



NATIONAL MALARIA STRATEGIC PLAN 2026 – 2030

MARCH 2026

**NATIONAL MALARIA ELIMINATION PROGRAMME
FEDERAL MINISTRY OF HEALTH & SOCIAL WELFARE**



**NATIONAL MALARIA
ELIMINATION PROGRAMME**

Federal Ministry of Health, Abuja

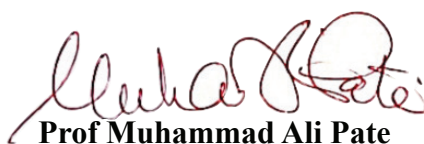
Malaria remains one of the most significant public health challenges in Nigeria, disproportionately affecting vulnerable populations, particularly children under five years of age and pregnant women. Despite notable progress over the past decade, the disease continues to impose a heavy burden on our health system, economy, and communities. The decline in malaria prevalence to 15.2% among children aged 6 - 59 months by 2025 reflects the collective efforts of government, partners, and communities, but also reminds us that much work remains to be done.

The National Malaria Strategic Plan (NMSP) 2026 - 2030 sets out Nigeria's renewed commitment to accelerate progress towards a malaria-free nation. This plan builds on lessons learned from previous strategic plan cycles and is informed by the 2025 Malaria Programme Review. It adopts a more targeted, data-driven, and equity-focused approach, recognizing the diverse epidemiological contexts across the country and the need for tailored interventions that respond to local realities.

Aligned with the National Health Sector Strategic Blueprint, the Sector-Wide Approach, and global malaria strategies, this NMSP emphasizes strengthened governance, improved access to high-impact interventions, enhanced surveillance systems, and sustainable financing. Central to this strategy is the Subnational Tailoring approach, which ensures that resources are deployed efficiently to achieve maximum impact. The plan also prioritizes equity, human rights, and gender equality, ensuring that no population, especially the most vulnerable is left behind.

The successful implementation of this strategic plan will require strong leadership, sustained political commitment, and robust collaboration across all sectors. Government at all levels, development partners, the private sector, civil society, and communities must work together in a coordinated manner to deliver on the ambitious targets set out in this document. Increased domestic resource mobilization and innovative financing mechanisms will also be critical to ensuring sustainability and long-term success.

As we embark on the implementation of this Strategic Plan, I call on all stakeholders to reaffirm their commitment to the fight against malaria. Together, through coordinated action, innovation, and accountability, we can significantly reduce the malaria burden and move closer to our shared vision of a malaria-free Nigeria.



Prof Muhammad Ali Pate
Honourable Coordinating Minister
Federal Ministry of Health & Social Welfare

The National Malaria Strategic Plan (NMSP) 2026–2030 outlines Nigeria’s renewed, evidence-based road-map for accelerating progress towards malaria elimination. It builds on the achievements and lessons of previous strategic cycles, particularly the NMSP 2021–2025, while responding to persistent challenges such as subnational disparities, ongoing transmission, and emerging threats to malaria control.

Although Nigeria has recorded notable reductions in malaria prevalence in recent years, the country continues to bear a significant proportion of the global malaria burden. This underscores the need for a more targeted, efficient, and data-driven response. The NMSP 2026–2030 addresses this by prioritizing Subnational Tailoring, strengthening health systems, improving access to high-impact interventions, enhancing surveillance and data use, and promoting sustainable financing, all within the framework of national and global health priorities.

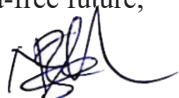
The development of this strategic plan followed a rigorous, inclusive, and phased methodology. It was anchored on the 2025 Malaria Programme Review, which provided a comprehensive assessment of programme performance, epidemiological trends, and key system gaps. Building on these findings, the NMSP was developed through a structured seven-phase process, including situation analysis, strategic framework development, implementation planning, and the design of a robust monitoring and evaluation framework.

The process was highly consultative and participatory, led by the National Malaria Elimination Programme in collaboration with the Malaria Technical Working Group and its subcommittees. It engaged stakeholders across federal, state, and local levels, including government ministries, development partners, civil society, academia, and the private sector. Both physical and virtual platforms were utilized to ensure broad participation and efficiency.

Analytical approaches such as epidemiological modelling, subnational stratification, and equity assessments informed the prioritization of interventions and target setting. Particular emphasis was placed on equity, human rights, and gender equality to ensure that vulnerable and underserved populations are effectively reached.

The NMSP 2026–2030 is aligned with Nigeria’s health sector reforms, including the National Health Sector Strategic Blueprint and the Sector-Wide Approach, as well as global frameworks such as the WHO Global Technical Strategy for Malaria. It provides a clear and practical guide for coordinated action, accountability, and results across all levels of implementation.

The successful implementation of this plan will depend on sustained political commitment, strengthened partnerships, and increased domestic resource mobilization. With collective effort and shared responsibility, Nigeria is well-positioned to significantly reduce the malaria burden and move closer to achieving a malaria-free future,



Dr Charles Nzelu

Director, Public Health

The development of the National Malaria Strategic Plan (NMSP) 2026-2030 marks a significant milestone in Nigeria's sustained efforts to eliminate malaria as a public health threat. This document is the result of a rigorous, inclusive, and highly consultative process that brought together a broad spectrum of stakeholders across sectors and all levels of the health system.

We express our sincere appreciation to the Honourable Coordinating Minister, Federal Ministry of Health and Social Welfare, Prof. Muhammad Ali Pate and the Minister of State for Health Dr. Iziaq Adekunle Salako for the visionary leadership and strategic stewardship throughout the development of this Plan. We also deeply acknowledge the invaluable support of the Permanent Secretary, whose strong administrative leadership, unwavering commitment, and effective oversight created an enabling environment for efficient coordination and timely delivery. Our profound gratitude goes to the Director of Public Health for providing sound technical guidance, clear policy direction, and sustained engagement, all of which were instrumental in ensuring the quality, coherence, and alignment of the Plan with national health priorities.

We gratefully recognize the immense contributions of the State Ministries of Health, including the Honourable Commissioners of Health, Directors of Public Health, Directors of Infectious Diseases Control, and State Malaria Programme Managers.

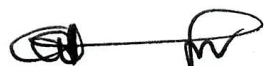
We deeply appreciate our indefatigable development partners, donor agencies; World Health Organization (WHO), World Bank and PATH MACEPA, Islamic Development Bank, the Gates Foundation, Catholic Relief Services (CRS), Society for Family Health (SFH), Malaria Consortium (MC), Management Sciences for Health (MSH), ACOMIN, CHAI and Solina. Our appreciation goes to GF Country Coordinating Mechanism, academic and research institutions, civil society organizations, and the private sector. Thank you for the technical expertise, financial support, and strategic insights that significantly shaped the direction and content of this Plan.

We particularly appreciate the World Bank and PATH MACEPA for providing funding support for the development of this document. We also appreciate the active participation of communities and frontline health workers, whose lived experiences and practical perspectives ensured that the Plan remains grounded in implementation realities.

Our sincere thanks go to the Technical Working Group (TWG), Subcommittees, Steering Committee, and reviewers who devoted their time, knowledge, and expertise to the drafting, validation, and finalization of this document. Special recognition is extended to the staff of the National Malaria Elimination Programme (NMEP) for their leadership in coordinating the process and for upholding technical rigor while ensuring alignment with both national and global priorities.

We further acknowledge the invaluable contributions of the Lead Consultant, Dr. Diwe Ekweremadu and all the technical Consultants, Dr. Petrus Inyama, Dr. Chuks Okoh, Dr. John Dada and Mr. Festus Okoh whose exceptional commitment and strong technical expertise were instrumental in the development of this strategic document.

The successful implementation of this Strategic Plan will require sustained collaboration, strong commitment, and collective action from all stakeholders. We remain confident that, together, we can accelerate progress and achieve the shared vision of a malaria-free Nigeria.



Dr. Nnenna Ogbulafor
National Coordinator

National Malaria Elimination Programme

TABLE OF CONTENTS

Forward	i
Preface	ii
Acknowledgment	iii
Executive Summary	1
1. Introduction	1
1.1 Policy and Programming environments	1
1.2 MSP and the national Planning cycle	3
1.3 The process of Developing the NMSP 2026-2030	4
2. Country Profile	5
2.1 Overview	5
2.2 Sociopolitical system	6
2.3 Ecosystem, environment and climate	6
2.4 Demographic data	6
2.5 Socioeconomic situation	7
2.6 Health system analysis	7
2.6.1 Leadership and Administration	7
2.6.2 NMEP Organizational Structure	8
2.6.3 Policy and Legislative Framework	9
2.6.4 Health Work Force	9
2.6.5 Health Product Management	10
2.6.6 Health Information System	10
2.6.7 Health Care and Malaria Financing	11
3. Situation Analysis	13
3.1 Historical Perspective of Malaria Control and Elimination	13
3.2 Epidemiology	14
3.2.1 Malaria Parasites distribution	14
3.2.2 Malaria vectors distribution	14
3.2.3 Dynamics of malaria transmission	15
3.2.4 Morbidity and mortality	15
3.2.5 Malaria Stratification, mapping and intervention mixes	17
3.2.6 Impact Projections	17
3.3. Review of previous MSP	20
3.3.1 Goal Level Achievement	22
3.3.2 Financing the MSP	23

