A DATA-DRIVEN CALL TO ACTION: SUSTAINING ETHIOPIA'S MALARIA RESPONSE

BRIDGE THE GAP INITATIVE

AKROS

FROM OUR EXECUTIVE DIRECTOR

Dr Peter Mumba
Executive Director
Bridge the Gap Initiative

Former Resident Advisor,
USAID Presidents Malaria
Initiative (PMI)

As a medical doctor, I've seen the devastating toll malaria exacts, especially on children under five and pregnant women. This knowledge fuels my deep commitment to advancing sustainable, high-impact solutions to end malaria.

In Ethiopia we are now facing a critical challenge. The recent decline in traditional donor funding—particularly from the U.S. President's Malaria Initiative (PMI)—has placed its malaria control efforts at risk. Without timely action, the country could see a reversal of decades of hard-won progress, particularly in high-burden regions.

The Bridge the Gap (BTG) Initiative was launched to respond to moments like this. Our approach is data-driven, country-led, and focused on rapidly identifying and addressing critical funding shortfalls. In addition to linking countries with global donors, BTG supports the strategic mobilization of domestic resources to ensure long-term resilience.

In Ethiopia, our collaboration with the Ethiopian Federal Ministry of Health (FMOH) National Malaria and Other Vector-Borne Disease (MOVBD) Program has already yielded a robust investment case and activity-level gaps inventory. This report presents that work, outlining the most urgent needs and the pathways—financial and operational—to sustain momentum through 2026.

This is more than a funding roadmap. It is a call to action and a reflection of what is possible when local leadership, technical excellence, and global solidarity converge. With urgency and partnership, I believe we can protect Ethiopia's progress and advance toward a malaria-free future.

With thanks,

Dr. Peter Mumba
Executive Director
Bridge the Gap Malaria Initiative at Akros

Bridging the Gap in Ethiopia's Malaria Response: A White Paper on Emerging Financing Gaps and Strategic Priorities

Prepared by:
Bridge the Gap (BTG) Initiative

Date:
October 2025

Disclaimer: The findings presented herein are the independent work of the Bridge the Gap (BTG) Initiative. They do not represent the official policy or position of the Government of Ethiopia

Acknowledgements

The findings and recommendations in this report are the independent contributions of the Bridge the Gap initiative. However, the development of this white paper would not have been possible without the generous collaboration of the Ethiopian Federal Ministry of Health (FMOH) National Malaria and Other Vector-Borne Disease (MOVBD) Desk. Their commitment to maintaining momentum in malaria control, despite evolving funding challenges, has been a guiding force behind this work.

We extend special acknowledgement to the technical experts and contributors from the Federal Ministry of Health (FMOH) and the Malaria and Other Vector-Borne Diseases Desk (MOVBD), whose strategic input and dedication were critical in constructing the evidence base and framing actionable recommendations. Their collective technical expertise and commitment greatly enriched the development of this white paper.

We also owe a debt of gratitude to: The Bridge the Gap Executive Leadership Team, whose backgrounds through the President's Malaria Initiative, including malaria strategy and policy helped shape the white paper's analytical rigor including Dr. Oliver Lulembo, Dr. Paul Psychas, Dr. Anna Winters, Mr. Sheleme Chibsa, Mr. Presley Musonda, Mr. Benjamin Winters. Support for data analysis, formatting and review was provided by Ms. Arden Saravis.

We extend our sincere gratitude to the Bridge the Gap Initiative advisory board members: Dr. Lawrence Barat (Former Senior Medical Officer and Technical Lead for USAID PMI Headquarters), and Dr. Peter McElroy (Malaria Branch Chief at the US Centers for Disease Control and Prevention).

Through shared purpose and rapid, impact-focused partnership, we hope this white paper not only highlights critical financing gaps but also catalyzes solutions that protect Ethiopia's malaria gains and support its path toward elimination.

Dr. Peter Mumba
Executive Director
Bridge the Gap Initiative

Table of Contents

Abbreviations

ALMA – African Leaders Malaria Alliance
API – Annual Parasite Incidence
BTG – Bridge the Gap
CDC – U.S. Centers for Disease Control and Prevention
CY – Calendar Year
DUP – Data Use Partnership
DRC – Democratic Republic of Congo
eCHIS – Electronic Community Health Information System
EFDA – Ethiopian Food and Drug Authority
ELT – Executive Leadership Team (BTG)
EMDHS – Ethiopia Mini Demographic and Health Survey
EPHI – Ethiopian Public Health Institute
EPI – Expanded Programme on Immunization
EPSS – Ethiopian Pharmaceuticals Supply Service
FAR – Foreign Assistance Review
FMOH – Federal Ministry of Health
GF – The Global Fund to Fight AIDS, Tuberculosis and Malaria
HEP – Health Extension Programme
HEW – Health Extension Worker
HMIS – Health Management Information System
HSS – Health System Strengthening
HRP2 – Histidine-Rich Protein-2 Gene
iCCM – Integrated Community Case Management
IDP – Internally Displaced People
IAA – Interagency Agreement
ITN – Insecticide-Treated Net
IPTp – Intermittent Preventive Treatment in Pregnancy
IRS – Indoor Residual Spray
LLIN – Long-Lasting Insecticidal Net
LSM – Larval Source Management
MAP – Malaria Atlas Project
MCH – Maternal and Child Health
MDA – Mass Drug Administration
M&E – Monitoring and Evaluation
MPR – Malaria Programme Review
MOH – Ministry of Health
MOP – Malaria Operational Plan
MOVBD – Malaria and Other Vector-Borne Diseases Desk
MIP – Malaria in Pregnancy
NMCP – National Malaria Control Program
NMSP – National Malaria Elimination Strategic Plan
OR – Operational Research
PHEM – Public Health Emergency Management
PMI – President's Malaria Initiative
PPE – Personal Protective Equipment
PPM – Public Private Mix
PSM – Procurement and Supply Management project
RBM – Roll Back Malaria

RDTs – Rapid Diagnostic Tests
RCD – Reactive Case Detection
RRFs – Reporting and Requisition Forms
SBC – Social and Behavior Change
SDG – Sustainable Development Goals
SMEO/SMEOR – Surveillance, Monitoring, Evaluation, and Operations Research
TA – Technical Assistance
TES – Therapeutic Efficacy Studies
UNICEF – United Nations International Children's Emergency Fund
USAID – U.S. Agency for International Development
USD – U.S. Dollar
USG – United States Government
WB – World Bank
WHO – World Health Organization

Executive Summary

Malaria remains one of Ethiopia's greatest public health threats, with more than 10.2 million cases and 1,324 deaths reported in 2024[1]. This represents a sharp rise from 3.7 million cases and 469 deaths in 2023, and a major reversal from fewer than one million cases in 2019, when Ethiopia was targeting elimination in 565 of 919 malarious districts by 2030[2]. Data indicate a further 65% increase in early 2025, with 2.2 million cases between January and April compared to 1.3 million during the same period in 2024. An estimated 69% of the country's 126.5 million people remain at risk, with transmission driven predominantly by *Plasmodium falciparum* (65%) and *Plasmodium vivax* (35%). Transmission is highly seasonal, peaking from September to December and again in April–May. Despite these challenges, Ethiopia's National Malaria Strategic Plan outlines integrated interventions across vector control, case management, surveillance, supply chain, and social and behavior change. However, the unprecedented surge now threatens to reverse the progress made toward elimination.

In addition to Ethiopia's government support, Ethiopia's malaria response has been underpinned by strong donor support from the U.S. President's Malaria Initiative (PMI) and the Global Fund (GF). Recent budget reductions by PMI and Global Fund, however, are creating urgent gaps in 2025–2026/27, particularly for vector control interventions (LLINs) including entomological monitoring and larval source management to fight against *An. stephensi;* and indoor residual spray (IRS) implementation, SBC programming, routine intervention planning, and surveillance. While GF has maintained its core allocations for life saving commodities and activities, the combined effect of declining external resources, as well as insecurity in some regions (including The Northern Ethiopia (Tigray conflict), Amhara and Oromia regions) threatens to reverse years of hard-won progress. To respond, the Bridge the Gap (BTG) Initiative, launched in early 2025, is working with Ethiopia's National Malaria and Other Vector-borne Diseases (MOVBD) Desk and partners to map and prioritize these shortfalls. The resulting Ethiopia Malaria Gaps Inventory highlights the most critical areas for immediate financing.

The BTG initiative has identified the most urgent investment opportunities for 2025–2026/27, structured around two complementary objectives. In the immediate timeframe, the priority is to prevent sickness and death during the upcoming peak malaria seasons by ensuring mass access to vector control, prompt diagnosis, and effective treatment. In the medium to long term, the focus must shift to resuming and sustaining progress toward elimination by staying ahead of emerging threats, investing in data-driven systems, and adopting new tools and innovations.

In the short term, Ethiopia requires bridging finance to avert a sharp rebound in malaria morbidity and mortality. The most acute needs include $2.64 million to procure and distribute insecticide-treated nets (ITNs) to fill gaps left by PMI reductions, $3.69 million to sustain annual IRS campaigns including procurement, planning, and supervision for 2026, $2.35 million for LSM to fight against *An. stephensi* and $3.35 million to strengthen case management at both facility and community levels, as well as to resume therapeutic efficacy studies.

The complete cancellation of social and behavior change programming has left a critical gap in community engagement, requiring $2.81 million to restore activities that promote early care-seeking and uptake of vector control. Finally, $7.89 million is urgently needed to rebuild both epidemiological and entomological surveillance and information systems that are essential for both immediate response and long-term planning. In addition, $0.45 million is needed to maintain functionality of the supply chain for malaria commodities.

Without urgent bridging finance, Ethiopia risks recording more malaria morbidity and mortality, particularly among children and other vulnerable groups in high-burden rural districts. Sustaining Ethiopia's malaria gains is

[1]Ethiopia Health Cluster Bulletin (December 2024) https://reliefweb.int/report/ethiopia/ethiopia-health-cluster-bulletin-december-2024#:~:text=%E2%80%A2%20December%202024%2C%20Ethiopia%20reported%2029%2C946%20measles%20cases,total%20of%2010%2C225%2C938%20malaria%20cases%20and%201%2C324%20deaths

[2]Ethiopia National Malaria Elimination Strategic Plan (2024/25-2026/27)

both a public health and a development imperative. Closing immediate gaps will prevent avoidable deaths and maintain momentum, while longer-term investments in systems and innovation will enable the country to accelerate toward elimination. We call on government, donors, private sector partners, and philanthropies to act decisively to close these financing gaps. Protecting Ethiopia's malaria progress is not only a matter of saving lives but also a strategic investment in national resilience, equity, and economic prosperity and stability.

It is hoped that this summary format might encourage potential new partners to identify areas that suit their technical portfolios and budget availability. The need is great, the chance to save lives is compelling, and the opportunities to build resilient systems are tremendous.

How to use this document

Widespread funding disruptions have further complicated an already complex environment for international malaria control. This report intends to carefully document resulting gaps and opportunities in Ethiopia, providing guidance to prospective donors, malariologists and, most importantly, Ethiopia's Federal Ministry of Health (FMOH) malaria control teams. By necessity, it is lengthy and detailed. Our team has attempted to structure it in a way to ensure accessibility by technicians and laypeople alike. Readers will find increasing detail by reading further into the document; those interested in high-level overviews may read the glossy primer at the beginning, while those looking for detailed information about specific vector control interventions, for example, would look towards later chapters.

The document begins with a brief overview of the current funding gaps, an introduction to the BTG team and analysis methods, closing with a commentary on the historical structure of international aid. While there is much to praise in the generosity and velocity of past efforts, there have been weaknesses worth considering during this restructuring phase. Following this, we provide a targeted list of priority interventions required, in our opinion, for Ethiopians to avoid unnecessary sickness and death in the short-term. Last, and longest, we provide detail on lower priority or longer-term investments benefitting Ethiopia's malaria control portfolio.

Introduction

Malaria Control at a Critical Juncture

The contraction of funding from the United States Agency of International Development (USAID) / President's Malaria Initiative (PMI) and The Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) has severely affected malaria control and elimination efforts across Africa, placing national programs at unprecedented risk. In the case of PMI, abrupt stop work-orders, project terminations, and the dismantling of USAID largely halted PMI funding flows and implementation support during the first half of 2025, with slow and still-uncertain resumption of partial implementation support under the US Department of State from mid-2025. Although the FMOH was able to mobilize some additional funding, the resources were insufficient to close the substantial gaps. Similarly, the Global Fund was not in a position to fully offset these shortfalls. Even major philanthropic organizations, such as the Gates Foundation—as highlighted by Bill Gates—do not have the resources required to support these interventions at scale[3]. Modeling from the Malaria Atlas Project (MAP) (February 2025) estimated that sustained support from PMI at 2025 business-as-usual levels could have averted up to 200,000 malaria cases and 400 deaths in Ethiopia alone[4]. In response to this growing crisis, the Bridge the Gap (BTG) Incubator[5]—a collaborative initiative launched by Akros and Population Explorer—was established to support country-led efforts to rapidly identify and address critical implementation and financing gaps in malaria programs across six high-burden countries.

Bridge the Gap (BTG) initiative - our team and goals

BTG supports national malaria programs by facilitating rapid, detailed assessment of funding shortfalls, producing targeted investment cases, engaging with donors, and coordinating the deployment of local implementation partners. Its approach is aligned with global strategies developed by the WHO, Roll Back Malaria (RBM), the GF, African Leaders Malaria Alliance (ALMA), and the former PMI. Target countries were selected based on high malaria burden and strategic need, and currently include Zambia, Tanzania, Ghana, Ethiopia, Nigeria, and the Democratic Republic of Congo (DRC).

The initiative was launched shortly after the February 2025 announcement of the USAID shutdown and is led by a core Executive Leadership Team (ELT) composed of former USAID, CDC and global malaria experts. This team works in close partnership with national malaria programs, technical agencies, and implementation partners in each country. BTG also receives strategic guidance from a Board of Advisors, comprising global leaders in malaria control and international development. As a lean, country-focused incubator, BTG has moved quickly, earning enthusiastic support from all participating countries and rapidly generating operational momentum.

The central aim of BTG is to mobilize the resources necessary to protect and sustain progress toward malaria control in the face of funding volatility. This white paper focuses specifically on Ethiopia, detailing the immediate resource needs created by the withdrawal of U.S. government support and outlining a locally led response to preserve gains and protect lives. Although the development of this white paper benefitted greatly from the collaboration of the FMOH and partners, the findings and recommendations represent BTG opinions.

---

[3] Rogelberg, S. (2025, March 18). *Bill Gates reportedly warned Trump his foundation won't be able to fund global health gaps if the administration keeps making major cuts. Fortune*. Retrieved from https://fortune.com/2025/03/18/bill-gates-warned-trump-administration-foundation-usaid-foreign-aid-funding/

[4] Symons et al 2025. Estimating the potential malaria morbidity and mortality avertable by the US President's Malaria Initiative in 2025: a geospatial modelling analysis. The Lancet. 405: 2231- 2240

[5] BTG website is found at www.malaria.akros.com

BTG methods

Using the PMI Malaria Operational Plan (MOP) and GF allocation documents as primary sources, BTG catalogued key interventions—such as vector control, case management, surveillance, and entomological monitoring—historically supported by these donors. We then collaborated closely with Ethiopia's National Malaria and Other Vector-borne Diseases (MOVBD) Desk (Attachment A, Letter of Support and Engagement, Ethiopia), former PMI staff, GF stakeholders, and implementing partners to assess which activities were likely to be cut, partially maintained, or remain unfunded in calendar years 2025 and 2026.

This painstaking process, which was initiated in February 2025 and was conducted during a period of rapid change to October 2025, enabled us to map expected funding shortfalls by intervention and to prioritize activities for alternate resource mobilization. For PMI, the assessment aimed to capture the *de facto* budget revisions resulting from the Foreign Assistance Review (FAR) which played out in the first half of 2025 while most PMI-funded activities were paused or cancelled outright. Following the FAR, it was assumed for planning purposes that USG support would decline by **approximately 30% in 2026.** For the GF grant, the assessment captured the formal budget revisions resulting from the reprioritization exercise in June-July which had been mandated by GF-Geneva. This approach permitted up-to-date estimations of *Original* versus *Revised* expected spending, by malaria intervention area, during the August 2025 to December 2026 period.

The result of this effort is the Ethiopia Malaria Gaps Inventory and Prioritization ("Inventory"), a live working document that provides a detailed, activity-level assessment of malaria control interventions across Ethiopia for the remaining months of 2025 and all of 2026, including budgets, implementing partners, current status, and mitigation options. Further, the gaps inventory outlines each activity's financial gap, potential mitigation pathways, and priority level for replacement funding.

International aid - where do we stand?

Strengthening local capacity

For over two decades now, malaria control and elimination stakeholders have invested heavily in two parallel objectives: providing technical and financial support to malaria interventions and strengthening the country-led systems to deliver those interventions. The overarching goal, whether directly stated or not, was to interrupt the unnecessary deaths of millions, while simultaneously empowering vulnerable countries to lead this fight without external assistance. We have seen remarkable progress on both objectives, but the recent, drastic cuts to foreign aid have exposed apparent weaknesses in our historical approach: malaria continues to rise, and many countries remain ill-equipped to counter this deadly threat on their own.

Our gap analysis should be read against this global history. Where systems remain under-capacitated, simply restoring budgetary line-items (if that were possible) would not, on its own, deliver on these ideals. The approach to aid must change, but the exact method is unclear. Finding and executing an effective solution will require patience, iteration, and close collaboration with governments.

Resources are shrinking

The rapid reductions in foreign aid in early 2025 compounded an already ominous global challenge: malaria resources are inadequate to meet the rising rate of infections and deaths. Our instinct is to meet this crisis

head-on, identifying the most vulnerable populations and bringing to them life-saving resources as quickly as possible. We recognize the clear tension this brings to the patient, capacity-building objectives detailed above.

Our position

Our stance is twofold. First, we will emphasize efficiency and precision in deploying interventions that prevent unnecessary deaths now. With a shrinking pool of resources, we cannot tolerate excess—large consultant footprints, sloppy targeting, or lax coverage indicators.

Second, every near-term efficiency gain should also harden country systems wherever feasible. In practice: default to FMOH/MOVBD platforms and routines when risk is manageable; where risk is high, use time-bound parallel channels with a clear plan—and date—for re-entry to country systems. The destination remains country leadership; the route must be pragmatic and sequenced.

