

MOZAMBIQUE MALARIA PROFILE

I. ABOUT

Launched in 2005, the [U.S. President's Malaria Initiative \(PMI\)](#) supports implementation of malaria prevention and treatment measures as well as cross-cutting interventions. PMI's 2021–2026 strategy, [End Malaria Faster](#), envisions a world free of malaria within our generation, with the goal of preventing malaria cases, reducing malaria deaths and illness, and eliminating malaria in PMI partner countries. PMI currently supports 274 countries in Sub-Saharan Africa and three programs across the Greater Mekong Subregion in Southeast Asia to control and eliminate malaria. Mozambique began implementation as a PMI focus country in FY 2007. Please see the [Mozambique Malaria Operational Plan](#) for more information on PMI's approach and investments.

II. CONTEXT

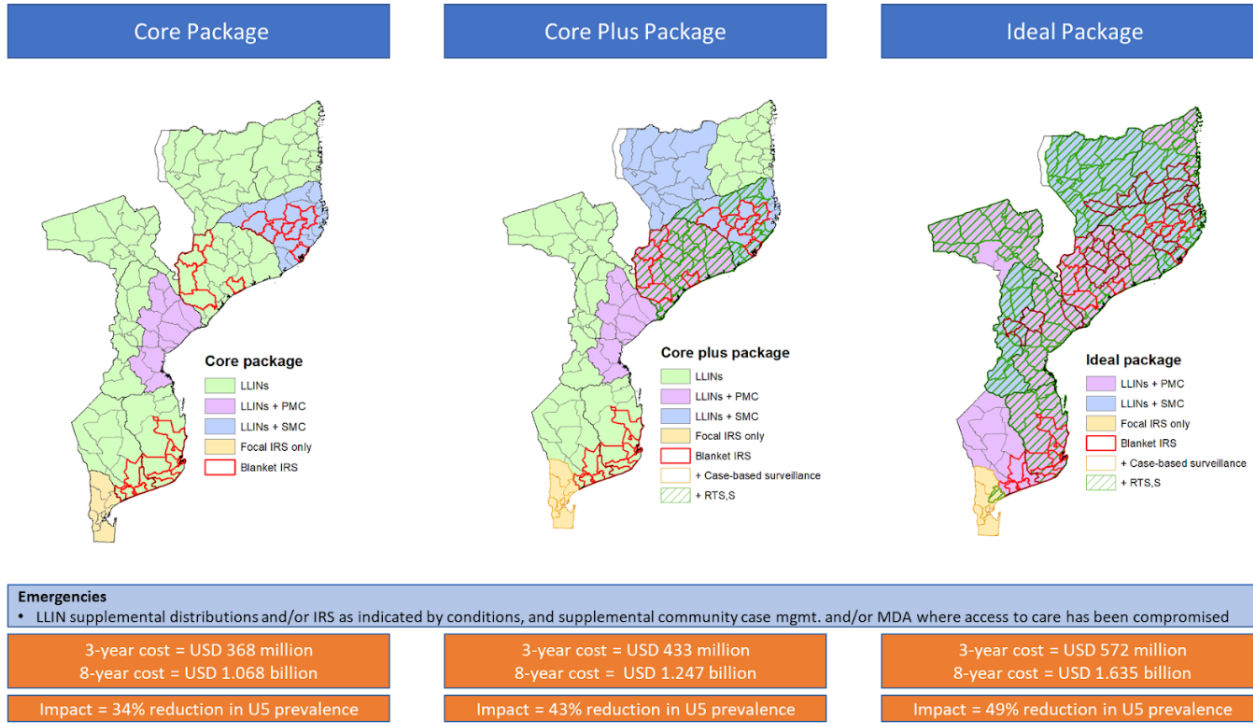
Table 1. General Demographics and Malaria Situation

Population	31,616,078 (INE, 2022)
Population at risk of malaria	31,616,078 (INE, 2022)
Malaria prevalence	38% (Malaria Indicator Survey [MIS], 2018)
Malaria incidence/1,000 population at risk	391.8 (District Health Information System 2 [DHIS2], known as SISMA, 2022)
Peak malaria transmission	December to April

STRATIFICATION

In 2022, the National Malaria Program (NMP) in collaboration with partners conducted a cost-effectiveness optimization model for stratification and subnational tailoring of interventions (see Figure 1). The stratification process is iterative and the NMP will continue to refine the models as needed.

Figure 1. Stratification Maps



IRS: indoor residual spraying; LLIN: long-lasting insecticide nets (dual AI); PMC: perennial malaria chemoprevention; SMC: seasonal malaria chemoprevention.

