tools and approaches	Number of newly adopted malaria case management innovations introduced and integrated into national guidelines or SOPs	This indicator measures the number of new or innovative malaria case management tools and approaches introduced, implemented, and monitored to improve malaria diagnosis, treatment, referral, or service delivery during the reporting period.		0	1	2	Implementation Report
SI	2.3.3	Introduce focal and targeted case management interventions to respond to malaria surveillance findings	Proportion of identified malaria transmission foci that receive appropriate focal case management interventions	**Numerator**: Number of identified malaria foci that received the recommended focal case management intervention. **Denominator:** Total number of malaria foci identified through surveillance during the reporting period.		0	TBD	TBD	CMIS/CBS Report
SO	**3**	To provide timely and reliable information on malaria and its control needed to take appropriate actions in different transmission risk and ensure resources are used in the most cost-effective manner	Proportion of malaria interventions implemented based on subnational stratification and surveillance evidence	**Numerator:** Number of malaria interventions implemented based on approved subnational stratification and surveillance evidence. **Denominator:** Total number of malaria interventions planned for implementation during the reporting period.		NA	TBD	TBD	NMCP annual work plans; Risk stratif. reports; Surveillance reports; Intervention deployment plans and Programme review reports
SA	**3.1**	Establish a comprehensive malaria surveillance and response system to inform stakeholders and respond to the emerging needs through an evidence-based platform	Proportion of planned surveillance and response activities implemented based on SMEL plan.	**Numerator**: Number of planned surveillance and response interventions implemented based on SMEL plan in a given time period. **Denominator**: Total number of planned Surveillance and response interventions in that period		100%	100%	100%	MPR 2025 report
SI	**3.1.1**	Strengthen malaria disease surveillance and response on routine detection, recording, reporting and analysis of malaria related data across all epidemiological strata	Proportion of health facilities with complete monthly malaria data uploaded into DHIS2	Numerator: Number of HFs uploaded complete monthly data in DHIS2 **Denominator**: Total number of Health facilities expected for reporting		93%	98%	100%	HMIS/DHIS2

		SO/SA/SI	Indicator	Definition	Risk	Baseline	Target		Source
						2025	2028	2030	
SI	3.1.2	Enhance malaria programmatic surveillance and response for improved performance	Proportion of planned programmatic surveillance surveys conducted	**Numerator**: Number programmatic surveillance conducted. **Denominator**: Total number of programmatic surveillances planned		100%	100%	100%	MTR/MPR report
SI	3.1.3	Strengthen malaria transmission surveillance and response	Number of malaria transmission surveys conducted	Number of malaria transmission survey conducted in a given time period		3	8	12	Survey Reports
SA	3.2	Institutionalize the continuum of monitoring and evaluation process during the implementation of malaria strategic plan	Percentage of health facilities scoring ≥75% in the DQA module (consistency, correctness and completeness)	**Numerator**: Number of health facility scoring ≥75% in the DQA Module (Consistency, correctness and completeness) **Denominator**: Total number health facility supervised using DQA module		60.5%	75%	85%	DQA Reports
SI	3.2.1	Strengthen the availability and quality of routine malaria related data at service delivery points	Proportion of facilities scoring ≥75% in the DQA module (consistency, correctness, completeness	**Numerator**: Number of facilities scoring ≥75% in the DQA module (consistency, correctness, completeness		60.5%	75.0%	85.0%	MPR report 2025
SI	3.2.2	Evaluation of malaria strategic plan implementation	MPR and MTR reports availability	MPR and MTR reports availability		1	1	2	MTR/MPR reports
SA	3.3	Strengthen a learning process based on comprehensive malaria strategic information system and operational research to generate knowledge for evidence-based planning and decision making at all levels	Availability of uninterrupted interactive web-based system providing routine and non-routine malaria information	Availability of uninterrupted interactive web-based system providing routine and non-routine malaria information		1	1	1	Fuctional CMIS
SI	3.3.1	Strengthening the systematic analysis and use of quality data to inform evidence-based decision-making	Proportion of malaria preventive interventions that are targeted based on analyzed data	**Numerator**: Number of preventive malaria interventions that are targeted based on analyzed data **Denominator:** Total number of eligible interventions		100%	100%	100%	Implementation Report
SI	3.3.2	Develop and implement prioritized operational research agenda to generate context-specific evidence that informs policy and improves service delivery effectiveness	Proportion of operational research conducted as per SME plan.	**Numerator**: Number of operational research studies conducted **Denominator:** Total targeted Operational research as per SME plan		4	3	5	Research report
SO	4	Ensure timely availability of safe, efficacious and quality malaria commodities and supplies at the service delivery points.	Proportion of quality assured and safe malaria commodities ordered and received within the specified time	**Numerator**: Malaria commodities delivered **Denominator**: All malaria commodities ordered		93.90%	100%	100%	Pipelines/ QAT
SA	4.1	Promote partnership to ensure malaria commodities are available in all service delivery points in the right quantity and when needed	Percentage of points of services with no stock-out of essential malaria commodities (ACTs, Artesunate injection, RDTs, ITNs and SP) for a specified reporting period	**Numerator**: Number of service delivery points reporting no ACTs, Artesunate, mRDT and SP in stock at the end of the month **Denominator**: Number of service delivery points eligible to use and report ACTs, Artesunate, mRDT and SP		93.30%	96%	98%	eLMIS