Pushing for rapid deployment of efficient interventions can feel at odds with the slower, patient work of country ownership. We must hold both truths. Protect children and other vulnerable groups now and ensure that each immediate gain is somehow paired with new methods for government engagement, so it persists beyond the current funding cycle.

Immediate priorities for Ethiopia's malaria control

At the time of this writing October 2025, the funding picture remains fluid. Although revised donor commitments by PMI and GF for the remainder of calendar year (CY) 2025 have largely come into focus, much uncertainty remains regarding PMI support in CY2026 and beyond, and regarding GF support in CY2027 and beyond. What is clear, is that the combination of funding cuts and shifts in donor priorities have created several alarming gaps in support for malaria control. These gaps place vulnerable populations at increased risk of malaria infection and death in the immediate term while threatening to undermine progress in the longer term.

In this context, based on its inventory and gap analyses, the BTG team has identified a set of major opportunities for new partners to make impactful investments in Ethiopia. During this time of budgetary constraints in global health, it is the BTG teams' informed opinion that a targeted set of interventions warrant urgent support: These are summarized in Table 1. More in-depth analysis is provided in the next chapter of this report.

The team prioritized activities based on two main criteria:
(1) They are significantly underfunded, with expected spending in 2025-26/27 much reduced from their original budgets for 2025-26/27

(2) They contribute centrally to one or more high-level malaria control objectives in Ethiopia:

- ***Prevent sickness and death*** during the upcoming peak malaria seasons (Sept - Dec 2025, April-May 2026, and Sept-Dec 2026) by ensuring access to core, life-saving interventions.
- ***Stay ahead of threats*** and make evidence-based investments.
- ***Resume and sustain progress*** in malaria burden reduction by strengthening national systems and human resources.

Table 1 (below) and related commentary comprise what BTG believes to be the most immediate and urgent requirements for Ethiopia to stave off malaria resurgence and protect vital health systems. The chapters following, beginning with an overview of Ethiopia's malaria environment, provide a more detailed analysis of both short-term and longer-term gaps, opportunities and risks.

Table 1. Bridging Gaps in the Malaria Fight in Ethiopia - Major Opportunities for Investment in 2025-26/27

Intervention	Acute needs	Gap	Rationale
ITN Mass Campaign (Rolling)	• Distribute the ITNs procured by GF to households in targeted districts • Meet universal coverage targets of the 2026 campaign	$2.64M	• Prevent infected mosquito bites to reduce malaria cases and save lives. • Rolling mass campaign to cover the selected 222 high malaria burden districts. • Since the more costly but effective dual-active ingredient nets were introduced in Ethiopia in 2024, there are gaps that need to be filled (GF cannot fill all the gaps).
IRS Campaign (annual)	• Planning, procurement, mapping, operations and supervision to assure quality, timely and high population coverage, for the 2026 IRS campaign.	$3.69M	• Targeted intervention to rapidly reduce mosquito populations in high-malaria burden areas. • Historically, IRS has been part of the core interventions for malaria control. • The NMSP 2023/24-2026/27 has clearly identified IRS as a high-priority intervention going forward.
LSM	• To fight *Anopheles stephensi* in selected towns with confirmed presence of the vector.	$2.35M	• *An. stephensi* is a worrisome invasive vector which thrives in urban water containers and has been linked to large urban outbreaks in Dire Dawa. • In Ethiopia, *An. stephensi* has been found in over 53 towns. Most towns have no IRS or ITNs being implemented. • There were eight towns where PMI was implementing LSM, but this intervention was later withdrawn. • If control measures against *An. stephensi* are not implemented, the vector will continue to spread across the Horn of Africa.
Case management implementation and Therapeutic Efficacy Studies (TES)	• Train, supervise, and provide quality assurance for healthcare facilities and HEWs. Track anti-malarial drug resistance. • Procure and distribute antimalaria drugs for gap filling	$3.35 M	• Provide prompt and effective diagnosis and treatment of malaria infections to prevent severe complications and save lives. • Leverage the dedication of Ethiopia's vast network of HEWs to sustain malaria service. • Threat detection and mitigation to anti-malaria drug resistance in the parasite which is a huge threat to Ethiopia. • Gap filling of antimalaria drugs due to the high consumption due to the current malaria resurgence
SBC	• Restore activities to promote consistent and correct uptake of malaria control measures by the public.	$2.81M	• Promote consistent and correct uptake of malaria control measures by the public. • Limit the damage from severe, abrupt funding cuts in this area.

Data for decision making	• Entomologic surveillance: Track insecticide resistance, invasive vectors. • Epidemiologic surveillance: Track malaria cases and deaths.	$7.89 M	• Data visibility to protect malaria investments. • Threat detection and mitigation, especially for insecticide resistance in the mosquito, and the dangerous, invasive *An. stephensi* mosquito. • Leverage Ethiopia's proven track record in data capture and use.
Supply chain strengthening	• To maintain functionality of the supply chain for malaria commodities.	$0.45M	• Prevent stock-outs of life-saving medicines and tests at service-delivery points. • Permit timely delivery of malaria preventative services (eg ITN and IRS campaigns).
	Total	$23.18M	

Malaria in Ethiopia

Overview

Ethiopia has been facing an unprecedented surge in malaria, with reported cases escalating from 3.7 million in 2023 to 10.2 million in 2024[6]. Concurrently, malaria-attributed mortality nearly tripled, rising from 469 deaths in 2023 to 1,324 in 2024. This dramatic increase is particularly striking given that in 2019, Ethiopia recorded only 994,000 cases (Figure 1). Significant reductions occurred over the past two decades prior to this rapid increase. Between 2010 and 2019, malaria cases declined from approximately 5 million to less than 1 million, while deaths fell from 3,000 in 2010 to 212 in 2021. Ethiopia launched sub-national malaria elimination in 2017 and is currently pursuing elimination activities in 565 districts out of 919 malarious districts aiming to achieve nationwide elimination by 2030[7,8]. According to data from Health Management Information System (HMIS) Ethiopia, malaria cases increased by 65% between January and April 2025, rising to 2,214,345 cases compared to 1,343,533 cases during the same period in 2024. As of 2023, the country's population was estimated to be 126.5 million[9] with approximately 69% of the population at risk of malaria[10].

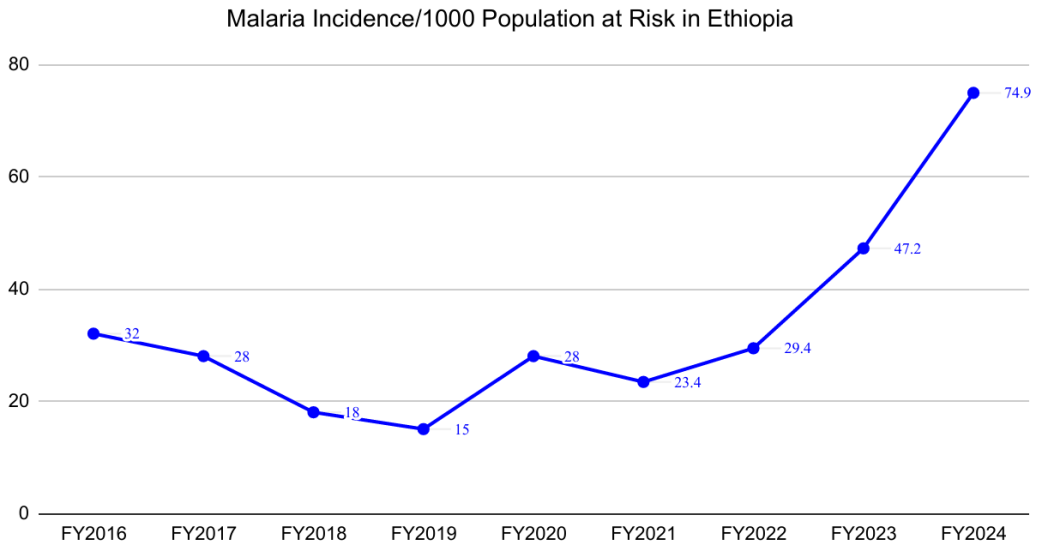


Figure 1. Trends in Malaria Incidence, Fiscal Years, source - Ethiopia FMOH: Annual Performance Report, FY 2016–2024. Data was not available for the Tigray region in 2021 and 2022.

Plasmodium falciparum, accounting for approximately 65% of confirmed cases, and *Plasmodium vivax*, accounting for 35% of confirmed cases, are the major malaria parasites in Ethiopia[11]. The presence of *P. vivax* means that malaria control in Ethiopia requires dual strategies — one targeting *P. falciparum* transmission and another focused on *P. vivax* relapse prevention and improved diagnostics. The updated national treatment guidelines have omitted G6PD testing and instead recommend that health workers conduct follow-up visits for patients treated with chloroquine and primaquine. This approach increases the workload for already overstretched health workers. Malaria transmission in Ethiopia is highly seasonal with the peak transmission periods running between

[6] WHO Ethiopia Cluster Reports 2023 and 2024

[7] Ethiopia National Malaria Elimination Strategic Plan (2024/25-2026/27)

[8] 26th Annual Review Meeting of the Health Sector, https://www.moh.gov.et/index.php/en/node/417?language_content_entity=en

[9] https://www.worldbank.org/en/country/ethiopia/overview

[10] https://www.severemalaria.org/ethiopia-1

[11] https://www.severemalaria.org/ethiopia-1

September and December following the primary rainy season (which occurs from June to September), and April to May after the secondary rainy season (which occurs from February to May)[12].

Regional Heterogeneity

Ethiopia covers an area of 1.1 million square kilometers with altitude ranging from 4,620 meters above sea level at Ras Dashen Mountain to 148 meters below sea level at the Danakil (Dallol) Depression. More than half of the country lies at high altitude above 1,500 meters. The highest-burden regions tend to have stable and intense malaria transmission at altitudes below 1,500 meters and temperatures between 24 and 30 degrees Celsius. These areas include the entire regions of Gambela and Benishangul-Gumuz; as well as western parts of Oromia; Amhara; Tigray; South Western Ethiopia and South Ethiopia regions[13] (Figure 2).

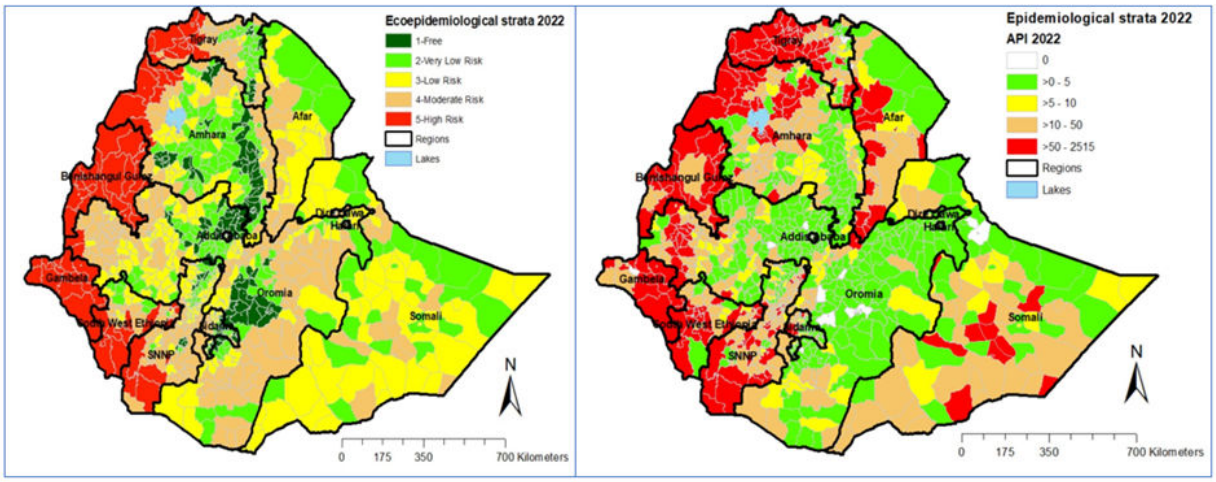


Figure 2. Eco-epidemiological stratification based on environmental and climatic risk variables (left) and annual parasite incidence (API) (right)

Factors Contributing to Malaria Transmission

One of the drivers of malaria transmission in Ethiopia is widespread insecticide resistance in malaria vectors that undermines the impact of long-lasting insecticidal nets and indoor residual spraying [14]. These challenges have been compounded by the spread of *Anopheles stephensi*, an invasive vector accelerating transmission in urban and low-endemic areas. Climate change is a major contributor. Ethiopia's topographic diversity and highly variable rainfall patterns, coupled with climate change-induced anomalies (e.g., El Niño/La Niña events), have altered and expanded the geographical range and seasonality of malaria Epidemics now occur frequently above 2,000m in the highlands, and shifting rainfall patterns have increased the unpredictability of transmission, promoting epidemic vulnerability among partially immune populations. Warming trends and changes in land use (e.g., expansion of irrigation and hydropower infrastructure) have increased the number of settlements at risk of malaria[15].

[12] https://www.who.int/emergencies/disease-outbreak-news/item/2024-DON542

[13] FY 24 Ethiopia Country Profile - https://drive.google.com/drive/u/1/folders/15tOMappeD6OVacrCC14KGwhG1QTd0Qn-

[14] https://www.who.int/emergencies/disease-outbreak-news/item/2024-DON542

[15] https://www.psi.org/research/actwatch/

The National Malaria Strategy and Progress to Date

Ethiopia's Federal Ministry of Health (FMOH) commissioned the country's National Malaria Elimination Strategic Plan (NMSP) for the period 2024 to 2027[16]. The NMSP (2024/25–2026/27) sets out several core goals outlined in Table 2. Strategies to achieve these goals include empowering communities, ensuring timely diagnosis and treatment, improving vector control, strengthening surveillance and research, enhancing supply chain efficiency, promoting equitable access, engaging diverse stakeholders, and reinforcing program management. Table 2. The NMSP sets several key goals, this table outlines the approaches by intervention area to achieve those goals.

Table 2. Priority interventions and associated goals within the Ethiopian National Malaria Elimination Strategic Plan 2024/25-2026/27.

Strategic Area/ Focus Investment Area	NMSP Goals (2024/25–2026/27)	NMSP Key Approaches
Vector Control	By 2024 and beyond, cover 100% of the eligible population living in low, moderate, and high malaria risk areas with one type of globally recommended core vector control interventions.	- ITNs as primary tool, targeted IRS, larval source management, entomologic surveillance. - New generation ITNs instead of pyrethroid-only LLINs shall be deployed. - No co-deployment of ITNs and IRS. - High malaria burden areas will be prioritized and in 2024, 222 districts was identified as high malaria burden districts in different regions. - LSM will be implemented in areas with *An. stephensi.*
Case Management	100% suspected cases tested; 100% confirmed cases treated within 24 hrs.	- Universal access to quality diagnosis & treatment. - Maintain drug supply & provider QA. - Strengthen HEW program. - Conduct proactive case detection for IDPs, refuges, isolated communities having limited access for health services, etc. - RDA recommended with reactive case detection (RCD) in areas nearing elimination.
Supply Chain	Improve malaria supply chain and quality of antimalarial commodities by 2024.	- Strengthen logistics systems. - Improve forecasting, procurement, and distribution. - Work with humanitarian partners to implement LMD in conflict affected areas.
Surveillance, Monitoring, Evaluation (SMEOR)	Generate evidence that facilitates decision-making of malaria programmes at all levels by 2024.	- Ensure eCHIS, PHEM and DHIS2 platforms are updated to have analytics, visualization, and feedback capabilities. - Conduct routine malaria data quality assessment (RDQA). - Enhance the referral linkages between community and health facilities. - Strengthening implementation of operational research and coordination.
Social Behavior Change (SBC)	By 2027, achieve adoption of recommended behavior regarding antimalarial interventions by 85% of households living in malaria risk areas.	- Update the malaria SBC strategy to broaden approaches for enhanced community engagement. - Use of community-based approaches to reach and expand access to interventions and enhance service delivery through community-based approaches.

[16] Ethiopia National Malaria Elimination Strategic Plan (2024/25-2026/27)

Despite the recent resurgence, Ethiopia's malaria program has registered important successes:

- Malaria-attributable deaths dropped from over 3,000 in 2010 to fewer than 200 annually in the late 2010s and early 2020s, with a more than 96% decline in age-standardized mortality rates between 1990 and 2015[17].
- Confirmed case counts reached an all-time low in 2019 (904,495 cases)[18].
- Universal coverage campaigns, IRS scale-up, health worker deployment, and test-and-treat policies have underpinned these gains[19] [20].
- The percentage of households with at least one LLIN rose to two-thirds in malarious areas[21].
- Community-based management has drastically improved access to prompt diagnosis and treatment[22].

Vector control remains the cornerstone of Ethiopia's malaria response, primarily through mass long lasting insecticide treated nets (LLIN) campaigns, continued indoor residual spray (IRS) implementation in high- and moderate-risk areas, and, increasingly, targeted larval source management (LSM). For case management, Ethiopia's "test-and-treat" policy mandates that all suspected malaria cases receive parasitological confirmation using either rapid diagnostic tests (RDTs) (in health posts, often multi-species) or microscopy (health centers/hospitals). National guidelines stipulate artemether-lumefantrine + single-dose primaquine for confirmed uncomplicated *P. falciparum* and chloroquine + primaquine for *P. vivax*. Dihydroartemisinin-piperaquine is reserved as second-line therapy and for seasonal mobile workers treatment; injectable artesunate is the standard for severe cases, supported by rectal artesunate as pre-referral management at the community level[23].

Recent years have seen a notable reduction in stockouts for antimalarial commodities, reaching the 5% target set by PMI's supply chain management strategy[24]. Shifted to non-HRP2/3 based RDTs due to HRP2/3 gene deletions[25], and the implementation of electronic Community Health Information System (eCHIS) in malaria elimination districts is underway to improve surveillance and decision-making[26].

The deployment of over 40,000 health extension workers (HEWs), strengthened by the Health Extension Program and integrated Community Case Management (iCCM), underpins Ethiopia's approach to decentralized prevention and early treatment[27]. HEWs are authorized to test and treat all ages, refer severe cases, and function as the backbone of Ethiopia's health system response—particularly in remote and challenging environments. Social behavior change (SBC) tailored to localities and seasons, is an embedded element of all intervention campaigns and increasingly utilizes radio, local leaders, and mobile messaging to reach at-risk groups[28].