Figure 2. Prevalence Map

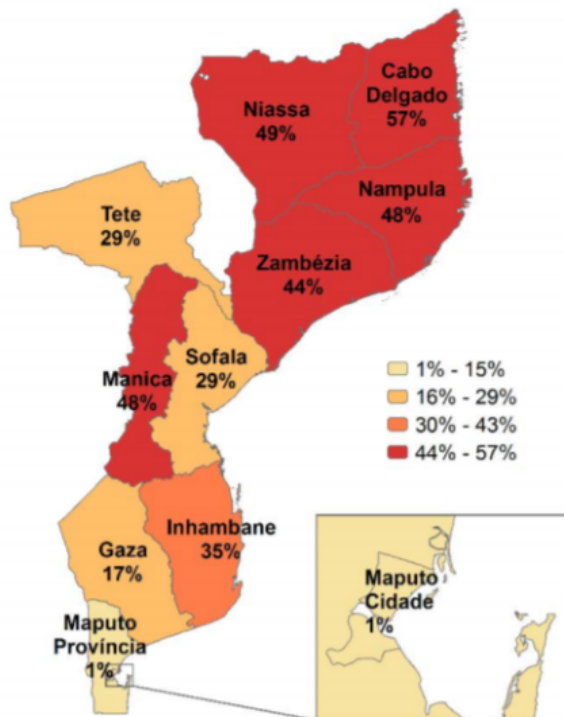


Figure 3. Incidence Maps

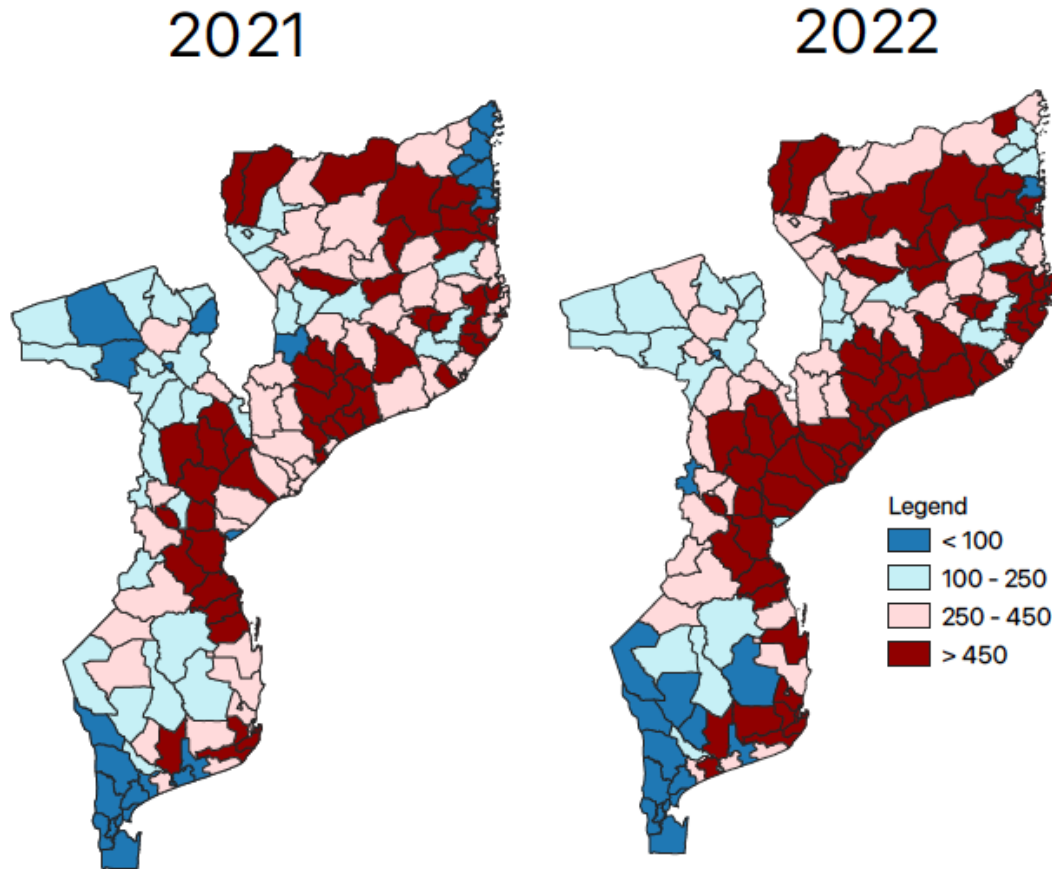


Table 2. Malaria Parasites and Vectors

Principal malaria parasites	Plasmodium falciparum (Mozambique Social and Behavior Change Protocol 2019)
Principal malaria vectors¹	<i>Anopheles gambiae</i> s.s., <i>An. arabiensis</i> , and <i>An. funestus</i> s.s. (National Malaria Control Program 2020)

¹ See the entomological monitoring section of the MOP for more details on vector bionomics and insecticide resistance and indoor residual spraying section for details on residual efficacy.