TABLE OF CONTENTS

3.3.3 Objective Level Achievement and Capacity to Implement Planned Activities	23
3.3.4 Key achievements on the Delivery of Malaria Services	25
3.3.5 Lessons Learnt	28
3.3.6 Future Strategic Direction	29
4.0. Strategic Framework	31
4.1. Vision	31
4.2. Mission	31
4.3. Strategic directions and policy priorities	31
4.4. Goals and objectives	32
4.4.1. Goals	32
4.4.2. Objectives	33
4.4.3. Supportive Cross-cutting priority areas	33
4.5. Strategies and Broad Activities.	35
4.5.1 Objective 1	31
4.5.2 Objective 2	33
4.5.3 Objective 3	37
4.5.4 Objective 4	40
4.5.5 Objective 5	43
5.0. Implementation Framework	48
5.1. MSP Work Plan	48
5.2. Implementation Arrangements	63
5.2.1. Programme Planning	65
5.2.2. Partnership Coordination Framework	65
5.2.3. Procurement and supply management (PSM) system	65
5.2.4. Financial Resource Management	67
5.2.5. Risk Management and Mitigation.	68
6.0 Monitoring and Evaluation Framework	70
6.1 Performance Framework	70
6.2 Data Management System	73
6.3 M&E Feedback, Complaint, and Response Mechanism (FCRM)	74
6.4 M&E Coordination Mechanisms	75

Table 1: Objective 1 Priority Areas, Strategies, and Broad Activities.	47
Table 2: Objective 2 Priority Areas, Strategies, and Broad Activities	49
Table 3: Supportive PSM Strategies (Objective 2 continued).	52
Table 4: Supportive ACSM Strategies (Objective 2 continued).	53
Table 5: Objective 3 Priority Areas, Strategies, and Broad Activities	54
Table 6: Supportive PSM Strategies (Objective 3 continued).	56
Table 7: Supportive ACSM Strategies (Objective 3 continued).	56
Table 8: Objective 4 Priority Areas, Strategies, and Broad Activities	57
Table 9: Supportive PSM Strategies (Objective 4 continued).	59
Table 10: Objective 5 Priority Areas, Strategies, and Broad Activities	60
Table 11: Supportive PSM Strategies (Objective 5 continued).	61
Table 12: Supportive ACSM Strategies (Objective 5 continued).	61
Table 13: Objective 1; Work Plan	63
Table 14: Objective 2; Work Plan	66
Table 15: Objective 3; Work Plan	70
Table 16: Objective 4; Work Plan	73
Table 17: Objective 5; Work Plan	77
Table 18: Risk categories and mitigation actions	85
Table 19: Summary of NMSP Budget by Objectives	88
Table 20: Summary of NMSP Budget by Intervention Areas	89
Table 21: Malaria Commodity Needs for 2026 - 2030	90
Table 22: Performance Framework for the NMSP 2026-2030	93

Fig 1: Map of Nigeria showing the States, Regions and the borders	19
Fig 2: Organogram of NMEP	23
Fig 3: Annual Entomological Inoculation Rate (EIR)	30
Fig 4: Malaria Prevalence by States	31
Fig 5: Trends in Malaria Prevalence (2015 - 2025)	31
Fig 6: Dynamic changes in state-level malaria prevalence (2021 - 2025)	32
Fig 7: SNT process for delivering sub-nationally targeted malaria interventions.	34
Fig 8: WHO transmission intensity continuum	34
Fig 9. Alignment of the NMSP with National and Global Strategies	42
Fig 10. Linkages between NMSP Objectives and HSSB Pillars and Enablers.	42
Fig 11: Banding and Stratification	62
Fig 12: Framework for Multisectoral Collaboration.	82
Fig 13: Structure of the NMSP Implementation Framework	87
Fig 14: Overview of the Implementation Arrangements	87
Fig 15: Summary of NMSP budget by Objectives.	89
Fig 16: Summary of NMSP budget by Intervention Areas	90
Fig 17: National Malaria data flow	98
Fig. 18: Feedback, Complaint, and Response Mechanism	99

References

LIST OF APPENDICES

Annex 1: Banding of states by Malaria Transmission Intensity	96
Annex 2 : Epidemiological Stratification	97

LIST OF ACRONYMS

ABER	Annual Blood Examination Rates
ACT	Artemisinin-based Combination Therapy
ACSM	Advocacy Communication and Social Mobilization
ACOMIN	Association of Civil Society in Malaria Control, Immunization and Nutrition
AIDS	Acquired Immune-Deficiency Syndrome
AL	Artemether- Lumefantrine
ANC	Antenatal Care
BHCPF	Basic Health Care Provision Fund
CBOs	Community-Based Organizations
CDC	Centre for Disease Control
CHMIS	Community Health Management Information System
CSO	Civil Society Organization
CM	Case Management
CMS	Central Medical Stores
CRF	Consolidated Revenue Fund
DFID	Department for International Development
DHS	Demographic and Health Survey
DHIS 2	District Health Information System 2
DOT	Directly Observed Therapy
DRF	Drug Revolving Fund
DQA	Data Quality Assessment
EPR	Epidemic Preparedness and Response
EIR	Entomological Inoculation Rate
EQA	External Quality Assurance
FBO	Faith-Based Organization
FCT	Federal Capital Territory
FGoN	Federal Government of Nigeria
FMoH	Federal Ministry of Health
GBV	Gender-Based Violence
GF	Global Fund
GRM	Grievance Redress Mechanism
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GON	Government of Nigeria
HBR	Human Biting Rate
HMIS	Health Management Information System

LIST OF ACRONYMS

HIV	Human Immune-Deficiency Virus
HW	Health Worker
iCCM	Integrated Community Case Management
IDSR	Integrated Disease Surveillance and Response
IDPs	Internally Displaced Persons
IMPACT	Immunization Plus and Malaria Progress by Accelerated Coverage and Transforming Services
IMSV	Integrated Monitoring and Supervisory Visit
IRM	Insecticide Resistant Monitoring
IPC	Interpersonal Communication
IPTp	Intermittent Preventive Treatment in pregnancy
IPTi	Intermittent Preventive Treatment in infant
IPTsc	Intermittent Preventive Treatment in school-aged children
IPV	Intimate-Partner Violence
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Net
IT	Information Technology
IsDB	Islamic Development Bank
LGAs	Local Government Areas
IVM	Integrated Vector Management
LLIN	Long Lasting Insecticidal Net
LMCU	Logistic Management Coordination Unit
LMIS	Logistics Management Information System
LSM	Larva Source Management
MBER	Monthly Blood Examination Rates
MDTF	Monthly Data Triangulation Form
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MHPLMS	Malaria Health Product Logistic Management System
MIS	Malaria Indicator Survey
MPSS	Malaria Parasites Sentinel Sites
MSP	Malaria Strategic Plan
MTEF&FSP	Medium-Term Expenditure Framework and Fiscal Strategy Paper

LIST OF ACRONYMS

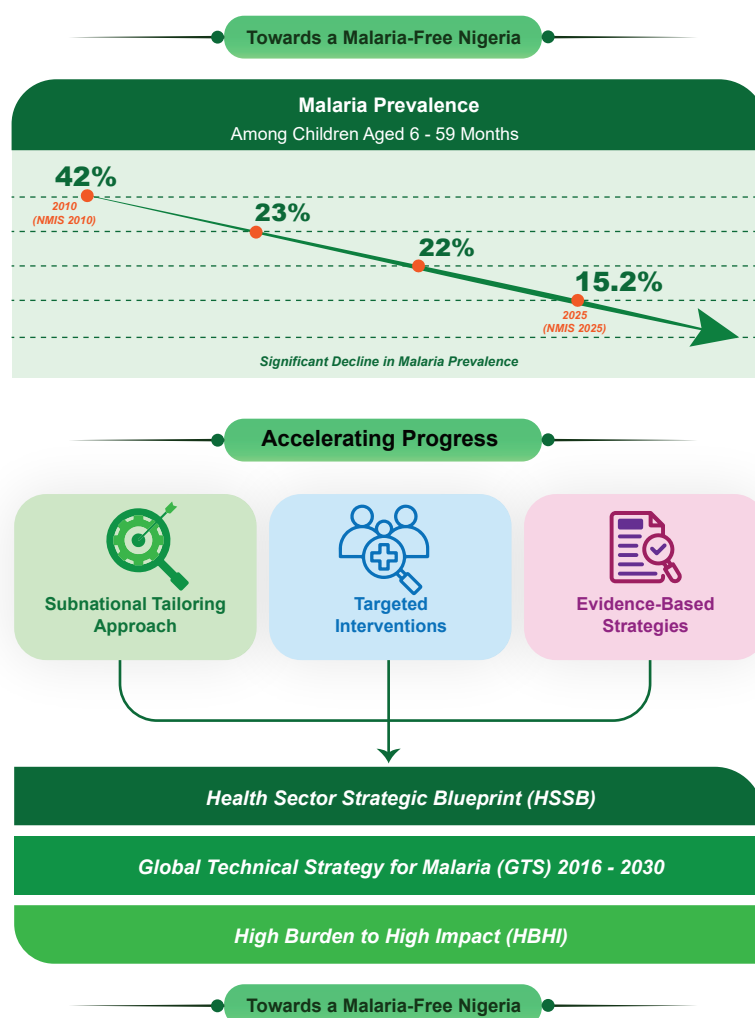
MTR	Mid-Term Review
FMoH&SW	Federal Ministry of Health & Social Welfare
MoU	Memorandum of Understanding
NAFDAC	National Agency for Food Drug Administration and Control
NASCP	National AIDs and STDs Control Programme
NAPPMED	National Association of Patent and Proprietary Medicine
NEMA	National Emergency Management Agency
NC	National Coordinator
NCH	National Council on Health
NGO	Non-Governmental Organization
NHA	National Health Account
NHIA	National Health Insurance Authority
NDHS	National Demographic Health Survey
NDP	Nigeria National Development Plan
NHP	National Health Policy
NHLMIS	Nigeria Health Logistic Management Information System
NMEP	National Malaria Elimination Programme
NMS	National Medical Stores
NMSP	National Malaria Strategic Plan
NToT	National Training of Trainers
NPHCDA	National Primary Health Care Development Agency
NTLCP	National Tuberculosis and Leprosy Control Programme
OCA	Organizational Capacity Assessment
ODK	Open Data Kit
OPD	Outpatient Department
OR	Operations Research
PHC	Primary Health Care
PMC	Perennial Malaria Chemoprevention
PSM	Procurement and Supply Management
PMIS	Pharmaceutical Management Information System
PPMV	Patent and Proprietary Medicine Vendors
PPP	Public-Private Partnerships
PPPP	Public-Private-Philanthropic Partnerships