Surveillance is a strategic priority, with targets for completeness and timeliness set at >95% nationally. Operational research and implementation of malaria case and focus investigation, classification, and rapid response systems have been rolled out in all elimination-targeted districts (538 as of 2022)[29]. Early warning and

[17] https://www.who.int/publications/i/item/9789240077489

[18] https://dhsprogram.com/publications/publication-MIS20-MIS-Final-Reports.cfm

[19] http://www.moh.gov.et/

[20] http://www.moh.gov.et/

[21] https://dhsprogram.com/publications/publication-MIS20-MIS-Final-Reports.cfm

[22] http://www.moh.gov.et/

[23] https://www.who.int/publications/i/item/9789240077489

[24] https://www.pmi.gov/resource-library/malaria-operational-plans-mops/

[25] http://www.ephi.gov.et/

[26] https://www.path.org/programs/malaria-control-and-elimination-partnership-africa-macepa/

[27] http://www.moh.gov.et/

[28] https://www.unicef.org/ethiopia/reports

[29] http://www.moh.gov.et/

epidemic preparedness systems are being promoted in collaboration with meteorological data services, with the ENACTS initiative serving as a model for climate-divergence-informed malaria risk monitoring[30].

The total estimated cost of the NMSP for three years, 2024/25 to 2026/27, is $695,278,448 (USD) with 63% of this estimated budget going to vector control interventions[31]. According to the NMSP 2024/25-2026/27, the financial commitments for malaria control in July 2023 were dominated by the Government, which contributed just over half of the total resources (53%) (Figure 3). Specifically, the Government contributes towards health system infrastructure which permits mass population access to services and has also allocated funds in moderate amounts for malaria-specific commodity and program support. The GF follows with nearly a quarter (24%), while PMI/USAID committed to provide about one-fifth (21%). Other sources were comparatively minor, with SDG accounting for less than 2%, and WHO and "Others" together representing a negligible share. This highlights the heavy reliance on two major external partners—GF and PMI/USAID and the Government of Ethiopia for sustaining Ethiopia's malaria response.

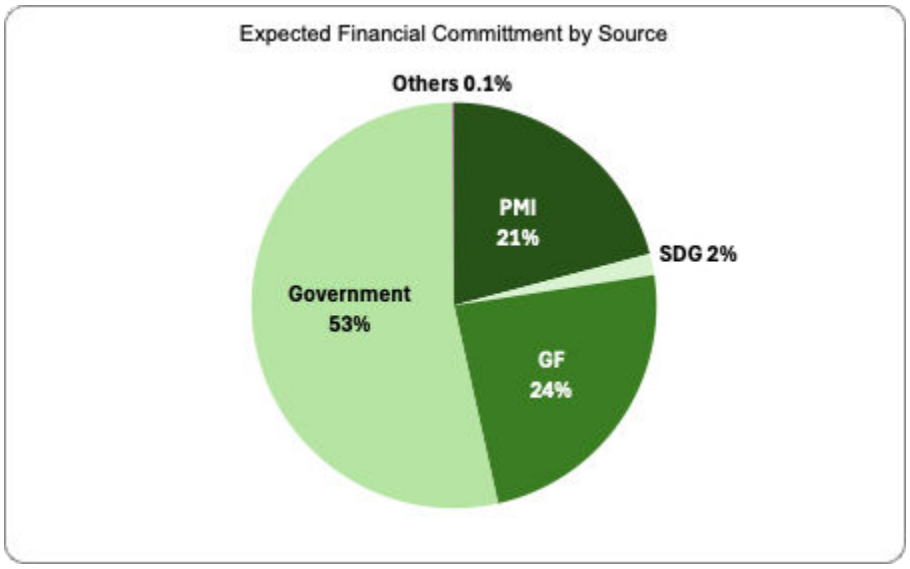


Figure 3. Expected Financial Commitment by Source (July 2023), Malaria and Other Vector-Borne Diseases (MOVBD) Prevention and Control Desk in Ethiopia.

Malaria Elimination Challenges

While the aspiration of a malaria-free Ethiopia remains intact, the country's ambitions are at a crossroads. The resurgence of malaria in the wake of sustained progress is a stark reminder of the fragility of public health gains in the face of conflict, climate change, vector adaptation, RDT HRP2/3 deletion, drug and insecticide resistance, and funding volatility[32] [33]. Ethiopia's malaria program has demonstrated the capacity for both innovation and resilience. However, closing the implementation and funding gaps will be essential for restoring progress toward elimination.

Health System and Implementation Bottlenecks

Ethiopia's malaria elimination aspirations—formalized as "zero indigenous cases by 2030"— face a growing array of implementation bottlenecks. Significant gains achieved up until 2019 have eroded due to intersecting crises, including armed conflict, population displacement, climate shocks, and emerging biological threats. This has significantly affected the functionality of the country's health information system. For instance, the malaria incidence trends shown in Figure 1 exclude data from the Tigray region for 2021 and 2022. According to the Ministry of Health Annual Performance Report, national reporting completeness and timeliness rates in 2024

[30] https://www.statsethiopia.gov.et/

[31] https://www.moh.gov.et/en/National_Malaria_Elimination_Program?language_content_entity=en

[32] https://endmalaria.org/resources

[33] https://www.who.int/emergencies/disease-outbreak-news

were 85% and 57%, respectively. Persistent insecurity has continued to undermine data quality and completeness in affected areas.

Health workforce density in Ethiopia remains below the World Health Organization (WHO) benchmark for Universal Health Coverage, estimated at only 1 per 1,000 population (vs. benchmark of 4.5/1,000) in 2018, and there are persistent shortages in skilled cadres such as medical doctors, pharmacists, and laboratory technologists—particularly acute in rural and conflict-affected areas[36]. As a result, the Health Extension Program (HEP) and network of Health Extension Workers (HEWs) play a pivotal role in outreach, but gaps remain in achieving comprehensive, high-quality service delivery at the last mile, especially where insecurity or inaccessibility prevails[37].

Funding Constraints

Ethiopia's malaria elimination trajectory is increasingly threatened by widening financing shortfalls. While domestic allocations have grown modestly, the program remains heavily dependent on external partners, particularly the USG through the PMI[38] and the GF[39]. Both donors face constrained budgets and competing global priorities, resulting in projected reductions in disbursements for Ethiopia over the 2024/25–2026/27 cycle. Ethiopia's malaria control and elimination strategic plan (2024/2025 - 2026/2027) is being implemented under a significant estimated budget shortfall. The current donor's funding cuts widens the gap more. These gaps are expected to exacerbate existing bottlenecks in implementation of indoor residual spraying (IRS), larval source management (LSM), malaria case management, surveillance, monitoring and evaluation (M&E), social behavior change communications (SBC) and operational research (OR). Already, the program struggles to sustain universal LLIN coverage, maintain adequate IRS coverage, and ensure uninterrupted supplies of diagnostics and antimalarials. Without bridging resources, Ethiopia risks reversal of a decade long gains, with fragile health systems unable to absorb the shortfall. The funding squeeze will not only slow progress toward the 2030 elimination goal but also heighten vulnerability to epidemics, particularly in conflict-affected and high-transmission regions and zones where donor support has historically underpinned service continuity. The government's pledge to finance at least 56% of required program costs by 2025/26 underscores continued firm commitment. This represents over 86.8 million yearly allocations, a fourfold increase from the 2020 government allocation (23.6 million). However, it still highlights the scale of the gap that must be filled[40].

Surveillance and Reporting Gaps

While the adoption of the DHIS2 platform and the Electronic Community Health Information System (eCHIS) extension have strengthened routine HMIS, ongoing surveillance completeness and timeliness are hampered in regions affected by security constraints and weak infrastructure. Although reporting completeness for DHIS2 now exceeds 89% nationally (with a target of >95%), under-reporting, delayed data flow, and limited granularity of case and death notification persist, especially in areas experiencing conflict or extreme weather events. Notably, only 20–25% of malaria cases are currently reported through community health channels, reflecting a missed opportunity for early detection and rapid response at the periphery[41].

[36] U.S. President's Malaria Initiative. Ethiopia Malaria Operational Plan FY 2025. Washington, DC: PMI, 2024.

[37] Federal Ministry of Health. Health Extension Program Review. Addis Ababa: FMOH, 2023.

[38] https://www.pmi.gov/resource-library/malaria-operational-plans-mops/

[39] https://www.theglobalfund.org/en/funding-requests/

[40] https://www.mofed.gov.et/

[41] https://www.path.org/programs/malaria-control-and-elimination-partnership-africa-macepa/

Case investigation, classification, and rapid response are established in elimination-targeted districts, though challenges in extending these approaches universally are evident. The routine use of molecular diagnostic tools remains limited, partially due to constraints in laboratory capacity and supply chain[42].

Diagnostic, Drug Resistance, and Socio-Cultural Barriers

As described previously, rising rates of HRP2/3 deletions undermine the sensitivity of the most commonly used RDTs, threatening accurate and timely case detection[43]. Drug resistance is an emergent threat, with artemisinin and partner drug efficacy showing concerning signals in localized studies[44]. The challenge of *P. vivax*, with its hypnozoite reservoir and ability to infect persists. *P. vivax*-infected persons in Ethiopia experience approximately three relapses within 12 months; such illness relapses could be especially harmful to pregnant and breastfeeding women unable to take primaquine, who have impaired immunity, an impaired nutritional status, and an increased risk of progression to severe or complicated malaria illnesses.[45] This necessitates careful diagnosis and treatment of cases as early as possible.

Socio-cultural barriers including risk misperceptions, and low health literacy curtail uptake of core prevention and treatment interventions such as LLINs, IRS refusal in certain locations, and early care seeking[46]. Communities in highly endemic and hard-to-reach settings often prioritize immediate livelihood needs over preventive health behaviors, with net misuse and attrition reducing the long-term effectiveness of vector control campaigns[47].

Population Mobility, Displacement, and Cross-border Transmission

The impacts of population displacement—driven by conflict, drought, and food insecurity—are acutely felt. As of May 2024, over 3.3 million internally displaced persons (IDPs) reside in over 2,700 sites, and more than one million refugees—half of whom are in highly endemic western lowlands—place additional strain on fragile health structures and contribute to malaria transmission dynamics[48].

Seasonal and economic migration—especially labor migration from malaria-free highlands to high transmission-prone lowlands—contributes to shifting epidemiological patterns, seeding transmission in previously low-burden regions and complicating elimination efforts. Cross-border transmission is compounded by Ethiopia's extensive land borders with six malaria-endemic neighbors, each facing their own health system challenges and frequent concurrent outbreaks[49].

Vector Control Challenges

In 2024, widespread insecurity in Ethiopia severely constrained access to areas targeted for IRS and ITN distribution, increasing implementation costs and resource needs. Entomological monitoring was also disrupted in several locations. To sustain vector control, Ethiopia transitioned from district-based to community-based IRS and mosquito surveillance, enhancing operational resilience.

Development, widespread insecticide resistance by local malaria vectors and the emergence of histidine-rich protein-2 (HRP2) gene deletions also emerged as challenges in the 2023 Malaria Programme Performance

[42] http://www.ephi.gov.et/

[43] http://www.ephi.gov.et/

[44] https://www.who.int/publications/i/item/9789240077489

[45] PMI Malaria Operational Plan 2015

[46] https://www.unicef.org/ethiopia/reports

[47] https://www.malariaconsortium.org/resources/publications

[48] https://endmalaria.org/resources

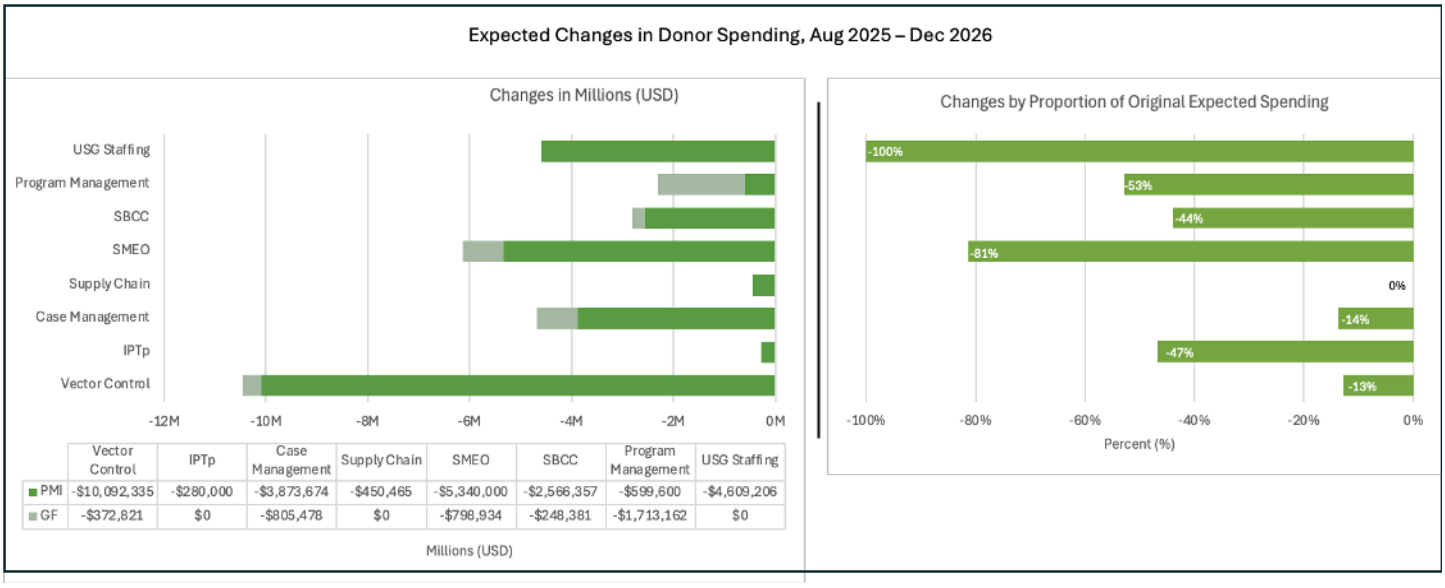
[49] https://endmalaria.org/resources

Review (MPR)[50]. Specifically, complete pyrethroid resistance has been confirmed nationwide. Bioefficacy data from Amhara region show that standard pyrethroid ITNs are ineffective against wild mosquitoes.. Moreover, PBO ITNs demonstrated rapid chemical degradation within five months, prompting the government and partners to recommend dual active ingredient (dual-AI) ITNs for future procurements.

However, the high cost of next-generation ITNs has led PMI and GF to reduce procurement volumes, forcing the NMEP to prioritize high and moderate burden areas, leaving lower transmission zones unprotected. Finally, implementation of LSM proved costly, highlighting the importance of early community and cross-sectoral engagement to enhance cost efficiency, sustainability, and smooth transitions.

2025 Funding Landscape

As of February and July 2025, PMI and the GF had already signaled reductions in planned allocations for the 2025–2026 period and beyond (Figure 4). For PMI, this includes significant cuts to activities not deemed life-saving in the short term, including IRS even though it is lifesaving, entomological monitoring within vector control category), surveillance, M&E, OR, surveys, SBC and malaria elimination activities, among others. Meanwhile, the GF's funding realignment exercise has led to the reduction or cancellation of activities totaling nearly US $7.3 for three years (2024/25-2026/27) and US $3.9 million for Ethiopia over the current two-year period (2025/26–2026/27). At the same time, the GC7 allocation has shifted some funds away from longer-term investments—such as data system strengthening, public education, and innovation—toward short-term commodity needs, including RDTs and ACTs. Although the Government of Ethiopia is expected to increase its allocation to health overall, and to malaria specifically, its fiscal space remains severely constrained.



	Vector Control	IPTp	Case Management	Supply Chain	SMEO	SBCC	Program Management	USG Staffing
PMI	-$10,092,335	-$280,000	-$3,873,674	-$450,465	-$5,340,000	-$2,566,357	-$599,600	-$4,609,206
GF	-$372,821	$0	-$805,478	$0	-$798,934	-$248,381	-$1,713,162	$0

Figure 4. Changes in Expected Donor Spending, August 2025-Dec 2026, by Intervention Area. The left-hand graph depicts the estimated difference between the original and revised spending levels, for each donor. The right-hand graph depicts the combined change for PMI and GF, expressed as a percentage of original expected spending.

The sudden contraction in financing and the uncertainty in future support jeopardizes gains made so far. Like non-island countries across sub-Saharan Africa, gains in case incidence had already stagnated by 2023. From 2025-26 onward, the anticipated reduction in mass access to prevention and treatment services—particularly in high-burden or hard-to-reach districts—could reverse trends in declining mortality as well. The loss of funding for IRS in high-burden areas, a major vector control intervention in the selected high malaria burden districts,

[50] https://drive.google.com/drive/u/1/folders/1nsxkevwsQos74zY0ITDv4Dc8F-wy167t

together with cuts to larval source management targeting *An. stephensi* in Ethiopia's urban cities, is likely to fuel the ongoing malaria upsurge. In addition, reductions in support for surveillance and data systems further weaken Ethiopia's ability to identify and mitigate threats such as antimalarial drug resistance and invasive vectors, detect outbreaks, and measure impact in real time. Given that ITN use in Ethiopia is already low—45% according to the Ethiopia Mini Demographic and Health Survey (EMDHS) 2019—the loss of SBC funding, which plays a critical role in raising household awareness, promoting intervention uptake, and engaging communities, will further exacerbate the country's malaria situation.

While Ethiopia's government is increasingly engaged in health financing, as mentioned its current fiscal space limits the ability to immediately absorb donor withdrawal. This creates an urgent need for bridging strategies, including catalytic donor engagement, reallocation and sustained domestic resources, and enhanced coordination across implementing partners.

Results: Ethiopia Malaria Gaps Inventory and Prioritization

The Ethiopia Malaria Gaps Inventory ("Inventory") is structured using the same intervention areas (aka "categories" or "focus investment areas") as found within the former USAID PMI Malaria Operational Plan (MOP) documents. MOPs are detailed implementation plans previously developed by PMI to guide malaria control and elimination efforts in specific countries. MOPs outline the strategies, activities, and funding allocations for PMI's support by fiscal year, aligning with NMCPs and global goals. These plans were previously developed in close collaboration with NMCPs and other key stakeholders.

A summary of inventory results is provided in Attachment B, organized by MOP 'focus investment areas' and capturing both PMI funding reductions and GF-FMOH grant reprioritization. The full inventory has been shared with the Ethiopian MOVBD. In Ethiopia, for 2025–2026, PMI's originally planned allocation of $70 million (US$35 million per year) has been revised downward by $27.8 million, leaving $42 million. Similarly, the GF-FMOH budget for years 2 and 3, initially set at $71.2 million, has been reduced to $67.3 million following reprioritization (a 3.9 million reduction).