COUNTRY HEALTH SYSTEM

In Mozambique, the public sector, specifically the National Health Service (NHS), dominates health service delivery. Although there is a growing private sector, it is largely limited to major cities. The public sector reaches an estimated 60 percent of the population. The NHS consists of four levels. Level I includes health centers and health posts. These level-I health facilities provide a package of primary health care services and usually have a maternity ward but do not provide inpatient services. According to a 2004 World Bank report, level-I facilities represent at least 40 percent of all health services and are typically the first point of contact with the health system for a large portion of the population. Level II includes district, general, and rural hospitals, usually serving as the referral facility for more than one district. Facilities at

this level offer diagnostic, surgical, and obstetric services and have general medical doctors on their staff. Level III consists of provincial hospitals, which offer curative services, have diagnostic services/equipment, and are training centers. They are the referral facility for the level II-facilities. Finally, level IV consists of the country's four referral hospitals in Maputo, Quelimane, Beira, and Nampula, serving the southern, central, and northern regions.

Recognizing the limitations of the NHS and the shortage of professionally trained health workers, the country has begun revitalizing the community health worker (CHW) program. The CHWs provide preventive and basic curative services, including malaria diagnosis using rapid diagnostic tests (RDTs) and treatment (with artemisinin-based combination therapy). In addition to malaria curative and preventative services, CHWs provide services related to integrated community case management (iCCM), family planning, management of postpartum hemorrhage, prevention of umbilical infections in neonates, distribution of vitamin A, and adherence to antiretroviral and tuberculosis treatments. CHWs are expected to cover between 500 and 1,200 inhabitants and work outside the catchment area of the nearest health facility. A new community health worker strategy is under development. Under this new strategy, the plan is to assign the preventive and curative responsibilities to a team of two CHWs per community. A number of national and international nongovernmental organizations also work within the NHS to assist in the provision of health services. Malaria control in the public health system consists of three administrative levels: central, provincial, and district. At the central level, the NMP is benefiting from strong leadership, allowing it to improve its ability to manage and coordinate programs. Each province has a provincial malaria team, composed of a program manager and four different focal points covering the following areas: case management; surveillance, monitoring, and evaluation (SM&E); social and behavior change; vector control; and entomology. Each district has a malaria focal point, who coordinates all malaria activities at that level.

At the health facilities, health providers record patient information, including basic demographics, symptoms, diagnostic tests, and results in a registry book. Once a month, malaria data are aggregated and summarized in a paper form per facility and shared with the district. At the district level, the statistics focal point entered the information into a DHIS-2 database called SIS-MA. Data from SIS-MA are synchronized with the integrated malaria information storage system (iMISS) *Sistema de Informação Integrada de Malaria*. The NMP vision is to use iMISS as a tool for malaria data storage and visualization. Data from SIS-MA and iMISS are available to Ministry of Health (MoH) staff at the district, provincial, and central levels. Every month, an epidemiologic bulletin is distributed to public health authorities at all levels, and data in iMISS can be visualized in a variety of dashboards. Other malaria information, such as vector control and integrated supervision data, can also be visualized on the iMISS platform.

Prevention of malaria in pregnant women through the use of sulfadoxine-pyrimethamine (SP) for intermittent preventive treatment for pregnant women (IPTp) and insecticide-treated mosquito net (ITN) distribution, has been promoted in Mozambique since 2006.

The country has been implementing the World Health Organization (WHO) updated guidelines on IPTp since 2014, which recommend administering IPTp as early as possible starting in the second trimester (13 weeks) and at each scheduled antenatal care (ANC) visit, as long as there has been an interval of approximately one month since the last SP dose. Although the NMP and its partners lead procurement of SP and ITNs for distribution through ANCs, the maternal and child health (MCH) department manages the implementation of MCH programs. Both entities have identified focal persons for malaria in pregnancy (MIP), and these individuals work very closely with one another. The priority for the MoH MCH program is the implementation of an integrated reproductive health/maternal-neonatal-child services package. In addition, NMP is also implementing integrated supportive supervision, which includes an MIP module.

