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

BRIDGE THE GAP INITATIVE

AKROS

FROM OUR EXECUTIVE DIRECTOR

Dr Peter Mumba
Executive Director
Bridge the Gap Initiative

Former Resident Advisor,
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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 Zambia, 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 provinces.

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 Zambia, our collaboration with the National Malaria Elimination 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 Zambia's progress and advance toward a malaria-free future.

With thanks,

Executive Director
Bridge the Gap Malaria Initiative at Akros

Bridging the Gap in Zambia's Malaria Response:

A White Paper on Emerging Financing Gaps and Strategic Priorities

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Prepared by:
Bridge the Gap (BTG) Initiative

Date:
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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 the Republic of Zambia (GRZ).

Acknowledgements

The findings and recommendations in this report are the independent contributions of the Bridge the Gap initiative and do not represent the views and official policy of the Government of the Republic of Zambia. However, the development of this white paper would not have been possible without the generous collaboration of the Zambia Ministry of Health and the National Malaria Elimination Centre (NMEC). Their commitment to maintaining momentum in malaria control, despite evolving funding challenges, has been a guiding force behind this work.

We extend special acknowledgment to the technical experts and contributors from the Ministry of Health (MOH) and the National Malaria Elimination Centre (NMEC), 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.

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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 Zambia's malaria gains and support its path toward elimination.

Dr. Peter Mumba
Executive Director
Bridge the Gap Initiative

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Abbreviations

ACT – Artemisinin-based Combination Therapy
ALMA – African Leaders Malaria Alliance
AMDR - Antimalarial Drug Resistance
AMF – Against Malaria Foundation
ANC - Antenatal Care
BTG – Bridge the Gap
CCAs - Community Change Agents
CBV - Community Based Volunteer
CD - Continuous Distribution
CDC – U.S. Centers for Disease Control and Prevention
CHAZ – Churches Health Association of Zambia
CHW – Community Health Worker
CY - Calendar Year
DSA - Daily Subsistence Allowance
DfID – Department for International Development (UK)
DRC – Democratic Republic of Congo
ELT – Executive Leadership Team (BTG)
EPI – Expanded Programme on Immunization
FAR - Foreign Assistance Review
FETP – Field Epidemiology Training Program
GF – The Global Fund to Fight AIDS, Tuberculosis and Malaria
GF OIG – Global Fund Office of the Inspector General
GRZ – Government of the Republic of Zambia
HFCA - Health Facility Catchment Area
HMIS – Health Management Information System
HSS – Health System Strengthening
iCCM – Integrated Community Case Management
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
MDA - Mass Drug Administration
M&E - Monitoring and Evaluation
MIS – Malaria Indicator Survey
MOH – Ministry of Health
MOP – Malaria Operational Plan
MIP – Malaria in Pregnancy
NMCP – National Malaria Control Program
NMEC – National Malaria Elimination Centre
NMESP – National Malaria Elimination Strategic Plan
OIG - Office of Inspector General
OTSS - Outreach Training and Supportive Supervision
PEPFAR – President's Emergency Plan for AIDS Relief
PMI – President's Malaria Initiative

PSC – Personal Services Contractor
PSM – Procurement and Supply Management project
RBM – Roll Back Malaria
RDTs – Rapid Diagnostic Tests
RCD – Reactive Case Detection
RMNCAH&N – Reproductive, Maternal, Newborn, Child, Adolescent Health & Nutrition
SBC – Social and Behavior Change
SMEO/SMEOR – Surveillance, Monitoring, Evaluation, and Operations Research
SLDPQ - Single Low Dose Primaquine
SP – Sulfadoxine-Pyrimethamine
TA – Technical Assistance
TBD - To be determined
TDY – Temporary Duty Assignment
UNICEF – United Nations International Children's Emergency Fund
USAID – U.S. Agency for International Development
USG – United States Government
USDH – US Direct Hire staff
USPC - US Personal Services Contractor
WB – World Bank
WHO – World Health Organization
ZAMMSA - Zambia Medicines and Medical Supplies Agency

Executive Summary

Malaria remains one of Zambia's greatest public health threats, with more than 8.5 million cases and 1,060 deaths reported in 2024. Rural provinces such as Luapula, Northern, Muchinga, North Western, and Western continue to carry the highest burden, with prevalence of malaria parasites exceeding 40% among children under five. Transmission is driven predominantly by *Plasmodium falciparum*, with *Anopheles funestus* and *An. gambiae* as the primary vectors. Despite these challenges, Zambia has a clear roadmap through its National Malaria Elimination Strategic Plan (NMESP 2022–2026), which integrates proven interventions across vector control, case management, supply chain reliability, surveillance, and social and behavior change (SBC). Implementation of this plan has delivered measurable progress in reducing the malaria burden, but the country's ability to sustain these gains is now at risk.

Historically, Zambia's malaria response has been underpinned by strong government leadership and policy as well as donor support from the U.S. President's Malaria Initiative (PMI) and the Global Fund (GF). Recent budget reductions by PMI, however, are creating urgent gaps in 2025–2026, particularly for entomological monitoring, SBC programming, routine intervention planning, and surveillance. While GF has maintained its core allocations, the combined effect of declining external resources, persistent health system challenges, and socioeconomic barriers threatens to reverse years of hard-won progress. To respond, the Bridge the Gap (BTG) Initiative, launched in early 2025, is working with the Zambia National Malaria Elimination Centre (NMEC) and partners to map and prioritize these shortfalls. The resulting Zambia Malaria Gaps Inventory highlights the most critical areas for immediate financing.

Of particular concern is the complete cancellation of PMI-funded **social and behavioral change (SBC)** activities, which undermines community engagement and prevention; and the under-funding of the **2026 insecticide-treated net (ITN) campaign**, which risks disrupting a cornerstone of malaria control. To meet immediate needs in ITNs as well as medications and tests, the Global Fund (GF) recipients (Ministry of Health (MOH) and Churches Association of Zambia (CHAZ)) have shifted funding away from longer-term investments in system strengthening, threat mitigation, and innovation. Unfortunately, this compounds PMI cancellation of activities in these same areas. As a result, major concerns have emerged as well in **case management implementation**; in **surveillance, monitoring, and evaluation**—critical for tracking drug resistance and invasive vectors; as well as insufficient support for **supply chain strengthening** and for **innovations** such as vaccine introduction and operational research. Vigilance is needed to monitor for potential future gaps in several other key interventions which, for 2025-26 were found to have relatively stable financing. Among these are **indoor residual spraying (IRS), case management commodities,** and **prevention of malaria in pregnancy (MIP)**.

Without urgent investment, Zambia risks a resurgence of malaria morbidity and mortality, particularly among children and other vulnerable groups in high-burden rural districts. Sustaining Zambia's malaria gains is 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 Zambia'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.

Depending on the activity area, the scope of funding required to make each of the **top-recommended impactful investments** varies from $2.6 million to over $8 million, as indicated in Table I. 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 Zambia, providing guidance to prospective donors, malariologists and, most importantly, the Government of the Republic of Zambia's (GRZ's) 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 in 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 crisis, 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 Zambians to avoid unnecessary sickness and death in the short-term. Last, and longest, we provide detail on the full set of intervention areas, covering both high and lower priority or longer-term investments benefitting Zambia'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. Despite substantial efforts from both the Global Fund (GF) and the Government of the Republic of Zambia (GRZ) to address funding shortfalls, neither were in a position to make up for the large gaps created. Bill Gates pointed out that even large foundations such as the Gates Foundation did not have the resources to step in to backfill intervention access at scale[1]. While the Government of the Republic of Zambia (GRZ) has affirmed its commitment to expanding domestic health financing and enhancing self-reliance amid declining external resources, supplementary funding will be vital in the short to medium term to maintain and strengthen Zambia's malaria control efforts. 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 392,486 malaria cases and 3,610 deaths in Zambia alone.[2]. Circumstances are rapidly evolving. While significant portions of US funding have been restored in the short-term (as of mid-2025), there remain critical gaps inhibiting effective control strategies (see Table 1), and the longer-term outlook is opaque at best. In response to this growing crisis, the Bridge the Gap (BTG) Incubator[3]—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), 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 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.

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[1] 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/

[2] 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

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

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 Zambia, 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 NMEC and partners, the findings and recommendations represent BTG opinions and not official GRZ policy.

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 the NMEC (Attachment A, Letter of Support and Engagement, Zambia MOH), 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 September 2025, enabled us to map expected funding shortfalls by intervention and geography and to prioritize areas 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. For the GF-MOH and GF-CHAZ grants, 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 Zambia Malaria Gaps Inventory and Prioritization ("Inventory"), a live working document that provides a detailed, activity-level assessment of malaria control interventions across Zambia for the remaining months of 2025 and all of 2026, including budgets, geographic focus, 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 Sustainable Malaria Control

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: intense malaria transmission continues in most beneficiary countries, and these 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, close collaboration with governments and iteration.

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 global need, and this shortfall creates unnecessary sickness and death. Our instinct is to meet this crisis head-on, identifying the most vulnerable populations and bring 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 MOH/NMEC 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 that progress persists beyond the current funding cycle.

Immediate priorities for Zambia's malaria control

At the time of writing September 2025, the funding picture remains fluid. Although revised donor commitments by PMI and GF for the remainder of calendar year (CY) 2025 had largely come into focus, much uncertainty remained 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 Zambia. During this time of budgetary constraints in global health, it is the BTG team's 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) Activities which are significantly underfunded for Zambia, with expected spending in 2025-26 much reduced from their original budgets for 2025-26.

(2) Activities which contribute centrally to one or more high-level malaria control objectives in Zambia:

- **Prevent sickness and death** during the upcoming peak malaria seasons (Jan- June 2026 and 2027) by ensuring mass 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 Zambia to stave off short-term malaria resurgence. The chapters following, beginning with an overview of Zambia's malaria environment, provide a more detailed analysis of both short-term and longer-term gaps, opportunities and risk.

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

Intervention	Acute needs	Gap	Rationale
ITN Mass Campaign Sept-Oct 2026	• Distribute the ITNs procured by GF and AMF. • Restore MOH target of universal coverage (excluding Lusaka city) • Fill major gaps in campaign supervision, M&E, SBC	$6.31M	• Prevent infected mosquito bites to reduce malaria cases and save lives • Once-in-3 year campaign • First-time scale-up of dual-active ingredient nets • Zambia's proven ability to reach high population coverage through ITN campaigns • Persistent historic challenges in achieving high population coverage through IRS campaigns
Case management implementation	• Train, supervise, and provide quality assurance for healthcare facilities and CHWs • Sustain activity levels of CHW volunteers through provision of enabler packages (bicycles, backpacks, job aids)	$7.1M	• Provide prompt and effective diagnosis and treatment of malaria infections to avert severe complications and save lives • Commodity needs (medicines, tests) are relatively well catered for in 2025-26, but implementation budgets have been slashed • Leverage the volunteer labor and zeal of Zambia's "army" of CHWs
SBC	• Inter-personal and mass communication activities targeting high-risk populations (pregnant women, young children)	$4.2M	• Promote consistent and correct uptake of malaria control measures by the public • Limit the damage of 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; track anti-malarial drug resistance • Program M&E: Use household surveys, geospatial tools, data analysis tools to guide investments • CDC technical assistance: Provide expert advising to increase impact of these activities	$8.35M	• Data visibility to protect malaria investments • Threat detection and mitigation, especially for insecticide resistance in the mosquito, anti-malaria drug resistance in the parasite, and the dangerous, invasive *Anopheles stephensi* mosquito • Zambia's proven track record in data capture and use • Limit the damage of severe, abrupt funding cuts in this area
Supply chain strengthening	• Warehouse and distribute malaria commodities (ITNs, pesticides, medicines, tests) • Provide last-mile delivery through third-party logistics, filling major gaps in supply chain • Carry out vigorous commodity security activities	$2.6M	• Prevent stock-outs of life-saving medicines and tests at service-delivery points • Permit timely delivery of malaria preventative services (e.g., ITN and IRS campaigns, IPTp) • Strengthen systems to prevent losses of commodities.

Malaria in Zambia

Overview

Malaria remains a major cause of illness and death in Zambia, with an estimated 20,000 cases and four deaths each day[4]. In 2024, the Ministry of Health reported about 8.5 million cases and 1,060 deaths[5]—a notable decline from 2023, likely due to interventions such as IRS and ITN distribution. The most recent national survey at the end of the 2024 rainy season, which ran from November 2020 to April 2024[6] found a malaria parasite prevalence of 13.8% in children under five years of age based on microscopy, up from 9.1% in 2018[7].

Similar to much of sub-Saharan Africa, Zambia has experienced stagnation in key malaria indicators since roughly 2015–2017, including prevalence, incidence, and the proportion of health facility catchment areas (HFCAs) in low-burden or elimination strata. The strategic goal of the National Malaria Elimination Strategic Plan (NMESP) 2022-2026[8] is to reduce malaria burden in high-transmission areas and achieve sub-national elimination in low transmission areas. While Zambia's NMEC has made progress—especially in reducing malaria mortality and scaling up community case management of malaria —persistent high transmission and uneven declines across regions indicate that the elimination milestones are not yet being met (Figure 1, 2). Despite strong implementation and surveillance systems, substantial challenges remain in expanding malaria-free zones.

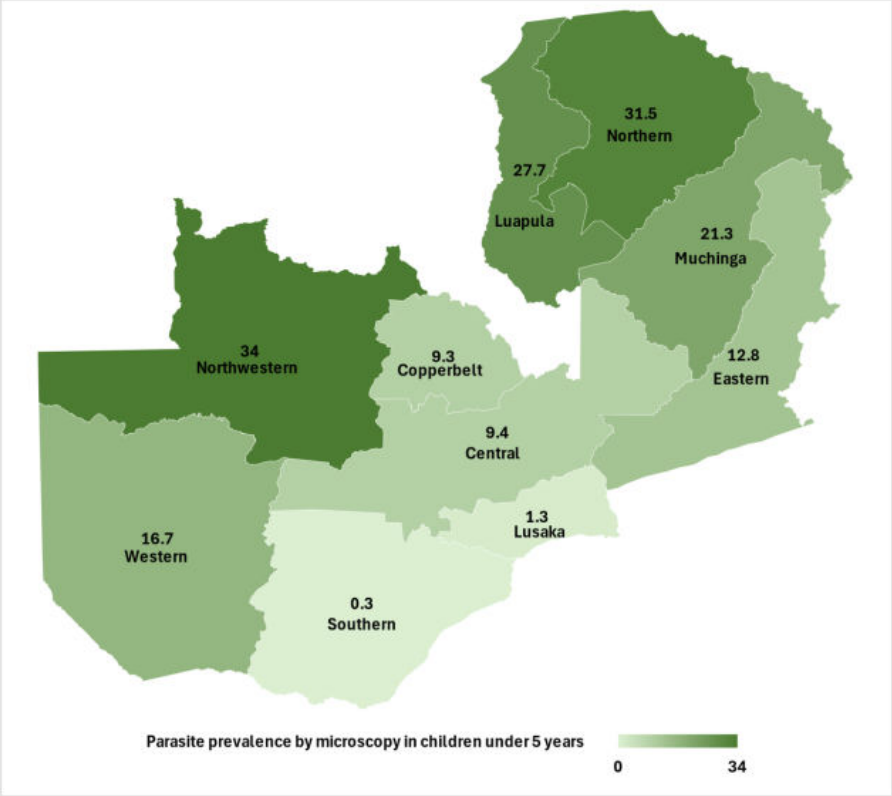

Figure 1. Parasite prevalence by microscopy in children under 5 years. Zambia 2024 Malaria Indicator Survey.