Overall, the combined net change across PMI and GF-FMOH funding for 2025–2026/27 amounts to a reduction of $31.8 million (Figure 5). The following sections detail and disaggregate these funding modifications by focus area.

Table 3. Summary of the Ethiopia Gaps and Priorities Inventory (for full table consult Attachment B). Original and revised or reprioritized budgets for CY 2025 and CY 2026 (and combined). "Net change" describes overall change in funding for both CY 2025 and CY 2026. While PMI and GF-FMOH funding has revised downward, other funding sources (government, SDG, WHO) have remained stable. A = full need (MOVBD); B = Original expected spending; C = Revised expected spending. Baseline Gap = [A-B]; Revised Gap = [A-C].

Donor		2025	2026	Combined (2025-2026)
PMI	Original	$35,000,000	$35,000,000	$70,000,000
	Revised	$23,136,705	$19,051,658	$42,188,363
	Net Change	-$11,863,295	-$15,948,342	-$27,811,637
GF (FMOH)	Original	$53,734,210	$17,499,876	$71,234,086

	Revised	$52,221,085	$15,074,225	$67,295,310
	Net Change	-$1,513,125	-$2,425,651	-$3,938,776
Government	Original	$86,640,537	$84,591,142	$171,231,679
	Revised	$86,640,537	$84,591,142	$171,231,679
	Net Change	$0	$0	$0
SDG	Original	$2,790,000	$2,790,000	$5,580,000
	Revised	$2,790,000	$2,790,000	$5,580,000
	Net Change	$0	$0	$0
WHO	Original	$5,000	$5,000	$10,000
	Revised	$5,000	$5,000	$10,000
	Net Change	$0	$0	$0
Others	Original	$37,550	$37,550	$75,100
	Revised	$37,550	$37,550	$75,100
	Net Change	$0	$0	$0
	Full Need (MOVBD) [A][51]	$162,057,186	$249,653,929	$411,711,115
Totals	Original [B]	$178,207,297	$139,923,568	$318,130,865
	Revised [C]	$164,830,877	$121,549,575	$286,380,452
	Net Change [B-C]	-$13,376,420	-$18,373,993	-$31,750,413
	Baseline Gap [A-B]	-$16,150,111	$109,730,361	$93,580,250
	Revised Gap [A-C]	-$2,773,691	$128,104,354	$125,330,663

[51] NMSP Ethiopia 2024 - 2027, Table 8 and 9

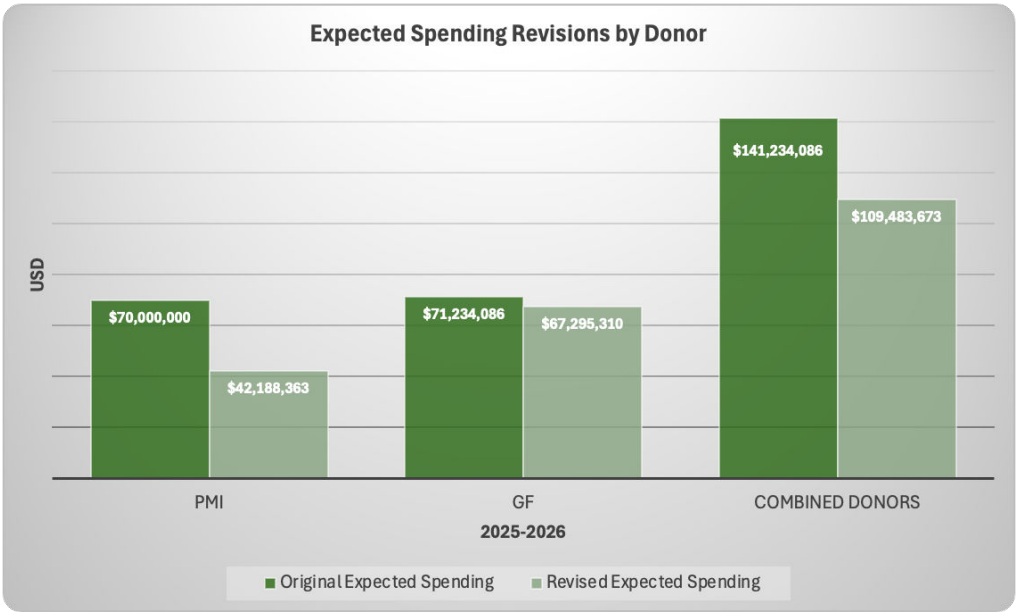


Figure 5. Funding was revised downward for PMI, GF-FMOH by a total of -$31.8 million across 2025 and 2026/27 (combined).

Vector Control

The Ethiopia Ministry of Health Vector-Borne Disease Division (MOVBD) and its partners have primarily invested in entomological monitoring, ITN distribution, and IRS for vector control. However, larval source management (LSM) has been specifically implemented to combat *An. stephensi*, a vector that does not respond to traditional malaria interventions like IRS and ITNs. Overall revisions in expected donor spending are given in Table 4, Figure 6 and Figure 7. Details of expected and revised spending by donors are given in Attachment B, with highlights provided in the following pages by vector control activity area.

Table 4. Expected spending revisions in vector control, for the period Aug 2025-Dec 2026 by PMI and July 2025 -July 2027 by GF.

Expected Spending Revisions, Vector Control, 2025-2026/27			
	PMI	GF (FMOH)	Totals
Original Expected Spending	$36,849,765	$45,634,112	$82,483,877
Revised Expected Spending	$26,757,430	$45,261,291	$72,018,721
Net Change	-$10,092,335	-$372,821	-$10,465,156

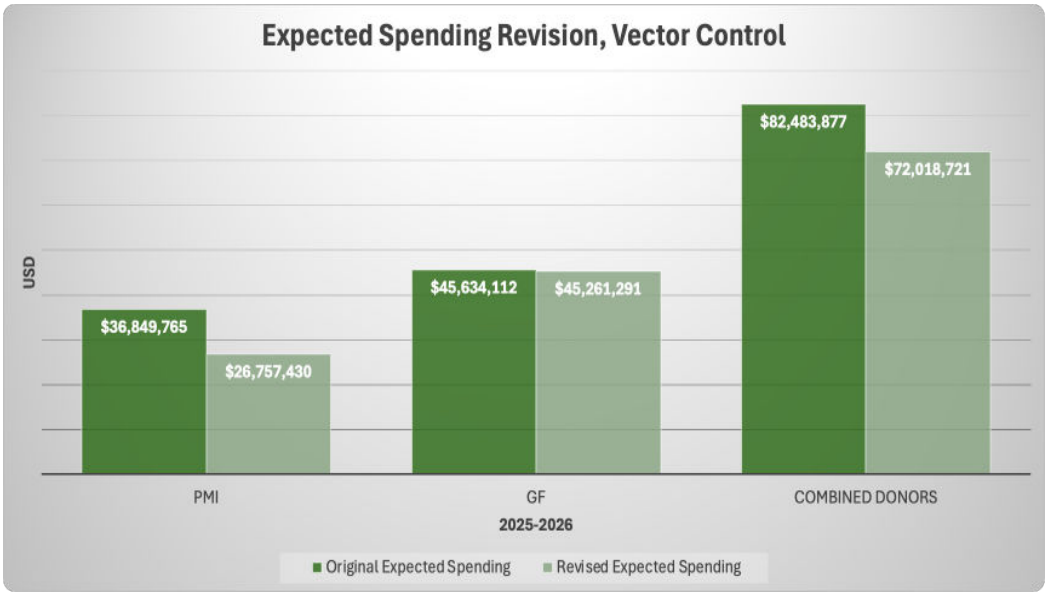


Figure 6. Expected spending revisions in vector control, for the period Aug 2025-Dec 2026 by PMI and July 2025 -July 2027 by GF.

To summarize, PMI reduced its expected spending on vector control by $10.1 million, falling from $36.8 million to $26.8 million (Table 3, Figure 6). In contrast, GF (FMOH) contributions were largely sustained, with only a marginal reduction of approximately $370,000—from $45.6 million to $45.3 million. Taken together, across both funding streams, Ethiopia is projected to face a net reduction of $10.5 million in vector control resources over the 2025–2026/27 period.

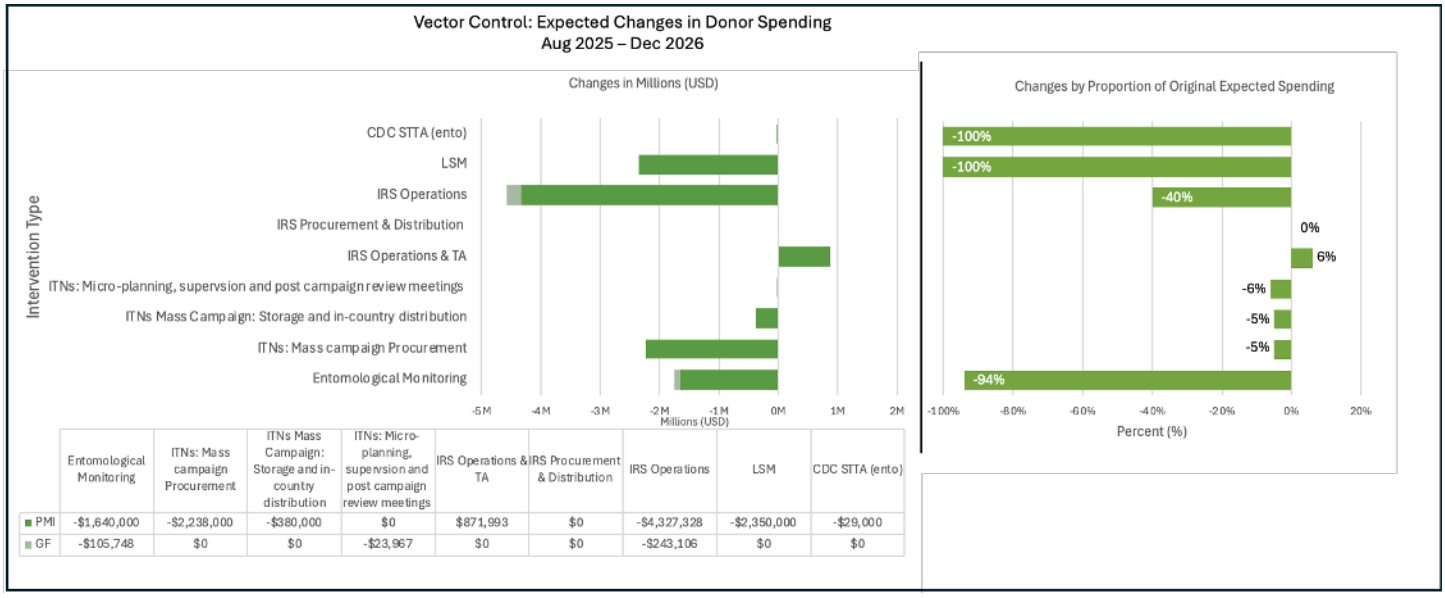


Figure 7. Expected spending revisions in vector control, for the period Aug 2025-Jun 2027, by donor and intervention area.

The following sections describe the funding modifications for each intervention associated with vector control which are depicted in Figure 7.

Entomological monitoring

Entomological monitoring is a cornerstone of Ethiopia's malaria elimination strategy, providing the evidence base needed to guide vector control interventions and adapt to emerging threats. Entomological monitoring involves

routine surveillance of mosquito species distribution, insecticide resistance, biting and resting behaviors, and transmission dynamics. These data inform decisions on the deployment of ITNs, IRS, and LSM, while also supporting the detection and response to the invasive mosquito species, *An. stephensi*. A national network of sentinel sites, supported by the MOVBD, the Ethiopia Public Health Institute (EPHI), and academic partners, provides robust evidence for the malaria programme. However, the continuation of these activities is now at risk due to significant reductions in donor funding.

PMI Funding

- PMI originally budgeted **$1.7 million** for the 2025–2026 period (**$900,000 for 2025** and **$800,000 for 2026**) to support IRS quality control at four sentinel sites, insecticide susceptibility testing at five sites, and surveillance for *Anopheles stephensi*.
- During budget reductions, this allocation was cut by **$1.64 million**, leaving only **$60,000**.
- As a result, coverage has been reduced to IRS quality control at just one site, insecticide testing at five sites, and no *An. stephensi* surveillance.

GF/FMOH Funding

- The GF/FMOH allocated **$165,329** for entomological monitoring across Year 2 (**$44,668 for July 2025–June 2026**) and Year 3 (**$120,641 for July 2026 – June 2027**).
- This funding was intended to support eight of the 20 operational sentinel sites, with a focus on strengthening surveillance activities and building capacity for monitoring the bionomics and vectorial capacity of *An. stephensi*.
- Following the de-prioritization exercise, the GF/FMOH budgets for entomological monitoring in Year 2 and Year 3 were reduced by **$105,748**, dropping from **$165,329** to **$59,581**.
- As a result, five operational sentinel sites will be dropped from surveillance. This will undermine the MOVBD's plan to halt the spread of *An. stephensi* and its potential impact in exacerbating malaria transmission.

Combined Reduction for 2025-2026/27

- The combined projected decrease in funding from both PMI and GF/FMOH for entomological monitoring over this period is **–$1,745,748**.

Risk Statement

The significant reduction in funding for entomological monitoring poses a critical risk to the effectiveness and sustainability of vector control efforts. This reduction will likely result in insufficient data to inform evidence-based decision-making and policy formulation for vector control programmes, inadequate monitoring and control of vector populations, and limited capacity to detect and respond to insecticide resistance, thereby compromising the effectiveness of ITNs and IRS. Ethiopia's proven track record in data capture and use underscores the importance of maintaining data visibility to protect malaria investments and help limit the damage caused by abrupt funding cuts.

Additionally, there is an increased risk from the invasive vector *An. stephensi*, which thrives in urban settings by breeding in man-made water sources such as tanks, cisterns, and construction pits. *An. stephensi* was detected in Eastern Ethiopia in 2016 and quickly spread to many parts of the country. *An. stephensi* was implicated in the malaria epidemic in Dire Dawa in eastern Ethiopia, near the border of the Oromia and Somali regions. Following

An. stephensi detection in 2012 in Djibouti City, malaria incidence increased from 2.5 cases per 1000 (2013) to 97.6 cases per 1000 (2020)[52] This vector thrives in urban environments and has been shown to accelerate malaria transmission in urban and low-burden settings year-round. The absence of surveillance for *An. stephensi* could lead to its unchecked spread, further complicating control efforts and potentially reversing gains made in malaria reduction. Failure to secure alternative funding sources could undermine the progress made in malaria control and pose a significant threat to public health.

Vector Control: Entomological monitoring
Priority level for seeking alternative funding: HIGH. **Expected Impact: LONGER TERM.** **Total net reduction (2025 - 2026/27) = -$1,745,748 approximately 93.6%** **Risk (brief):** The severe reduction of 94% in PMI and GF/FMOH support threaten Ethiopia's ability to monitor insecticide resistance, track *An. stephensi*, and sustain sentinel site surveillance, undermining the effectiveness of vector control interventions.

Insecticide Treated Nets

In Ethiopia, ITN mass campaigns and IRS are implemented as core vector control interventions, tailored to sub-national eco-epidemiological stratification (high, moderate, and low malaria risk areas). These interventions are designed to achieve the NMSP objective of 100% coverage of eligible populations with globally recommended core vector control interventions by 2024 and beyond.

ITNs are distributed annually through rolling mass campaigns, with the aim of replacing nets every three years. These campaigns are integrated into the public health care system, with HEWs distributing nets directly to targeted communities. The distribution strategy prioritizes high and moderate malaria risk areas for ITN distributions — specifically where the Annual Parasite Incidence (API) is over 50 but IRS is not provided, as well as areas with an API between 10 and 50. Some zones in low-risk areas with moderate to high API (30–50) are also included. In addition, the approach targets vulnerable groups such as internally displaced persons (IDPs) and refugees, aiming to achieve at least 50% ITN coverage among these populations. However, the continuation and reach of these campaigns are now at risk due to significant reductions in donor funding.

PMI Funding

- The original PMI budget for 2025 remains unchanged at **$9,472,000**, allocated for the procurement, storage, and in-country distribution of **1,850,000 Dual AI nets** in 222 high-burden districts. This budget also covers micro-planning, supervision, and post-campaign review meetings.
- In 2026, however, PMI's budget was reduced by **$2,618,000**, decreasing from **$9,240,000** to **$6,662,000**.

[52] Al-Eryani, S.M., Irish, S.R., Carter, T.E. et al. Public health impact of the spread of Anopheles stephensi in the WHO Eastern Mediterranean Region countries in Horn of Africa and Yemen: need for integrated vector surveillance and control. Malar J 22, 187 (2023). https://doi.org/10.1186/s12936-023-04545-y

- As a result, the procurement and distribution of the more costly Dual AI nets will be scaled back, limiting coverage in 2026-27 and potentially impacting malaria prevention efforts.

GF/FMOH Funding

- In Year 2, the GF/FMOH budget remained relatively stable, with only a marginal decrease of **$5,013**—from **$32,578,259** to **$32,573,246**. This funding supports procurement, storage, and nationwide distribution of Dual AI nets across high, moderate, and low malaria transmission areas with an API greater than 10, as well as micro-planning, supervision, and post-campaign review meetings.
- In Year 3, the budget was slightly reduced by **$18,954**, from **$287,914** to **$268,960**, designated for supervision and post-campaign review activities.
- These reductions, though relatively small, nevertheless constrain the ability to fully sustain campaign operations.

Combined Funding Reduction (2025–2026/27)

- The total reduction in funding from PMI and GF/FMOH for ITN mass campaigns in Years 2 and 3 amounts to **–$2,641,967**.
- This shortfall threatens Ethiopia's ability to maintain universal coverage targets, particularly in high and moderate malaria risk areas, and places vulnerable populations such as IDPs and refugees at greater risk of inadequate protection (see *Figure 7*).

Risk Statement

The significant reduction in ITN funding poses an immediate risk to Ethiopia's malaria prevention efforts. With fewer resources, the procurement and distribution of ITNs (including those procured by GF) will be scaled back, creating gaps in coverage that could lead to increased malaria transmission, particularly in high and moderate malaria risk areas. Vulnerable populations such as IDPs and refugees are especially at risk of being left unprotected. Without alternative funding, Ethiopia may fall short of its NMSP objective of universal coverage with core vector control interventions, undermining recent gains in malaria control and threatening progress toward elimination.

Vector Control: ITN Mass Campaign (Rolling)
Priority level for seeking alternative funding: HIGH. **Expected Impact: IMMEDIATE.** **Total gap for ITN mass campaign resources = -$2,641,967 approximately 5%** **Risk (brief):** PMI budget cuts of 10% significantly reduce ITN procurement and distribution, creating coverage gaps and increasing the risk of malaria transmission, particularly in high and moderate malaria risk areas and among vulnerable populations.