Medicines and other health commodity products are a core component of a functioning health care system. In 2013, recognizing the critical need to ensure access to medicines, the MoH adopted the Strategic Plan for Pharmaceutical Logistics (PELF). Given the current and future needs of medicines in the NHS, the PELF aims to ensure that safe and effective, quality-approved, vital, and essential medicines and products are available in sufficient quantities when and where they are needed to prevent, diagnose, or treat priority health problems. It also aimed to do this at the lowest possible cost to the patient and community. To achieve this goal, PELF established several reforms based on global best practices, such as supply chain optimization design, by establishing three regional warehouses and 30 intermediate warehouses. This is one of the PELF key reforms that will decrease costs and increase the sustainability of the operation. The Central Medical Store (CMAM) is the national entity within the MoH with the primary responsibility for all central-level supply chain functions, including procurement of all pharmaceuticals and related health supplies. In collaboration with NMP, CMAM manages all functions related to forecasting malaria commodities and commodity supply planning, procurement, storage, inventory management, and distribution, except ITNs, from the central level to provincial and intermediate warehouses as they are opened. CMAM distributes malaria drugs and RDTs via two logistics systems: the prepackaged CHW kit and the classic system. PMI currently supports the local production process of malaria drug kits for the community health workers at CMAM facilities, and their distribution is in conjunction with the essential medicines kit. The CHW malaria kit system was developed in response to the bulky artemisinin-based combination therapy (ACT) packaging, making it difficult to fit into the essential medicine kit. Malaria medicines kits are distributed to CHWs through health facilities using a push-based system. The second logistics system, the classic system, distributes medicines (including ACTs and SP) and RDTs quarterly based on requisitions. Products are stored in regional warehouses in Maputo, Beira, and Nampula, from which central hospitals are supplied, and then to the still existing 11 provincial warehouses and the one open intermediate warehouse. Each of the 10 provincial warehouses supplies the provincial, general, and rural hospitals and district warehouses. Malaria drugs are administered within this system, which uses a logistics management information system to generate consumption, stock, loss, and adjustment data. These systems provide the supply chain and NMP with data

for informed management decision making. Despite these two distribution systems, facility-level stockout challenges persist. Delays in the arrival of shipments are a major cause of the problem, as delayed arrivals at the central level can result in stockouts at service delivery points due to the time it takes to transport commodities from port to province, province to district, and district to facilities and communities. Additionally, lack of transportation from the province level to health facilities and communities, as well as accessibility constraints during the higher transmission season, have resulted in stockouts at service delivery points. CMAM and NMP have begun implementation of PELF to strengthen the system. Specifically, the intermediary warehouse concept of eliminating one of the four levels (regional, provincial, and district warehouses and health facilities) of the in-country supply chain and combining the current 11 provincial warehouses and 144 district warehouses into 30 intermediary warehouses optimally located across the territory has begun. By April 2022, three regional warehouses were opened, one in the south (Vilanculos District, Inhambane Province) and two in the center (Chimoio City, Manica Province and Mocuba District, Zambézia Province). Two more regional warehouses opened in September 2022, in the districts of Ile and Mopeia (Zambézia Province).

OTHER CONTEXTUAL INFORMATION

Mozambique is prone to natural disasters, such as drought, cyclones, and floods, which have likely contributed to increases in malaria transmission in recent years, particularly in low-lying coastal areas and along major rivers. In 2019, the country was devastated by back-to-back cyclones, which killed at least 600 people and damaged or destroyed at least 240,000 homes, creating recovery needs estimated at \$3.02 billion. By April 2022, the country had already been hit by two cyclones and one tropical storm, which affected more than 300,000 people. In 2023, the longest lasting tropical cyclone—Freddy—impacted Mozambique three times. Approximately 239,500 people were affected; 281,200 acres of agricultural fields were inundated; more than 30,000 houses were damaged or destroyed; and almost 13,000 people were displaced.

Additionally, since late 2017, a violent extremist group now linked to the Islamic State, known as Islamic State–Mozambique, has carried out over 580 attacks against government and civilians in gas-rich Cabo Delgado, killing nearly 2,000 people and causing more than 662,828 internal displacements.

III. NMP STRATEGIC PLAN

The focus of the National Malaria Strategic Plan (NMSP) 2023–2030 is to reduce the burden of malaria in areas with high transmission and to sustain the gains in areas with low transmission to accelerate toward elimination.