LIST OF ACRONYMS

PSC	Pyrethrum Spray Catch
QA	Quality Assurance
QAQC	Quality Assurance Quality Control
QGIS	Quality Geographical Information System
QOC	Quality of Care
RBM	Roll Back Malaria
RMNCAH +MaN	Reproductive Maternal, Neonatal and Child and Adolescent Health Including Malaria and Nutrition
RDts	Rapid Diagnostic Tests
RMNCH	Reproductive and Maternal Neonatal Child Health
SMC	Seasonal Malaria Chemoprevention
SMEOR	Surveillance Monitoring, Evaluation, and Operation Research
SSHIA	State Social Health Insurance Agencies
SPHCDA	State Primary Health Care Development Agency
SPAQ	Sulphadoxine Pyrimethamine Amodiaquine
SP	Sulphadoxine-Pyrimethamine
SOP	Standard Operating Procedure
TWG	Technical Working Group
NMIS	Nigeria Malaria Indicator Survey
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
U5MR	Under Five Mortality Rate
USD	United States Dollars
USAID	United States Agency for International Development
WHO	World Health Organization
WHOPES	World Health Organization Pesticides Evaluation Scheme

Nigeria remains central to global malaria response efforts, with the Government of Nigeria and its partners continuing to invest in reducing the malaria burden and mortality, while advancing towards a malaria-free Nigeria. Over the past two decades, successive National Malaria Strategic Plans (NMSPs) have expanded access to core interventions while increasingly emphasizing impact, accountability, and data-driven decision-making. While the NMSP 2021-2025 did not fully achieve its targets, significant progress was recorded, notably a reduction in malaria parasite prevalence among children aged 6-59 months to 15.2% (NMIS 2025). This reflects a sustained decline from 42% in 2010 (NMIS 2010) to 23% in 2018 (NDHS 2018), 22% in 2021 (NMIS 2021), and further to 15.2% in 2025. Despite these national gains, there are marked subnational disparities across states.

To accelerate progress, Nigeria has adopted and strengthened a Subnational Tailoring (SNT) approach, enabling targeted, data-driven deployment of interventions based on epidemiological evidence and local context. The NMSP 2026-2030 builds on lessons learned and aligns with national policies and global frameworks, including the Health Sector Strategic Blueprint (HSSB), the Global Technical Strategy for Malaria (GTS) 2016-2030, and the High Burden to High Impact (HBHI) approach.



Vision, Mission, Goals and Objectives of NMSP 2026-2030

Vision: A malaria-free Nigeria

Mission: To deliver equitable, high-impact malaria interventions, through context-specific, community-owned and collaborative sector-wide approaches that contribute to a resilient health system.

Goals: To reduce parasite prevalence by 50% and deaths attributed to malaria by 50% from 2025 levels by 2030; and to achieve very low prevalence in low transmission intensity areas, a 30% reduction in prevalence in moderate transmission intensity areas, and a 60% reduction in prevalence in high transmission intensity areas from 2025 levels, by 2030.

Objectives

-  To strengthen governance and improve organizational capacity for malaria programme implementation to at least 90% from the baseline by 2030.
-  To Improve access to and utilization of preventive interventions to at least 80% by 2030, from the current baseline levels.
-  To improve effective coverage for diagnosis and appropriate treatment for at least 90% of the target populations at risk by 2030.
-  To improve the effectiveness of malaria surveillance systems in generating complete, timely, and accurate data for programme decision-making, with a targeted increase from 47% to 70% by 2030.
-  To achieve sustainable and equitable malaria financing with at least 60% of resources mobilized from domestic resources by 2030.

Implementation of the NMSP

Implementation of the NMSP 2026-2030 will leverage the Sector-Wide Approach (SWAp) and High Burden to High Impact (HBHI) strategy to ensure coordinated planning, sustainable financing, and effective service delivery across all levels of the public and private sectors. The SMEPs will lead decentralized implementation through Annual Operational Plans (AOPs), supported by NMEP and partners. Successful implementation will require strong multisectoral collaboration and sustained partnerships, building on the lessons learned from the NMSP 2021-2025.

Guiding Principles for the NMSP

The implementation of this NMSP will be guided by the following principles:

-  **Subnational Tailoring (SNT):** Deployment of interventions at the subnational level will be targeted and data-driven, based on epidemiological evidence and local context. SMEPs will be required to develop and update their AOPs based on the recommended SNT intervention mixes
-  **Sector-Wide Approach (SWAp):** Alignment with the overall coordination of donor and partner support under national priorities to enhance efficiency, harmonization, and results
-  **Multi-Stakeholder and Multisectoral Approach:** Robust engagement between NMEP, MDAs, private sector, partners, and civil society for integrated and effective implementation

-  **Partnership Coordination:** Strengthen partnerships at national and subnational levels to improve coordination and implementation effectiveness
-  **Equity, Human Rights, and Gender Equality (EHRGE):** Ensure inclusive interventions targeting vulnerable groups, including women, children U5, rural populations, migrants, IDPs, and refugees
-  **Efficiency:** Optimize allocation and use of resources, emphasize evidence-based planning, integration, synergy, and accountability mechanisms
-  **Performance Tracking:** Institutionalize the monitoring of implementation, finances, and commodities to support adaptive management, accountability, and results
-  **Leveraging Community Health Services:** Build on existing community structures, civil society networks, and community health worker platforms to enhance reach, ownership, and sustainability
-  **Risk Management:** Proactively identify, assess, and mitigate risks through structured frameworks addressing standards, internal controls, and quality assurance

Total estimated budget (2026 - 2030)



Total Budget (2026 - 2030)

₦6,476,672,798,609



Equivalent in USD

USD4,317,781,866

The total budget for the NMSP 2026-2030 is six trillion, four hundred and seventy-six billion, six hundred and seventy-two million, seven hundred and ninety-eight thousand, six hundred and nine Naira (₦6,476,672,798,609).

Four billion, three hundred and seventeen million, seven hundred and eighty-one thousand, eight hundred and sixty-six US dollars (USD4,317,781,866)

Exchange Rate: **₦1,500 = \$1**

Resource Mobilization

To achieve sustainable financing for the NMSP 2026-2030, NMEP and partners will implement a Malaria Resource Mobilization Strategy to diversify funding sources. This will prioritize increased domestic financing through federal and state budgets, expansion of health insurance schemes, innovative financing mechanisms, and strengthened public-private partnerships (PPP), including engagement with the End Malaria Council for intensified malaria advocacy.

Key financing sources will include government allocations, pooled funding through a National Malaria Financing Facility, private sector and community contributions, and continued donor support. This approach aims to close funding gaps, enhance accountability, and ensure long-term sustainability of malaria programming amid evolving global financing dynamics.

Performance Framework

The Performance Framework (PF) provides a structured approach to track implementation, outcomes, and impact of the NMSP 2026-2030 using defined targets and indicators. The PF serves as a key management tool for measuring progress, assessing intervention effectiveness, and it also informs timely course correction.

Introduction

1.1 Policy and Programming environments

The development of the National Malaria Strategic Plan (NMSP) 2026-2030 is grounded in Nigeria's evolving health policy landscape. It aligns with national development priorities, sector-wide reforms, and global commitments towards achieving Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs). The NMSP is informed by key policy and strategic frameworks, including the National Health Sector Strategic Blueprint (HSSB), health sector reforms focusing on a sector wide approach (SWAp), and the WHO Global Technical Strategy for Malaria (2021-2030). The NMSP is being developed in the era of the Roll Back Malaria (RBM) Partnership's "Big Push", a global call for accelerated action, increased investment, and renewed political commitment, aligning with the RBM/30 Unity framework to strengthen country leadership, coordinate efforts, and drive focused, adaptable progress towards ending malaria.[Roll Back Malaria (RBM) Partnership: Unity 2030 Strategic Framework.] This additional context provides a critical opportunity for Nigeria to align national priorities with global momentum, scale up high-impact interventions, strengthen systems, and mobilize the resources needed to achieve malaria elimination targets.

The National Health Sector Strategic Blueprint (HSSB) 2023-2027 succeeded the National Strategic Health Development Plan (NSHDP II) 2018-2022, and it sets out a comprehensive development agenda for Nigeria's health sector in alignment with the Renewed Hope Agenda.[Federal Ministry of Health & Social Welfare: National Health Sector Strategic Blueprint (HSSB) 2023–2027.] The Blueprint addresses critical system gaps and seeks to improve health outcomes, governance, equity, and quality of care through 13 priority areas and strategic initiatives such as the Sector-Wide Approach (SWAp). In other words, the HSSB serves as the current policy compass for Nigeria's health sector transformation and focuses on building a resilient, people-centered, and results-driven health system by strengthening Primary Health Care (PHC), expanding universal access to essential services, including malaria prevention, diagnosis, and treatment, and leveraging technology, innovation, and data-driven planning. Within this context, the NMSP 2026-2030 is positioned to serve as a key vehicle for translating the HSSB's vision into malaria-specific priorities.