In Zambia, 60% of the total population (11 million people) resides in rural areas[9], where risk of malaria infection is 4.5 times greater than in urban areas. Malaria risk is highest in the wetter, rural, impoverished provinces of Luapula, Northern, Muchinga, North Western, and Western provinces (17-34% microscopy-based prevalence in the 2024 Malaria Indicator Survey), and in adjacent rural areas of the Copperbelt and Eastern provinces. Malaria risk is lowest in Lusaka Province (1.3% by microscopy) and Southern Province (0.3% by microscopy) (Figure 1). Figure 2 shows that while estimated malaria cases have fluctuated between two and four million

[4] https://www.nmec.org.zm/malaria-overview

[5] Health Management Information System 2025

[6] https://climateknowledgeportal.worldbank.org/country/zambia/climate-data-historical.

[7] Zambia Malaria Indicator Survey [MIS] 2024

[8] Zambia National Malaria Elimination Strategic Plan (NMESP) 2022-2026

[9] ZamStats 2022

annually since 2010, the total number of confirmed cases has increased over time, likely due to policy changes promoting the use of confirmatory diagnostics as well as the persistence of malaria risk, particularly in the northern and western reaches of the country. The sustained declines in malaria hospitalizations and malaria deaths since 2010 are gratifying.

Malaria incidence rose from 205 cases per 1,000 population in 2024 to 236 cases per 1,000 population during the first half of 2025 across all provinces except for Northern, Luapula, and Muchinga. At the same time, malaria mortality declined from 3.6 deaths per 100,000 population in 2024 to 3.0 deaths per 100,000 population in 2025[10]. These figures imply that malaria is being diagnosed and treated earlier in its course (with the aid of community health workers (CHWs)), and that the quality of care for severe malaria has improved, among other factors. Avoidance of back-sliding in malaria mortality trends in the coming years is a top priority of the Zambian MOH and partners.

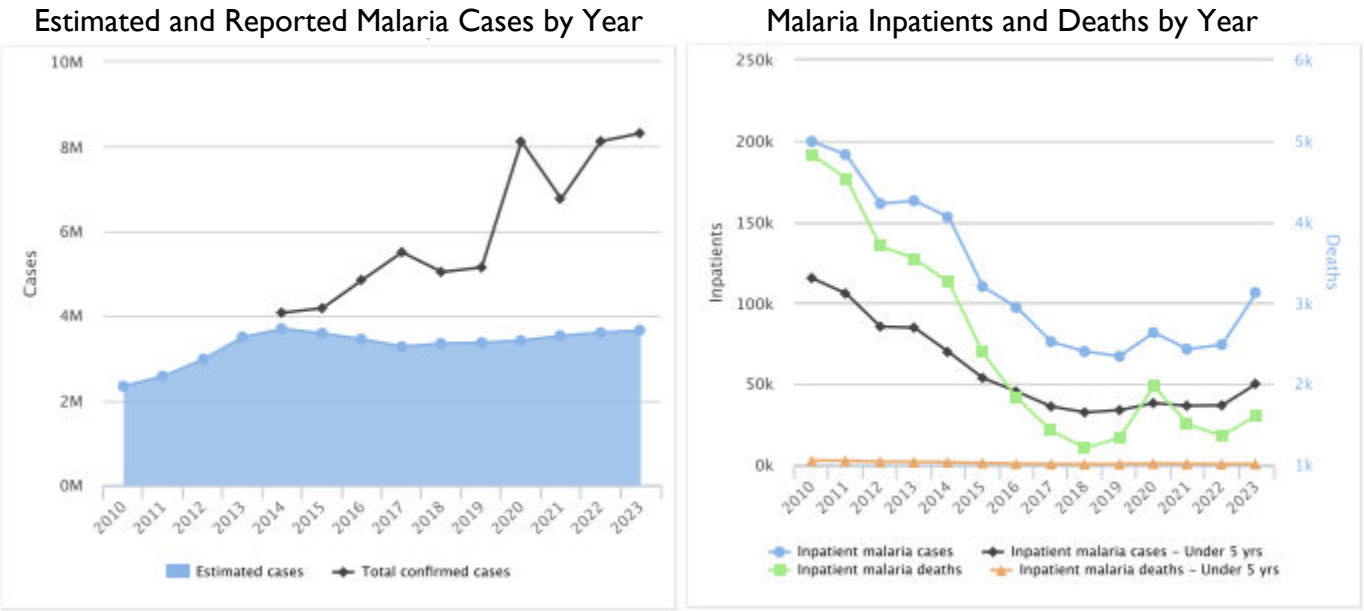

Figure 2. Estimated and reported cases by year, Zambia (Left); Malaria inpatients and deaths by year, Zambia (Right) [World Malaria Report 2024].

Malaria Vectors, Parasites and Transmission

Malaria transmission occurs year-round, with variations in transmission intensity across the country. Parasite prevalence is highest at the end of the peak transmission season in April and May. *Plasmodium falciparum* is the predominant malaria parasite, causing the most severe forms of malaria and accounting for 98% of all malaria infections in Zambia. The composition of malaria vector species is heterogeneous at the national level. Overall, there are three main vector species, *Anopheles funestus s.s.*, *An. gambiae s.s.*, and *An. arabiensis*. *An. funestus s.l.* is the primary and *An. gambiae s.l.* is the secondary vector; both are highly efficient at transmitting malaria, with both largely biting and resting indoors. There is some geographic variation: in some locations, *An. funestus s.l.* and *An. gambiae s.l.* have an equivalent abundance; in other locations, *An. gambiae s.l.* is more abundant than *An. funestus s.l.*

[10] Bridge the Gap and Zambia NMEC. (2025, August 19). *BTG/NMEC* Internal meeting notes. Available upon request.

Malaria Elimination Challenges

Zambia, one of the eight southern African countries in the Elimination Eight (E8) alliance that have committed to the joint goal of eliminating malaria by 2030[11], faces significant challenges in progressing toward this ambitious target. The malaria control and elimination challenges include inadequate infrastructure, limited health systems, and an environment conducive to persistent Anopheline vectors[12]. Disruptions to supply chains, particularly for diagnostic tests and treatments, and gaps in data collection and reporting within the healthcare system, especially in remote areas, also impede progress[13]. Most of these challenges are further influenced by the limited availability of long-term sustainable funding in Zambia's health sector. Zambia, as a signatory to the 2001 Abuja Declaration, remains committed to the goal of allocating at least 15% of the national budget to the health sector[14]. Historically, donor funding has played an important role in supporting health sector needs and supplementing available resources for malaria elimination.

The 2019 Lancet Commission on Malaria Eradication highlighted three main areas of constraint to malaria elimination globally. These include: 1) biological challenges (parasite complexity, vector adaptation, immunity dynamics and genetic diversity); 2) resource challenges (financing gaps, health system capacity, commodity supply chain, human resources) and 3) implementation challenges (program reach and coverage, surveillance gaps, and cross-border transmission)[15]. It is informative to apply this analytical framework to Zambia's situation. Related to **biological challenges,** persistent high malaria incidence (levels 3–4, moderate to very high transmission intensity) remains entrenched in impoverished, high-rainfall rural areas across Zambia's northern tier. In many districts, there is an overwhelming vectorial capacity meaning a greater likelihood of malaria transmission and limited effectiveness of IRS, a pattern well documented, for example, in Nchelenge district in Luapula Province[16,17]. Equally concerning is the potential introduction of *Anopheles stephensi*[18], an urban-adapted, pesticide-resistant malaria vector common in Western Asia. In addition, antimalarial drug resistance (AMDR), notably resistance to first-line ACTs, has been detected recently in Eastern and Southern Africa and poses a looming threat to treatment efficacy.

Implementation challenges were cited by the Lancet Commission as the greatest constraint to further progress globally and are known to remain a significant barrier in Zambia as well. Examples include periodic shortages of artemisinin-based combination therapies (ACTs) and rapid diagnostic tests (RDTs), which have occasionally limited community health workers service delivery; antenatal care clinics experiencing shortages of insecticide-treated nets (ITNs) or intermittent preventive treatment in pregnancy (IPTp); delayed indoor residual spraying (IRS) campaigns leading to lower-than-expected district-level population coverage; reactive case detection (RCD) and mass drug administration (MDA) at times deployed inappropriately in high-burden settings. These gaps highlight the well-recognized needs (not at all unique to Zambia) for stronger operational planning, supply chain management, supervisory supports, enhanced stakeholder accountability across the GRZ and its partners, and resource prioritization to ensure interventions reach those most in need.

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[11] https://tis.sadc.int/english/sarn/elimination-eight-e8

[12] https://pmc.ncbi.nlm.nih.gov/articles/PMC5985430/

[13] https://mesamalaria.org/ZAMBIA-Malaria-Profile-PMI-FY-2024.

[14] https://www.africanconstituency.org/where-does-zambia-stand-with-the-abuja-declaration/

[15] Feachem, Richard GA et al. Malaria eradication within a generation: ambitious, achievable, and necessary. The Lancet, Volume 394, Issue 10203, 1056 - 1112.

[16] Ferris et al (2023). The impact of household and community indoor residual spray coverage with Fludora Fusion in a high malaria transmission setting in Northern Zambia. Am J Trop Med Hyg 109(2) p 248-257

[17] Hast, MA et al (2019). The impact of 3 years of targeted indoor residual spraying with pirimiphos-methyl on malaria parasite prevalence in a high-transmission area of northern Zambia. American journal of epidemiology, 188(12), 2120-2130.

[18] Sinka ME et al. A new malaria vector in Africa: Predicting the expansion range of Anopheles stephensi and identifying the urban populations at risk. Proc Natl Acad Sci U S A. 2020;117(40):24900-24908.

Malaria control strategies, funding landscape, and progress achieved to date

The Zambia NMESP (2022–2026) aims to reduce malaria infection, disease, and death; increase the proportion of the population living in malaria-free HFCAs; and maintain malaria-free status by preventing reintroduction and importation into areas where the disease has been eliminated. The strategic plan outlines the priority interventions such as vector control, case management, supply chain management, surveillance monitoring evaluation and operational research, as well as social and behaviour change, which are described in Table 2, below:

Table 2. Priority interventions and associated goals within the Zambian National Malaria Elimination Strategic Plan (NMESP) 2022-2026.

Strategic Area/Focus Investment Area	NMESP Goals (2022–2026)	NMESP Key Approaches
Vector Control	Raise coverage from 57% → 86%	- ITNs as primary tool, targeted IRS, larval source management, entomologic surveillance. - Mass ITN campaigns nationwide (excluding Lusaka). - Continuous facility distribution for vulnerable groups; school/community top-ups. - Responsive IRS in low/malaria-free areas based on hotspot surveillance.
Case Management	100% suspected cases tested; 100% confirmed cases treated within 24 hrs	- Universal access to quality diagnosis & treatment. - Maintain drug supply & provider QA. - CHW training/supply support in underserved areas. - Targeted interventions (MDA, RCD). - Strengthen IPTp uptake via supply, reproductive health integration, and clinic coordination.
Supply Chain	Uninterrupted commodity availability	- Strengthen logistics systems; expand eLMIS & patient-level CHW data. - Improve forecasting, procurement, and distribution. - Reinforce QA & pharmacovigilance. - Expand storage capacity; secure supply chain via SOPs, anti-theft measures, and anomaly detection.
Surveillance, Monitoring, Evaluation (SMEOR)	Malaria Rapid Reporting in all HFCAs by 2026	- Expand digital reporting & SMART objectives. - Strengthen data use via training, supervision, and regular reviews. - National surveys & operational research to inform policy and improve delivery.
Social Behavior Change (SBC)	Boost uptake and correct use of interventions	- Tailored messaging by transmission level. - Updated materials for new tools. - Facility talks, household visits, and community leader engagement. - National strategy alignment & civil society partnerships for consistent messaging.

Challenges for the Zambia National Malaria Program

The NMEC faces a pivotal moment in malaria control, with substantial funding cuts compounding a pre-existing stall in progress, as key indicators have plateaued despite sustained interventions. While the sustained declines in malaria deaths are impressive and commendable, national elimination remains a distant goal, with significant advances confined to a few high-performing districts, and overall efforts holding steady rather than advancing. This fragile status is now at risk, as funding cuts from PMI and the GF threaten not only future progress but also the preservation of hard-won gains, adversely affecting the continuity of essential interventions nationwide.

Zambia's malaria response has historically relied on government funding and substantial external assistance. Contributors to malaria funding for malaria prevention, treatment and control in Zambia include most notably PMI (USAID, now funded through the US Department of State). PMI/Zambia's annual funding was $28-30 million from FY2017 through FY2024.

The GF has also contributed substantially through a series of 3-year grants to the MOH and CHAZ for HIV, TB, and malaria interventions alongside broader health systems strengthening under MOH leadership. In the most recent GF grant (Grant Cycle 7, GC7), Zambia was allocated a total of US$362 million for the 3-year period of 2024 to 2026, out of which the MOH malaria grant is $54.07 million, and the CHAZ malaria grant is $23.17 million. Additional contributors have included the World Bank (WB), World Health Organization (WHO), United Nations International Children's Emergency Fund (UNICEF), the Gates Foundation, the Department for International Development (DfID) United Kingdom, and the Rotary Club, among others[19].

The GRZ, in addition to providing the health system infrastructure which permits mass population access to services, has also allocated funds in moderate amounts for malaria-specific commodity and program support. During the period 2009 to 2018, according to the proportion of funds towards interventions, about 30% of the funding came from PMI/USAID, 26% from the GF, 17% from the GRZ and the remaining 27% coming from the other partners.

By 2025, approximately 40.9% of funds were being contributed by PMI/USAID, 19.7% by GF (MOH), 7.6% by GF (CHAZ), 25.5% by GRZ and 6.3% by other sources (Figure 3)[20]. In Zambia, outside of major cities, the private sector plays a minor role in providing malaria prevention and treatment services, and takes a back seat in the impoverished rural areas where malaria burden is highest. Notable private sector contributions have included a $1 million in-kind donation from Africa Global Logistics (AGL) and ongoing investments from mines and plantations (FY 2025 MOP).