The goals of this NMSP are to, by 2030, reduce national incidence from 392 to 216 cases per 1,000 population; reduce malaria hospital mortality from 1.3 to 0.77 deaths per 100,000 population; and to eliminate local transmission in at least 20 districts with low transmission. To reach this vision, the NMSP includes the following six objectives:

1. Strengthen intra- and intersectoral management and coordination capacity to achieve the objectives of the strategic plan;
2. Ensure that all districts with medium-high transmission benefit in a timely manner from at least one vector control intervention and additionally from chemoprevention and/or vaccination, where applicable;
3. Test 100 percent of suspected cases of malaria and treat 100 percent of confirmed cases of malaria at the health facility and community level, in accordance with national guidelines;
4. Ensure access to information about malaria so that 85 percent of people seek health care in a timely manner and accept and correctly use malaria prevention methods;
5. Strengthen the capacity of the malaria surveillance, monitoring, and evaluation system, including data use, at all levels; and
6. Ensure access to malaria interventions in humanitarian interventions.

PMI worked closely with the NMP in drafting this plan, and the objectives and their associated activities are well aligned with PMI's in-country priorities. PMI provides direct support for all intervention areas described above, except for elimination, as there is complementary regional donor support (Elimination 8 and the Mozambique, South Africa and Eswatini Fund) in this area. PMI support is also complementary to that of the Global Fund. Diagnostics and treatments procured by PMI and the Global Fund are pooled and distributed nationwide through the national supply chain. Global Fund procures insecticides for indoor residual spraying (IRS) and ITNs for routine ANC and campaign distribution, complementing PMI support for IRS implementation. Additionally, the Bill & Melinda Gates Foundation (BMGF) supports national and targeted surveillance strengthening that is coordinated and complements PMI investments.

PMI supports commodities for the whole country, but currently targets case management, MIP, health system strengthening, SM&E, and social and behavioral change activities in the provinces of Nampula, Zambezia, and Manica. The selection of these provinces was based on the incidence, prevalence, and unmet service needs in those provinces. PMI covers all non-insecticide operational costs for IRS in targeted districts of Zambezia and provides some technical support to the MoH-led IRS program in Nampula. PMI supports direct entomological data collection in Zambezia and Nampula and provides financial support for entomological collection in the remaining provinces in the central and northern regions, which complement other donor support in the southern region.

IV. KEY MALARIA DATA

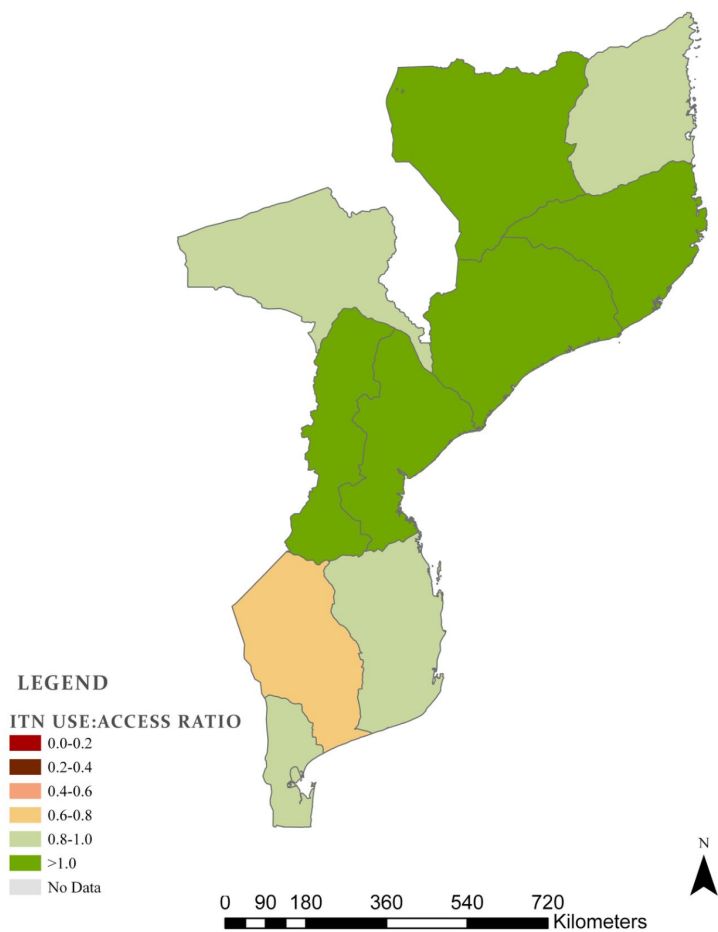
EVOLUTION OF KEY SURVEY-BASED MALARIA INDICATORS