The NMSP 2026-2030 equally aims to align with other national health reform efforts, particularly the Health Sector Renewal Investment Initiative (NHSRII), to ensure consistency and coherence with the broader sector priorities, strengthen health system integration, and promote sustainable, country-led malaria response.

Additionally, this plan is designed to align with the WHO Global Technical Strategy (GTS) 2021-2030, to ensure that Nigeria's malaria response is grounded in evidence-based, globally recognized best practices, which allows the country to adopt proven, high-impact interventions, harmonize country efforts with global goals, and monitor progress using measurable targets and indicators for more effective performance tracking and accountability.

The National Primary Health Care Development Agency (NPHCDA) has articulated a strategic vision through its Strategic Blueprint that seeks to revamp Primary Health Care (PHC) across Nigeria. This blueprint is aligned with the HSSB, NHSRII, and the Basic Health Care Provision Fund (BHC PF). The key components of the NPHCDA blueprint include Governance, institutional strengthening and accountability; expanding and optimizing the functionality of PHCs; developing and retaining healthcare workforce; improving quality, equity, and access essential services; emergency preparedness; and use of digital tools, data and innovation. These provide several alignment opportunities for the NMSP 2021-2030.

The evolution of Community-Based Health Care Services (CBHCS) in the country presents significant opportunities to strengthen malaria prevention, diagnosis, treatment, and surveillance at the community level. The NMSP 2026-2030 will leverage the ongoing re-design and expansion of community healthcare workers platforms to ensure effective delivery of malaria services and to enhance community-level ownership and accountability. The CBHCS represents the broader service delivery platform at the community level, providing a comprehensive package of essential health services delivered at the community level, with the aim of bringing care closer to the people especially in rural, underserved, or hard-to-reach populations. However, the Community-Based Health Workers Programme (CBHWP) is the operational backbone of the CBHCS, providing a structured programme for recruiting, training, deploying, and supporting the workforce that delivers the CBHCS mandate. Specifically, the framework comprises a mix of formally trained, certified and regulated Junior community health Extension Workers (JCHEWs) and informal Assistant community-based health workers recruited from the communities they will work in.

This framework of the re-designed CBHWs will be implemented along 12 dimensions (roles, profiles and responsibilities, governance, financing, supervision, supplies and tools, data collection & use, community involvement, remuneration and incentives, training, accreditation, recruitment and placement, and career advancement) across three domains (Strategic, operational and workforce development)

The scope of work of the Community Based Health Workers includes Community Mapping, Health promotion and demand creation, Integrated Community Case Management, Continuity of care for essential services and community distribution of commodities, Screening for important health conditions, Surveillance and epidemic response

The WHO Global Technical Strategy for Malaria 2016-2030 (GTS), adopted by the World Health Assembly in 2015, provides the overarching framework for malaria control and elimination in endemic countries.[World Health Organization: Global Technical Strategy for Malaria (GTS) 2016-2030.] It sets ambitious yet achievable goals, including:

-  Reducing malaria case incidence by at least 90%,
-  Reducing malaria mortality rates by at least 90%,
-  Eliminating malaria in at least 35 countries, and
-  Preventing malaria resurgence in all malaria-free countries by 2030.

Nigeria, as one of the 11 High Burden to High Impact (HBHI) countries, was identified by WHO and partners to adopt subnational stratification of malaria interventions. In line with WHO's HBHI initiative launched in 2018, the concept of subnational tailoring (SNT) was introduced in Nigeria around 2018-2019 to ensure more targeted and context-specific interventions.

The HBHI approach is anchored on four pillars:

-  Political will to reduce malaria deaths,
-  Strategic information to drive impact,
-  Better guidance, policies, and strategies, and
-  A coordinated national malaria response.

In response, the National Malaria Elimination Programme (NMEP) and partners initiated formal subnational malaria stratification exercises in 2019, leveraging state-level data such as parasite prevalence, entomological indicators, health system capacity, and intervention coverage. This marked a shift from one-size-fits-all programming to data-driven, stratified responses tailored to the epidemiological and operational realities of each state. This current strategic plan is developed in tandem with the sub-national tailoring. Nigeria's malaria response is further shaped by commitments to equity, human rights, and gender-responsive programming. Recent policy frameworks, including the National Gender Policy (2021-2026), the Discrimination against Persons with Disabilities Act (2019), and the Global Fund's Human Rights and Gender Strategy provide the basis for ensuring that malaria interventions reach underserved populations. The 2025 Malaria Programme Review (MPR) and the 2021 Malaria Matchbox assessment confirmed that Internally Displaced Persons (IDPs), refugees, the poor, and marginalized populations face various barriers resulting in service delivery gaps. Findings of the thematic sub-committees and Equity, Human Rights and Gender Equality (EHRGE) related reviews also underscore the need for EHRGE principles to be systematically embedded into the NMSP 2026-2030.[Federal Ministry of Women Affairs: National Gender Policy, 2021-2026.].[National Malaria Elimination Programme (NMEP): Malaria Programme Review (MPR) 2025.]

Nigeria's current malaria elimination strategy is guided by the NMSP 2026-2030, and the overall aim is to markedly reduce the burden of malaria and malaria-related deaths. The strategic plan focuses on reducing malaria prevalence across the country through targeted approaches that reflect varying transmission contexts and local settings. It articulates the country's priority thrusts for governance, vector control, prevention for high-risk populations, case management, effective surveillance system, and sustainable financing. The 2025 Malaria Programme Review highlighted key gaps in the previous NMSP and informed the strategic priorities and implementation approaches for the new plan.

1.2 MSP and the national Planning cycle

Nigeria's Ministry of Finance, and Budget and Planning lead in national planning and the preparation of an annual budget for all sectors of the economy. This process ensures that resource allocation is prioritized in a manner that allows funds to reach where they are most required. Section 81 of the Constitution of the Federal Republic of Nigeria, 1999 allows the President and the Governors to prepare and lay before the National and State Legislatures at any time in each financial year estimates of the revenues and expenditure of the Federation for the following financial year using the Medium-Term Expenditure Framework and Fiscal Strategy Paper (MTEF/FSP). The MTEF/FSP provides estimates and projections that guide annual budget planning and fiscal management over three years. In Nigeria, crude oil production continues to shape government finances and foreign exchange earnings, even though its role in the wider economy has declined. In the first quarter of 2020, the oil sector accounted for about 9.5% of real GDP, contributed roughly 50% of federal government revenues, and generated nearly 90% of foreign exchange earnings. By contrast, in 2024, oil's share of GDP fell to an annual average of 5.5%, and further to 4.6% in the fourth quarter, as non-oil sectors such as services and agriculture drove most of the growth. Despite this reduced contribution to output, oil revenues remained critical, providing around two-thirds of federal government income and sustaining about 90% of foreign currency inflows into the country in 2024 and early 2025. This underscores Nigeria's continued heavy dependence on oil exports for fiscal and external stability, even as its economy diversifies toward non-oil sectors.

The annual planning and financing for health in Nigeria are anchored on the Health Sector Strategic Blueprint (HSSB) 2023-2027, which serves as the overarching framework for coordinated action in the sector. Malaria control is one of the focus areas of this blueprint, featuring prominently under Strategic Objective 6, Priority Initiative 10 of Strategic Pillar Two.² Both the HSSB and the National Malaria Strategic Plan (NMSP) 2026-2030 are operationalized through the respective annual operational plans, ensuring alignment of priorities and resources.

The Malaria Programme Review 2025 highlighted that planning cycles can sometimes overlook the specific needs of displaced populations, PWDs, and marginalized groups.⁵ The NMSP 2026-2030 will therefore ensure that equity and rights are systematically integrated into planning, financing, and annual operational plans. Mechanisms such as the BHCPF and NHIA already track and prioritize vulnerable populations, ensuring that financial protection reaches those most at risk. The BHCPF and NHIA are the primary equity-financing mechanisms, mandated to extend financial protection to underserved groups.

The HSSB 2023-2027 provides the foundation for the development of the NMSP 2026-2030. It defines clear objectives, interventions, and performance targets for addressing endemic diseases, including malaria, while strengthening accountability for results within the health sector.

1.3 The process of Developing the NMSP 2026-2030

The National Malaria Elimination Programme and partners commissioned a Malaria Programme Review (MPR) in February 2025. The findings and recommendations of the MPR set the tone for the development of the National Malaria Strategic Plan, 2026-2030. Following the approval of the Hon. Coordinating Minister of Health and Social Welfare, the process of development started with the setting up of the Secretariat Advisory Committee. The Technical Working Group (TWG) Malaria, and its sub committees supported the development of a detailed work plan/protocol for the planning process and supported the recruitment of the consultants for the MPR thematic desk review and NMSP development.

The recent changes in the global funding landscape interrupted the initial planning process for the Malaria Programme Review (MPR) and the development of the National Malaria Strategic Plan (NMSP). The resultant funding gap necessitated adjustments to the original implementation approach, including a reduction in the number of Technical Assistants, and planned residential meetings were converted to non-residential and virtual sessions in order to minimize costs.

While these adaptations enabled the achievement of the set targets, the processes were protracted. Stakeholders faced competing priorities and limited availability, which slowed down the pace of activities. Consequently, although the objectives of the MPR and NMSP development were met, the process required more time and effort than initially anticipated.

The MSP development process was categorized into seven (7) phases:



As part of the MPR and NMSP development process, the stakeholders have agreed that the 2026–2030 malaria strategy will mainstream the Equity, Human Rights, and Gender Equality (EHRGE) as a cross-cutting theme. Through consultations with NMEP, TWG subcommittees, CSOs, and partners, specific attention was given to vulnerable groups such as IDPs, refugees, PWDs, prisoners, and miners. These perspectives have been woven into the strategic framework, financing considerations, and monitoring indicators, ensuring inclusivity in both design, data systems, and implementation.