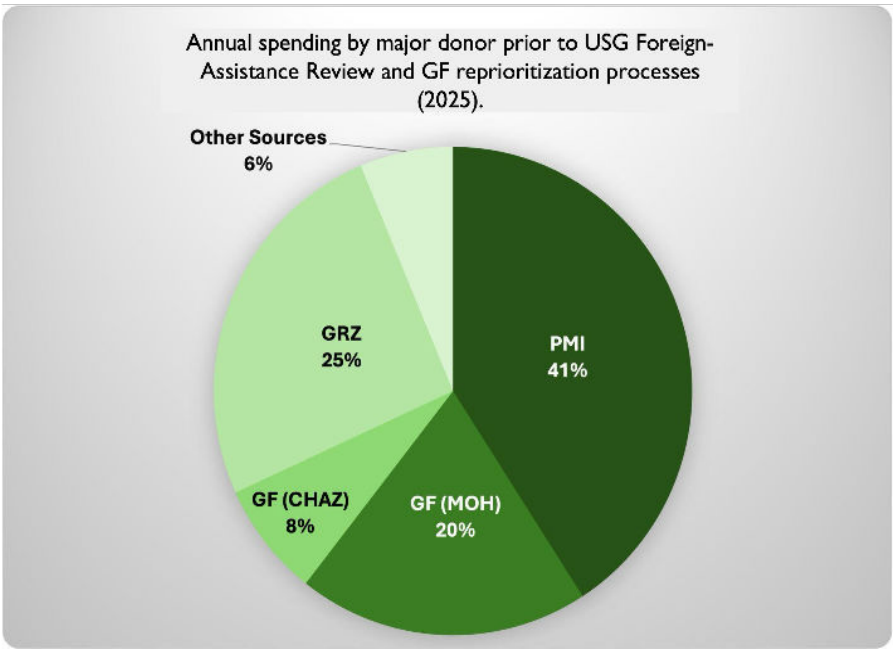


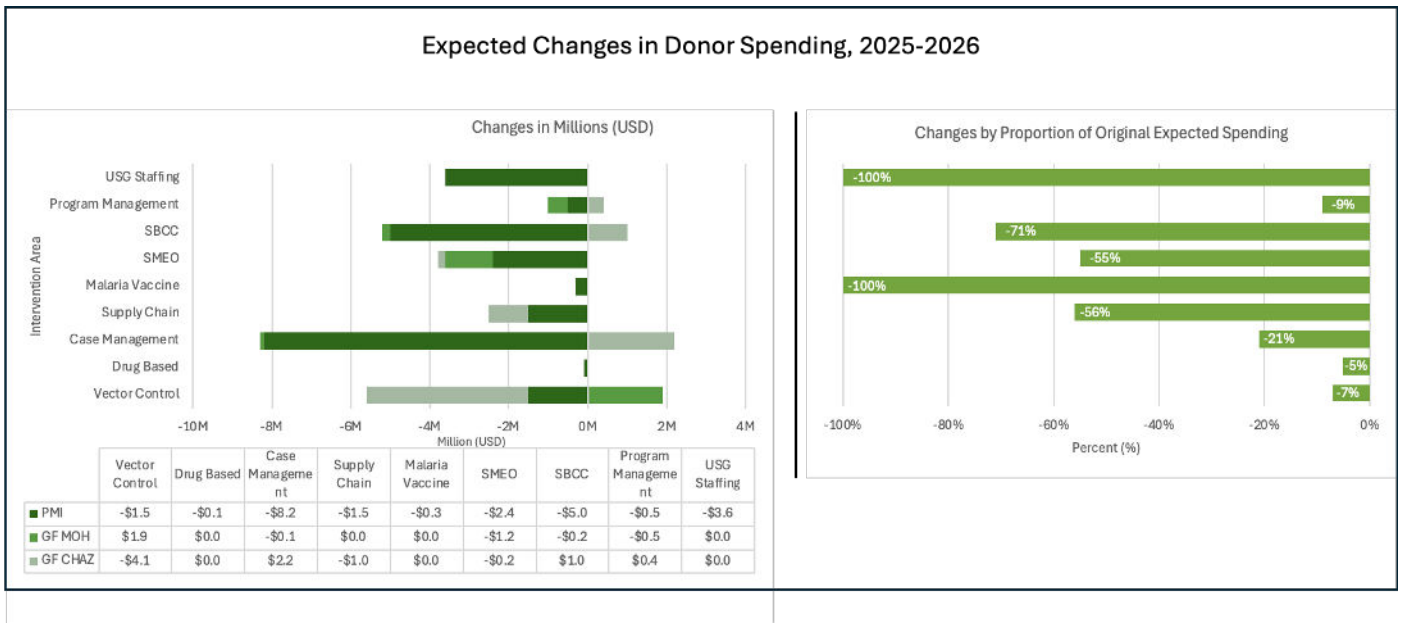
Figure 3. Annual spending by major donor prior to USG FAR and GF reprioritization processes (2025).

[19] https://pmc.ncbi.nlm.nih.gov/articles/PMC9306103/

[20] 2022-2026 NMESP - Table 9, thematic program projected costs by year; GF Financial Gap Overview Table

2025 Funding Landscape

As of mid-2025, however, both PMI and the GF are either signaling (or have already enacted) reductions in planned allocations for the 2025–2026 period and beyond. For PMI, this includes significant cuts to activities not deemed lifesaving in the short term, including entomological monitoring (within vector control category), social and behavior change campaigns (SBCC), supply chain support, malaria elimination tools, and surveys, among others (Figure 4). Meanwhile, at the time of writing, GF's funding realignment exercise has so far spared Zambia's GF-MOH grant from cuts in total funding levels; however, in response to external funding pressures, the GF-MOH grant allocation (GC7) has shifted significantly from longer-term investments (e.g. in data system strengthening, public education, and innovation) to short-term commodity needs (i.e. RDTs and ITNs). The GF-CHAZ grant has been reduced by $1.73M (11% of the planned spending for 2025-26). It is expected that the GRZ will aim to increase its allocation to health overall and to malaria specifically.



	Vector Control	Drug Based	Case Management	Supply Chain	Malaria Vaccine	SMEO	SBCC	Program Management	USG Staffing
PMI	-$1.5	-$0.1	-$8.2	-$1.5	-$0.3	-$2.4	-$5.0	-$0.5	-$3.6
GF MOH	$1.9	$0.0	-$0.1	$0.0	$0.0	-$1.2	-$0.2	-$0.5	$0.0
GF CHAZ	-$4.1	$0.0	$2.2	-$1.0	$0.0	-$0.2	$1.0	$0.4	$0.0

Figure 4. 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 all three donors, expressed as a percentage of original expected spending.

The sudden contraction in financing and the uncertainty in future support poses a risk to the 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 reduction in the funding also weakens Zambia's surveillance and data systems, making it harder to identify and mitigate threats (e.g., anti-malarial drug resistance and invasive vectors), detect outbreaks or measure impact in real time.

While the Zambian 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: Zambia Malaria gaps inventory and prioritization

The Zambia Malaria Gaps Inventory ("Inventory") is structured using the same intervention areas (aka "categories" or "focus investment areas") as found within the USAID PMI Malaria Operational Plan (MOP) documents. MOPs are detailed implementation plans previously developed by the President's Malaria Initiative (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 national malaria control programs (NMCPs) and global goals. These plans were previously developed in close collaboration with NMCPs and other key stakeholders.

A summary of Inventory results are available as Attachment B and are structured by MOP 'focus investment area'. The full inventory has been shared with the Zambian NMEC. The Inventory was developed taking into account both USAID PMI funding modifications as well as GF modifications. Fortunately, GF allocations for MOH activity for CY2024 and CY2025 (from original GC7 Grant) in Zambia remain largely the same and have not suffered funding cuts similar to PMI. However, GF-MOH monies have been reprioritized, largely towards commodities required. Hence, the Inventory results provided in Attachment B describe PMI funding reductions as well as GF-MOH and GF-CHAZ grant reprioritization.

The full need, described in the NMESP for malaria control in Zambia totals $119.7m for 2025 [A][21]. Prior to the FAR, the original expected spending for 2025 was $68m [B], leaving a **baseline gap for 2025 of $51m**. Post the FAR, the revised expected spending for 2025 was $63m, leaving a **revised gap for 2025 of $56.5m**. The significant reduction in the two major donors (PMI and GF) thus further exacerbates the already existing problem of insufficient funds to meet the malaria control needs in Zambia. Table 3 describes these data for 2025 (and also 2026) and Figure 5 illustrates these data for both years and by donor.

Table 3 summarizes the Zambia Gaps and Priorities Inventory (for full table consult Attachment B). Original and revised or reprioritized budgets for CY 2025 and CY 2026 (and combined). A = full need (NMESP 2025); B = Original expected spending; C = Revised expected spending. "Net change" [B-C] describes overall change in funding across PMI and GF (MOH and CHAZ grants) for both CY 2025 and CY 2026; Baseline Gap = [A-B]; Revised Gap = [A-C].

[21] Zambia National Malaria Elimination Strategic Plan

Table 3. Expected spending (original and revised) by donor and year

Donor	Expected Spending	2025	2026	Combined (2025-2026)
PMI	Original	$28,000,000	$28,170,000	$56,170,000
	Revised	$23,351,798	$9,702,302	$33,054,100
	Net Change	-$4,648,202	-$18,467,698	-$23,115,900
GF (MOH)	Original	$13,478,463	$26,956,926	$40,435,390
	Revised	$13,454,407	$26,908,816	$40,363,224
	Net Change	-$24,056	-$48,110	-$72,165
GF (CHAZ	Original	$5,213,439	$10,426,878	$15,640,317
	Revised	$4,635,926	$9,271,851	$13,907,777
	Net Change	-$577,513	-$1,155,027	-$1,732,540
GRZ	Original	$17,475,516	$17,475,516	$34,951,031
	Revised	$17,475,516	$17,475,516	$34,951,031
	Net Change	$0	$0	$0
Other Sources	Original	$4,321,142	$4,401,002	$8,722,144
	Revised	$4,321,142	$4,401,002	$8,722,144
	Net Change	$0	$0	$0
Totals	Full Need (NMESP) [A]	$119,716,330	$78,756,498	$198,472,828
	Original [B]	$68,488,560	$87,430,322	$155,918,882
	Revised [C]	$63,238,788	$67,759,487	$130,998,277
	Net Change [B-C]	-$5,249,771	-$19,670,835	-$24,920,605
	Baseline Gap [A-B]	$51,227,770	-$8,673,824	$42,553,946
	Revised Gap [A-C]	$56,477,542	$10,997,011	$67,474,551

Figure 5. Funding was revised downward for PMI, GF (MOH and CHAZ grants) by a total of -24.92 million across 2025 and 2026 (combined).

Vector Control

Under vector control, the NMEC and its partners have deployed entomological monitoring, ITN distribution, and IRS as the major investments. Larval source management (LSM), including larviciding and environmental manipulation have been funded on a limited scale and falls into the category of "other vector control" interventions. The aggregate funding gap across CY2025 and 2026 for each intervention classified vector control intervention area is described below area (Table 4).

Table 4. Expected spending revisions in vector control, for the period Aug 2025-Dec 2026, by donor.

Expected Spending Revisions, Vector Control, 2025-2026				
	PMI	GF (MOH)	GF (CHAZ)	Totals
Original Expected Spending	$20,000,380	$25,485,989	$7,268,428	$52,754,797
Revised Expected Spending	$18,496,798	$27,386,413	$3,166,869	$49,050,080
Net Change	-$1,503,582	$1,900,425	-$4,101,559	-$3,704,716

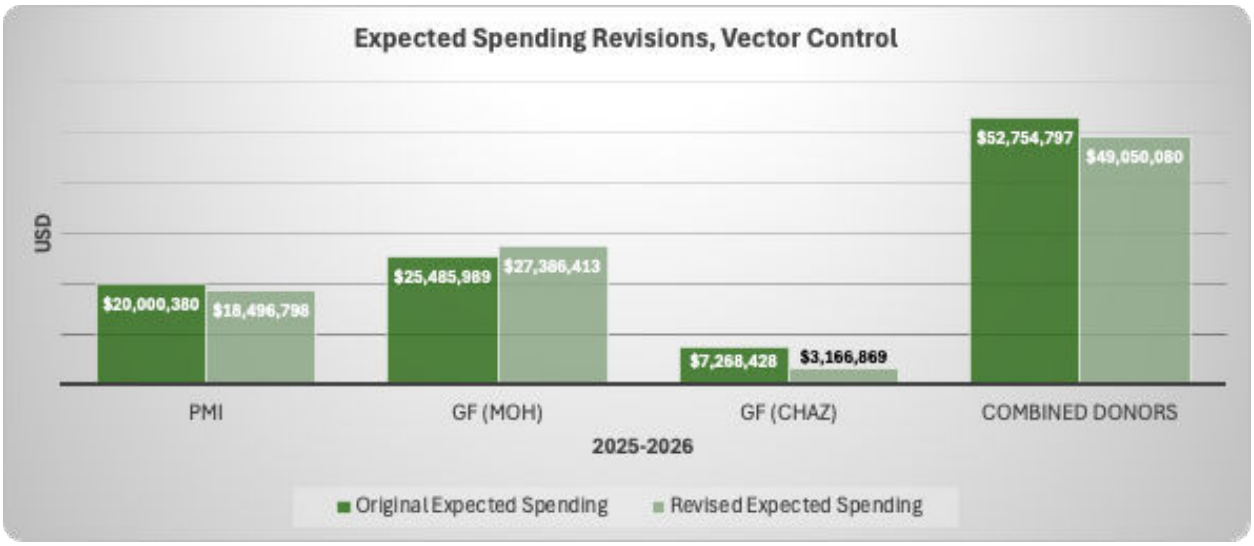


Figure 6. Expected spending revisions in vector control, for the period Aug 2025-Dec 2026, by donor.

Overall revisions in expected donor spending on vector control are given in Table 4 and Figure 6. Details of expected and revised spending by donor are given in Attachment B, with highlights provided in the following pages by vector control activity area.

To summarize, PMI cut vector control spending by $1.5 million (from $20 million to $18.5 million. GF (MOH) increased contributions for vector control during the reprioritization process - up by $1.9 million (USD) (from $25.5 million to $27.4 million, while GF (CHAZ) decreased theirs by $4.1 million (from $7.3 million to $3.2 million).

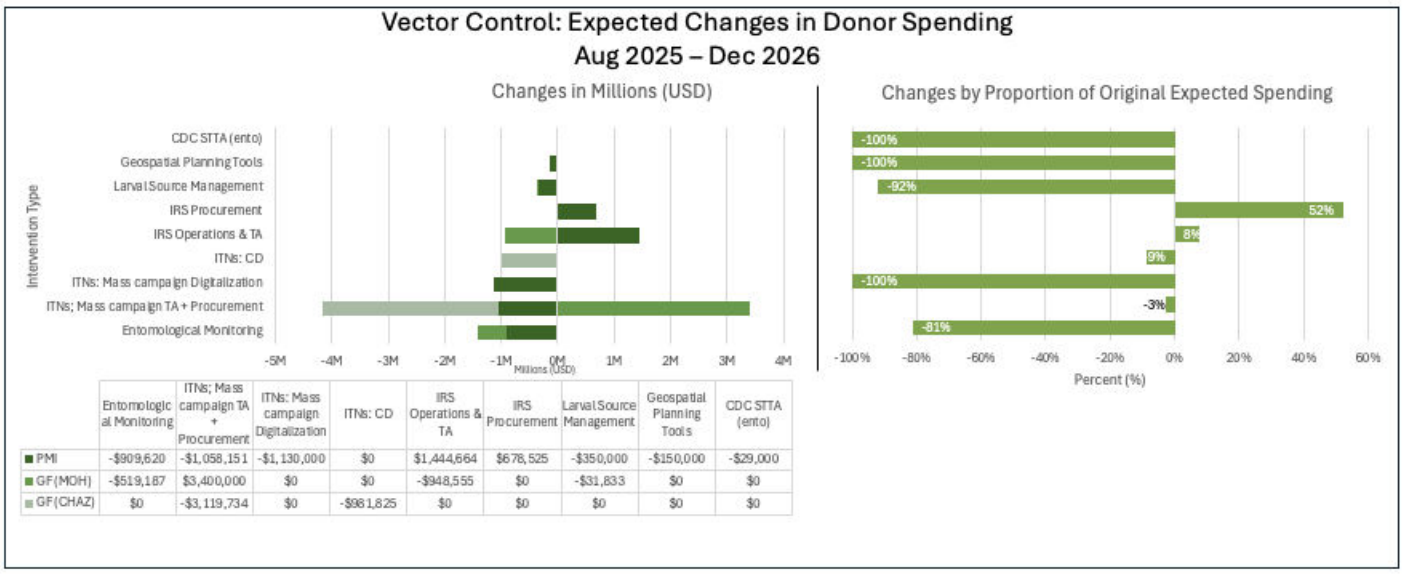


Figure 7. Expected spending revisions in vector control, for the period Aug 2025-Dec 2026, by donor and intervention area

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

Entomological monitoring

Over the 2025/2026 period, PMI had originally allocated $1million USD ($500,000 for each calendar year) to support entomological monitoring at 14 sentinel sites—including resistance intensity/synergist testing, molecular analysis, and NMEC capacity building to leverage GF, GRZ, and other partner investments. During budget reductions, this was cut by $909,620 (91%) for 2025/2026 [-$459,620 in 2025; -$450,000 in 2026] reducing coverage from 14 to three monitoring sites, on the stated basis that entomological monitoring was not immediately life-saving compared to ITNs or IRS.