Indoor Residual Spraying

IRS is a core vector control intervention in Ethiopia, implemented in malarious districts that are not covered by ITN mass campaigns and strategically targeted to high and moderate malaria transmission areas with an API above 50, in line with eligibility criteria. The MOVBD has efficiently coordinated IRS deployment in these priority regions, covering over 1.5 million structures and protecting nearly 5 million people annually. IRS has demonstrated substantial impact, with model-based projections showing up to an **85% reduction in malaria incidence** across all age groups in targeted districts[53]. Implementation is supported by thorough planning, comprehensive training, and robust monitoring across all administrative levels to ensure adherence to health and environmental standards. However, the continuation and reach of IRS are now at risk due to significant reductions in donor funding.

PMI Funding

- In 2025, PMI's budget was reduced by **$1,475,335**, decreasing from **$7,458,765** to **$5,983,430**. This allocation supports the procurement and distribution of IRS insecticides, IRS operations, and technical assistance.
- In 2026, PMI's budget was further cut by **$1,980,000**, from **$6,600,000** to **$4,620,000**.
- Overall, PMI funding will decrease by **$3,455,335** over the 2025–2026 period, resulting in reduced procurement and distribution of IRS commodities and operations.

GF/FMOH Funding

- In Year 2, the GF/FMOH budget increased slightly by **$119,986**, from **$8,007,515** to **$8,127,501**, designated for procurement and distribution of IRS insecticides, PPEs, and IRS operations.
- In Year 3, however, the budget decreased by **$363,092**, from **$4,595,095** to **$4,232,003**.
- The projected total funding change for Years 2 and 3 is **–$243,106**.

Combined Funding Reduction for 2025–2026/27

- The combined reduction in PMI and GF/MOH funding for IRS in Years 2 and 3 amounts to **–$3,698,441**.

Risk Statement

Due to the budget reduction in 2025, PMI scaled back IRS from 33 districts and eight refugee camps to 15 districts and five refugee camps, reducing coverage from nearly 500,000 structures (protecting 1.3 million people) to 260,000 structures (protecting about 850,000 people), and leaving an estimated 450,000 people unprotected from malaria. The reduction in IRS funding poses a significant risk to Ethiopia's malaria control program. While IRS has proven highly effective in reducing malaria incidence, cuts in funding will limit the procurement and distribution of insecticides and reduce operational coverage. This could leave high-risk populations unprotected, particularly in districts with an API above 50, where IRS is most critical. Sustained reductions in IRS coverage could lead to sudden malaria outbreaks, increase vulnerability to malaria resurgence, erode long-term gains, and compromise Ethiopia's ability to maintain progress toward elimination. Without alternative funding, IRS procurement, planning, mapping, operations, and supervision may be disrupted, leading to untimely delivery, coverage gaps and increased malaria risk, especially in high and moderate transmission areas (see Figure 7). Securing alternative funding is therefore essential to sustain IRS operations and protect vulnerable communities.

[53] Nsekuye, O., Malamba, S.S., Omolo, J. et al. Indoor residual spraying uptake and its effect on malaria morbidity in Ngoma district, Eastern province of Rwanda, 2018–2021. Malar J 23, 381 (2024). https://doi.org/10.1186/s12936-024-05194-5

Vector Control: IRS
Priority level for seeking alternative funding: HIGH. **Expected Impact: IMMEDIATE.** **Total net change (2025 - 2026) = -$3,698,441 approximately 13.8%** **Risk (brief):** Funding reductions of 34% are expected to limit IRS procurement and operations, creating coverage gaps and increasing malaria risk in high and moderate transmission areas.

Other vector control

Larval Source Management

LSM is being implemented in Ethiopia to address the growing threat of *Anopheles stephens*i. Unlike traditional rural vectors, *An. stephensi* poses a significant malaria risk in towns and cities, as it bites outdoors and in the early evening, reducing the effectiveness of ITNs and IRS. Because its breeding sites are relatively fixed, accessible, and targetable, LSM offers a practical and complementary approach to reduce larval populations, limit adult mosquito densities, and slow urban malaria transmission.

PMI has supported larviciding in eight towns, providing valuable lessons for optimizing this intervention against urban vector species such as *An. stephensi*. By 2024, more than 53 towns had confirmed the presence of *An. stephensi*, and the MOVBD planned to expand LSM to an additional 45 districts with increased resources. However, the sustainability of LSM is now at risk due to significant donor funding reductions.

PMI Funding

- In 2025, PMI's budget for LSM was reduced by **$1,000,000**, decreasing from **$1,000,000** to **$0**. This allocation had been designated to support procurement and implementation of LSM in eight eligible towns.
- In 2026, PMI's budget was further reduced by **$1,350,000**, from **$1,350,000** to **$0**.
- Overall, PMI's full cancellation of support for LSM implied a budget reduction across 2025 and 2026 amounts to **–$2,350,000**.

GF/FMOH Funding

- No GF allocations were made for LSM activities.
- The FMOH has committed some domestic resources to support LSM, but these are not sufficient to offset the loss of donor funding.

Combined Funding Reduction for 2025–2026/27

- The combined reduction in funding from PMI and GF/FMOH for LSM during 2025–2026/27 amounts to **–$2,350,000**.

Risk Statement

The elimination of PMI funding for LSM poses a critical risk to Ethiopia's malaria program. Without external support, the planned expansion to over 45 towns with confirmed presence of *An. stephensi* cannot be realized, leaving urban and peri-urban populations vulnerable to malaria transmission (see Figure 7). The absence of donor funding also jeopardizes Ethiopia's ability to respond effectively to the spread of *An. stephensi*, an invasive vector that thrives in urban environments and accelerates malaria transmission in low-burden settings including outside of Ethiopia across the Horn of Africa. Without adequate resources, Ethiopia risks losing a vital tool for integrated vector management, potentially reversing gains in malaria control and undermining progress toward elimination.

Vector Control: LSM
Priority level for seeking alternative funding: HIGH. **Expected Impact: IMMEDIATE.** **Total net change (2025 – 2026/27) = –$2,350,000 (100%).** **Risk (brief):** Withdrawal of PMI funding (100%) eliminates donor support for LSM, threatening Ethiopia's ability to scale up larval control in 45 towns and respond to the spread of *An. stephensi.*

Drug-based Prevention

Prevention of Malaria in Pregnancy

Ethiopia's NMSP 2024/25–2026/27 does not explicitly include the prevention and treatment of MIP. Ethiopia has not yet adopted IPTp, citing the relatively low intensity of malaria transmission in most areas of the country and the anticipated minimal benefits compared to the relatively high costs of implementation[54]. However, pregnant women are targeted with other measures, including education, ITN distribution, and if warranted, case management.

PMI has supported training and supportive supervision of health workers in the prevention of MIP. These activities aim to strengthen the capacity of frontline providers to deliver appropriate counselling, diagnosis, and treatment for pregnant women in malaria-affected districts. However, this support is now at risk due to reductions in donor funding.

PMI Funding

[54] https://ephi.gov.et/wp-content/uploads/2014/04/Evidence-brief-on-ITTp-22-2.pdf

- In 2025, PMI's budget for prevention of malaria in pregnancy was reduced by **$190,000**, decreasing from **$300,000** to **$110,000**. This allocation had been designated to support training and supportive supervision of health workers in 338 districts.
- In 2026, PMI's budget was further reduced by **$90,000**, from **$300,000** to **$210,000**.
- Overall, PMI's budget reduction for prevention of malaria in pregnancy across 2025 and 2026 amounts to **–$280,000** (see *Figure 8*).

GF/FMOH Funding

- No GF/FMOH funding was allocated specifically to prevention of malaria in pregnancy activities.

Combined Funding Reduction for 2025–2026/27

- The combined reduction in funding from PMI and GF/MOH for prevention of MIP during 2025–2026/27 amounts to **–$280,000**.
- This leaves Ethiopia without sufficient external support to sustain training and supervision activities for health workers in this area.

Risk Statement

The reduction in funding for MIP activities poses a moderate but important risk to Ethiopia's malaria program. While IPTp has not been adopted nationally, the training and supportive supervision of health workers remain critical to ensuring that pregnant women in malaria-affected districts receive appropriate counselling, diagnosis, and treatment. Cuts to PMI funding will limit the reach of these activities, potentially leaving health workers less prepared to manage malaria in pregnancy. This could increase the vulnerability of pregnant women and their newborns to malaria-related complications, undermining maternal and child health outcomes. Without alternative funding, Ethiopia risks losing momentum in strengthening provider capacity for MIP prevention and care.

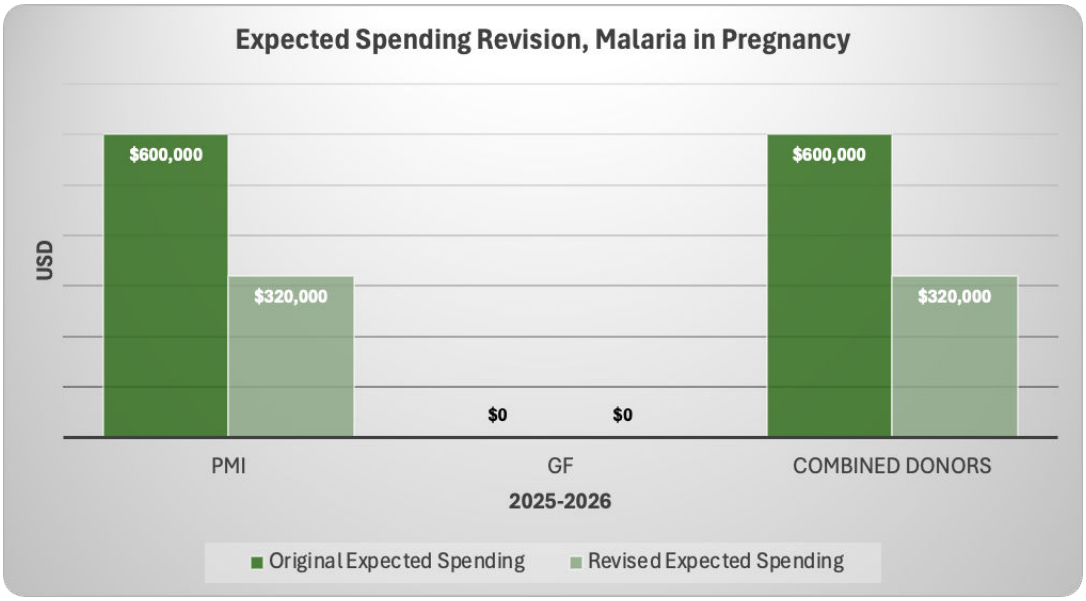


Figure 8. Revision to expected donor spending on malaria in pregnancy. A significant funding reduction of $280,000 was made to PMI funds across 2025-2026; GF/FMOH did not directly support IPTp.

Prevention of Malaria in Pregnancy
Priority level for seeking alternative funding: MODERATE. **Expected Impact: MEDIUM TERM.** **Total net change (2025 - 2026/27) = - $280,000 approximately 47%** **Risk (brief):** Ethiopia does not implement IPTp. Funding cuts reduce training and supervision for health workers on the interventions for malaria in pregnancy (education, ITNs, case management), weakening Ethiopia's ability to protect pregnant women and newborns from malaria-related complications.

Targeted Drug Administration for Seasonal Mobile and Migrant Workers

The NMSP 2024/25–2026/27 recognizes the elevated risk of malaria among seasonal mobile and migrant workers, many of whom travel from low-risk to high-risk areas within the country and may carry malaria parasites back to their home communities. To address these risks, the strategy emphasizes the deployment of mobile test-and-treat stations and the implementation of targeted mass drug administration (MDA) in locations where these workers reside. Initiatives such as the Sennay project, a collaboration between Malaria Consortium and the Ethiopian government, are central to these efforts, aiming to reduce malaria morbidity and mortality among seasonal mobile workers by addressing critical gaps in prevention and control that are tailored to their unique

circumstances[55]. Implementation of MDA was delayed because the supporting research under PMI was not finalized. However, in 2025, the MOH has started implementing MDA in five regions in Ethiopia where migrant workers are concentrated.

Case Management Activities

Commodity Procurement and Distribution (Medicines and Tests)

Ethiopia's malaria case management strategy requires parasitological confirmation of all suspected cases through rapid diagnostic tests (RDTs) at health posts or microscopy at higher-level facilities. Treatment guidelines recommend artemether-lumefantrine with a single dose of primaquine for uncomplicated *P. falciparum,* and chloroquine with primaquine for *P. vivax*, while dihydroartemisinin-piperaquine remains the designated second-line therapy. Severe malaria is managed with injectable artesunate, complemented by rectal artesunate for pre-referral care at the community level.

In recent years, Ethiopia has strengthened the availability and distribution of essential malaria commodities, with stockout rates for medicines and diagnostics declining to levels consistent with global supply chain performance targets. Ongoing efforts include the phased transition to non-HRP2/3-based RDTs in response to gene deletions, alongside the rollout of the electronic Community Health Information System (eCHIS) in malaria elimination districts to enhance surveillance, case tracking, and supply chain decision-making. However, these gains are now at risk due to reductions in donor funding.

PMI Funding

- In 2025, PMI maintained its budget of **$1,942,243** for procuring medicines to treat severe malaria—including injectable artesunate and rectal artesunate suppositories—as well as chloroquine for *P. vivax*.
- In 2026, however, PMI's budget was reduced by **$1,310,696**, decreasing from **$4,368,986** to **$3,058,290**.
- This funding reduction directly impacts the procurement of life-saving medicines, injectable artesunate, for severe malaria and chloroquine for *P. vivax* treatment, threatening the continuity of Ethiopia's malaria case management program.

GF/FMOH Funding

- The GF/FMOH budget allocations for core case management commodities have been **protected from recent deprioritization cuts**.
- As a result, the original allocations for Year 2 (**$8,950,192**) and Year 3 (**$8,562,548**) remain fully preserved.
- While this stability is positive, the lack of expansion in allocations limits the program's ability to adapt to the growing population (see *Figure 9*).

Combined Funding Reduction for 2025–2026/27

[55] https://www.google.com/url?source=gmail&sa=D&sa=E&q=https://www.malariaconsortium.org/projects/sennay-reducing-malaria-burden-among-seasonal-mobile-workers-through-innovative-approaches-in-the-amhara-region

- The overall funding gap for commodity procurement in Years 2 and 3—arising mainly from the PMI cut in 2026—amounts to **–$1,310,696**.

Risk Statement

The anticipated 6% shortfall in commodity procurement funding for Years 2 and 3—driven largely by the reduction in PMI's budget—represents a moderate threat to the sustainability and effectiveness of Ethiopia's malaria case management program. If the current funding gap is not addressed, there is an increased likelihood of stockouts and disruptions in the procurement and distribution of vital malaria commodities. This threatens to contribute to reversing recent advancements in malaria control, heighten the occurrence of severe cases, and diminish the overall effectiveness of case management interventions. Despite preserved GF/FMOH allocations, Ethiopia's case management program faces fiscal pressures that could undermine recent progress in commodity availability and distribution). Ensuring uninterrupted procurement and distribution of essential medicines and diagnostics remains critical for effective diagnosis and treatment of malaria infections to prevent severe complications, particularly in the context of shifting donor priorities and potential supply chain vulnerabilities (Figure 10).

Case Management Activities: Procure Case Management-Related Commodities
Priority level for seeking alternative funding: MODERATE **Expected Impact: MEDIUM TERM** **Total net change (2025 - 2026/27) = -**$1,310,696 **approximately 5.5%** **Risk (brief):** PMI budget cuts of 6% threaten the uninterrupted procurement and distribution of essential malaria medicines and diagnostics, increasing the risk of stockouts, severe cases, and reversal of recent gains in malaria control.

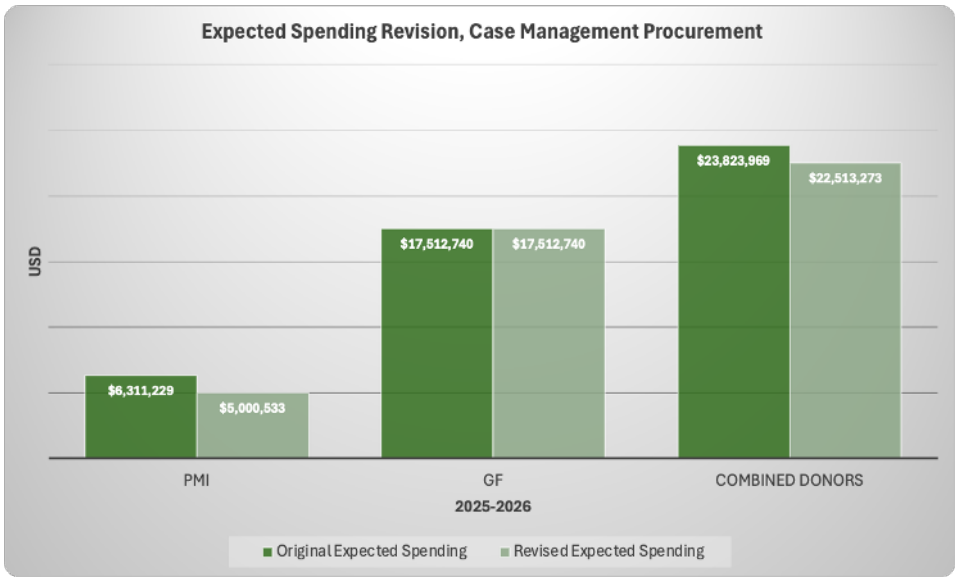


Figure 9. Combined funding reductions for case management commodities procurement for 2025-26 is $1,310,696.

Case Management Implementation

The effective implementation of malaria case management in Ethiopia hinges on a dual approach that integrates both health facility and community-level interventions, complemented by private sector participation and drug quality assurance measures. This comprehensive model promotes the consistent delivery of high-quality care across all tiers of the health system, advancing the goals of the NMSP.

At the facility level, skilled healthcare providers deliver timely diagnosis and evidence-based treatment, supported by laboratory quality assurance protocols to safeguard diagnostic accuracy and reliability. At the community level, HEWs, through the Health Extension Program and integrated Community Case Management (iCCM), play a pivotal role in expanding access to care, particularly in remote and underserved areas. These HEWs are trained, equipped, and mentored to provide effective testing, treatment, and referral services for all age groups.