Country Profile

2.1 Overview

Nigeria, the most populated country in Africa lies between latitudes 4° and 14°N and longitudes 2° and 15°E on the West coast of the continent with a total surface area of 923,708 sq. km. It borders Cameroon in the East, Benin to the West, Chad to the North- East, Niger to the North and on the south by the Atlantic Ocean (see figure 1 below).

The topography of its landmass is diverse with its terrain consisting of lowlands in the South, plateaus and hills towards the Centre, mountains in the South-East and plains in the North. The highest point is Chappal Waddi at 2,419m in Taraba State in the North-Eastern Region of the Country. The Rivers Niger and Benue run from the North-Western and North-Eastern parts of the Country respectively with their confluence in Lokoja from which it runs to the Delta region in the South where it communicates with the Atlantic Ocean.

While Nigeria's geography creates ecological diversity in malaria transmission, its demographic profile adds further equity considerations. With an estimated population exceeding 237 million in 2025,[National Population Commission (2025): Nigeria Population Estimates.] the country is predominantly young, with nearly 46% under 15 years. Nigeria also hosts over 126,000 refugees and asylum seekers, mainly in Cross River, Benue, and Taraba, further compounding the equity challenge for malaria control.

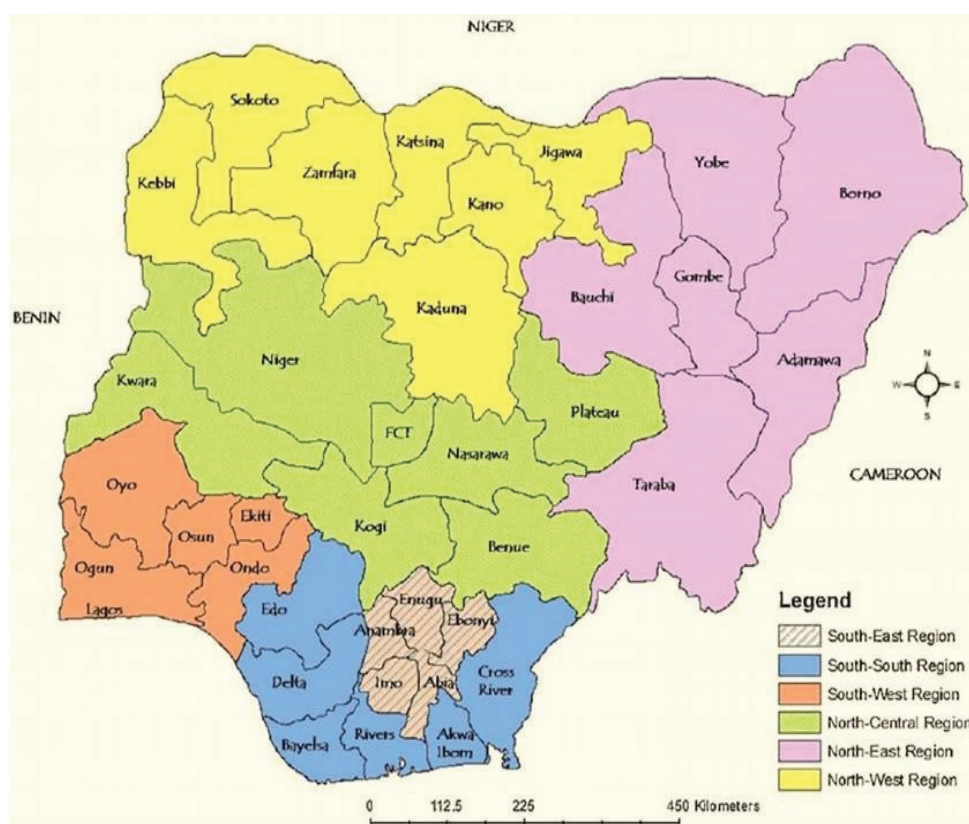


Fig 1: Map of Nigeria showing the States, Regions and the borders

2.2. Socio Political system

Administratively, Nigeria operates a three-tiered federal system of governance comprising Federal, the 36 States and the FCT, and 774 Local Government Areas (LGAs). The LGAs are further divided into 9,565 political wards, which are the focus of PHC revitalization to achieve Universal Health Coverage. For political and administrative purposes, the country is divided into 6 geopolitical zones (North-East, North-West, North Central, South-East, South-West and South-South). These geopolitical zones comprise states with a similar culture, ethnic groups, and common history.

2.3. Ecosystem, environment and climate: the ecological drivers or risk factors of malaria transmission in the country

Nigeria has various ecological zones with vegetation changing from Sahel savannah in the far north followed by Sudan savannah merging into Guinea savannah in the middle belt, then Rain Forest in the south and Mangrove Forest in the coastal areas.

In the northern part of the country, the transmission is highly intense during the short-wet season as compared with the low transmission during the long dry season. In the central and southern parts of the country, the transmission is intense, stable, and uniform throughout the year. The climate varies from arid in the North, with annual rains of 600-1,000 mm lasting for 3-4 months to predominantly humid weather in the South with an annual average of 1,300-1,800 mm (and in some coastal areas up to 2,500 mm) lasting for 9-12 months.

Rainfall is highest in the Northern parts of the country between June and September and from March to November in the Southern parts, which usually coincides with the peak transmission of malaria. The geographic location of Nigeria makes the climate suitable for malaria transmission throughout the country. It is estimated that up to 97 per cent of the country's population are at risk of getting the disease. The remaining 3 percent of the population who live in the mountains in southern Jos (the Plateau State) at an altitude ranging from 1,200 to 1,400 meters are at relatively low risk for malaria.

2.4. Demographic data: the important disaggregated population groups at risk of malaria

Nigeria is the largest country in Africa with a population of about 237,000,600. Nigeria has about 374 ethnic groups that are broadly divided into ethnic "majorities" and ethnic "minorities". The major ethnic groups are the Hausa-Fulani of the north, the Yoruba of the southwest, and the Igbo of the southeast. These ethnic groups speak over 500 different native languages and are identified with a wide variety of cultures. The dependent age groups constitute 50% of the population (disaggregated into 46% for children aged 0 - 14 years and 4% for adults aged 65 years and above). Also, children aged 0-17 constitute more than half (52%) of the population.

The broad base of the population pyramid shows that Nigeria's population is typical of countries with a low life expectancy and high fertility rates. The average household size is 4.7 persons (disaggregated into 5.0 persons for rural and 4.3 persons for urban households respectively). The majority (82%) of the households are headed by men³. The segments of the population most affected by malaria are the children under-5 and pregnant women who constitute 20% and 5% of the population respectively. The under-5 mortality rate and maternal mortality ratio are 132 per 1,000 live births and 556 per 100,000 live births respectively. According to the World Malaria Report 2024,[World Health Organization: World Malaria Report (WMR) 2024.] Nigeria accounts for approximately 31% of global malaria deaths. The country is also responsible for 27% of total malaria cases worldwide. These numbers highlight the significant burden of malaria in Nigeria, with the disease-causing substantial morbidity and mortality, particularly among children under five years old, who account for nearly 40% of global malaria deaths in this age group.

Building on the 2025 Malaria Program Review and consultations, the NMSP 2026-2030 will broaden its focus to additional priority groups whose malaria risk and service access gaps are now better documented. These include Internally Displaced Persons (≈3.3M), prisoners (≈81,400 inmates), youths in boarding schools and madrassas (≈11M), artisanal mine workers (≈500,000), and an estimated 25M persons with disabilities. Each of these groups faces unique challenges. IDPs experience recurrent ACT and LLIN stockouts in camps. Prisoners show malaria prevalence rates ranging from 15% to over 80% due to overcrowding and poor vector control. Boarding schools and religious institutions face weak malaria oversight, while mine workers are exposed to stagnant water in open pits with limited occupational health protections. People with disabilities remain excluded from campaigns due to lack of adapted protocols. Addressing these disparities will be central to achieving equitable malaria elimination under the NMSP 2026-2030.

2.5. Socioeconomic situation: socioeconomic drivers or risk factors of malaria transmission

According to the World Bank's April 2025 Poverty & Equity Brief, rural poverty in Nigeria reached about 75.5%, compared with about 41.3% in urban areas.[World Bank: Poverty & Equity Brief; Nigeria (April 2025)] This aligns with the 2022 Multidimensional Poverty Index (MPI) conducted by the National Bureau of Statistics (NBS) in collaboration with UN agencies, which shows that 63% of Nigerians (about 133 million people) are multidimensionally poor, indicating persistent deprivation across health, education, and living standards.[National Bureau of Statistics (NBS): Nigeria Multidimensional Poverty Index 2022.] Also, this is a significant increase from the 40.1% (roughly 82.9 million people) identified as purely monetarily poor in the 2019 National Living Standards Survey, underscoring the deepening structural inequality. Life expectancy at birth, a critical indicator of human development, has steadily improved. In 2016, Nigeria's life expectancy was approximately 53.0 years which was below global standard. By 2022, average life expectancy had risen to 54.08 years, with males at 55.1 years and females at 57.2 years. Recent reports place overall life expectancy around 54.6 years, compared to a global average of 73.3 years.