The 2025-2026 GF/MOH remaining balance for entomological monitoring has been reduced by US $519,187 (from $758,777 to $239,590) due to portfolio deprioritisation, resulting in a narrower scope of activities. Consequently, IRS quality control and insecticide susceptibility testing will be carried out at 10 district sentinel sites instead of 17. The GF-CHAZ grant did not include support for entomologic monitoring.

There has been a total net reduction in funding allocated by PMI and GF across 2025 and 2026 of -$1,428,807 specific to entomological monitoring meaning that additional resources would be required to restore the original sentinel sites—14 for PMI and 17 for GF– and the laboratories and insectaries which support them. The significant contraction of donor funding for entomological monitoring will constrain Zambia's capacity to produce entomological data required for malaria vector control decisions. Entomological monitoring is important for selecting suitable vector control interventions and products. Examples of key data for decision making include (a) annual sampling for the development of resistance to pesticides in local mosquito populations and (b) monitoring for shifts in malaria-bearing mosquito species and their biting behaviors, and (c) surveillance for the feared introduction from the Horn of Africa of the difficult-to-manage, invasive vector *Anopheles stephensi*

Vector Control: Entomological monitoring
Priority level for seeking alternative funding: HIGH. **Expected Impact: LONGER TERM** **Total net reduction (2025 - 2026) = -$1,428,807** ● Reduced PMI and GF/MOH funding will narrow surveillance coverage, weaken resistance detection, and limit monitoring of intervention impact. ● This risks vector control decisions being based on outdated evidence, leading to less effective interventions and potential loss of malaria gains.

Insecticide Treated Nets

In Zambia, two primary distribution strategies have been employed to provide ITNs throughout the country: continuous distribution (CD) as well as mass distribution campaigns. For both, several types of costs are included namely procurement, distribution, implementation, and digitalization of the distribution processes.

ITNs - 2026 mass distribution campaign

In Zambia as in many African countries, the backbone of malaria prevention efforts has been scaled-up population access to ITNs, achieved in large part through mass campaigns conducted every three years which distribute nets free of charge to enumerated households. Zambia's **ITN campaign in 2020-21** was under-resourced (5.6 million nets distributed), with emphasis placed instead on IRS. But IRS scale-up proved to be difficult, and this "mosaic approach" resulted in worrisome declines in overall vector control access. (ITN use in young children dropped from 69% in 2018 to 46% in 2021, and access to ITN and/or IRS dropped from 84% to 71%; 2021 MIS[22]). However, the **next campaign, in 2023-24,** was well resourced (11.6 million nets distributed), based on close coordination between the MOH and the major donors PMI, the GF, the Against Malaria Foundation (AMF), and AGL Logistics. The 2024 campaign targeted all districts other than Lusaka, and resulted in much-improved population access (ITN use rebounded to 68% and access to ITNs and/or IRS increased to 82%[23]).

For the **upcoming mass campaign in 2026**, the NMEC and partners again aspire to universal coverage (excepting Lusaka), but current targets recently have been scaled-back due to perceived budgetary constraints – specifically, the suspension of PMI commitments. The original plan aimed for universal coverage, with a target population (based on the 2023 household registration exercise) of 22,259,937. This translated into a ITN need of 12,366,632 dual active ingredient nets and a budget (procurement, shipping and implementation) of $48,393,103. However, the current plan constricted the target, excluding over 2M people in districts which are planned for IRS. In the current, revised plan, 33 largely rural and mainly high-burden districts would be left to receive IRS for vector control, with target population reduced to 20.0M, ITNs to 11.1M, and budget to $43.8M. **Yet this is far from optimal**. Historically, Zambia's IRS campaigns tend to exclude significant portions of local households based on various targeting criteria, and in addition face numerous challenges in delivering timely IRS to high proportions of those targeted households, undermining intervention effectiveness.

An updated gap analysis shows that Zambia could revert to its original, much-preferred plan for universal coverage if it could **mobilize $6.31 million in additional support** (Attachment C). This would allow the campaign to reach its afore-mentioned $48.3M budget by adding to the $21.57M in the original GF-MOH grant, the $3.40M top-up from the GF-MOH reprioritization, a generous $11.97M ITN donation from AMF, and the $4.53 M in expected PMI FY25 funding which is already in the pipeline. Of note, this gap analysis accounts for a recent $3.1M reprogramming of GF-CHAZ funds away from campaign implementation to meet urgent ACTs gaps. The BTG analysis also assumes that any PMI FY26 funds, whose status remains highly uncertain, would not be available in time to support the campaign.

A fully-funded 2026 ITN mass campaign would put an innovative new vector control product, the dual active ingredient net, in the homes of Zambia's at-risk population. Learning lessons from the country's 2020 and 2023 campaigns, and recognizing the proven effectiveness of ITNs in malaria control, it seems clear that bridging the gap for the upcoming ITN mass campaign is a top opportunity for impactful investment in Zambia.

[22] Zambia Malaria Indicator Survey [MIS] 2021

[23] Zambia Malaria Indicator Survey [MIS] 2024

Vector Control: Mass Campaign
Priority level for seeking alternative funding: HIGH. **Expected Impact: IMMEDIATE.** **Total gap for ITN mass campaign resources = -$6,312,169** ● Decreased PMI funding prompted the NMEC and partners to pull back from targeting the full at-risk population in its next ITN mass campaign (2026). There are insufficient resources for the critical components of the campaign—including procurement, distribution, and digitization ● This risks leaving vulnerable populations without adequate protection and undermines Zambia's commendable efforts to achieve universal ITN coverage and guard against malaria rebound. ● By mobilizing the necessary resources, the mass campaign could reach its universal coverage targets, whereby all households would own and use ITNs. ● The campaign has high potential for impact, as it will be Zambia's first-time scale up of a Dual Active Ingredient net product.

ITNs - Continuous distribution channels

Zambia follows the international best practice of supplementing its periodic mass campaigns with continuous distribution (CD) of ITNs to reach the high-risk populations of pregnant women and children under 5. At public health facilities nationwide, free of charge, pregnant women receive ITNs at ante-natal care (ANC) clinics and children around 9 months old receive ITNs at their well-child checks (EPI clinics). (Zambia has also piloted distribution through schools, although the scope of school-based distribution in Zambia remains very limited.)

To support ITN continuous distribution PMI originally allocated $4.3 million in CY2025, with $3.65 million for procurement, $300,000 for distribution via the ANC and EPI clinics, and $350,000 for training, supervision and other implementation. The comparable support for CY2026 totals $2,150,000. PMI support is channeled through the USG contractors (aka implementing partners) Evolve and PSM. Fortunately, this funding is expected to continue to flow, with allocations for CY2025 and CY2026 largely unchanged. In CY2025, 1.1 million PBO nets are expected to be procured and distributed across Eastern, Luapula, Muchinga, and Northern Provinces through routine continuous distribution (CD) channels. In CY2026, domestic (GRZ) and USG/PMI resources together are projected to deliver 2,030,508 nets, covering only about 85% of the requirement for these channels. GF/MOH funding for 2026 is expected to remain unchanged and would cover the 2026 balance of 345,690 nets.

In contrast, GF-CHAZ support appears to have been cut and may create a significant gap. The 2025-2026 GF/CHAZ expected spending for CD nets reduced by $981,825 during the reprioritization process, from an estimated amount of $3,603,952 to a reprogrammed amount of $2,622,127) The NMEC may be considering redirecting of these nets to the 2026 mass campaign (details unclear at the time of writing). Thus, there appears to be a funding gap of $981,825 for CD nets that will require additional resources.

However, it is notable that the Zambia government from its own funds has begun to procure ITNs for CD in recent years, amounting to a reported $2million in 2024-25. These ITNs, imported in part overland through Tanzania, have contributed meaningfully to meet national needs. This example of increased domestic resource mobilization is commendable and seems to imply that external donor support is more urgently required elsewhere.

Vector Control: Continuous Distribution Channels
Priority level for seeking alternative funding: MODERATE. **Expected Impact: IMMEDIATE.** **Total net change (2025 - 2026) = -$981,825** ● Funds are needed to close the remaining ITN supply gap for continuous distribution in 2026, vulnerable groups such as pregnant women and young children may be left unprotected. The need could become more acute if nets were to be diverted to the mass campaign, and if the anticipated USG commitment were not to materialize. ● The government of Zambia's recent annual investments in ITNs for continuous distribution is a commendable instance of domestic resource mobilization for malaria control and implies that external donor support may be less urgently required in this area.

Indoor Residual Spraying

IRS has a long history in Zambia, dating to the influential copper mine programs in the 1940s, and continues to be prioritized by the Zambian government and its partners at a time when numerous other countries have seen discontinuation or drastic scaling back. Spraying largely takes place in September-November before the rainy season, providing protection during the months of peak malaria transmission. Zambia did reduce IRS targeting moderately during the 2021-24 period, with major funding covered by the government, GF-MOH grant, PMI, and several mines and plantations. Core activities included training spray teams and supervisors, monitoring and evaluation, SBC for IRS, safe pesticide storage and disposal, and covering operational spraying costs. Capacity was also built for focal or responsive IRS where appropriate.

For the NMEC-led IRS program, PMI support leveraged GF and GRZ resources to fund microplanning, trainer preparation, supervision, environmental compliance, and post-spray waste management.

The original CY2025 PMI budget was $2,800,000 ($2 million for implementation, the rest for procurement of insecticides) to spray 429,793 structures in 12 districts of Eastern and Luapula Provinces, covering 1.6 million people. The budget has since increased by $2,123,189 to $4,923,189, with $3,444,664 for operations and $1,478,525 for procurement of insecticides. While USG funds for IRS operations have been increased, all the SBC funds have been cut which will likely limit IRS uptake and impact. (See SBC section later in this document.) In CY2025, PMI planned to procure insecticides and IRS supplies sufficient to cover at least 240,000 structures in Eastern Province and other target areas (to be determined). Pesticide choice and spray locations were guided by entomological data (e.g., resistance and efficacy), NMEC and PMI policies, and geospatial analysis. The PMI CY2026 funding may be expected to remain unchanged from the original allocation of $2,500,000 ($2 million for implementation and $500,000 for insecticide procurement).

The GF/MOH 2025-2026 remaining balance has been reduced by $948,555 because of reprioritization efforts. Funding allocations for insecticide procurement and campaign implementation remain unchanged; however, reductions have been made to the budgets for training, environmental compliance inspections, IRS waste disposal, and monitoring and supervision. Supplies such as IRS pesticides, personal protective equipment, and related commodities will be sourced from existing GRZ and GF inventories that were originally designated for the 2024 campaign and remain available for use.

The GF-CHAZ grant does not support IRS, historically, although in 2024 some CHAZ funds were reprogrammed to cover certain implementation gaps.

For the 2025-2026 period, the combined net change for PMI (funding surplus of +$2,123,189) and GF/MOH (funding reduction of -$948,550) results in an overall IRS surplus of +$1,174,634.

Thus the IRS funding landscape presents a mixed picture. There appears to be an overall net surplus in IRS funding for 2025-2026 resulting from increased revised PMI allocations in CY2025. Vigilance will be necessary to monitor the impact of the reduction in GF/MOH IRS funding. The shortfall in GF/MOH contributions may lead to underfunded critical activities, such as training, environmental compliance, and supervision, that are not fully offset by the surplus in PMI funding. Combined with the discontinuation of funding for SBC activities, these gaps could result in operational deficiencies, reduced IRS coverage, and an increased risk of malaria transmission among vulnerable populations, potentially jeopardizing Zambia's efforts toward universal coverage and malaria elimination.

Vector Control: IRS
Priority level for seeking alternative funding: MODERATE. **Expected Impact: LONGER TERM.** **Total net change (2025 - 2026) = +$1,174,634** ● There appears to be an overall IRS funding increase. However, the reduction in GF/MOH funds may threaten critical activities like training, compliance, and supervision, which could undermine IRS coverage and malaria control efforts. Vigilance will be required, especially in the lead-ups to the 2026 season. ● Targeted IRS remains a key component of the Zambia malaria control strategy. The annual campaigns build on an 80-year history of IRS in Zambia and enjoy strong popular and political support.

Other vector control

Larval Source Management

Larval source management (LSM) includes the application of larvicides to mosquito breeding sites and manipulating the environment to eliminate sites, e.g. through improved drainage or filling. Although LSM has a long history and is cited in the NMEC, international donors have generally not funded this intervention due to perceived cost ineffectiveness for reaching high-risk populations at scale.

Modest PMI CY2025 and CY2026 funds had originally been allocated for an LSM demonstration project in 1-2 districts but were cut. The USG cited its limited applicability outside low-burden areas as PMI cancelled its support for malaria elimination activities.

During the reprioritization process, the GF/MOH 2025-2026 remaining balance allocated for environmental manipulation & modification and LSM has been reduced by $31,833 (from $65,408 to $33,575) retaining only training and supervision costs. This will support a limited number of low-burden districts, namely Lusaka, Ndola, Livingstone, Kazungula, Chikankata, Mazabuka, Sinda, Katete, and Shibyunji. For 2025-2026, there will be a net funding decrease of $381,833 for LSM and environmental manipulation and modification in pre-elimination areas. Additional funds will be required to address this gap.

The GF-CHAZ grant does not include funding for LSM.

Inadequate funding for LSM and environmental manipulation and modification in pre-elimination districts could allow mosquito populations to rebound, lessening the impact of interventions like IRS and ITNs and increasing the risk of malaria returning to vulnerable areas. However, cuts to LSM in Zambia would pose limited risk of increased mortality, given the minor extent of current LSM activities and its strategic suitability for low-burden settings.

Vector Control: LSM
Priority level for seeking alternative funding: LOWER. **Activity Paused for 2025-26.** **Total net change (2025 - 2026) = -$381,833** ● LSM is cited in the NMESP as a key component of vector control in pre-elimination settings, especially urban and peri-urban. However, countering the cuts takes lower priority due to the limited geographic scope and low risk to malaria mortality. ● For long term goals of eliminating malaria in increasing numbers of districts, it would be valuable to maintain local capacity in LSM planning and operations.