Recognizing the significant contribution of the private sector, Ethiopia's malaria case management strategy incorporates the public-private mix (PPM) approach. Private health facilities are engaged to provide anti-malarial drugs free of charge and laboratory services at subsidized rates. This partnership addresses challenges such as diagnostic and treatment quality, client affordability, and reporting completeness, while supporting the national malaria elimination program through advocacy and operational collaboration.

Central to the system is a focus on monitoring and supportive supervision of health workers, which was being implemented in PMI-supported districts and has led to measurable improvements in adherence to national standards. Laboratory quality assurance protocols further improve diagnostic accuracy, while Therapeutic Efficacy Studies (TES) facilitate the early identification of drug resistance and guide timely updates to treatment guidelines. Additionally, to ensure the safety, effectiveness, and reliability of anti-malarial products, the program requires both pre-shipment lot testing and post-marketing pharmacovigilance, with associated costs incorporated into procurement planning for facility-based case management.

PMI Funding

- In 2025, PMI's budget for case management implementation was reduced by **$900,000**, decreasing from **$4,300,000** to **$3,400,000**. This allocation had been designated to support training of HEWs in high-burden districts, in-service training for providers, supportive supervision of districts, and laboratory quality assurance visits.
- In 2026, PMI's budget was further reduced by **$1,242,978**, from **$4,143,261** to **$2,900,283**.
- Overall, PMI's budget reduction for case management implementation across 2025 and 2026 amounts to **–$2,142,978**.
- In addition, PMI withdrew its previously planned allocation of **$400,000** for TES in 2025, with no funding allocated in 2026. The **$10,000 CDC short-term technical assistance. allocation** for case management in 2025 was also withdrawn, with no funds earmarked for 2026.

GF/FMOH Funding

- In Year 2, the GF/FMOH budget for case management implementation was cut by **$227,625**, decreasing from **$667,572** to **$439,947**.
- In Year 3, the budget faced an additional reduction of **$321,049**, from **$583,143** to **$262,094**.
- Altogether, these adjustments result in a total budget decrease of **–$548,674** across Years 2 and 3.
- GF/FMOH also eliminated its planned allocation for TES of **$400,000** in Year 2 and **$256,804**in Year 3, leaving no resources for surveillance of the threat of anti-malarial drug resistance

Combined Funding Reduction 2025–2026/27

- The combined reduction in funding from PMI and GF/MOH for case management implementation during 2025–2026/27 amounts to **–$2,691,652**.

When including the withdrawal of TES allocations across both donors, a total of **$656,804** in threat surveillance funding has been eliminated.

Risk Statement

The reduction in funding for case management implementation poses a substantial threat to Ethiopia's malaria program. Cuts to PMI and GF/FMOH budgets will limit training and supervision of health workers, reduce laboratory quality assurance activities, and weaken the capacity of HEWs to deliver effective community-based care. The complete withdrawal of TES funding eliminates Ethiopia's ability to monitor drug resistance, creating a critical blind spot that could delay detection of treatment failures and compromise national treatment guidelines. Without alternative funding, the quality and reliability of malaria case management will decline, increasing the risk of stockouts, misdiagnosis, treatment failures, and ultimately higher morbidity and mortality.

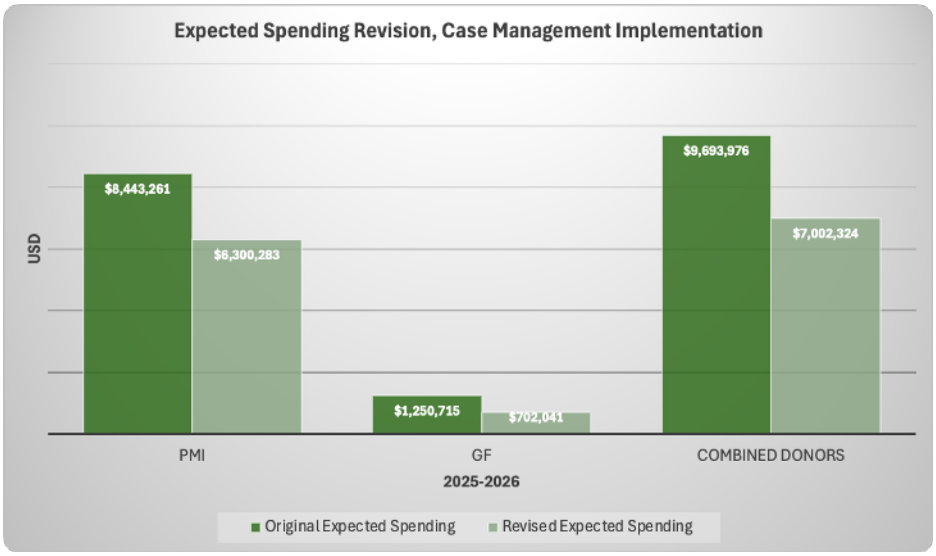


Figure 10. Combined funding reductions for case management implementation for 2025-2026 is -$2,691,652.

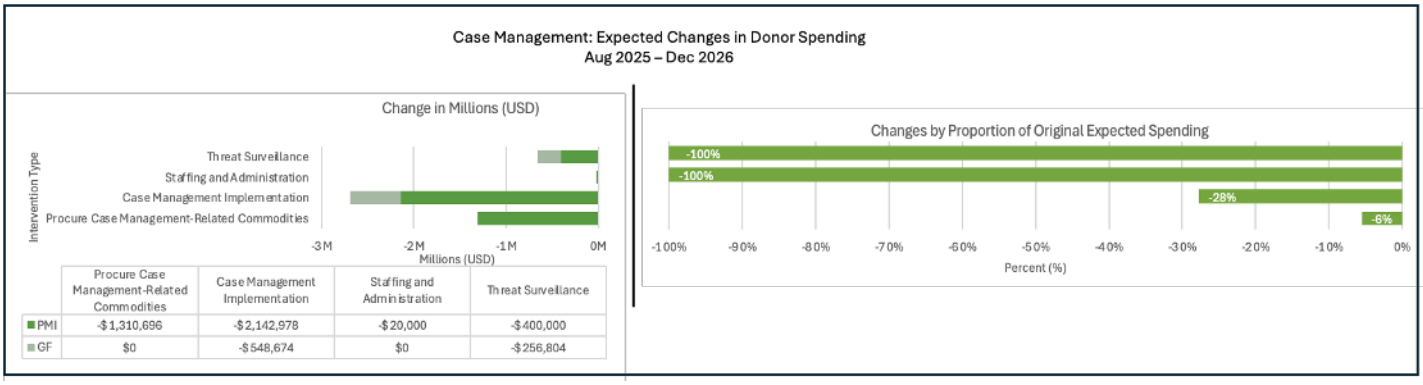


Figure 11. Expected spending revisions in case management for the period Aug 2025-Jun 2027, by donor and intervention area.

Case Management Implementation
Priority level for seeking alternative funding: HIGH. **Expected Impact: IMMEDIATE.** **Total net change (2025 - 2026/27) = -$2,691,652 approximately 27.8%** **Risk (brief):** Funding cuts of 28% threaten training, supervision, and laboratory quality assurance, while the elimination of TES funding removes Ethiopia's capacity to monitor drug resistance, undermining the effectiveness and sustainability of malaria case management.

Supply Chain Strengthening Activities

In-Country Supply Chain

A reliable supply chain is essential to Ethiopia's malaria elimination strategy, ensuring the timely availability of high-quality antimalarial commodities at all levels of the health system. The NMSP 2024/25–2026/27 prioritizes strengthening supply chain systems to improve forecasting, procurement, clearing, and distribution of commodities, while also promoting their rational use.

During the review period of the previous NMSP 2021–2025, notable improvements were achieved in procurement and supply management (PSM), including shorter procurement lead times, more timely submission of reporting and requisition forms (RRFs), and overall increases in product availability. Despite these gains, challenges remain, particularly the inconsistent availability of malaria commodities at service delivery points and last mile delivery especially to the conflict affected areas.

The Ethiopian Pharmaceuticals Supply Service (EPSS) plays a central role in managing the malaria supply chain, working closely with the NMCP. Key partners include PMI and the GF, which provide technical and financial support. However, reductions in donor funding now threaten the sustainability of these improvements.

PMI Funding

- In 2025, PMI's budget for supply chain remained unchanged at **$1,799,032.** This funding was used to provide technical assistance to the EPSS for strengthening their capacity in quantification, procurement, and distribution of malaria commodities. It also supported technical assistance to the Ethiopian Food and Drug Authority (EFDA) to enhance post-market surveillance and inspection. Additionally, the allocation covered warehousing and distribution costs for malaria commodities, as well as End-User Verification surveys.
- In 2026, PMI's budget was reduced by **$450,465**, from **$1,501,550** to **$1,051,085**.
- Overall, PMI's budget reduction for the supply chain across 2025 and 2026 amounts to **–$450,465**.

GF/FMOH Funding

- For the GF, supply chain funds were embedded within systems strengthening allocations, with some amounts also combined with procurement funds. As a result, it was difficult to isolate the funds dedicated solely to the supply chain in 2025/26 or 2026/27.

Combined Funding Reduction for 2025–2026/27

- The combined reduction in funding from PMI and GF/MOH for the supply chain during 2025–2026/27 amounts to **–$450,465** (see *Figure 11*).
- This reduction limits Ethiopia's ability to sustain recent gains in supply chain performance and threatens the consistent availability of malaria commodities at service delivery points.

Risk Statement

The reduction in supply chain funding poses a high but important risk to Ethiopia's malaria program. While PMI continues to provide technical assistance and operational support, the budget cut in 2026 reduces resources for warehousing, distribution, and quality assurance activities. Without adequate funding, the risk of stockouts and delays in commodity delivery (including ITN and IRS campaigns, diagnostic tests, and life-saving medicines) increases, undermining the effectiveness of malaria prevention and treatment interventions.

Supply Chain Strengthening Activities: In-Country Supply Chain
Priority level for seeking alternative funding: HIGH. **Expected Impact: LONGER TERM.** **Total net change (2025 - 2026) = –$450,465, approximately 13.6%** **Risk (brief):** Reduced PMI support threatens warehousing, distribution, and quality assurance, increasing the risk of stockouts and weakening Ethiopia's malaria supply chain.

Malaria Vaccine Introduction

The NMSP 2024/25–2026/27 includes a strategy to "provide malaria vaccine for eligible children," aligning with the WHO recommendation for the RTS,S/AS01 malaria vaccine to prevent *P. falciparum* malaria in children residing in moderate and high transmission areas. The vaccine is estimated to prevent malaria cases by 40% and severe cases by 30%.

Ethiopia's diverse malaria epidemiology makes certain high-transmission areas suitable for vaccine introduction. The vaccine is administered in a four-dose schedule to children aged 5–18 months in districts with moderate and high malaria burden, as per WHO classification. The NMSP outlines activities to explore optimal delivery of the vaccine, including assessments to identify eligible districts and collaboration with the Maternal and Child Health (MCH) Lead Executive Office to develop an implementation manual for integrating the vaccine into the national Expanded Programme on Immunization (EPI).

Ethiopia successfully approved the R21 malaria vaccine application through Gavi, the Vaccine Alliance. The initial phase of introduction targets 58 high-risk districts across eight regions: Afar, Amhara, Benishangul Gumuz, Gambela, Oromia, Somali, South Ethiopia, and South West Ethiopia. The rollout began in Turmi town, South Ethiopia region, on September 18, 2025, making Ethiopia the first country to launch the R21/Matrix-M malaria vaccine. Delivered alongside ITNs, the vaccine provides double protection for children in targeted districts. Over 186,000 initial doses have been received. The R21/Matrix-M vaccine, developed by the University of Oxford, Serum Institute of India, and Novavax, demonstrated up to 77% efficacy in clinical trials and was endorsed by WHO in 2023 for use in children under three in malaria-endemic areas[56].

Despite this progress, Ethiopia faces significant challenges. The country is the fourth-highest global contributor of "zero-dose children", with 1.13 million unvaccinated children, which may hinder malaria vaccine coverage.

[56] Genton B. R21/Matrix-M™ malaria vaccine: a new tool to achieve WHO's goal to eliminate malaria in 30 countries by 2030?. J Travel Med. 2023;30(8):taad140. doi:10.1093/jtm/taad140

Studies in Southwest[57] and Northwest Ethiopia[58] (2019) revealed low caregiver willingness to accept a malaria vaccine, influenced by knowledge, household wealth, prior malaria experience, household size, and vaccination history. These findings underscore the importance of health education and communication to improve vaccine acceptance.

PMI Funding

- No PMI funding was allocated for malaria vaccine activities during the 2025–2026 period.

GF/FMOH Funding

- No GF/MOH funding was allocated for malaria vaccine activities during the 2025–2026 period.
- The malaria vaccine implementation is supported by the FMOH.

Other Funding Sources

- The malaria vaccine rollout is primarily supported by **Gavi**, in collaboration with the FMOH.
- Additional technical and operational support is provided through integration with the national EPI platform.

Combined Impact for 2025–2026/27

- With no PMI or GF/MOH allocations, Ethiopia's malaria vaccine program relies heavily on Gavi and domestic resources.
- This dependence creates vulnerabilities in sustainability, scale-up, and integration with broader malaria control efforts.

Risk Statement

● The main support for the malaria vaccine in Ethiopia comes from Gavi. Although PMI provided technical assistance during the vaccine rollout, its withdrawal is unlikely to have a significant impact, as existing vaccine partners are well-positioned to mitigate any potential gaps.

[57] Asmare G. Willingness to accept malaria vaccine among caregivers of under-5 children in Southwest Ethiopia: a community based cross-sectional study. Malar J. 2022;21(1):146. Published 2022 May 12. doi:10.1186/s12936-022-04164-z

[58] Wagnew Y, Hagos T, Weldegerima B, Debie A. Willingness to Pay for Childhood Malaria Vaccine Among Caregivers of Under-Five Children in Northwest Ethiopia. Clinicoecon Outcomes Res. 2021;13:165-174. Published 2021 Mar 15. doi:10.2147/CEOR.S299050

Malaria Vaccine Activities:
Priority level for seeking alternative funding: NOT APPLICABLE. **Expected Impact: LONGER TERM.** **Total net change (2025 - 2026/27) =** No PMI or GF/FMOH allocations (full reliance on Gavi/FMOH) **Risk (brief):** Ethiopia's malaria vaccine rollout depends entirely on Gavi and domestic resources, with no history of PMI or GF support. While scale up of malaria vaccine access will be very important for Ethiopia, assessment of the funding landscape is not applicable to this report.

Surveillance, Monitoring and Evaluation and Operations Research (SMEO) Activities

Surveillance Monitoring and Evaluation

The Surveillance, Monitoring and Evaluation and Operations Research (SMEO) platform underpins Ethiopia's malaria elimination strategy by ensuring that interventions remain evidence-based, targeted, and sustainable. It strengthens routine data systems such as DHIS2 and PHEM for kebele-level stratification, expands community-based surveillance through HEWs, schools, and local platforms, and supports outbreak prediction and rapid response via Emergency Operation Centers. In addition, SMEO advances operational research on emerging threats such as *An. stephensi* and the vulnerabilities of migrant worker populations, thereby providing the evidence base needed to adapt strategies to evolving challenges. However, sustaining these critical functions is now at risk due to significant reductions in donor funding.

PMI Funding

- In 2025, PMI initially allocated $3.4 million to support data use partnership (DUP), PHEM strengthening, and surveillance in 57 districts, but this was reduced by $3 million, leaving only $0.4 million to sustain community surveillance activities.
- In 2026, PMI's allocation of $2.9 million was reduced by $2.34 million, leaving just $0.56 million available for implementation.
- Across the two years, PMI's support decreased by a total of $5.34 million, as illustrated in Figure 12.

GF/MOH Funding

- In Year 2, GF/MOH allocated $0.92 million, but this was reduced by $0.61 million, leaving $0.31 million to support activities.
- In Year 3, the allocation of $0.33 million was reduced by $0.18 million, leaving only $0.14 million available.
- Together, these GF/MOH reductions amount to $0.80 million over the two years, as shown in Figure 12.

Combined Reduction for 2025–2026/27

- When combined, the overall reduction in funding from PMI and GF/MOH between 2025 and 2026/27 amounts to $6.14 million.

- This reduction means that total available resources for SMEO activities fall from $7.55 million to just $1.41 million, a dramatic contraction of over 80% that is clearly depicted in Figures 12 and 13.

Risk Statement

The reduction in SMEOR funding across PMI and GF/MOH allocations poses a serious threat to Ethiopia's malaria surveillance and evidence-based decision-making capacity. These cuts risk undermining the very systems that enable targeted, cost-effective interventions—such as kebele-level stratification, outbreak prediction, and community-based surveillance—while also weakening the country's ability to respond rapidly to emerging threats like *An. stephensi* and mobile populations. Without adequate resources, targeted interventions at the kebele level, community surveillance, and data-driven decision-making will be compromised, undermining both the effectiveness and sustainability of malaria programs. Without additional resources, Ethiopia will struggle to predict, detect and respond to malaria surges, likely threatening recent progress. To mitigate this risk, urgent efforts are needed to mobilize alternative funding and safeguard core SMEOR functions essential to malaria elimination.

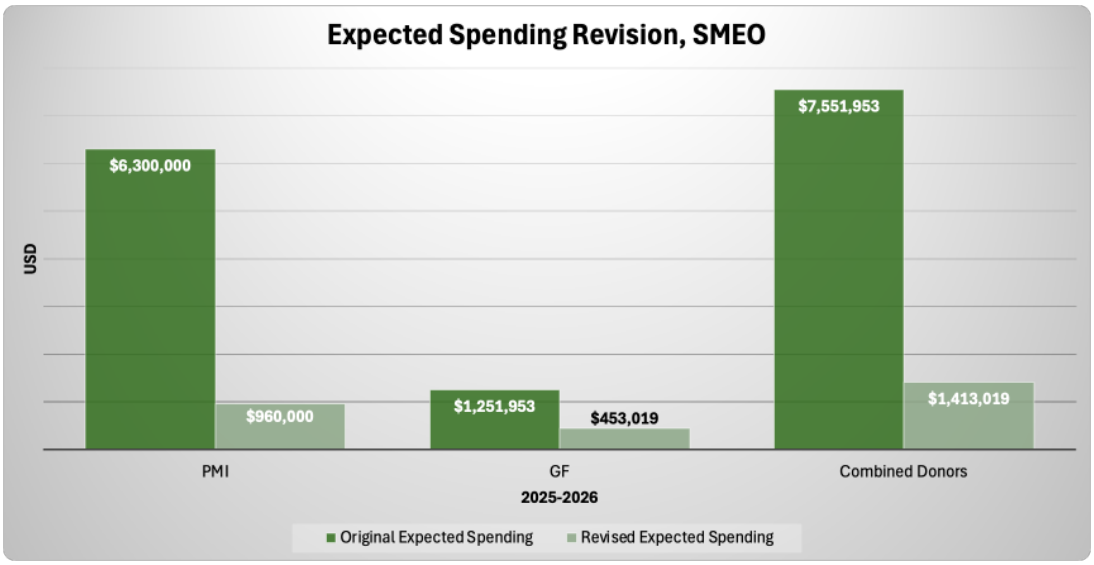


Figure 12. Funding for surveillance, monitoring and evaluation, and operational research (SMEO) in 2025-2026/27 has been significantly reduced, suffering an overall funding reduction of -$6,138,934 for PMI and GF/MOH activities.