		SO/SA/SI	Indicator	Definition	Risk	Baseline	Target		Source
						2025	2028	2030	
SI	4.1.1	Facilitate timely availability of malaria commodities and supplies at the service delivery points	Percentage of points of services with no stock-out of ACTs for a specified reporting period	**Numerator**: Number of service delivery points reporting no ACTs in stock at the end of the month **Denominator**: Number of service delivery points eligible to provide ACTs		90.50%	95%	98%	eLMIS
			Percentage of points of services with no stock-out of Artesunate injection for a specified reporting period	**Numerator**: Number of service delivery points reporting no Artesunate injection in stock at the end of the month **Denominator**: Number of service delivery points eligible to provide Artesunate injection		95.20%	97%	98%	eLMIS
			Percentage of points of services with no stock-out of mRDT for a specified reporting period	**Numerator**: Number of service delivery points reporting no mRDT in stock at the end of the month **Denominator**: Number of service delivery points eligible to provide mRDT		95.20%	97%	98%	eLMIS
			Percentage of points of services with no stock-out of ITNs for a specified reporting period	**Numerator**: Number of service delivery points reporting no ITNs in stock at the end of the month **Denominator**: Number of service delivery points eligible to provide ITNs		92.30%	95%	98%	eLMIS
			Percentage of points of services with no stock-out of SP for a specified reporting period	**Numerator**: Number of service delivery points reporting no SP in stock at the end of the month **Denominator**: Number of service delivery points eligible to provide SP		92.90%	95%	98%	eLMIS
SA	4.2	Promote partnership with regulatory authorities to ensure all malaria commodities used at service delivery points are quality assured and safe	Proportion of commodities batches tested at port of entry and post market surveillance with quality assurance certification	**Numerator**: Number of commodities batches with quality assurance certification at port of entry and post market surveillance. **Denominator**: Number of commodities batches tested at port of entry and post market surveillance		100%	100%	100%	TMDA, TPHPA, TBS
SI	4.2.1	Facilitate quality assurance of malaria commodities	Proportion of commodities batches tested at port of entry and post market surveillance with quality assurance certification	**Numerator**: Number of commodities batches with quality assurance certification at port of entry and post market surveillance. **Denominator**: Number of commodities batches tested at port of entry and post market surveillance		100%	100%	100%	TMDA, TPHPA, TBS
SI	4.2.2	Facilitate assessment of safety for malaria commodities	Number of malaria commodities evaluated for safety and registered by delegated authorities	**Numerator**: Number of malaria commodities evaluated for safety and registered by delegated authorities **Denominator**: 1		100%	100%	100%	TMDA/TPRI Reports
SO	5	To strengthen an enabling environment that empowers individuals and communities at risk of malaria to constituently protect themselves and	Proportion of the population with access to an ITN in their household who slept under an ITN	**Numerator:** Number of people with access to an ITN in their household who slept under an ITN the previous night. **Denominator:** Total number of people with access to an ITN		90%	100%	100%	SMPS

		SO/SA/SI	Indicator	Definition	Risk	Baseline	Target		Source
						2025	2028	2030	
		their families and seek timely and appropriate malaria care		in their household. **Data source:** School Malaria Parasitological Survey (SMPS). **Disaggregation:** Region, council, malaria transmission stratum, age group, and sex (where applicable).					
SA	5.1	Promote social and behavior change among communities and strengthen advocacy efforts among leaders through effective risk reduction communication	Percentage of target audience reached through SBC channel/activities	**Numerator**: Number of people reached by SBC channels/activities **Denominator**: All people interviewed		52.70%	70%	85%	SMPS
SI	5.1.1	Strengthen knowledge, attitude and practices among community members on positive uptake of malaria interventions	Percentage of household's population with knowledge of ways to prevent malaria	**Numerator**: Number of individuals in surveyed households who correctly identify at least one effective way to prevent malaria **Denominator**: Total number of individuals in the surveyed households		73.9%	85.00%	90%	SMPS
SI	5.1.2	Enhance malaria advocacy to political leaders and decision makers to strength commitment, and increased malaria visibility	Proportion of sensitized political leaders and decision-makers actively advocating for malaria prevention and control	**Numerator**: Number of sensitized political leaders and decision-makers who undertake at least one documented malaria advocacy action **Denominator**: Number of political leaders and decision makers sensitized		NA	65%	85%	NMCP report
SI	5.1.3	Strengthen the quality, coverage, and effectiveness of interpersonal communication (IPC) to increase uptake of key malaria interventions	Proportional of the population reached with malaria message through IPC	**Numerator**: Number of people interviewed reached with IPC **Denominator**: All people interviewed		30%	50%	60%	SMPS
SA	5.2	Promote community engagement and active participation in malaria control and elimination interventions within their respective settings	Proportion of councils implementing at least one of community engagement activities for promotion, prevention, community case management in all transmission strata	**Numerator**: Number of councils implementing community engagement through CHWs **Denominator**: All Councils		38.60%	60%	80%	NMCP reports
SI	5.2.1	Enhance malaria knowledge and practices among malaria-vulnerable groups to raise awareness of their risks and enable effective uptake of preventive and curative services available.	Proportion of children under five for whom advice or treatment was sought the same or next day	**Numerator**: Number of parents/care takers who sought advice or treatment for their children under five years of age with fever in the last two weeks **Denominator**: number of Parents/cares takes of children under five years of age with fever in the last two weeks interviewed during the survey		86.30%	90%	95%	SMPS
SI	5.2.2	Strengthen community engagement and participation to promote and implement malaria control and elimination initiatives.	Proportion of the household population that perceives malaria as the most serious health problem in their community in the high- and moderate strata.	**Numerator**: Number of people perceiving malaria as a major health problem in high- and moderate strata Denominator: Total population Surveyed in high- and moderate strata		66.40% 81.70%	80% 90%	90% 95%	SMPS