Geospatial Planning Tools

Geospatial tooling has been used to inform the targeting and deployment of vector control interventions, building on past work in Zambia. PMI has supported the development and implementation of such tools to maximize household access to combined vector control methods given available resources (ITNs primarily, complemented by IRS and LSM in targeted localities). The original CY25 budget allocated $150,000 for geospatial tooling and this was revised to $0. For CY2026, no funds were allocated for this TA. Although geospatial planning tools are not a standard approach in IRS operations worldwide, funds should be identified to update already existing GRID 3 maps for all the districts to provide updated population and spray target information for planning purposes. There is an overall funding gap of $150,000 that requires securing additional resources.

Insufficient funding for geospatial planning tools and for updating and utilizing detailed districts maps (GRID 3 project maps), poses a significant risk to the effective targeting and deployment of vector control interventions, such as ITNs, IRS, and LSM, resulting in gaps in coverage and increased risk of malaria transmission. Further, with fewer districts scheduled to receive ITNs under current plans, it is even more crucial that IRS be delivered at maximum population coverage—a goal that geospatial tools can help achieve.

Vector Control: Geospatial Planning
Priority level for seeking alternative funding: HIGH. **Expected Impact: IMMEDIATE.** **Total net change (2025 - 2026) = - $150,000** • Reduced funding for geospatial planning and mapping tools threatens the ability to effectively target and deploy malaria control interventions, potentially leading to coverage gaps and increased transmission risk.

Drug-based Prevention

In Zambia, this intervention area applies in practice only to intermittent preventative treatment in pregnancy (IPTp). Other drug-based preventative programs such as seasonal chemoprophylaxis (SMC) are not deployed.

Prevention of Malaria in Pregnancy

Intermittent Preventive Treatment in pregnancy (IPTp) with quality-assured sulfadoxine-pyrimethamine (SP) is a core, high-impact intervention to protect pregnant women and their unborn children from the devastating consequences of malaria. Nationwide, eligible women are given this medicine each month during their ANC visits. In 2024, 80% of Zambian women reported having received IPTp at least 3 times during their last pregnancy (MIS), a remarkable achievement.

The PMI CY2025 budget for IPTp stayed steady at $1,250,000. This funding supports training and supervision of health workers, mentoring of community workers in Eastern, Luapula, Muchinga, and Northern Provinces, as well as SP procurement for nationwide use. The PMI CY2026 allocation, however, has been reduced by $102,302 (from $804,604 to $702,302), thus across 2025 and 2026 total funding went from $2.05 to $1.95 million (Figure 8). This modest 5% reduction may directly impact the quality of care provided at antenatal care (ANC) clinics, potentially reducing uptake and adherence to IPTp guidelines.

The procurement of SP remains funded by GRZ and PMI for the 2025-2026 period. GF/MOH has ring-fenced the 2025-2026 remaining balance funding under specific prevention intervention for conducting SBC engagement activities in conjunction with the MOH Reproductive Health Unit. The GF/CHAZ grant did not include funding for drug-based prevention of malaria in pregnancy.

Additional resources will be needed for the following reasons: to address the funding gap of $102,302, to maintain SBC activities after the cancellation of all PMI funding for SBC, and to replace CD nets redirected to the mass campaign, should NMEC decide to proceed with that approach.

Figure 8. Revision to expected donor spending on IPTp. A modest funding reduction of $102,302 was made to PMI funds in 2026; GF (MOH and CHAZ grants) did not directly support IPTp.

Drug-based Prevention: Prevention of Malaria in Pregnancy
Priority level for seeking alternative funding: MODERATE. **Expected Impact: IMMEDIATE.** **Total net change (2025 - 2026) = - $102,302** ● Pregnant women are at high risk of developing complications of malaria, including life-threatening infections, severe anemia, low birth weight, and still birth. A disruption in the supply of SP and ITNs, training and supervision of health workers and CHWs, SBC activities compromise the effectiveness of the entire MIP program, leaving a highly vulnerable population at risk. ● However, the modest (5%) reduction in donor support may be expected to be mitigated by the GRZ more readily than other gaps, potentially reducing the urgency of mobilizing new alternative support.

Case Management Activities

Commodity Procurement and Distribution (Medicines and Tests)

Mass access to effective clinical management of malaria cases is a cornerstone of malaria control programs. Prompt, correct diagnosis and treatment benefits the individual patient by limiting the severity and duration of symptoms. It benefits the general population by limiting the time a patient can infect others via the mosquito vector. Naturally, a critical component is the sustained availability of medicines and tests (aka malaria commodities). "No product, no program," as went the slogan of the long-serving USAID DELIVER project.

In Zambia, support for commodity procurement and distribution has contributed to the country's commendably high rates of test-confirmed malaria diagnoses and its falling incidences of severe malaria and malaria deaths. The major donors have focused on aiding the procurement and distribution of key products in the case management sequence, namely: for diagnosis - rapid diagnostic tests (RDTs) and microscopy supplies; for treatment of uncomplicated cases - ACTs (in particular artemisinin-lumefantrine, the first-line medicine); for treatment of severe cases - artemisinin by injection or rectal suppository. In addition, a few districts at very low burden levels have introduced treatment with single low-dose primaquine (SLDPQ) as a malaria elimination tool.

PMI's planned procurement of these essential commodities remains largely intact for CY 2025, at $4,180,000. However, the funding landscape shifts dramatically in CY 2026. In May 2025, the US embassy in Lusaka announced it will withhold USD $50m in commodity support for Zambia's health sector. At the time of this report, the Embassy has not provided public clarification on whether the suspension will apply in full or only partially to malaria commodities. The rationale for this withdrawal, as communicated by Zambia Minister of Health, Hon Dr. Elijah Muchima – "…recurring thefts of medicines….stemming from systemic weaknesses in oversight and supply chain management, under previous governments"[24] – taken alongside US Ambassador

[24] Available at: https://www.facebook.com/10006472578691 2/posts/pfbid02x9zdQj1au2avnNwhM4Ti1GbRoap5rk79RpEm8LjyyFNTehgXNAtrBiMp8WZJioNbl/

Michael Gonzales' commentary ("minimal action"[25] has been taken to remedy the situation), casts strong doubt on future, USG-sponsored commodity support.

In response to the sudden threat of future stock outs, in mid-2025 the GF-MOH grant reprogrammed funds into RDTs, and the GF-CHAZ grant reprogrammed funds into ACTs, thereby substantially increasing the expected spending for medicines and tests. For GF-MOH, the 2025-26 expected spending increased from $3,825,859 to $5,846,859 (increase of $2,021,000). For GF-CHAZ, the 2025-26 expected spending increased from an estimated original budget of $4,502,687 to a revised budget of $6,699,837 (increase of $3,568,707). As a result, the combined expected donor spending for malaria medicines and tests in 2025-26 has increased from $15,220,993 to $16,241,094, a net increase of $1,020,191. The GRZ is reported to be increasing its allocations to medicines and tests as well.

This funding shift was necessary to avoid sustained stockout of medications, which would have directly and immediately led to an increase in severe malaria, preventable deaths, and onward transmission. The combined budget reallocations seem likely to offset the shortfall resulting from the PMI CY2026 funding reduction. However, analysis of the reprogrammed budgets shows that this has been at the expense of other necessary investments, notably ITNs, SBC, program supervision, and data system strengthening.

Case Management Activities: Procure Case Management-Related Commodities
Priority level for seeking alternative funding: LOWER. **Expected Impact: LONGER TERM.** **Total net change (2025 - 2026) = +$1,020,191** ● The MOH and partners have found near-term solutions to prevent stockouts of ACTs and RDTs in the face of PMI funding withdrawal. This is a success story of country-led adaptation and resilience in the face of sudden threat. ● Vigilance will be required to assure adequate stocks in 2027 and beyond.

Case Management Implementation

Beyond commodities, prompt diagnosis and effective treatment of malaria depends on a chain of correct human behaviors. Beginning with appropriate health seeking behavior by patients with symptoms suspicious for malaria (notably fever), extending to accurate diagnosis by trained health workers with parasitologic confirmation (RDT or microscopy), and then to correct and timely treatment with effective medications, coupled with appropriate clinical decision making (whether sending patient home with oral meds and counseling, or admitting them to a hospital for skilled supportive care and injectable medicines). When they are performed well, these case management steps reduce the incidence of severe malaria and lower the case fatality rate.

[25] Available at: https://www.npr.org/sections/goats-and-soda/2025/05/09/g-s1-65236/u-s-ambassador-drugs-zambia-cried-michael-gonzales

In Zambia's formal health sector, malaria cases are managed by healthcare professionals at health facilities and at the community level by a large cadre of CHWs) who are trained to correctly diagnose, treat, and track malaria cases. The CHWs form the backbone of Integrated Community Case Management (iCCM). The impact of essential life-saving commodities depends on the efficiency and effectiveness of both health facility-based and community-based delivery systems.

All three major donors support a range of activities to strengthen case management implementation. As detailed in Attachment B, these range from quality assurance for microscopy; to on-site supervision of health facility staff; to training, deploying and supporting community health workers (CHWs); to incentivizing the CHWs with enablers such as bicycles. Historically, PMI, the MOH and CHAZ have coordinated closely to avoid duplication of effort while reaching the widest range of health care settings possible. PMI's geographic focus has been Luapula, Northern, Muchinga and Eastern provinces, while GF-CHAZ has focused on North Western, Southern, and parts of Eastern.

Worryingly, all three donors are simultaneously curtailing their investments in case management implementation. Understandably during a time of belt-tightening, their cuts begin with partial or complete pauses on support for elimination tools in very low burden areas, such as reactive case detection (testing and treating individuals who are not ill), malaria case detection, and single low dose primaquine. However, the cuts extend into curtailing services in moderate and high-burden areas as well. PMI's expected spending in 2025-26 would be channeled through the PMI Reach project and appears to have decreased from original budget of $5.1M to a revised budget of $2.5M, a reduction of $2.6M. GH-MOH decreased from $1,805,868 to $333,413, a reduction of over $1.47M. GF-CHAZ for its part reduced from $1,807,499 to $379,039, a reduction of over $1.4M. Altogether, the donors reduced their investment by over $7M, a 25% reduction.

One noteworthy cut is surveillance for anti-malaria drug resistance through a Therapeutic Efficacy Study (TES) under the GF-MOH grant. This lessens Zambia's capacity to detect whether the drug resistance emerging in East Africa is now undermining treatments locally. Another unfortunate cut under the GF-MOH and GF grant is the training and provisioning of CHWs to treat pneumonia and diarrhea alongside malaria at community level.

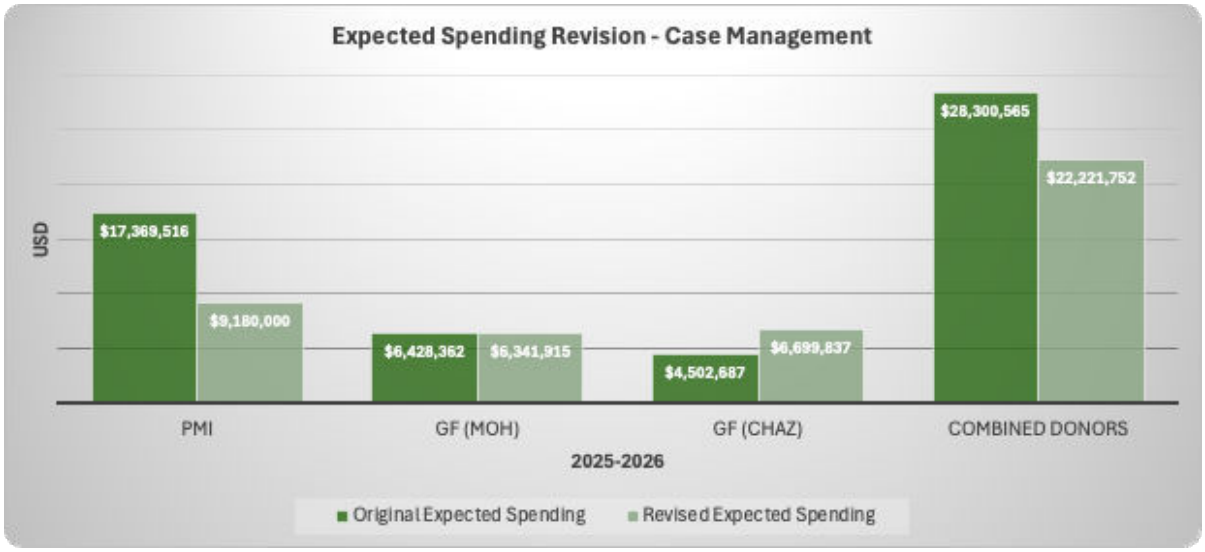


Figure 9. Combined funding reductions for case management commodities and implementation for 2025-26 total over $6 million.

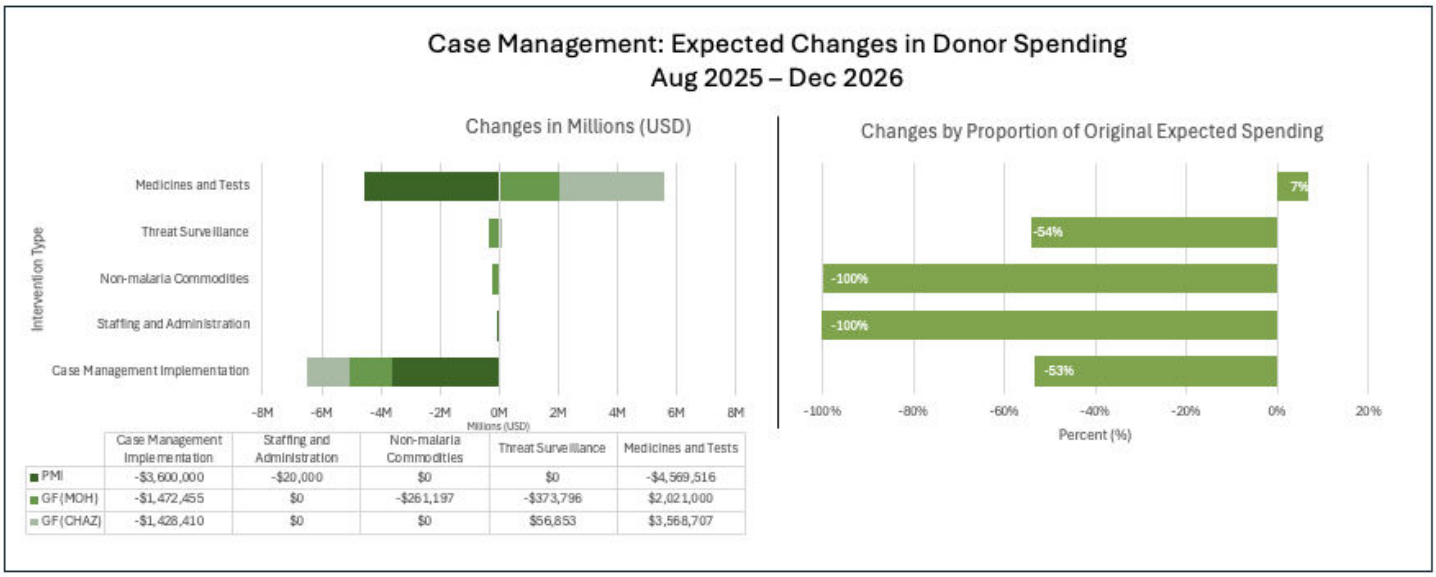


Figure 10. Funding for case management commodities has been kept stable through reprogramming, but case management implementation activities have been cut sharply.