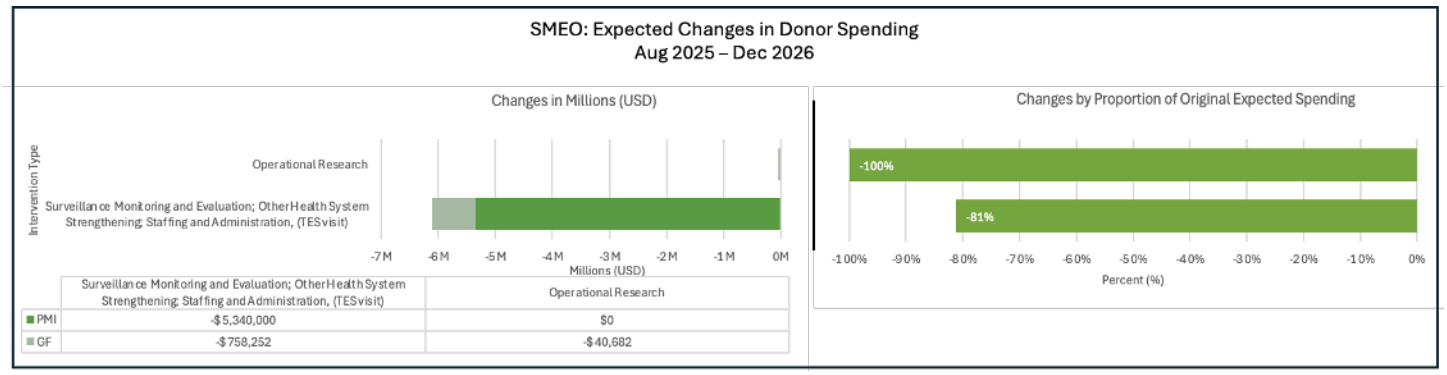


Figure 13. SMEO interventions all received significant funding cuts - including surveys, operational research, and system strengthening of data systems.

Surveillance, Monitoring and Evaluation and Operations Research (SMEO) Activities: Surveillance Monitoring and Evaluation

Priority level for seeking alternative funding: HIGH.

Expected Impact: Both IMMEDIATE and LONGER TERM.

Total net change (2025 - 2026) = -$6,138,934 approximately about 81.3%

Risk (brief): Severe reductions in PMI and GF/MOH support threaten Ethiopia's ability to sustain malaria surveillance, community-based detection, and rapid outbreak response.

Short-Term Technical Assistance from CDC

Ethiopia has long benefited from the technical expertise provided by the United States Centers for Disease Control and Prevention (CDC), which is recognised as one of the leading global institutions in malaria research and control. Through the CDC Interagency Agreement (IAA) with USAID, Ethiopia received short-term, high-level technical assistance in areas such as vector control, case management, surveillance, monitoring and evaluation, and operational research. These expert visits provided a cost-effective mechanism for technical quality control, program oversight, and specialized support to the national malaria program.

With the termination of the CDC IAA, all PMI funding for short-term CDC technical assistance has been cancelled. This has meant cancellation of planned expert visits (budgeted at $49,000 for 2025-2026) for technical assistance in vector control and surveillance, monitoring and evaluation, and/or operational research activities. This decision eliminates a long-standing source of specialized expertise and leaves Ethiopia without a critical layer of external technical support.

Risk Statement

The cancellation of CDC technical assistance funding deprives Ethiopia of a cost-effective, long-standing source of specialized support. Without CDC engagement, the national malaria program loses access to high-level expertise in vector control, surveillance, monitoring and evaluation, and operational research. This gap reduces the program's ability to ensure technical quality, adapt to emerging challenges, and maintain rigorous oversight. Addressing this gap would require only modest additional resources, but the loss of CDC engagement represents a significant setback for program quality assurance and innovation.

Short-Term Technical Assistance from the CDC
Priority level for seeking alternative funding: MODERATE. **Expected Impact: LONGER TERM.** **Total net change (2025 - 2026) = $49,000 (100%)** **Risk (brief):** Cancellation of CDC technical assistance funding removes a cost-effective, long-standing source of specialized expertise, weakening technical oversight and program quality.

Social and Behavioral Change Communications (SBC)

SBC is central to Ethiopia's malaria elimination strategy, ensuring that households and communities adopt and sustain preventive and treatment behaviors. SBC activities promote the correct and consistent use of ITNs, uptake of IPTp, prompt care-seeking for malaria symptoms, and community participation in vector control, including *An. stephensi* management. These interventions are delivered through mass media, school-based initiatives, and community mobilization, often in partnership with civil society organizations that have proven expertise in shaping resilient social norms. However, the continuation and reach of these activities are now at risk due to significant reductions in donor funding.

PMI Funding

- In 2025 and 2026, PMI initially allocated **$2.57 million** for SBC and related health systems strengthening, but this was **zeroed out**, leaving a **$2.57 million** gap.
- These funds were originally intended to sustain communication campaigns in high-burden districts, focusing on ITN use, IPTp uptake, timely care-seeking, and community engagement in *An. stephensi* control.
- The reduction reflects a deprioritization of SBC within U.S. foreign assistance (see *Figure 14*).

GF/FMOH Funding

- In Years 2 and 3, GF/MOH initially allocated **$1.64 million** for SBC activities, but this was reduced by **$0.25 million**, leaving **$1.39 million**.
- This funding supports mainstream media campaigns, school-based initiatives, and community mobilization, implemented in collaboration with civil society organizations.
- Despite the smaller scale of reductions compared to PMI, the cuts still constrain the breadth and consistency of SBC programming (see *Figure 14*).

Combined Reduction for 2025–2026/27

- Together, the reductions from PMI and GF/MOH amount to **$2.81 million** over the 2025–2026/27 period.
- As a result, total SBC funding falls from **$4.21 million** to **$1.39 million**, a contraction that significantly limits Ethiopia's ability to achieve its strategic goal of **85%** household adoption of recommended antimalarial behaviors by June **2027**.

Risk Statement

The reduction in SBC funding poses a substantial threat to Ethiopia's malaria program. With fewer resources, the effectiveness, consistency and reach of essential interventions such as ITN use, IRS uptake, and IPTp coverage are likely to be compromised. Decreased funding also risks weakening efforts to encourage early health care-seeking, undermining malaria control initiatives and increasing the likelihood of continued transmission, illness, and mortality among vulnerable populations. Without alternative funding, community engagement efforts may falter, reducing the effectiveness of other malaria interventions and slowing progress toward national malaria targets.

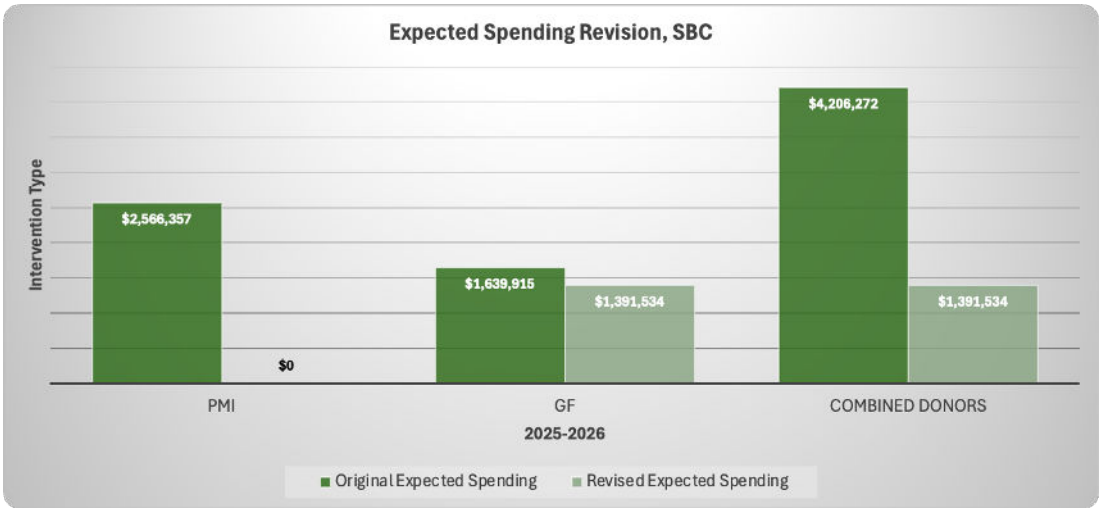


Figure 14. The overall funding decrease for SBC is substantial - a total of -$2,814,738 for 2025-2026/27.

Social and Behavioral Change Communications (SBC)
Priority level for seeking alternative funding: HIGH. **Expected Impact: IMMEDIATE** **Total net change (2025 - 2026/27) = -$2,814,738 which represents a 67% reduction** **Risk (brief):** Reduced PMI and GF/FMOH support threatens Ethiopia's ability to sustain SBC campaigns, undermining ITN use, and timely care-seeking and weakening progress toward malaria elimination targets.

Program Management

Effective program management is central to Ethiopia's malaria elimination efforts, ensuring that planning, execution, monitoring, evaluation, and reporting are coordinated and aligned with national priorities. International donors complement government investments in health personnel and systems by supporting activities grouped under "other health system strengthening," including human resources, operations, planning, and supervision.

For the GF/FMOH, program management encompasses both the administrative and technical aspects of the malaria program. Two core components are emphasized, coordination and management of the national malaria elimination program, and grant management. These functions are essential to sustaining operational efficiency, accountability, and the effective use of resources. However, reductions in donor funding now threaten the continuity of these critical functions.

PMI Funding

- In 2025, PMI's budget for program management was reduced by **$300,000**, decreasing from **$300,000** to **$0**. This allocation had been designated to support capacity building of health workers in selected regions.
- In 2026, PMI's budget was further reduced by **$299,600**, from **$299,600** to **$0**.
- Overall, PMI's budget reduction for program management across 2025 and 2026 amounts to **–$599,600** (see *Figure 15*).

GF/FMOH Funding

- In Year 2, the GF/MOH budget for program management was cut by **$947,359**, decreasing from **$1,820,402** to **$873,043**.
- In Year 3, the budget faced an additional reduction of **$765,803**, from **$1,867,445** to **$1,101,642**.
- Altogether, these adjustments result in a total budget decrease of **–$1,713,162** across Years 2 and 3 (see *Figure 15*).

Combined Funding Reduction for 2025–2026/27

- The combined reduction in funding from PMI and GF/MOH for program management during 2025–2026/27 amounts to **-$2,312,762**.
- These cuts significantly weaken Ethiopia's ability to coordinate malaria elimination activities, manage grants effectively, and sustain oversight functions (see *Figure 15*).

Risk Statement

The reduction in program management funding poses a high-level risk to Ethiopia's malaria elimination program. Cuts to PMI and GF/FMOH allocations undermine the capacity to coordinate national malaria activities, manage grants, and provide technical and administrative oversight. Without adequate funding, essential functions such as planning, supervision, monitoring, and evaluation may be disrupted, leading to inefficiencies, reduced accountability, and weaker program performance. The loss of resources for capacity building further threatens the ability of health workers and program managers to adapt to evolving challenges. Unless alternative funding is secured, Ethiopia risks losing the operational backbone required to sustain progress toward malaria elimination. Despite these concerns, the risk was ultimately rated as moderate due to prevailing budget constraints.

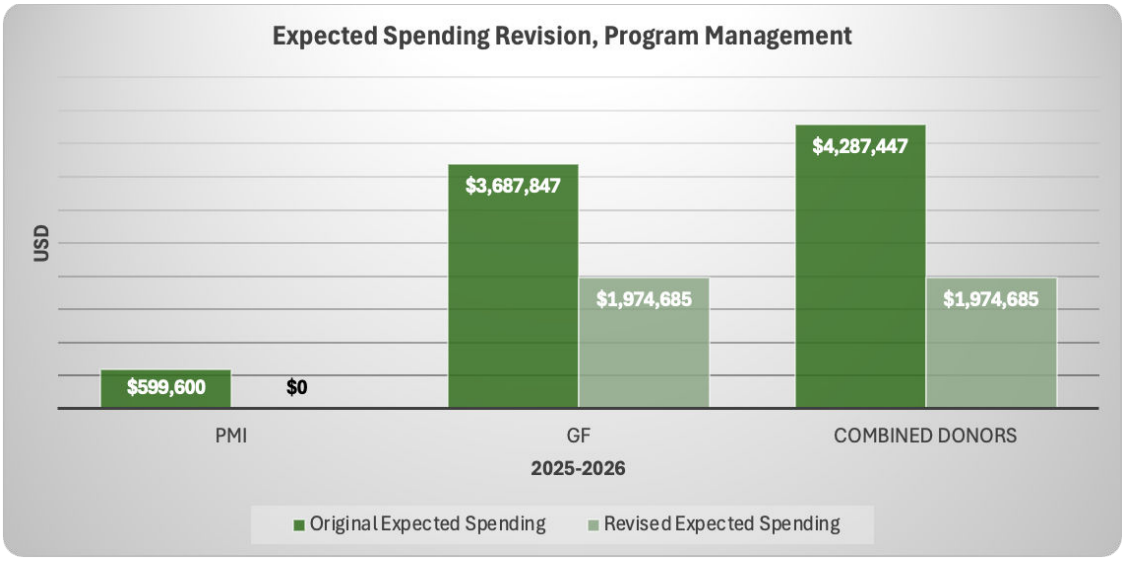


Figure 15. In total, program management funding for PMI, GF/FMOH, in 2025-2026/27, declined by $2,312,762.

Program Management Activities
Priority level for seeking alternative funding: MODERATE **Expected Impact: IMMEDIATE** **Total net change (2025 - 2026/27) = –$2,312,762 (about 54%)** **Risk (brief):** Cuts to PMI and GF/FMOH support undermine coordination, grant management, and oversight, weakening the operational backbone of Ethiopia's malaria elimination program.

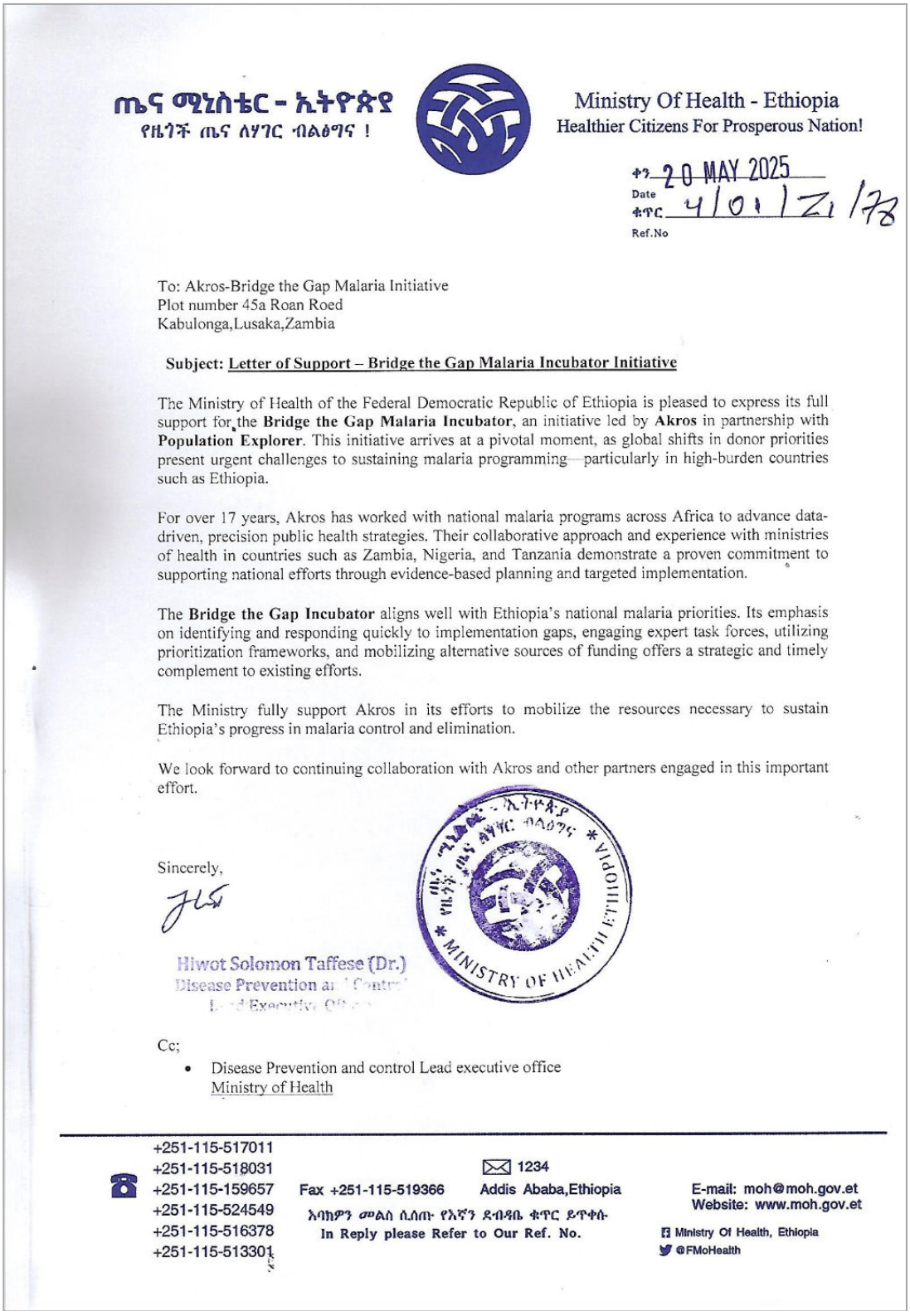
USG Staffing and Administration

Funding for direct USG staffing and administrative support for the PMI program has been eliminated. This is due to the termination of the CDC IAA and the dismantling of USAID in the country. These budget lines covered the salaries, benefits, travel, and other support costs for in-country USG staff from both CDC and USAID who provided direct management and oversight of the malaria portfolio. While these functions are essential for program continuity, the associated costs are internal to the USG and are not considered funding gaps to be filled by external partners.