Communicable diseases (including malaria, HIV/AIDS, and tuberculosis) continue to exert a heavy toll on Nigeria's population and life expectancy. Health outcomes vary sharply across regions. For instance, under-five mortality rates (U5MR) ranged dramatically from around 59 per 1,000 live births in the South-West to 153 per 1,000 in the North-West.[National Population Commission (NPC). Nigeria Demographic and Health Survey (NDHS) 2023-2024.] Similarly, antenatal care uptake by skilled providers ranged from just 42% in Zamfara to 96% in Lagos State. Malaria prevalence also shows pronounced subnational disparities, highlighting important contextual and epidemiological differences across states and regions.[National Malaria Elimination Programme (NMEP), and National Population Commission (NPC): Nigeria Malaria Indicator Survey (MIS) 2025 Key Indicators Report.]

Additionally, factors such as low maternal education, rural residence, and membership in the lowest wealth quintile increase children's risk of malaria, whereas children from wealthier households and urban areas experience lower risk. Insecurity continues to severely disrupt health systems, especially in the Northeast, where ongoing attacks by groups like Boko Haram and ISWAP have displaced millions, destroyed health infrastructure, and made the delivery of care extremely challenging. These dynamics have created a new imperative to address malaria in humanitarian settings.

Overall, these circumstances demonstrate that malaria transmission is deeply influenced by poverty and inequality. The MPR 2025 highlighted how displacement, gender norms, and disability intersect with poverty to produce stark inequities in malaria outcomes. Rural poor communities, displaced populations, and informal sector workers face higher exposure and reduced access to prevention and treatment services, underscoring the importance of vulnerability-based planning in the NMSP 2026-2030.

2.6. Health system analysis: description of the health system performance in delivering personal and population-based services to those in need & when required

2.6.1 Leadership and Administration

Nigeria's health system is organized along the three tiers of government, viz., federal, state, and local, which mirrors the country's political and administrative structure. At the federal level, the Ministry of Health formulates policies, regulates the system, and oversees tertiary and specialized services through teaching hospitals, federal medical centres, specialist hospitals, and research institutes. It also coordinates national health programmes such as malaria, HIV/AIDS, tuberculosis, immunization, and supply chain management, with support from agencies like NPHCDA and NAFDAC.

State governments provide mainly secondary health care through general hospitals and sometimes tertiary care through state-owned teaching hospitals. They also coordinate primary health care through State Primary Health Care Development Agencies and State Health Management Boards. Local governments are responsible for implementing primary health care, working with ward and village health committees, community structures, private providers, and traditional or alternative practitioners to extend services and mobilize communities.

2.6.2 NMEP Organizational Structure

The National Malaria Elimination Programme (NMEP), under the Federal Ministry of Health's Department of Public Health, leads and coordinates Nigeria's malaria response. Its Coordination Framework strengthens national, state, and local alignment by clarifying roles, and harmonizing partner activities in line with the "Three Ones" principle (One Plan, One Coordination Mechanism, One M&E system).

NMEP operates through six technical branches: Programme Management, ACSM (Advocacy, Communication, and Social Mobilization), IVM (Integrated Vector Management), SMEOR (Surveillance, Monitoring, Evaluation and Operational Research), Case Management, and Procurement Supply chain Management - each headed by a branch head. These feed into the Malaria Technical Working Group (mTWG), which provides technical support and progress monitoring. Stakeholder coordination extends to donors, implementing partners, civil society, commercial actors, and the private sector.

At subnational levels, State Malaria Elimination Programmes (SMEPs) adapt and implement strategies with NMEP alignment, while LGAs are expected to tailor interventions to local needs and drive community engagement.

Nigeria's malaria efforts face persistent coordination challenges, weak alignment with government structures, limited private sector engagement, and funding shortfalls worsened by post-COVID economic strain and donor programme closures. Stronger government leadership is vital to drive the National Malaria Strategic Plan forward. To address these persistent challenges, there is an ongoing engagement between the malaria community and the government leadership with respect to restructuring the NMEP to enhance its autonomy and strengthen its technical capabilities.

Despite these reforms, humanitarian actors continue to deliver malaria services in IDP camps, while refugees and migrants rely on UNHCR and NGO services rather than BHCPF or NHIA mechanisms. Prisons, mining communities, and PWDs remain outside routine malaria reporting systems, to a large extent. To close these gaps, the NMSP 2026–2030 will commit to equity-disaggregated monitoring and inclusive programmatic models that link humanitarian, correctional, and occupational health sectors to the national malaria response.

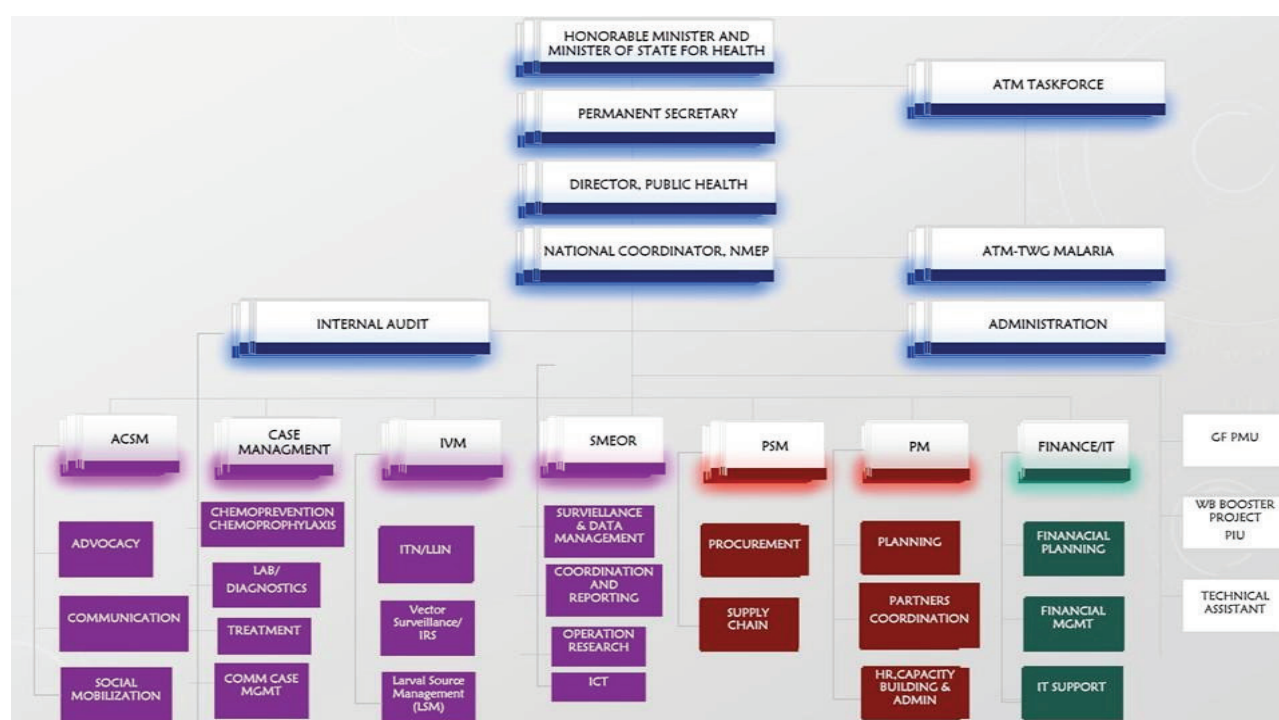


Fig 2: Organogram of NMEP

2.6.3 Policy and Legislative Framework

The National Health Policy 2016 and National Health Act, 2014 prioritize the provision of a comprehensive health care package that is based on Primary Health Care (PHC) to achieve universal health coverage (UHC). The FMOH has launched a ‘Reach Every Ward’ strategy which aims to have at least one functional PHC in each political ward for the delivery of the Basic Minimum Package of Health Services including malaria. The strategy also advocates community participation to facilitate ownership and accountability through the establishment of the Ward Development Committee (WDC) comprising selected community members.

2.6.4 Health Workforce

Skilled health workers, including doctors, nurses, and midwives predominantly provide care across tertiary, secondary, and primary health care (PHC) facilities. At the community level, health services are delivered by Community Health Extension Workers (CHEWs), who are mandated to spend at least 60% of their time within communities, complemented by various cadres of Volunteer Health Workers (VHWs). However, these VHWs are currently engaged through fragmented programmes with inconsistent standards and incentive structures.

To address this fragmentation and strengthen community-level service delivery, the National Primary Health Care Development Agency (NPHCDA) established the Community Health Influencers, Promoters and Services (CHIPS) programme. The CHIPS strategy was introduced to transition all existing community-based workers from phasing-out programmes into a unified national platform, thereby ensuring one curriculum, one training programme, and one standardized cadre of community-based health workers – collectively referred to as CHIPS Personnel.

This cadre consists of CHIPS Agents and Community Engagement Focal Persons (CEFPs). However, the CHIPS programme had challenges and gaps which necessitated the transition to a new initiative called the Community Based Health Workers Programme (CBHWP). This model balances the need for skilled service provision with the realities of workforce availability and state-level resource constraints.

For the CBHWP, it is recommended that the minimum number of CBHWs to be deployed per ward should be ten (10). States are at liberty to determine the proportion of JCHEW to Assistant Community-based Health Workers required based on empirical evidence of availability of the JCHEWs and state capacity. However, the two cadres of CBHWs are expected to work in tandem within the wards, with JCHEWs prioritized for deployment to hard-to-reach (HTR) /underserved communities.

CBHWs will be deployed to households to provide health counselling, create demand for essential services, and refer clients to PHC facilities. They also deliver basic preventive services, first aid, and case management for malaria, diarrhoea, and pneumonia in children under five, thereby extending access to care and improving health-seeking behaviour at community and facility levels.

The CBHWP is anchored on the functionality of PHC facilities in each ward, which serves as referral hubs, supervisory bases, and commodity distribution points. Ensuring a minimum of one functional PHC per ward, as prioritized under the NPHCDA Strategic Blueprint (2024–2026), is therefore critical to the programme's success. Together, these measures aim to professionalize community health delivery, improve competence, expand access, and restore public trust in the PHC system.