Case Management Implementation
Priority level for seeking alternative funding: HIGH. **Expected Impact: IMMEDIATE.** **Total net change (2025 - 2026) = -$7,099,005** • Simultaneous, substantial funding reductions from all three donors (PMI, GF-MOH and GF-CHAZ) will severely disrupt service delivery systems, halting essential training and supervision for healthcare workers, degrading quality of care, and leading to wasted resources and poor health outcomes. • Urgent support is needed to train, supervise, and provide quality assurance for healthcare facilities and CHWs. • Urgent support is needed to sustain activity levels of CHW volunteers through provision of enabler packages (bicycles, backpacks, job aids). This will leverage the volunteer labor and zeal of Zambia's "army" of CHWs.

Supply Chain Strengthening Activities

In-Country Supply Chain

A strong supply chain is the final, critical link ensuring that life-saving medicines and supplies reach the patients who need them. Moreover, strengthening supply chain transparency and accountability will be central to restoring donor confidence in commodity security.

For 2025-2026, PMI appears to have discontinued all funding for operational logistics and commodity security, including last-mile distribution and anti-diversion monitoring. As these activities have relied on USG resources for approximately 80% of their funding, this change presents a substantial risk of extensive stock-outs. PMI's remaining investment is solely focused on high-level technical assistance for national entities like the Zambia Medicines and Medical Supplies Agency (ZAMMSA),

The cancellation of PMI's operational supply chain support for 2025-2026 results in a total funding gap of $1,457,500. This includes a 2025 gap of $697,500 (warehousing/distribution: $320,000; 3rd party monitoring: $40,000; spot checks: $337,500) and a 2026 gap of $760,000 (warehousing/distribution: $320,000; 3rd party monitoring: $40,000; spot checks: $400,000) (Figure 11). Without alternative funding, there is a strong risk of commodity shortages, distribution challenges, and inadequate supply chain oversight. These challenges could hurt the delivery of vital health products, disrupt patient care, and undo progress in malaria control.

In contrast, GF has maintained its robust, multi-million-dollar investment in foundational systems, such as supply chain information systems, planning capacity, and waste management. An analysis of deprioritized GF funds shows that no core supply chain strengthening activities were paused. The GF/MOH 2025-2026 remaining balance has been minimally reduced by -$19,708 (from $236,939 to $217,230)

The emerging gap is not due to coordinated budget cuts but to PMI's unilateral withdrawal from operational support. As a result, there is now a disconnect between the strengthened central planning systems and the operational capacity required to distribute commodities at the last mile, which currently lacks sufficient funding. While the primary public-sector supply chain faces challenges, CHAZ manages a parallel distribution system for GF supported commodities to its network of health facilities, though it also relies on the national system for last-mile logistics. The GF/CHAZ 2025-2026 remaining balance for strengthening the supply chain information systems has been reduced by -$982,253 (from $998,239to $15986), due to the deprioritization process.

There is an overall funding reduction for supply chain strengthening for PMI, GF/MOH and GF/CHAZ in 2025-2026 of $2,459,461, which will require additional resources.

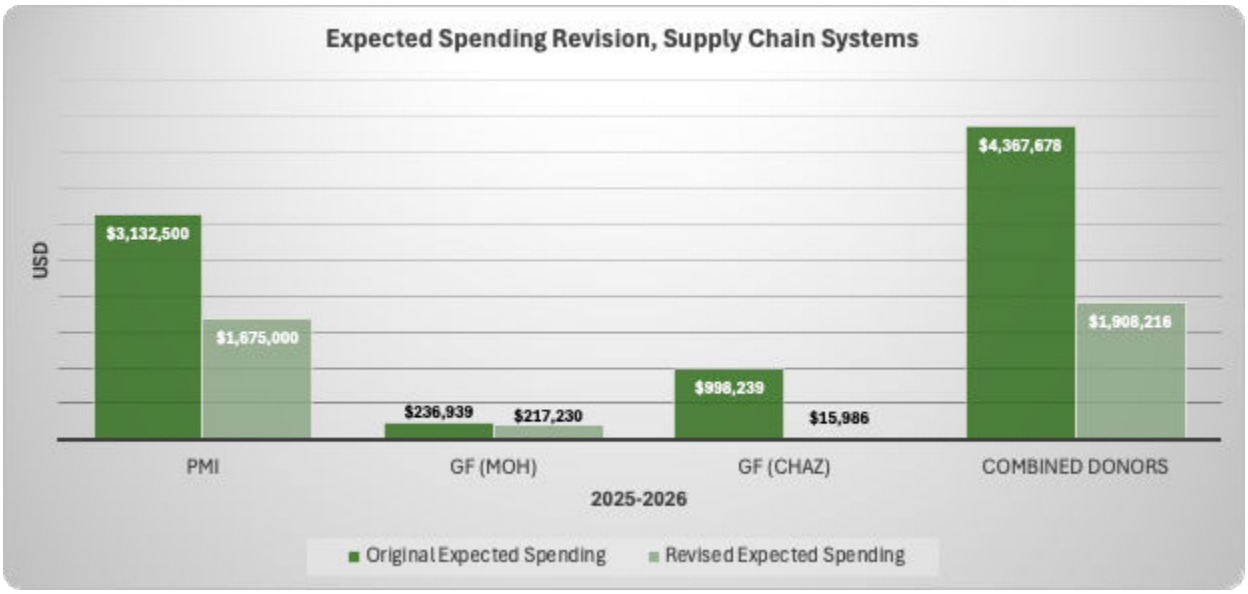


Figure 11. Expected spending revision in Supply Chain System strengthening. An overall funding reduction of $2,459,461 supply chain strengthening for PMI, GF/MOH and GF/CHAZ was made in 2025-2026.

Supply Chain Strengthening Activities: In-Country Supply Chain
Priority level for seeking alternative funding: HIGH. **Expected Impact: LONGER TERM.** **Total net change (2025 - 2026) = -$2,459,461** • Without alternative funding for supply chain operations, there is a high risk of widespread stock-outs and distribution challenges, adversely affecting access to life-saving malaria commodities (e.g. tests and medicines) and undermining malaria prevention efforts (e.g. ITNs, IPTp and IRS). • Urgent support is needed to warehouse and distribute malaria commodities (nets, pesticides, medicines, tests and to provide last-mile delivery through third-party logistics, filling major gaps in the supply chain

Malaria Vaccine Introduction

PMI funding for malaria vaccine introduction in 2025 ($250,000) and 2026 ($50,000) has been cancelled (Figure 12). This includes technical assistance intended to support the MOH with program development, coordination between the NMEC and immunization teams, and the operational rollout of the new vaccine.

The cancellation has been particularly concerning as it coincided with Zambia's approval for GAVI funding in January 2025, with a vaccine rollout planned to begin by September 2025. The situation was potentially

compounded by the fact that broader U.S. Government support for Gavi has also been cut. There is a funding gap of $300,000 for the introduction and scale up of the malaria vaccine that requires additional resources.

Neither the GF-MOH nor the GF-CHAZ grants support vaccine introduction. Gavi is the major donor. Fortunately, by the time of writing in August 2025, Gavi's finances had been shored up globally and all indications were that Zambia's plans for rolling out the R21 vaccine in over 80 high-burden districts were on course. Nevertheless, PMI's cancellation leaves a significant gap in technical and coordination support at the precise moment Zambia is preparing to launch this new, life-saving intervention for children.

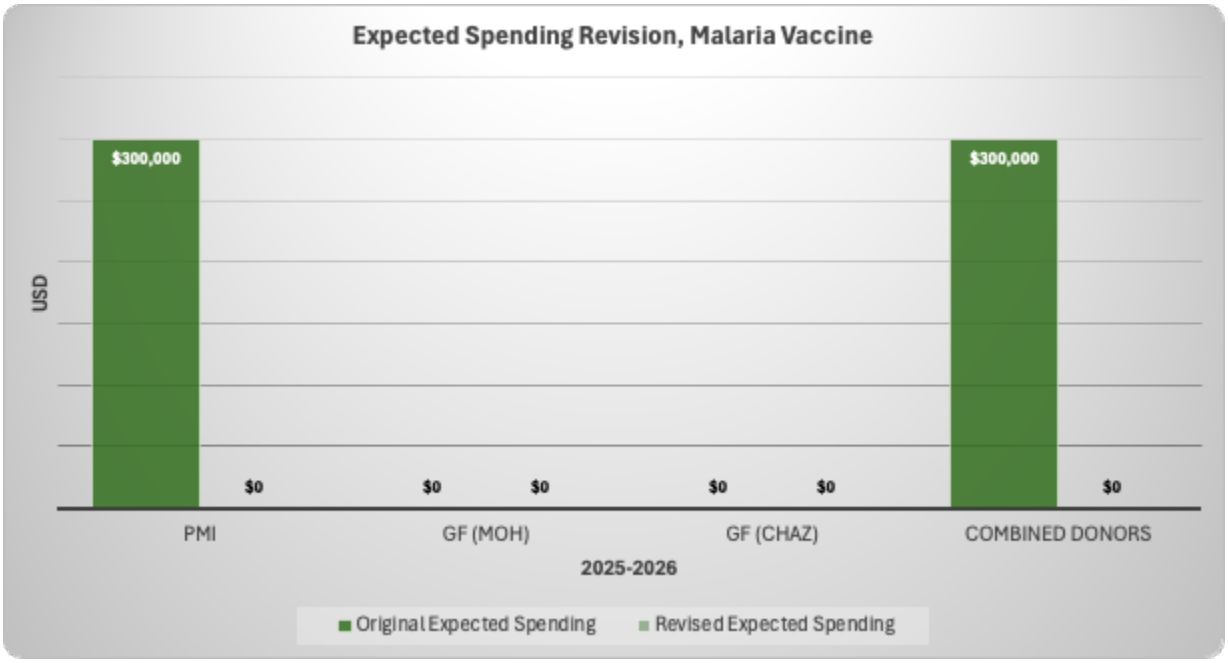


Figure 12. Revisions in expected donor spending on R21 vaccine introduction. PMI funding for malaria vaccine introduction in 2025 ($250,000) and 2026 ($50,000) has been cancelled; GF (MOH and CHAZ grants) did not support malaria vaccine interventions.

Malaria Vaccine Activities:
Priority level for seeking alternative funding: MODERATE. **Expected Impact: LONGER TERM.** **Total net change (2025 - 2026) = -$300,000** • The withdrawal of technical assistance from PMI at a critical moment could delay the effective rollout of the vaccine, hindering Zambia's ability to leverage this powerful new tool and potentially leaving thousands of children unprotected. • However, since the main support for malaria introduction is Gavi, the loss of PMI support may be relatively minor, and the prospects for mitigation by existing vaccine partners may be adequate.

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

Surveillance Monitoring and Evaluation

Zambia has a well-deserved reputation for having steadily built its technical and programmatic capacity to capture and utilize key malaria datasets. For example, Zambia has been a pioneer in implementing the WHO-recommended practice of sub-national tailoring of malaria control interventions, which requires reliable local data on malaria case incidence and a culture of data-driven resource allocation. Zambia has also been a leader in conducting regular household surveys (at least every 3 years since 2006) and using the data to track the coverage of malaria control interventions, informing investment decisions. The country has been fertile ground for research which improves the knowledge base and efficiency of interventions – notably in community case management and IRS.

Yet funding for surveillance, monitoring and evaluation, and operational research (SMEO) in 2025-2026 has been significantly reduced. PMI funding will continue with partial support for routine data systems at the peripheral level; however, all national-level activities have been discontinued, including technical support for malaria database management and resources for the next Malaria Indicator Survey (MIS). The PMI 2025 budget of $2,330,000 for SMEO activities has been reduced by $1,580,000. Similarly, the 2026 budget of $1,840,000 for SMEO has an expected reduction of $840,000 (Figure 13, Figure 14).

The situation worsened when the GF paused funding for M&E activities and surveys. Additionally, the GF/MOH 2025-2026 remaining balance has decreased by $1,154,090 (from $2,049,649 to $895,559) impacting the MIS and other surveys, supervision and monitoring activities, epidemic preparedness and response (EPR), and malaria case investigation.

CHAZ is responsible for the M&E of its programs and contributes data to the national HMIS. GF/CHAZ 2025-2026 remaining balance for SMEO activities, specifically, data systems strengthening and operational research has been reduced by $211,368 (from $724,315 to $512,947).

There is an overall funding reduction of $3,785,458 for SMEO activities for PMI, GF/MOH and GF/CHAZ in 2025-2026. The SMEO budget actions have required several activities to be curtailed, paused, or cancelled outright. This has left a major gap in national data analysis, database management, and key evaluations needed for strategic planning. The cuts to already limited budgets for the NMEP's operational research agenda has undercut Zambia's ability to innovate and improve on malaria service delivery. An example would be studies to assist Zambia in deciding whether and how to adopt the newly WHO-approved spatial repellant tools for enhanced vector control. Additional resources will be required to address these funding shortfalls.

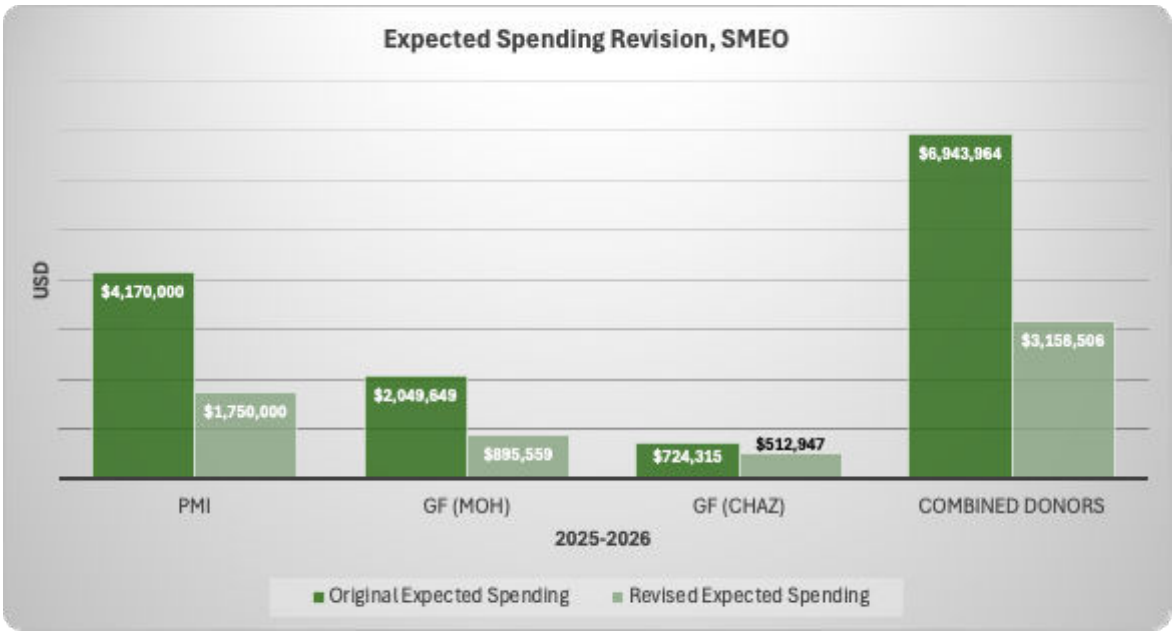


Figure 13. Funding for surveillance, monitoring and evaluation, and operational research (SMEO) in 2025-2026 has been significantly reduced, suffering an overall funding reduction of $3,785,458 for PMI, GF/MOH and GF/CHAZ activities.