Priority level for seeking alternative funding: Not Applicable (These are internal USG operational costs).

Funding Gap: The total eliminated budget for these internal USG costs for 2025-2026 is $4,609,206 (Attachment B).

Attachment A: Letter of Support and Engagement, Ethiopia FMOH



ጤና ሚኒስቴር - ኢትዮጵያ
የዜጎች ጤና ለሃገር ብልፅግና !

Ministry Of Health - Ethiopia
Healthier Citizens For Prosperous Nation!

ቀን Date 20 MAY 2025
ቁጥር Ref.No 4/01/21/78

To: Akros-Bridge the Gap Malaria Initiative
Plot number 45a Roan Roed
Kabulonga,Lusaka,Zambia

Subject: Letter of Support – Bridge the Gap Malaria Incubator Initiative

The Ministry of Health of the Federal Democratic Republic of Ethiopia is pleased to express its full support for the **Bridge the Gap Malaria Incubator**, an initiative led by **Akros** in partnership with **Population Explorer**. This initiative arrives at a pivotal moment, as global shifts in donor priorities present urgent challenges to sustaining malaria programming—particularly in high-burden countries such as Ethiopia.

For over 17 years, Akros has worked with national malaria programs across Africa to advance data-driven, precision public health strategies. Their collaborative approach and experience with ministries of health in countries such as Zambia, Nigeria, and Tanzania demonstrate a proven commitment to supporting national efforts through evidence-based planning and targeted implementation.

The **Bridge the Gap Incubator** aligns well with Ethiopia's national malaria priorities. Its emphasis on identifying and responding quickly to implementation gaps, engaging expert task forces, utilizing prioritization frameworks, and mobilizing alternative sources of funding offers a strategic and timely complement to existing efforts.

The Ministry fully support Akros in its efforts to mobilize the resources necessary to sustain Ethiopia's progress in malaria control and elimination.

We look forward to continuing collaboration with Akros and other partners engaged in this important effort.

Sincerely,

Hiwot Solomon Taffese (Dr.)
Disease Prevention and Control
Lead Executive Officer

Cc;

- Disease Prevention and control Lead executive office
  Ministry of Health

+251-115-517011
+251-115-518031
+251-115-159657
+251-115-524549
+251-115-516378
+251-115-513301
Fax +251-115-519366
1234
Addis Ababa,Ethiopia
E-mail: moh@moh.gov.et
Website: www.moh.gov.et
አሳክዎን መልስ ሲሰጡ የእኛን ደብዳቤ ቁጥር ይጥቀሱ
In Reply please Refer to Our Ref. No.
Ministry Of Health, Ethiopia
@FMoHealth

Attachment B: Ethiopia Gaps and Inventory Table

Table 1: 2025 Expected Spending, PMI and Global Fund Ethiopia								
		PMI			GF Ethiopia			Net Difference (PMI & GF-MOH) [5]
	Intervention	Original [1]	Revised after FAR (Aug-Dec) [2]	Difference [3]	Original [4]	Revised [5]	Difference After GF Prioritization	
Vector Control	Entomological Monitoring	$900,000	$30,000	-$870,000	$44,688	$30,624	-$14,064	-$884,064
	Procurement of ITNs for Mass Campaign and other Handling Fees	$7,807,000	$7,807,000	$0	$28,472,656	$28,472,656	$0	$0
	ITNs Mass Campaign: Storage and in-country distribution and other costs	$1,665,000	$1,665,000	$0	$4,003,967	$4,003,967	$0	$0
	ITNs: Micro-planning, supervision and post campaign review meetings at national, regional and district levels			$0	$101,636	$96,623	-$5,013	-$5,013
	IRS Insecticide & PPE procurement and Distribution	$2,470,000	$4,001,993	$1,531,993	$6,965,206	$6,965,206	$0	$1,531,993
	IRS operations	$4,988,765	$1,981,437	-$3,007,328	$1,042,309	$1,162,295	$119,986	-$2,887,342
	LSM procurement and implementation	$1,000,000	$0	-$1,000,000	$0	$0	$0	-$1,000,000
	CDC STTA (ento)	$14,500	$0	-$14,500	$0	$0	$0	-$14,500
	Subtotal Vector Control	**$18,845,265**	**$15,485,430**	**-$3,359,835**	**$40,630,462**	**$40,731,371**	**$100,909**	**-$3,258,926**
IPTp	Prevention of Malaria in Pregnancy	$300,000	$110,000	-$190,000	$0	$0	$0	-$190,000
	Subtotal IPTp	**$300,000**	**$110,000**	**-$190,000**	**$0**	**$0**	**$0**	**-$190,000**
Case Management	Procure Case Management-Related Commodities (ACTs, RDTs, inj artesunate and RAS)	$1,942,243	$1,942,243	$0	$8,950,192	$8,950,192	$0	$0
	Case Management Implementation (community and facility case management)	$4,300,000	$3,400,000	-$900,000	$667,572	$439,947	-$227,625	-$1,127,625
	CDC STTA (case mgmt)	$10,000	$0	-$10,000	$0	$0	$0	-$10,000
	Threat Surveillance Implementation	$0		$0	$0	$0	$0	$0
	Threat Surveillance (TES)	$400,000	$0	-$400,000	$0	$0	$0	-$400,000
	Subtotal Case Manage	**$6,652,243**	**$5,342,243**	**-$1,310,000**	**$9,617,764**	**$9,390,139**	**-$227,625**	**-$1,537,625**

Supply Chain	In-Country Supply Chain	$1,799,032	$1,799,032	$0	$0	$0	$0	$0
	Subtotal Supply Chain	**$1,799,032**	**$1,799,032**	**$0**	**$0**	**$0**	**$0**	**$0**
Malaria Vaccine	Vaccine	$0	$0	$0	$0	$0	$0	$0
	Subtotal Malaria Vaccine	**$0**		**$0**	**$0**	**$0**	**$0**	**$0**
SMEO	Surveillance Monitoring and Evaluation; Other Health System Strengthening and community malaria surveillance	$3,400,000	$400,000	-$3,000,000	$904,485	$310,402	-$594,083	-$3,594,083
	Data Systems Strengthening - General	$0		$0	$0	$0	$0	$0
	Data Systems Strengthening - Logistics	$0		$0	$0	$0	$0	$0
	Surveys	$0		$0	$0	$0	$0	$0
	Operational Research	$0		$0	$20,341	$0	-$20,341	-$20,341
	Subtotal SMEO	**$3,400,000**	**$400,000**	**-$3,000,000**	**$924,826**	**$310,402**	**-$614,424**	**-$3,614,424**
SBCC [8]	SBC for ITN LSM and case management	$1,536,357	$0	-$1,536,357	$740,756	$916,130	$175,374	-$1,360,983
	Subtotal SBCC	**$1,536,357**	**$0**	**-$1,536,357**	**$740,756**	**$916,130**	**$175,374**	**-$1,360,983**
Program Management	Capacity building, human resources, operations and planning $ supervision	$300,000	$0	-$300,000	$1,820,402	$873,043	-$947,359	-$1,247,359
	Human Resources	$0	$0	$0	$0	$0	$0	$0
	Operations	$0	$0	$0	$0	$0	$0	$0
	Planning and Supervision	$0	$0	$0	$0	$0	$0	$0
	Subtotal Program Manage	**$300,000**	**$0**	**-$300,000**	**$1,820,402**	**$873,043**	**-$947,359**	**-$1,247,359**
USG Staffing	CDC	$475,000	$0	-$475,000	$0	$0	$0	-$475,000
	USAID	$1,692,103	$0	-$1,692,103	$0	$0	$0	-$1,692,103
	Subtotal USG Staffing	**$2,167,103**	**$0**	**-$2,167,103**	**$0**	**$0**	**$0**	**-$2,167,103**
Total		**$35,000,000**	**$23,136,705**	**-$11,863,295**	**$53,734,210**	**$52,221,085**	**-$1,513,125**	**-$13,376,420**

Table 2: 2026 Expected Spending, PMI and Global Fund Ethiopia								
		PMI			GF Ethiopia			
	Intervention	**Original [1]**	**Revised after FAR (Aug-Dec) [2]**	**Difference [3]**	**Original**	**Revised**	**Difference After GF Prioritization**	**Net Difference (PMI & GF-MOH)**
Vector Control	Entomological Monitoring	$800,000	$30,000	-$770,000	$120,641	$28,957	-$91,684	-$861,684
	Procurement of ITNs for Mass Campaign and other Handling Fees	$7,460,000	$5,222,000	-$2,238,000	$0	$0	$0	-$2,238,000
	ITNs Mass Campaign: Storage and in-country distribution and other costs	$1,780,000	$1,400,000	-$380,000	$0	$0	$0	$0
	ITNs: Micro-planning, supervision and post campaign review meetings at national, regional and district levels				$287,914	$268,960	-$18,954	-$398,954
	IRS Insecticide & PPE procurement and Distribution	$2,200,000	$1,540,000	-$660,000	$3,567,598	$3,567,598	$0	-$660,000
	IRS Operations	$4,400,000	$3,080,000	-$1,320,000	$1,027,497	$664,405	-$363,092	-$1,683,092
	LSM	$1,350,000	$0	-$1,350,000	$0	$0	$0	-$1,350,000
	CDC STTA (ento)	$14,500	$0	-$14,500	$0	$0	$0	-$14,500
	Subtotal Vector Control	**$18,004,500**	**$11,272,000**	**-$6,732,500**	**$5,003,650**	**$4,529,920**	**-$473,730**	**-$7,206,230**
IPTp	Prevention of Malaria in Pregnancy	$300,000	$210,000	-$90,000	$0	$0	$0	-$90,000
	Subtotal IPTp	**$300,000**	**$210,000**	**-$90,000**	**$0**	**$0**	**$0**	**-$90,000**
Case Management	Procure Case Management-Related Commodities (ACTs, RDTs, inj artesunate and RAS)	$4,368,986	$3,058,290	-$1,310,696	$8,562,548	$8,562,548	$0	-$1,310,696
	Case Management Implementation (community and facility case management)	$4,143,261	$2,900,283	-$1,242,978	$583,143	$262,094	-$321,049	-$1,564,027
	STTA CDC (case mgmt)	$10,000	$0	-$10,000	$0	$0	$0	-$10,000
	Non-malaria Commodities	$0	$0	$0	$0	$0	$0	$0
	Threat Surveillance (TES)	$0	$0	$0	$256,804	$0	-$256,804	-$256,804
	Subtotal Case Manage	**$8,522,247**	**$5,958,573**	**-$2,563,674**	**$9,402,495**	**$8,824,642**	**-$577,853**	**-$3,141,527**

Supply Chain	In-Country Supply Chain	$1,501,550	$1,051,085	-$450,465	$0	$0	$0	-$450,465
	Subtotal Supply Chain	**$1,501,550**	**$1,051,085**	**-$450,465**	**$0**	**$0**	**$0**	**-$450,465**
Malaria Vaccine	Vaccine	$0	$0	$0	$0	$0	$0	$0
	Subtotal Malaria Vaccine	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
SMEO	Surveillance Monitoring and Evaluation; Other Health System Strengthening and community malaria surveillance	$2,900,000	$560,000	-$2,340,000	$306,786	$142,617	-$164,169	-$2,504,169
	Data Systems Strengthening - General	$0	$0	$0	$0	$0	$0	$0
	Data Systems Strengthening - Logistics	$0	$0	$0	$0	$0	$0	$0
	Surveys	$0	$0	$0	$0	$0	$0	$0
	Operational Research	$0	$0	$0	$20,341	$0	-$20,341	-$20,341
	Subtotal SMEO	**$2,900,000**	**$560,000**	**-$2,340,000**	**$327,127**	**$142,617**	**-$184,510**	**-$2,524,510**
SBCC	SBC; Other HSS	$1,030,000	$0	-$1,030,000	$899,159	$475,404	-$423,755	-$1,453,755
	Subtotal SBCC	**$1,030,000**	**$0**	**-$1,030,000**	**$899,159**	**$475,404**	**-$423,755**	**-$1,453,755**
Program Manage	Capacity building, human resources, operations and planning $ supervision	$299,600	$0	-$299,600	$1,867,445	$1,101,642	-$765,803	-$1,065,403
	Human Resources	$0	$0	$0			$0	
	Operations	$0	$0	$0			$0	
	Planning and Supervision	$0	$0	$0			$0	
	Subtotal Program Manage	**$299,600**	**$0**	**-$299,600**	**$1,867,445**	**$1,101,642**	**-$765,803**	**-$1,065,403**
USG Staffing	CDC	$750,000	$0	-$750,000	$0	$0	$0	-$750,000
	USAID	$1,692,103	$0	-$1,692,103	$0	$0	$0	-$1,692,103
	Subtotal USG Staffing	**$2,442,103**	**$0**	**-$2,442,103**	**$0**	**$0**	**$0**	**-$2,442,103**
Total		**$35,000,000**	**$19,051,658**	**-$15,948,342**	**$17,499,876**	**$15,074,225**	**-$2,425,651**	**-$18,373,993**

Table 3: 2025 2026 Combined Expected Spending, PMI and GF Ethiopia								
		PMI			GF			Net Difference (PMI & GF-MOH)
	Intervention	Original [1]	Revised after FAR (Aug-Dec) [2]	Difference [3]	Original	Revised	Difference After GF Prioritization	
Vector Control	Entomological Monitoring	$1,700,000	$60,000	-$1,640,000	$165,329	$59,581	-$105,748	-$1,745,748
	Procurement of ITNs for Mass Campaign and other Handling Fees	$15,267,000	$13,029,000	-$2,238,000	$28,472,656	$28,472,656	$0	-$2,238,000
	ITNs Mass Campaign: Storage and in-country distribution and other costs	$3,445,000	$3,065,000	-$380,000	$4,003,967	$4,003,967	$0	-$380,000
	ITNs: Micro-planning, supervision and post campaign review meetings at national, regional and district levels	$0	$0	$0	$389,550	$365,583	-$23,967	-$23,967
	IRS Operations & TA	$4,670,000	$5,541,993	$871,993	$10,532,804	$10,532,804	$0	$871,993
	IRS Insecticide & PPE procurement and Distribution	$0	$0	$0	$0	$0	$0	$0
	IRS Operations	$9,388,765	$5,061,437	-$4,327,328	$2,069,806	$1,826,700	-$243,106	-$4,570,434
	LSM	$2,350,000	$0	-$2,350,000	$0	$0	$0	-$2,350,000
	CDC STTA	$29,000	$0	-$29,000	$0	$0	$0	-$29,000
	Subtotal Vector Control	**$36,849,765**	**$26,757,430**	**-$10,092,335**	**$45,634,112**	**$45,261,291**	**-$372,821**	**-$10,465,156**
IPTp	Prevention of Malaria in Pregnancy	$600,000	$320,000	-$280,000	$0	$0	$0	-$280,000
	Subtotal IPTp	**$600,000**	**$320,000**	**-$280,000**	**$0**	**$0**	**$0**	**-$280,000**
Case Management	Procure Case Management-Related Commodities	$6,311,229	$5,000,533	-$1,310,696	$17,512,740	$17,512,740	$0	-$1,310,696
	Case Management Implementation (community and facility case management)	$8,443,261	$6,300,283	-$2,142,978	$1,250,715	$702,041	-$548,674	-$2,691,652
	Staffing and Administration	$20,000	$0	-$20,000	$0	$0	$0	-$20,000
	Non-malaria Commodities	$0	$0	$0	$0	$0	$0	$0
	Threat Surveillance	$400,000	$0	-$400,000	$256,804	$0	-$256,804	-$656,804
	Subtotal Case Manage	**$15,174,490**	**$11,300,816**	**-$3,873,674**	**$19,020,259**	**$18,214,781**	**-$805,478**	**-$4,679,152**

Supply Chain	In-Country Supply Chain	$3,300,582	$2,850,117	-$450,465	$0	$0	$0	$0
	Subtotal Supply Chain	**$3,300,582**	**$2,850,117**	**-$450,465**	**$0**	**$0**	**$0**	**$0**
Malaria Vaccine	Vaccine	$0	$0	$0	$0	$0	$0	$0
	Subtotal Malaria Vaccine	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
SMEO	Surveillance Monitoring and Evaluation; Other Health System Strengthening; Staffing and Administration, (TES visit)	$6,300,000	$960,000	-$5,340,000	$1,211,271	$453,019	-$758,252	-$6,098,252
	Data Systems Strengthening - General	$0	$0	$0	$0	$0	$0	$0
	Data Systems Strengthening - Logistics	$0	$0	$0	$0	$0	$0	$0
	Surveys	$0	$0	$0	$0	$0	$0	$0
	Operational Research	$0	$0	$0	$40,682	$0	-$40,682	-$40,682
	Subtotal SMEO	**$6,300,000**	**$960,000**	**-$5,340,000**	**$1,251,953**	**$453,019**	**-$798,934**	**-$6,138,934**
SBCC	SBC; Other HSS	$2,566,357	$0	-$2,566,357	$1,639,915	$1,391,534	-$248,381	-$2,814,738
	Subtotal SBCC	**$2,566,357**	**$0**	**-$2,566,357**	**$1,639,915**	**$1,391,534**	**-$248,381**	**-$2,814,738**
Program Management	Capacity building, human resources, operations and planning $ supervision	$599,600	$0	-$599,600	$3,687,847	$1,974,685	-$1,713,162	-$2,312,762
	Human Resources	$0	$0	$0	$0	$0	$0	$0
	Operations	$0	$0	$0	$0	$0	$0	$0
	Planning and Supervision	$0	$0	$0	$0	$0	$0	$0
	Subtotal Program Manage	**$599,600**	**$0**	**-$599,600**	**$3,687,847**	**$1,974,685**	**-$1,713,162**	**-$2,312,762**
USG Staffing	CDC	$1,225,000	$0	-$1,225,000	$0	$0	$0	-$1,225,000
	USAID	$3,384,206	$0	-$3,384,206	$0	$0	$0	-$3,384,206
	Subtotal USG Staffing	**$4,609,206**	**$0**	**-$4,609,206**	**$0**	**$0**	**$0**	**-$4,609,206**
Total		**$70,000,000**	**$42,188,363**	**-$27,811,637**	**$71,234,086**	**$67,295,310**	**-$3,938,776**	**-$31,299,948**