2.6.5 Health Product Management

Nigeria has put in place several policies, guidelines, and institutions to ensure the sustainable supply of safe, high-quality, and affordable medicines, vaccines, and other health products. A key institution in this regard is the National Agency for Food and Drug Administration and Control (NAFDAC), which regulates and controls the manufacture, importation, exportation, distribution, advertisement, sale, and use of regulated products including food, medicines, cosmetics, medical devices, packaged water, chemicals, and detergents.

To strengthen supply chain integration across public health programmes, the Government of Nigeria, with support from the Global Fund, established the National Product Supply Chain Management Programme (NPSCMP). The programme coordinates national efforts on the quantification, procurement, warehousing, and distribution of health commodities, under the oversight of the Department of Food and Drug Services (DFDS) of the Federal Ministry of Health and Social Welfare (FMoHSW). At the sub-national level, supply chain activities are coordinated through State Logistics Management Coordination Units (LMCUs), which now operate in all 36 states and the Federal Capital Territory. These units serve as the focal point for planning, monitoring, and coordination of health commodity logistics at state level, ensuring alignment with national systems.

In recent years, Nigeria has advanced further through the Nigeria Supply Chain Integration Project (NSCIP), which introduced end-to-end data visibility systems (such as the National Health Logistics Management Information System, NHLMIS), harmonized standard operating procedures (SOPs), and strengthened governance frameworks to improve efficiency and accountability. A major institutional milestone is the creation of the Supply Chain Operations Unit (SCOU) under the NPSCMP, supported by the Global Fund's Resilient and Sustainable Systems for Health (RSSH) grant (2024-2026). The SCOU functions as the national lead logistics management unit, providing oversight for warehousing, distribution, and performance monitoring, while also building state-level capacity for sustainable supply chain operations.

Together, these reforms mark a transition from fragmented logistics arrangements to a more integrated, professionalized, and accountable health product supply chain, aimed at ensuring uninterrupted access to essential health products at service delivery points nationwide.

2.6.6 Health Information System

The Revised Health Information System (HIS) Policy (2014) and accompanying HIS Strategic Plan (2014–2018) continue to set the structural framework for how health-related data is collected, collated, analyzed, stored, disseminated, and used across the health sector. At the heart of routine data collection is District Health Information Software 2 (DHIS2), which remains the nationally recommended electronic platform for reporting from both public and private primary and secondary health facilities. Oversight and capacity-building responsibilities for the HIS rest with the Department of Planning, Research, and Statistics (DPRS) within the Federal Ministry of Health and Social Welfare (FMoHSW).

To ensure strategic use of data for decision-making, governance is embedded through the Health Data Governance Council (HDGC), chaired by the Honourable Coordinating Minister of Health, and its operational counterpart, the Health Data Consultative Committee (HDCC). These bodies are replicated at the state and LGA levels to ensure coordinated oversight and responsiveness across all jurisdictional tiers. Since 2019, integration efforts have extended to other program-specific platforms like the National Health Workforce Registry (NHWR), bringing them under the unified governance of HDGC-HDCC. This approach has promoted sustainability and prevented the proliferation of fragmented systems.

In 2020, the National Malaria Elimination Programme (NMEP) officially established the National Malaria Data Repository (NMDR) as a complementary digital system to DHIS2. The NMDR consolidates malaria-specific data - including routine health facility data, surveillance reports, survey findings, and partner data into a centralized repository. This initiative was developed to enhance malaria data harmonization, improve data quality, facilitate real-time analytics, and support evidence-based planning and response in malaria control efforts.

2.6.7 Health Care and Malaria Financing

Approximately 10% of malaria programme funding is sourced from the government, primarily through health sector budgetary allocations across the three tiers of government, viz. federal, state, and local.

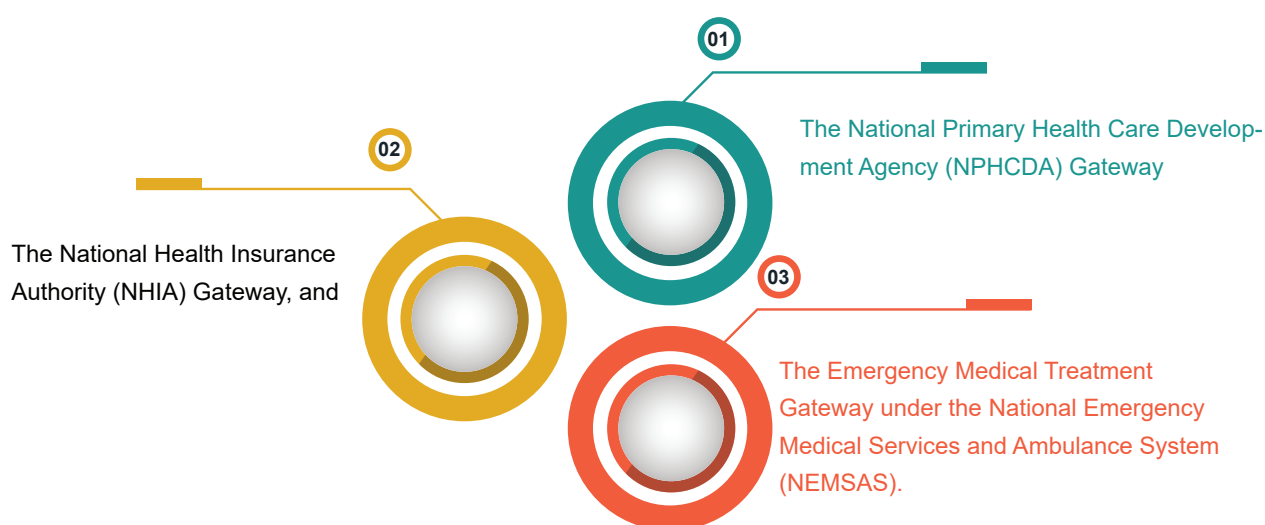
These allocations are drawn from the country's oil and tax revenues. However, given the broader context of chronic underfunding in the health sector, this contribution remains grossly inadequate to meet the scale of malaria prevention and control needs.

In the last five years, direct allocations to the malaria programme consistently remained below 1% of the total health budget. However, considering that the National budget as well as the health sector component progressively increased during this period, these allocations to the malaria programme surpassed the 25% annual increase targeted in the National Malaria Strategic Plan-NMSP 2021-2025 (Improve funding for malaria control by at least 25% annually through predictable and innovative sources to ensure sustainability at federal and sub-national levels).

In addition to the annual budgetary allocations to the Ministry of Health, malaria service delivery in Nigeria also receives government funding through various special schemes, programmes, and agencies. These funding streams include:

1. The Basic Health Care Provision Fund (BHCPF)

The Basic Health Care Provision Fund (BHCPF) was established under Section 11 of the National Health Act of 2014 as a catalytic funding mechanism to strengthen Nigeria's primary healthcare system. It is implemented through three main gateways:

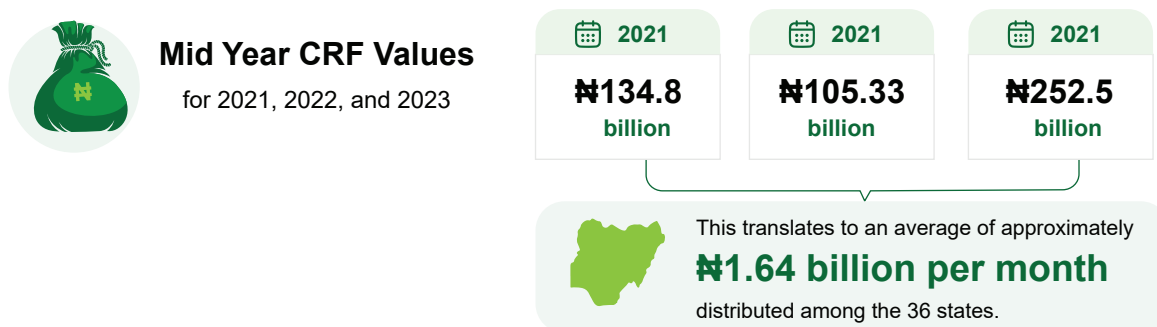


The Basic Health Care Provision Fund (BHCPF) is financed from the following sources:

-  A statutory annual grant of at least 1% of the Consolidated Revenue Fund (CRF) from the Federal Government
-  Funding support and Grants from international donor partners
-  Contributions from other sources, including the private sector.

Malaria programme delivery is supported through the BHCPF in two primary ways:

- 35% of programmatic funds under the NPHCDA Gateway are allocated to Decentralized Facility Funding, which covers essential drugs, vaccines, and consumables (20%)
- The NHIA Gateway channels funds to State Social Health Insurance Agencies (SSHIA), enabling access to the basic minimum package of services, including malaria-related interventions for vulnerable populations.



2. The National Health Insurance Authority (NHIA)

Previously known as the National Health Insurance Scheme (NHIS), the National Health Insurance Authority (NHIA) serves as a key health financing mechanism aimed at achieving Universal Health Coverage (UHC) for essential health services, including malaria-related interventions. Malaria case management, comprising diagnosis and treatment, is a core component of the benefit package under both the formal and informal sector schemes administered by NHIA. However, enrolment across the country remains low, currently below 5%, with coverage predominantly concentrated in the formal employment sector. To address this gap, the government has made significant efforts to expand access. Between 2020 and 2024, the number of enrollees increased from approximately 10 million to over 19 million. Additionally, several states have established their own health insurance schemes to broaden coverage, particularly among the informal sector and vulnerable populations.