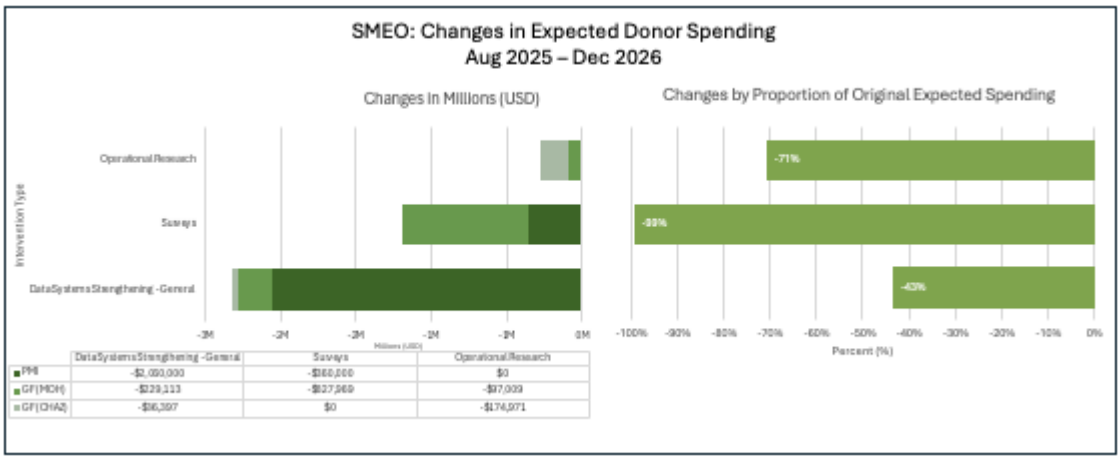


Figure 14. SMEO interventions all received significant funding cuts - including surveys, operational research, and system strengthening of data systems.

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) = -$3,785,458

- Zambia has a proven track record in data capture and use. Urgent support is needed for data visibility to protect malaria investments. Urgent support is needed to limit the damage of severe, abrupt funding cuts in this area
- The SMEO budget cuts have left a major gap in national data analysis, database management, and key evaluations needed for program planning and oversight.
- Without additional resources, Zambia will struggle to predict, detect and respond to malaria surges, likely threatening recent progress.

Short-Term Technical Assistance from CDC

All PMI funding for short-term, high-level technical assistance from the United States Center for Disease Control and Prevention (CDC) has been cancelled due to the termination of the CDC Interagency Agreement (IAA) with USAID. This has cancelled the planned expert visits (budgeted at $59,000 for 2025-2026) in technical assistance in vector control, case management, and surveillance, monitoring and evaluation, and/or operational research activities. Until the PMI cuts, the CDC had one of the world's largest and most comprehensive assemblage of malaria technical experts, with a decades-long history of collaboration in Zambia. The loss of this support removes a cost-effective mechanism for technical quality control, program oversight, and specialized support for the national malaria program. Addressing the resulting funding gap would require only modest additional resources.

Short-Term Technical Assistance from the CDC

Priority level for seeking alternative funding: HIGH.

Expected Impact: LONGER TERM.

Total net change (2025 - 2026) = -$59,000

- Cancellation of CDC technical assistance funding deprives Zambia of a cost-effective, long-standing source of support.
- CDC expert advising will be especially valuable for threat identification and mitigation, including anti-malaria drug resistance, insecticide resistance, and invasive vectors.

Social and Behavioral Change Communications (SBC)

The original PMI budget allocations of $2,693,000 for CY2025 and $2,340,000 for CY2026 have been fully eliminated because of deprioritization of SBC in US foreign assistance (Figure 15). These funds were intended to support multi-faceted communication activities aimed at improving the proper and consistent use of ITNs by enhancing community-level interpersonal communication through Community Change Agents (CCAs); increasing uptake of IPTp during pregnancy by promoting early antenatal care visits and expanding preventive malaria treatment through engagement with communities, local dialogues, and partnerships with faith-based organizations; and encouraging prompt care-seeking for malaria symptoms by strengthening community-based messaging, fostering collaboration between CHWs and CCAs, and supporting national coordination efforts. This funding also includes support for SBC for other health systems strengthening for the End Malaria Council and the US Peace Corps.

GF/MOH has maintained its limited 2025-2026 remaining balance of $124,864 for vector control SBC (messaging for annual malaria events commemoration), while reducing the 2025-2026 remaining balance for case management SBC (community engagement activities, advocacy with civic leaders, and malaria annual event materials) from $390,482 to $226,930—a decrease of $163,552. This simultaneous reduction in funding from both primary donors presents a significant gap that may compromise the effectiveness of other interventions, as their outcomes are closely tied to robust community engagement and the promotion of positive health behaviors.

The GF/CHAZ grant provides complementary support for vector control and case management SBC, with a focus on community-level engagement. Based on uncertain assumptions of original expected spending, the 2025-2026 remaining balance for CHAZ appears to have increased to $1,014,223.

The overall funding decrease for SBC is substantial. Taken together, the next change in PMI, GF/MOH and GF/CHAZ budgets for 2025-2026 is $4,182,329.

Figure 15. The overall funding decrease for SBC is substantial - a total of $4,182,329 for 2025-2026.

Social and Behavioral Change Communications (SBC)
Priority level for seeking alternative funding: HIGH. **Expected Impact: IMMEDIATE** **Total net change (2025 - 2026) = -$4,182,329** ● If alternative funding is not secured to address the SBC funding gap, there is a significant risk that essential malaria prevention and treatment activities—including the proper use of ITNs, uptake of IRS and IPTp, and timely care-seeking for malaria symptoms—will be severely compromised. This could undermine community engagement efforts, reduce the effectiveness of other malaria interventions, and impede progress toward national malaria targets. ● Urgent support is needed for Inter-personal and mass communication activities targeting high-risk populations (pregnant women, young children). This would limit the damage of severe, abrupt funding cuts.

Program Management

Effective program management plays a key role in supporting the national response. International donors complement the government's investments in health personnel and programs by supporting a range of activities, grouped in this assessment as "other health system strengthening' (largely human resources), operations, and planning and supervision.

The PMI combined 2025 and 2026 budgets for program management included the relatively modest sums of $190,000 for NMEC staff development and a new $300,000 allocation for local capacity training. These budgets have been entirely withdrawn (Figure 16).

Historically, the GF-MOH and CHAZ grants have been far more prominent than PMI in this area. In the current 3-year grant cycle, the GF-MOH original budget provided over $7.8 million in program management support, covering a wide range of activities in the categories of human resources, operations, planning and supervision. The comparable GF-CHAZ original 3-year budget allocated an estimated $3.7 million.

The GF reprioritization exercise has resulted in reductions in program management budgets of 9% for GF-MOH (approximately $548,792 out of $5.7 million) and 20% for GF-CHAZ ($351,267 out of $1.8 million). Details are provided in Attachment B. Although not insubstantial, the programs were felt to be adequately resourced for core grant management functions for the remainder of the GC7 grant cycle. Concern remained around resources for field supervision of malaria interventions.

Overall, program management funding for PMI, GF/MOH, and GF/CHAZ in 2025-2026 declined by $687,525, implying a need for additional resources. These cuts may undermine the NMEC's ability to coordinate partners, manage finances, and oversee the execution of the national strategy—capabilities that are especially critical during periods demanding strong leadership

Figure 16. In total, program management funding for PMI, GF/MOH, and GF/CHAZ in 2025-2026 declined by $687,552.

Program Management Activities
Priority level for seeking alternative funding: MODERATE **Expected Impact: IMMEDIATE** **Total net change (2025 - 2026) = -**$687,525 . • While not a direct service delivery cost, a functional and capable NMEP is essential for the effective use of all other resources. Weakened program management puts other investments at risk of inefficiency and implementation challenges. • The reduced budgets are not likely to impair GF-MOH and GF-CHAZ grant management functions. However, they could hinder the NMEC's ability to build local capacity, coordinate malaria responses efficiently, and sustain recent progress in malaria control initiatives.

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 $3,620,000 (Attachment B).

Attachment A: Letter of Support and Engagement, Zambia MOH

All Correspondence should be addressed to the
Permanent Secretary
Telephone: +260 211 253030
Fax: +260 211 253344

In reply please quote:

No.....

REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH

NDEKE HOUSE
P. O. BOX 30205
LUSAKA

June 18, 2025

Benjamin Winters,
Co-Founder
AKROS
GLOBAL HEALTH

Letter of Support

Re: Bridge the Gap Malaria Incubator

Reference is made to the above subject matter.

The Ministry of Health wishes to acknowledge receipt of correspondence dated May 5, 2025, from AKROS GLOBAL HEALTH where the institution seeks letter of support to accompany the funding proposal that aims at bridging the gap that has been left due to shifting global donor priorities that have led to increased uncertainty in malaria funding.

Over the past 17 years the National Malaria Elimination Centre (NMEC) has collaborated with AKROS to implement targeted, evidence-based strategies that have delivered measurable public health impact.

We look forward to supporting the work proposed in this application aimed at identifying the implementation gaps and developing sustainable funding pathways in high-burden countries, including Zambia.

Your continued support to the National Malaria Elimination Program is highly appreciated.

Dr. George Sinyangwe
Permanent Secretary-Donor Coordination
MINISTRY OF HEALTH

Attachment B: Zambia Gaps and Inventory Table

Table 1

2025 Expected Spending, PMI and Global Fund (MOH, CHAZ Grants)							
		PMI			GF (MOH)		
	Intervention	**Original [1]**	**Revised [2]**	**Difference [3]**	**Balance after Reprioritization (Aug-Dec) [4]**	**Difference (Aug-Dec) [3]**	**Net Difference (PMI & GF-MOH) [5]**
Vector Control	Entomological Monitoring	$500,000	$40,380	-$459,620	$79,863	-$173,062	-$632,682
	ITNs; Mass campaign TA and Procurement	$250,000	$4,533,229	$4,283,229	$8,222,737	-$1,133,333	$3,149,896
	ITNs Mass campaign Digitilization	$480,000	$0	-$480,000	$0	$0	-$480,000
	ITNs: CD	$4,300,000	$4,300,000	$0	$307,368	$0	$0
	IRS Operations & TA	$2,000,000	$3,444,664	$1,444,664	$507,644	-$316,185	$1,807,004
	IRS Procurement	$800,000	$1,478,525	$678,525			
	Larval Source Management	$0	$0	$0	$11,192	-$10,611	-$10,611
	Geospatial Planning Tools	$150,000	$0	-$150,000	$0	$0	-$150,000
	STTA CDC	$14,500	$0	-$14,500	$0	$0	-$14,500
	Subtotal Vector Control	**$8,494,500**	**$13,796,798**	**$5,302,298**	**$9,128,804**	**-$1,633,191**	**$3,669,107**
IPTp	Prevention of Malaria in Pregnancy	$1,250,000	$1,250,000	$0	$0	$0	$0
	Subtotal Drug Based	**$1,250,000**	**$1,250,000**	**$0**	**$0**	**$0**	**$0**
Case Management	Case Management Implementation	$5,100,000	$2,500,000	-$2,600,000	$111,138	-$200,048	-$2,800,048
	STTA CDC (Case Mgmt)	$10,000	$0	-$10,000	$0	$0	-$10,000
	Non-malaria Commodities	$0	$0	$0	$0	-$85,601	-$85,601
	Threat Surveillance	$0	$0	$0	$53,881	-$124,599	-$124,599
	Medicines and Tests	$4,180,000	$4,180,000	$0	$1,948,953	-$673,667	-$673,667
	Subtotal Case Manage	**$9,290,000**	**$6,680,000**	**-$2,610,000**	**$2,113,972**	**-$1,083,915**	**-$3,693,915**

Supply Chain	Supply Chain Systems Strengthening	$1,572,500	$875,000	-$697,500	$72,410	-$6,569	-$704,069
	Subtotal Supply Chain	**$1,572,500**	**$875,000**	**-$697,500**	**$72,410**	**-$6,569**	**-$704,069**
Malaria Vaccine	Vaccine	$250,000	$0	-$250,000	$0	$0	-$250,000
	Subtotal Malaria Vaccine	**$250,000**	**$0**	**-$250,000**	**$0**	**$0**	**-$250,000**
SMEO	Data Systems Strengthening - General	$2,130,000	$750,000	-$1,380,000	$263,255	-$76,371	-$1,456,371
	Surveys	$200,000	$0	-$200,000	$2,928	-$278,918	-$478,918
	Operational Research	$0	$0	$0	$32,336	-$32,336	-$32,336
	Subtotal SMEO	**$2,330,000**	**$750,000**	**-$1,580,000**	**$298,519**	**-$387,625**	**-$1,967,625**
SBCC [6]	SBC	$2,693,000	$0	-$2,693,000	$117,264	-$54,518	-$2,747,518
	Subtotal SBCC	**$2,693,000**	**$0**	**-$2,693,000**	**$117,264**	**-$54,518**	**-$2,747,518**
Program Management	Local Capacity Strengthening	$150,000	$0	-$150,000	$0	$0	-$150,000
	Other Health Systems Strengthening	$110,000	$0	-$110,000	$650,676	-$24,805	-$134,805
	Operations	$0	$0	$0	$903,547	-$52,884	-$52,884
	Planning and Supervision	$0	$0	$0	$169,215	-$103,778	-$103,778
	Subtotal Program Manage	**$260,000**	**$0**	**-$260,000**	**$1,723,438**	**-$181,467**	**-$441,467**
USG Staffing	CDC	$600,000	$0	-$600,000	$0	$0	-$600,000
	USAID	$1,260,000	$0	-$1,260,000	$0	$0	-$1,260,000
	Subtotal USG Staffing	**$1,860,000**	**$0**	**-$1,860,000**	**$0**	**$0**	**-$1,860,000**
Total		**$28,000,000**	**$23,351,798**	**-$4,648,202**	**$13,454,407**	**-$3,347,285**	**-$7,995,487**