Table 3. Key Survey Indicators

Indicator	2007 MIS	2008 MICS	2009 INSIDA	2011 DHS	2015 IMASIDA	2018 MIS
% of households with at least one ITN	16	31	N/A	51	66	82
% of households with at least one ITN for every two people	N/A	N/A	N/A	23	39	51
% of population with access to an ITN	N/A	N/A	N/A	37	54	69
% of population that slept under an ITN the previous night ¹	N/A	N/A	N/A	30	45	68
% of children under the age of five who slept under an ITN the previous night ¹	7	23	49	36	48	73
% of pregnant women who slept under an ITN the previous night ¹	7	N/A	N/A	34	52	76
% of children under the age of five with a fever in the last two weeks for whom advice or treatment was sought	36	N/A	N/A	56	63	69
% of children under the age of five with a fever in the last two weeks who had a finger or heel stick	N/A	N/A	N/A	30	40	48
% of children under the age of five receiving an ACT among those with a fever in the last two weeks who received any antimalarial drug	N/A	N/A	N/A	60	93	99
% of women who attended four ANC visits during their last pregnancy	N/A	N/A	N/A	51	55	50 ²
% of women who received three or more doses of IPTp during their last pregnancy in the last two years	N/A	N/A	N/A	N/A	23	41
Under-five mortality rate per 1,000 live births	N/A	N/A	N/A	64	N/A	N/A
% of children under the age of five with parasitemia by microscopy ¹	38	N/A	N/A	35	N/A	N/A
% of children under the age of five with parasitemia by RDT ¹	51	N/A	N/A	38	40	39
% of children under the age of five with severe anemia (Hb<8gm/dl)	12	N/A	N/A	9	8	14

¹ DHS and MICS are generally fielded during the dry season, whereas MIS are deliberately fielded during the high-transmission season, which should be taken into consideration when interpreting these indicators. ² The DHS Program STATcompiler. DHS: Demographic and Health Survey; MICS: Multiple Indicator Cluster Survey; MIS: Malaria Indicator Survey; IMASIDA: Survey of Indicators on Immunization, Malaria, and HIV/AIDS in Mozambique; INSIDA: National Survey on the Impact of HIV and AIDS in Mozambique.

Figure 4. ITN Use-to-Access Ratio Map



Source: MIS 2018.

Table 4. Evolution of Key Malaria Indicators Reported through Routine Surveillance Systems

Indicator	2018	2019	2020	2021	2022
# of all-cause patient consultations	46,550,843	47,786,613	43,526,510	43,502,461	50,967,475
# of suspect malaria cases ¹	NA	19,776,616	19,516,184	19,231,932	23,225,241
# of patients receiving diagnostic test for malaria ²	18,752,761	19,737,180	19,503,860	19,221,147	23,206,871
Total # of malaria cases ³	10,336,065	10,904,113	11,331,009	10,105,075	12,405,868
# of confirmed cases ⁴	10,301,229	10,864,667	11,318,685	10,094,290	12,387,459
# of presumed cases ⁵	34,836	39,436	12,324	10,785	18,409
% of malaria cases confirmed ⁶	99.7%	99.6%	99.9%	99.9%	99.9%
Test positivity rate (TPR) ⁷	54.9%	55.0%	58.0%	52.5%	53.4%
Total # of malaria cases in children under the age of five ⁸	4,796,243	5,031,140	5,064,404	4,338,001	5,220,192
% of cases in children under the age of five ⁹	46.4%	46.1%	44.7%	42.9%	42.1%
Total # of severe cases ¹⁰	70,676	72,941	57,703	47,316	70,118
Total # of malaria deaths ¹¹	1,114	734	563	411	423
# of facilities reporting ¹²	19,512	19,656	19,855	20,244	20,599
% of data completeness ¹³	98.8%	95.5%	96.4%	97.7%	96.9

¹Number of patients presenting with signs or symptoms possibly due to malaria (suspect malaria cases) are defined as the sum of presumed cases and the number of patients receiving diagnostic tests for malaria. ²RDT or microscopy, all ages, outpatient and inpatient. ³Total reported malaria cases; all ages, outpatient and inpatient, confirmed and unconfirmed cases. ⁴Diagnostically confirmed; all ages, outpatient and inpatient. ⁵Clinical/presumed/unconfirmed, all ages, outpatient and inpatient. ⁶Number of confirmed cases divided by total number of cases. ⁷Confirmed cases divided by the number of patients receiving a diagnostic test for malaria (RDT or microscopy). ⁸Outpatient and inpatient, confirmed and unconfirmed. ⁹Total number of cases in children under the age of five divided by total number of cases. ¹⁰Severe cases are those hospitalized with malaria and reported to HMIS here. ¹¹All ages, outpatient, inpatient, confirmed, and unconfirmed; ¹²Total number of health facilities reporting data into the HMIS/DHIS2 system that year. ¹³Number of monthly reports from health facilities divided by the number of health facility reports expected (average for the calendar year).