		SO/SA/SI	Indicator	Definition	Risk	Baseline	Target		Source
						2025	2028	2030	
SI	5.2.3	Strengthen verification and quality control mechanisms of SBCA&CE for malaria interventions and activities across all levels of implementation	Proportion of councils where SBCA&CE verification exercises have been conducted.	**Numerator:** Number of councils' verification conducted **Denominator**: All councils		*80*	85%	90%	NMCP report
SO	6	To strengthen efficient and effective implementation of malaria strategies through accountable leadership and partnership	Proportion of malaria control service delivery mechanisms implemented.	**Numerator**: Number of service delivery mechanisms implemented Denominator: Total number of service delivery mechanisms planned		90%	90%	90%	MTR/MPR report
SA	6.1	Provide effective leadership to ensure program's objectives are met	Proportion of planned National Malaria Strategic Plan (NMSP) governance and leadership milestones achieved	The percentage of governance and leadership milestones outlined in the NMSP that are achieved during the reporting period, including policy development, coordination, advocacy, capacity strengthening, and implementation oversight.		90%	95%	100%	Approved NMCP Annual Work Plan (AWP); Quarterly and annual programme performance reports; Annual Malaria report; Technical Working Group (TWG) and coordination meeting reports; Supervision and monitoring reports; Policy and guideline approval documents
SI	6.1.1	Strengthen governance, advocacy, and coordination	Proportion of governance and technical meetings conducted as per plan	**Numerator**: Number of governance and technical meetings conducted as per the approved plan during the reporting period. **Denominator**: Total number of governance and technical meetings planned for the same reporting period.		90%	90%	90%	Malaria Annual and Meeting Report
SI	6.1.2	Enhance appropriate strategies and technical capacity for implementation of malaria interventions	Proportion of updated strategic and technical documents available	**Numerator**: Number of strategic and technical documents that are updated (reviewed within the defined time period) and available **Denominator**: Total number of required strategic and technical documents		100%	75%	100%	MTR and MPR reports
SA	6.2	Promote harmonized **partnership** for malaria control and elimination	Proportion of planned malaria interventions jointly implemented by NMCP and partners	**Numerator:** Number of planned malaria interventions jointly implemented by NMCP and partners **Denominator:** Total number of planned malaria interventions requiring joint implementation		25%	50%	75%	Malaria Annual Report
SI	6.2.1	Institutionalize multi-sectoral collaboration for malaria control and elimination	Proportion of planned multi-sectoral malaria interventions jointly implemented	**Numerator**: Number of planned multi-sectoral malaria interventions jointly implemented. **Denominator**: Total number of planned multi-sectoral malaria interventions.		NA	TBD	TBD	Malaria Annual Report
SI	6.2.2	Enhance implementation of effective cross-border initiatives	Proportion of planned cross-border initiatives that are jointly implemented and completed according to	**Numerator**: Number of planned cross-border initiatives that are jointly implemented and completed jointly by all relevant neighboring countries.		0	75%	90%	NMCP Annual report

		SO/SA/SI	Indicator	Definition	Risk	Baseline	Target		Source
						2025	2028	2030	
			agreed protocols between neighboring countries.	**Denominator**: Total number of cross-border initiatives planned between neighboring countries within the same reporting period.					
SA	6.3	Establish a sustainable environment for resource mobilization	Percentage of malaria strategic plan funding gap covered	The percentage of the total estimated financial requirement for implementing malaria strategic plan interventions that is secured through domestic and external resource mobilization efforts. (**Numerator:** Total resources secured for malaria interventions. **Denominator:** Total financial requirement for the malaria strategic plan.)		51%%	60%	100%	MPR report
SI	6.3.1	Strengthen the resource mobilization mechanisms for sustainable implementation of malaria strategies	Proportion of total program funding mobilized from domestic, donor, and partnership sources.	**Numerator**: Total amount of funds mobilized. **Denominator**: Total program funding required or budgeted for the same period		51%	75%	100%	MPR report

Evolution of Strategic Planning and Resource Mobilization for Malaria Control Programme, 1990–2030