Table 2

2026 Expected Spending, PMI and Global Fund (MOH, CHAZ Grants)							
		PMI			GF (MOH)		
	Intervention	**Original [1]**	**Revised [2]**	**Difference [3]**	**Balance after Reprior (Aug-Dec) [4]**	**Difference (Aug-Dec) [5]**	**Net Difference (PMI & GF-MOH) [5]**
Vector Control	Entomological Monitoring	$500,000	$50,000	-$450,000	$159,727	-$346,125	-$796,125
	ITNs; Mass campaign TA + Procurement	$5,341,380	$0	-$5,341,380	$16,445,474	$2,266,667	-$3,074,713
	ITNs: Mass campaign Digitalization	$650,000	$0	-$650,000	$0	$0	-$650,000
	ITNs: CD	$2,150,000	$2,150,000	$0	$614,737	$0	$0
	IRS Operations & TA	$2,000,000	$2,000,000	$0	$1,015,288	-$632,370	-$632,370
	IRS Procurement	$500,000	$500,000	$0			$0
	Larval Source Management	$350,000	$0	-$350,000	$22,383	-$21,222	-$371,222
	Geospatial Planning Tools	$0	$0	$0	$0	$0	$0
	STTA CDC	$14,500	$0	-$14,500	$0	$0	-$14,500
	Subtotal Vector Control	**$11,505,880**	**$4,700,000**	**-$6,805,880**	**$18,257,609**	**$1,266,950**	**-$5,538,930**
IPTp	Prevention of Malaria in Pregnancy (TA + Procurement)	$804,604	$702,302	-$102,302	$0	$0	-$102,302
	Subtotal Drug Based	**$804,604**	**$702,302**	**-$102,302**	**$0**	**$0**	**-$102,302**
Case Management	Case Management Implementation	$3,500,000	$2,500,000	-$1,000,000	$222,276	-$981,636	-$1,981,636
	STTA CDC (Case Mgmt)	$10,000	$0	-$10,000	$0	$0	-$10,000
	Non-malaria Commodities	$0	$0	0	$0	-$171,203	-$171,203
	Threat Surveillance	$0	$0	0	$107,761	-$249,197	-$249,197
	Medicines and Tests	$4,569,516	$0	-$4,569,516	$3,897,906	$1,347,333	-$3,222,183
	Subtotal Case Manage	**$8,079,516**	**$2,500,000**	**-$5,579,516**	**$4,227,943**	**-$54,703**	**-$5,634,219**
Supply Chain	Supply Chain Systems Strengthening	$1,560,000	$800,000	-$760,000	$144,820	-$13,139	-$773,139

	Subtotal Supply Chain	**$1,560,000**	**$800,000**	**-$760,000**	**$144,820**	**-$13,139**	**-$773,139**
Malaria Vaccine	Vaccine	$50,000	$0	-$50,000	$0	$0	-$50,000
	Subtotal Malaria Vaccine	**$50,000**	**$0**	**-$50,000**	**$0**	**$0**	**-$50,000**
SMEO	Data Systems Strengthening - General	$1,680,000	$1,000,000	-$680,000	$526,511	-$152,742	-$832,742
	Surveys	$160,000	$0	-$160,000	$5,857	-$557,836	-$717,836
	Operational Research	$0	$0	$0	$64,672	-$64,672	-$64,672
	Subtotal SMEO	**$1,840,000**	**$1,000,000**	**-$840,000**	**$597,040**	**-$775,250**	**-$1,615,250**
SBCC	SBC; Other HSS	$2,340,000	$0	-$2,340,000	$234,529	-$109,035	-$2,449,035
	Subtotal SBCC	**$2,340,000**	**$0**	**-$2,340,000**	**$234,529**	**-$109,035**	**-$2,449,035**
Program Manage	Local Capacity Training	$150,000	$0	-$150,000	$0	$0	-$150,000
	Other Health Systems Strengthening	$80,000	$0	-$80,000	$1,301,352	-$49,610	-$129,610
	Operations	$0	$0	$0	$1,807,093	-$105,768	-$105,768
	Planning and Supervision	$0	$0	$0	$338,430	-$207,555	-$207,555
	Subtotal Program Manage	**$230,000**	**$0**	**-$230,000**	**$3,446,875**	**-$362,933**	**-$592,933**
USG Staffing	CDC	$600,000	$0	-$600,000	$0	$0	-$600,000
	USAID	$1,160,000	$0	-$1,160,000	$0	$0	-$1,160,000
	Subtotal USG Staffing	**$1,760,000**	**$0**	**-$1,760,000**	**$0**	**$0**	**-$1,760,000**
Total		**$28,170,000**	**$9,702,302**	**-$18,467,698**	**$26,908,816**	**-$48,110**	**-$18,515,808**

Table 3

2025 2026 Combined Expected Spending, PMI and GF (MOH and CHAZ Grants)															
		PMI			GF (MOH)			GF (CHAZ)							
	Intervention	**Original [1]**	**Revised [2]**	**Difference [3]**	**Original**	**Balance after Reprior (Aug-Dec) [4]**	**Difference (Aug-Dec) [5]**	**Original**	**Balance after Reprior (Aug-Dec) [4]**	**Difference (Aug-Dec)**	**Original Total**	**Revised, Reprior Total**	**Net Difference (PMI, GF-MOH)**	**Net Difference (PMI, GF-MOH, GF-CHAZ)**	**Relative Difference**
Vector Control	Entomological Monitoring	$1,000,000	$90,380	-$909,620	$758,777	$239,590	-$519,187	$0	$0	$0	$1,758,777	$329,970	-$1,428,807	-$1,428,807	-81%
	ITNs; Mass campaign TA and Procurement	$5,591,380	$4,533,229	-$1,058,151	$21,268,210	$24,668,210	$3,400,000	$3,664,476	$544,742	-$3,119,734	$30,524,066	$29,746,181	$2,341,849	-$777,885	-3%
	ITNs Mass campaign Digitilization	$1,130,000	$0	-$1,130,000	$0	$0	$0	$0	$0	$0	$1,130,000	$0	-$1,130,000	-$1,130,000	-100%
	ITNs: CD	$6,450,000	$6,450,000	$0	$922,105	$922,105	$0	$3,603,952	$2,622,127	-$981,825	$10,976,057	$9,994,232	$0	-$981,825	-9%
	IRS Operations & TA	$4,000,000	$5,444,664	$1,444,664	$2,471,487	$1,522,932	-$948,555	$0	$0	$0	$6,471,487	$6,967,596	$496,109	$496,109	8%
	IRS Procurement	$1,300,000	$1,978,525	$678,525				$0	$0	$0	$1,300,000	$1,978,525	$678,525	$678,525	52%
	Larval Source Management	$350,000	$0	-$350,000	$65,408	$33,575	-$31,833	$0	$0	$0	$415,408	$33,575	-$381,833	-$381,833	-92%
	Geospatial Planning Tools	$150,000	$0	-$150,000	$0	$0	$0	$0	$0	$0	$150,000	$0	-$150,000	-$150,000	-100%
	STTA CDC	$29,000	$0	-$29,000	$0	$0	$0	$0	$0	$0	$29,000	$0	-$29,000	-$29,000	-100%
	Subtotal Vector Control	**$20,000,380**	**$18,496,798**	**-$1,503,582**	**$25,485,989**	**$27,386,413**	**$1,900,425**	**$7,268,428**	**$3,166,869**	**-$4,101,559**	**$52,754,797**	**$49,050,080**	**$396,843**	**-$3,704,716**	**-7%**
IPTp	Prevention of Malaria in Pregnancy	$2,054,604	$1,952,302	-$102,302	$0	$0	$0	$0	$0	$0	$2,054,604	$1,952,302	-$102,302	-$102,302	-5%
	Subtotal Drug Based	**$2,054,604**	**$1,952,302**	**-$102,302**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$2,054,604**	**$1,952,302**	**-$102,302**	**-$102,302**	**-5%**
Case Management	Case Management Implementation	$8,600,000	$5,000,000	-$3,600,000	$1,805,868	$333,413	-$1,472,455	$1,807,449	$379,039	-$1,428,410	$12,213,317	$5,712,452	-$5,072,455	-$6,500,865	-53%
	STTA CDC (Case Mgmt)	$20,000	$0	-$20,000	$0	$0	$0	$0	$0	$0	$20,000	$0	-$20,000	-$20,000	-100%
	Non-malaria Commodities	$0	$0	$0	$261,197	$0	-$261,197	$0	$0	$0	$261,197	$0	-$261,197	-$261,197	-100%
	Threat Surveillance	$0	$0	$0	$535,438	$161,642	-$373,796	$49,710	$106,563	$56,853	$585,148	$268,205	-$373,796	-$316,943	-54%
	Medicines and Tests	$8,749,516	$4,180,000	-$4,569,516	$3,825,859	$5,846,859	$2,021,000	$2,645,528	$6,214,235	$3,568,707	$15,220,903	$16,241,094	-$2,548,516	$1,020,191	7%
	Subtotal Case Manage	**$17,369,516**	**$9,180,000**	**-$8,189,516**	**$6,428,362**	**$6,341,915**	**-$86,448**	**$4,502,687**	**$6,699,837**	**$2,197,150**	**$28,300,565**	**$22,221,752**	**-$8,275,964**	**-$6,078,814**	**-21%**
Supply Chain	Supply Chain Systems Strengthening	$3,132,500	$1,675,000	-$1,457,500	$236,939	$217,230	-$19,708	998,239	$15,986	-$982,253	$4,367,678	$1,908,216	-$1,477,208	-$2,459,461	-56%
	Subtotal Supply Chain	**$3,132,500**	**$1,675,000**	**-$1,457,500**	**$236,939**	**$217,230**	**-$19,708**	**$998,239**	**$15,986**	**-$982,253**	**$4,367,678**	**$1,908,216**	**-$1,477,208**	**-$2,459,461**	**-56%**

Malaria Vaccine	Vaccine	$300,000	$0	-$300,000	$0	$0	$0	$0	$0	$0	$300,000	$0	-$300,000	-$300,000	-100%
	Subtotal Malaria Vaccine	**$300,000**	**$0**	**-$300,000**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$300,000**	**$0**	**-$300,000**	**-$300,000**	**-100%**
SMEO	Data Systems Strengthening - General	$3,810,000	$1,750,000	-$2,060,000	$1,018,879	$789,766	-$229,113	$533,243	$496,846	-$36,397	$5,362,122	$3,036,612	-$2,289,113	-$2,325,510	-43%
	Surveys	$360,000	$0	-$360,000	$836,754	$8,785	-$827,969	$0	$0	$0	$1,196,754	$8,785	-$1,187,969	-$1,187,969	-99%
	Operational Research	$0	$0	$0	$194,016	$97,008	-$97,009	$191,072	$16,101	-$174,971	$385,088	$113,109	-$97,009	-$271,980	-71%
	Subtotal SMEO	**$4,170,000**	**$1,750,000**	**-$2,420,000**	**$2,049,649**	**$895,559**	**-$1,154,090**	**$724,315**	**$512,947**	**-$211,368**	**$6,943,964**	**$3,158,506**	**-$3,574,090**	**-$3,785,458**	**-55%**
SBCC	SBC; Other HSS	$5,033,000	$0	-$5,033,000	$515,346	$351,794	-$163,552	$371,015	$1,385,238	$1,014,223	$5,919,361	$1,737,032	-$5,196,552	-$4,182,329	-71%
	Subtotal SBCC	**$5,033,000**	**$0**	**-$5,033,000**	**$515,346**	**$351,794**	**-$163,552**	**$371,015**	**$1,385,238**	**$1,014,223**	**$5,919,361**	**$1,737,032**	**-$5,196,552**	**-$4,182,329**	**-71%**
Program Management	Local Capacity Training	$300,000	$0	-$300,000	$0	$0	$0	$0	$0	$0	$300,000	$0	-$300,000	-$300,000	-100%
	Other Health Systems Strengthening	$190,000	$0	-$190,000	$2,026,442	$1,952,028	-$74,415	1,775,633	$2,126,900	$351,267	$3,992,075	$4,078,928	-$264,415	$86,852	2%
	Operations	$0	$0	$0	$2,873,685	$2,710,640	-$163,045	0	0	$0	$2,873,685	$2,710,640	-$163,045	-$163,045	-6%
	Planning and Supervision	$0	$0	$0	$818,977	$507,644	-$311,333	0	0	$0	$818,977	$507,644	-$311,333	-$311,333	-38%
	Subtotal Program Manage	**$490,000**	**$0**	**-$490,000**	**$5,719,105**	**$5,170,313**	**-$548,792**	**$1,775,633**	**$2,126,900**	**$351,267**	**$7,984,738**	**$7,297,213**	**-$1,038,792**	**-$687,525**	**-9%**
USG Staffing	CDC	$1,200,000	$0	-$1,200,000	$0	$0	$0	$0	$0	$0	$1,200,000	$0	-$1,200,000	-$1,200,000	-100%
	USAID	$2,420,000	$0	-$2,420,000	$0	$0	$0	$0	$0	$0	$2,420,000	$0	-$2,420,000	-$2,420,000	-100%
	Subtotal USG Staffing	**$3,620,000**	**$0**	**-$3,620,000**	**$0**	**$0**	**$0**	$0	**$0**	**$0**	**$3,620,000**	**$0**	**-$3,620,000**	**-$3,620,000**	**-100%**
Total		**$56,170,000**	**$33,054,100**	**-$23,115,900**	**$40,435,390**	**$40,363,224**	**-$72,165**	**$15,640,317**	**$13,907,777**	**-$1,732,540**	**$112,245,707**	**$87,325,101**	**-$23,188,065**	**-$24,920,605**	**-22%**

[1] Original funds allocated

[2] Revision of funds based on USG directive (Federal Review). Also, for comparison purposes, all PMI spending in 2025 is assumed to take place in Aug-December. Rationale: Between January and July, very little PMI spending on intervention implementation occurred due to stop work orders, project terminations, and funding system disruptions. A partial exemption was commodity procurement, whose spending here is tallied as occurring in Aug-Dec.

[3] Difference between Original (1) and Revision (2)

[4] Funding remaining allocated by GF following a reprioritization exercise in Q2 2025

[5] Overall difference in expected funding combining both GF [MOH] and PMI

[6] Note: SBC categories varied in primary GF MOH and GF CHAZ data sheets. These have been consolidated under "SBC" within this table.

Attachment C: ITN Planning Scenarios

PLANNING SCENARIOS	ORIGINAL PLAN	CURRENT PLAN (If no PMI)	CURRENT PLAN (If + PMI)	PREFERRED PLAN (If no PMI)	PREFERRED PLAN (If + PMI)
		NMEC 19 Aug 2025 ppt	NMEC 19 Aug 2025 ppt	NMEC 2 June 2025 ppt	NMEC 2 June 2025 ppt
		NMEC GF reprioritization	NMEC GF reprioritization	NMEC GF reprioritization	NMEC GF reprioritization
Reference	NMEC 2 Jun 2025 ppt		PMI inventory		PMI inventory
NEEDS					
Strategy	Universal	Constricted	Constricted	Universal	Universal
Target areas	All except Lusaka District	Exclude Lusaka and IRS areas	Exclude Lusaka and IRS areas	All except Lusaka District	All except Lusaka District
Target pop	22,259,937	20,094,760	20,094,760	22,259,937	22,259,937
ITNs	12,366,632	11,163,756	11,163,756	12,366,632	12,366,632
Funds required	$48,353,530	$43,650,284	$43,650,284	$48,353,530	$48,353,530
RESOURCES					
GF-MOH	$21,574,711	$21,574,712	$21,574,713	$21,574,714	$21,574,715
GF-MOH top-up from reprior'zn	$0	$3,400,000	$3,400,000	$3,400,000	$3,400,000
GF-CHAZ	$3,664,476	$3,664,477	$3,664,478	$3,664,479	$3,664,480
GF-CHAZ reprogramming to ACTs (i)	$0	-$3,100,000	-$3,100,000	-$3,100,000	-$3,100,000
AMF	$11,968,937	$11,968,937	$11,968,937	$11,968,937	$11,968,937
PMI FY25	$250,000	$0	$4,533,229	$0	$4,533,229
PMI FY26 (ii)	$0	$0	$0	$0	$0
Funds available	$37,458,124	$37,508,126	$42,041,357	$37,508,130	$42,041,361
GAP	$10,895,406	$6,142,158	$1,608,927	$10,845,400	$6,312,169