Table 5. Disaggregated Community-Level Data

Indicator	2020	2021	2022
# of patients receiving diagnostic test for malaria from a CHW	2,211,731	2,163,706	2,106,887
Total # of malaria cases reported by CHWs ¹	1,404,804	1,276,696	1,270,207
% of CHW reported cases (among total malaria cases) ²	12.4%	12.6%	10.2%

¹Includes all ages, confirmed and unconfirmed. ²Total number of malaria cases reported by CHWs divided by total number of malaria cases in previous table.

V. Other Implementation Information

Table 6. Results of Durability Monitoring

Site/Net Type	Survey and Time Since Distribution (months)	Attrition to Wear and Tear (%)	Nets in Serviceable Condition (%)	Optimal Insecticidal Effectiveness in Bioassay (%)
Mandimba, Niassa/ Royal Guard	12 months	8.7	79	100% of nets tested met the WHO criteria for pyrethroid bioefficacy at 12 months 60% of nets tested met the WHO criteria for pyriproxyfen bioefficacy at 12 months
	24 months	32	47	
Changara, Tete/OlysetPlus	12 months	5.6	67	100% of nets tested met the WHO criteria for pyrethroid bioefficacy at 12 months 53% of nets tested met the WHO criteria for PBO bioefficacy at 12 months
	24 months	30	54	
Guro, Manica/Interceptor G2	12 months	0.0	93	100% of nets tested met the WHO criteria for pyrethroid bioefficacy at 12 months 97% of nets tested met the WHO criteria for chlorfenapyr bioefficacy at 12 months
	24 months	7	71	

Table 7. Summary of Completed Therapeutic Efficacy Studies

Year	Site	Treatment Arm(s)	Efficacy (PCR-corrected adequate clinical and parasitological result) for Each Drug at Each Site
2018	Massinga	AL, ASAQ	AL: 95.4% ASAQ: 100%
2018	Moatize	AL, ASAQ	AL: 100% ASAQ: NA
2018	Montepuez	AL, ASAQ	AL: 100% ASAQ: 100%
2018	Mopeia	AL, ASAQ	AL: 95.5% ASAQ: 98.8%

Source: Nhama, A., L. Nhamússua, E. Macete, et al. 2021. “In vivo efficacy and safety of artemether-lumefantrine and amodiaquine-artesunate for uncomplicated *Plasmodium falciparum* malaria in Mozambique, 2018.” *Malaria Journal* 20 (1): 390. <https://doi.org/10.1186/s12936-021-03922-9>.

Note: Both AL and ASAQ have therapeutic efficacies above the 90 percent threshold recommended by the WHO, and are well-tolerated in Mozambique. AL: artemether-lumefantrine; ASAQ = artesunate-amodiaquine; NA = not applicable; PCR: polymerase chain reaction.

VI. Key Policies

Table 8. Policies in Mozambique

National Strategic Plan (2017–2022)	
National SM&E Plan (2017–2022)	
National Social Behavior Change/Communication Strategy (2021–2027)	
National Supply Chain Strategy/Master Plan (2012)	
National Vector Control Strategy and/or Integrated Vector Management Plan (2021–2026)	
Malaria Case Management Policy (2017)	
What is/are the first-line treatment(s) for uncomplicated <i>P. falciparum</i> malaria*?	Artemether and lumefantrine Artesunate and amodiaquine
What is/are the second-line treatment(s) for uncomplicated <i>P. falciparum</i> malaria*?	N/A
What is the first-line treatment for severe malaria?	Artesunate, injectable
In pregnancy, what is the current first-line treatment for uncomplicated <i>P. falciparum</i> malaria in the first trimester?	Artemether and lumefantrine
Given the WHO policy change to recommend AL as treatment for uncomplicated malaria in the first trimester, does the MOH plan to update the policy on treatment of MIP in the first trimester? And if so, what is the status of this policy change and implementation of the new policy?	Yes, the change has been implemented in Mozambique

In pregnancy, what is/are the first-line treatment(s) for uncomplicated <i>P. falciparum</i> malaria in the second and third trimesters?	Artemether and Lumefantrine Artesunate and Amodiaquine
In pregnancy, what is the first-line treatment for severe malaria?	Artesunate, injectable
Is pre-referral treatment of severe disease recommended at peripheral health facilities? If so, with what drug(s)?	Yes, it is recommended. Drug: Artesunate, injectable
Is pre-referral treatment of severe disease with rectal artesunate recommended for community health workers?	Yes, it is recommended.
Community Health Policy (NMSP, 2017–2022)	
What is the # of CHWs currently providing iCCM?	7,096
What is the country's target for the number of CHWs providing iCCM?	8,800
What percent of the country's target is met?	81%
Does the country have a policy that enables the routine, regular payment of salaries/stipends for CHWs?	Yes
Do CHWs have the authority to test and treat all ages for malaria?	Yes
Prevention of Malaria in Pregnancy Policy (NMSP, 2017–2022)	
At what gestational age is the first dose of IPTp-SP to be given to pregnant women according to the national guidelines for malaria and MCH?	13 weeks
Do the national ANC guidelines reflect the WHO 2016 recommendation of eight ANC scheduled contacts (plus one additional contact for early initiation of IPTp at 13–16 weeks)? If not, how many ANC contacts are recommended?	Yes
What is the status of training ANC providers on the WHO recommended eight or more contacts?	All have been trained
Have HMIS/DHIS2 and ANC registers been updated to include eight or more contacts?	No
Are ANC/IPTp data collected as single months where the January 2022 data represent the number of doses administered in January 2022, or cohort data, representing the cumulative data from pregnancies which began six months prior?	Cohort data are used
Is ANC/IPTp provided by facility staff conducting ANC outreach to communities?	Yes
Can CHWs deliver IPTp and if so, which specific cadres and beginning with which dose? How many districts are targeted for c-IPTp implementation?	No. Based on the results from a pilot c-IPTp project and resources available, c-IPTp has not been adopted as policy.

VII. PARTNER LANDSCAPE

PMI emphasizes the importance of partner alignment for malaria control, recognizing that different partners bring complementary expertise and resources. In recent years, PMI, the Global Fund, and the BMGF have harmonized financial, supply chain, and programmatic data. In particular, PMI and the Global Fund agreed to a harmonized financial taxonomy to aid comparison of our investments to better identify potential overlap or gaps.

Due to the U.S. government's fiscal year budget cycle and approximate timing of annual appropriations, PMI funds activities that largely occur during the following fiscal year. For example, this FY 2024 MOP is anticipated to largely fund implementation of activities starting in 2025. Global Fund resources are based on the calendar year (CY) and planned for a three-year grant cycle. Most partner country governments and other partners also budget based on the calendar year.

The figures below summarize contributions by key external partners and partner country governments in CY 2020–2023, providing insight into total country investments. Because the Global Fund 2023–2025 grant cycle is in development and will begin later in 2023, Global Fund country investments may still evolve; the 2021–2023 funding cycle is included in Table 9. The partner country government invests substantial funding into the national-to-local infrastructure and service delivery that benefits malaria programs and many other efforts. However, it is not always possible to attribute funding for malaria specifically from the partner country government without a standardized method. There may be similar challenges to attributing other partner funds.

Table 9. Partner Landscape

Partner	Key Technical Interventions	Geographic Coverage	Funding Amount or In-kind Contribution	Time Frame
Global Fund	<ul style="list-style-type: none"> • Support for nationwide mass ITN campaign in 2022/23 • Procurement of ACTs and RDTs • Procurement of insecticides for indoor residual spraying • Procurement of supplies for malaria microscopy • Training and supportive supervision in seven provinces • Support for health system strengthening activities 	<ul style="list-style-type: none"> • National for ITN campaign, procurement of commodities, and health system strengthening activities • Nine regions for training and supportive supervision 	<p>MoH malaria grant: \$144,600,000</p> <p>World Vision malaria grant: \$67,400,000</p> <p>Total: \$212,000,000</p>	Current grant covers 2021 to 2023
BMGF/Global Fund/Private Sector	<ul style="list-style-type: none"> • Co-financing MOSAWA (Mozambique, South Africa, and Eswatini) regional grant • Program management support • Technical assistance and capacity development support focused on surveillance systems, data quality, data use, case management, genomic epidemiology, entomological surveillance, analytics, and modeling 	<ul style="list-style-type: none"> • Primarily support to central MOH with additional support for surveillance and program management in four provinces 	\$50,000,000	Current grant covers 2023 to 2025
BMGF	<ul style="list-style-type: none"> • Co-financing MOSAWA (Mozambique, South Africa, and Eswatini) regional grant • Program management support • Technical assistance and capacity development support focused on surveillance systems, data quality, data use, case management, genomic epidemiology, entomological surveillance, analytics, and modeling 	<ul style="list-style-type: none"> • Primarily support to central MOH with additional support for surveillance and program management in four provinces 	\$35,000,000	Current grant covers 2023 to 2025