3. Credit Facility Funding and Projects

In 2020, Nigeria secured a total of USD 300 million in funding for malaria control through the Immunization Plus and Malaria Progress by Accelerating Coverage and Transforming Services (IMPACT) Project. This included USD 200 million from the World Bank and USD 100 million from the Islamic Development Bank (IsDB) via the Lives and Livelihoods Fund. The credit facility, set for an initial period of five years, aims to support malaria service delivery in 11 states that previously lacked significant donor support. The project incorporates counterpart funding mechanisms with the benefiting states and focuses on core malaria prevention and case management interventions. Its primary objective is to enhance child survival and reduce under-five mortality through improved access to life-saving malaria services. Analysis of the funding showed that about 70% of the financing was for procurement and distribution of malaria case management and vector control interventions (ITNs).

The WB/ISDB project effectively took off in 2022 across most of the beneficiary states. However, bureaucratic delays affected the procurement and distribution of commodities such as ITNs for routine use, ACTs and diagnostic test kits to the health facilities.

Trends of Financial Contributions to Malaria from Other Government Ministries and Agencies

Additional government support for malaria includes drug revolving funds (mostly at secondary and tertiary health facilities, although plagued with issues of poor supervision and accountability), and state-level initiatives such as Reproductive, Maternal, Newborn, and Child Health (RMNCH) programmes, free medical outreach services by Federal and State Ministries of Health, and special allocations for malaria response in emergencies and among internally displaced persons (IDPs). However, financial contributions from other government agencies remain difficult to track and assess due to a lack of comprehensive data.

State-level reports indicate substantial extra-budgetary spending on malaria, particularly for interventions like mass distribution of Insecticide Treated Nets (ITNs) and Seasonal Malaria Chemoprevention (SMC).

Moreover, several malaria-related activities funded by other Ministries, Departments, and Agencies (MDAs) are not systematically reflected in official annual plans. These gaps, compounded by weak budget tracking mechanisms, make it challenging to accurately determine the actual level of government spending on malaria. As a result, actual expenditures may exceed the figures reported in the national health accounts.

3. Situation Analysis

3.1 Historical Perspective

Malaria has remained one of the most significant public health challenges globally and continues to be recognized as a major impediment to socioeconomic development, particularly in low- and middle-income countries. Efforts to control malaria date back several decades and have evolved through different phases of global strategy, scientific advancement, and policy commitments.

Early global malaria control efforts were largely driven by vector control and treatment innovations. The discovery of synthetic antimalarial medicines such as chloroquine in the 1930s and the use of insecticides such as DDT in the mid-20th century led to major advances in malaria control. These innovations contributed to the elimination of malaria transmission in many parts of Europe and North America between the late 1930s and 1950s. Building on these successes, the World Health Organization (WHO) proposed the Global Malaria Eradication Programme in 1955, which focused heavily on vector control strategies including indoor residual spraying.

Although global eradication was not achieved, these early initiatives laid the foundation for modern malaria control strategies. In Africa, including Nigeria, several pilot malaria control projects were implemented during this period, including the WHO Garki Project in northern Nigeria between 1969 and 1976, which provided important insights into malaria epidemiology and the complexity of transmission dynamics in high-burden settings.

Global commitment to malaria control intensified in the late 1990s and early 2000s. In 2000, the Roll Back Malaria (RBM) Partnership was launched alongside the Abuja Declaration, through which African leaders committed to intensifying malaria control efforts across the continent. Malaria was subsequently prioritized under the Millennium Development Goals (MDGs), particularly within the targets related to child mortality, maternal health, and communicable disease control. During this period, major investments were made to scale up proven interventions including insecticide-treated nets (ITNs), indoor residual spraying (IRS), rapid diagnostic testing, and artemisinin-based combination therapies (ACTs).

These efforts resulted in substantial progress in malaria control globally. However, despite significant gains during the MDG era, progress has slowed in recent years. According to WMR 2024,⁷ there were an estimated 263 million malaria cases and 597,000 deaths globally in 2023, with the WHO African Region accounting for approximately 94-95% of the global burden. Emerging challenges such as insecticide and drug resistance, climate variability, population growth, humanitarian crises, and persistent funding gaps continue to threaten progress. The global malaria response is now guided by the WHO Global Technical Strategy (GTS) for Malaria 2016-2030, which provides a framework for reducing malaria incidence and mortality while accelerating progress towards elimination. The strategy emphasizes universal access to core interventions, strengthened surveillance systems, stratified approaches tailored to local transmission patterns, and increased domestic financing and political commitment. Malaria elimination is also embedded within the Sustainable Development

Goals (SDGs), which call for ending the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases by 2030.

Nigeria bears the largest share of the global malaria burden and therefore plays a critical role in global malaria control efforts. In response, the country has implemented successive National Malaria Strategic Plans (NMSPs) over the past two decades (2001-2005, 2006-2010, 2009-2013, 2014-2020, and 2021-2025) to scale up malaria prevention, diagnosis, and treatment interventions. These strategic plans have evolved alongside global guidance, with earlier strategies primarily focused on expanding access to core interventions such as insecticide-treated nets (ITNs), artemisinin-based combination therapies (ACTs), and rapid diagnostic testing, while more recent plans have increasingly emphasized measurable impact, strengthened surveillance systems, and improved programme accountability.

As Nigeria moves into the 2026-2030 strategic planning period, the national malaria programme will continue to align with the WHO Global Technical Strategy (GTS) for Malaria 2016-2030, while strengthening political commitment, domestic financing, and the deployment of innovative tools such as next-generation ITNs and malaria vaccines. Building on lessons from previous strategic plans, the country will adopt a strengthened stratified and data-driven approach, tailoring interventions to varying transmission patterns across states and local government areas to accelerate progress toward malaria elimination.

3.2 Epidemiology

3.2.1 Malaria Parasites Distribution

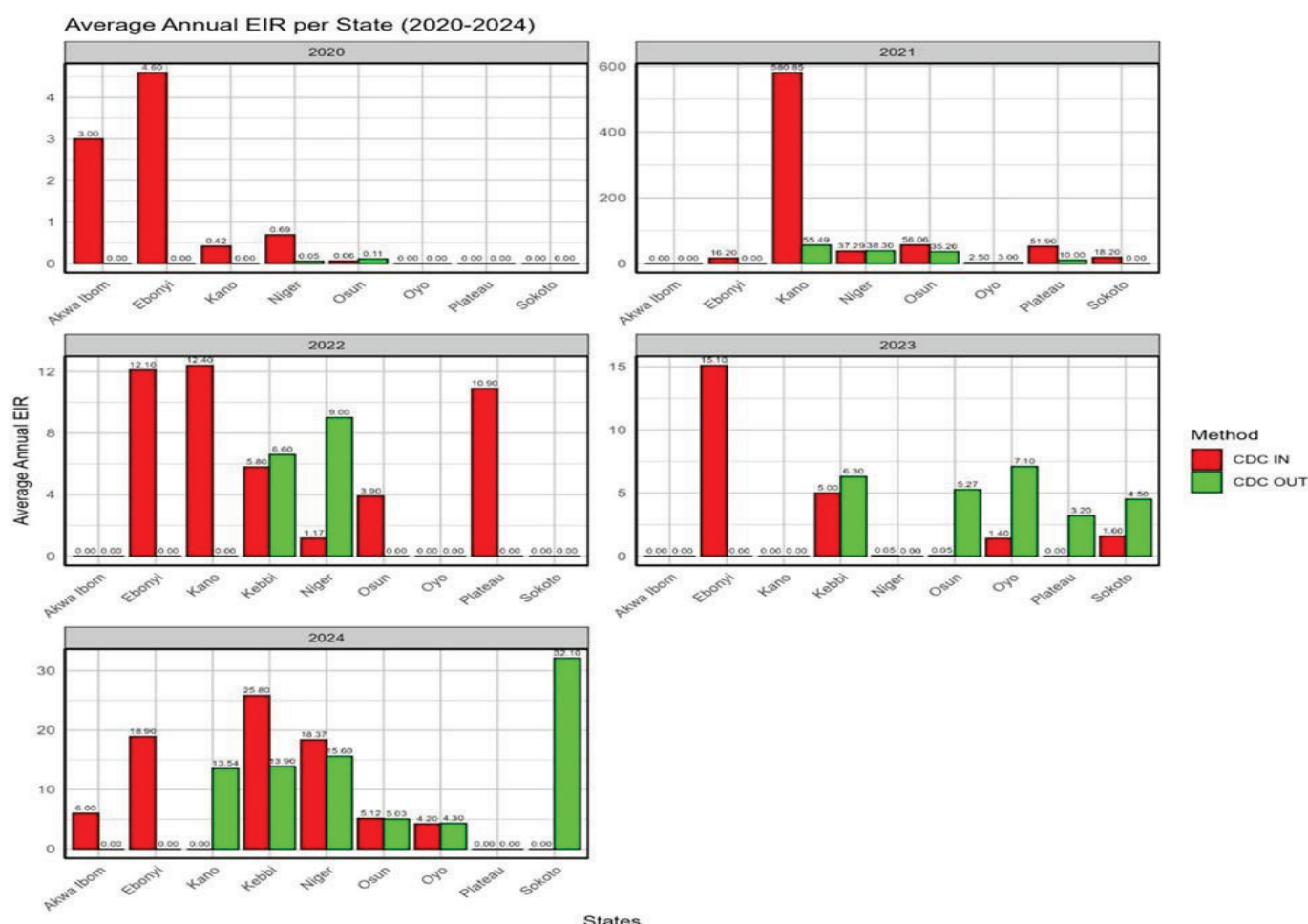
Malaria is endemic in Nigeria with all year transmission. *Plasmodium falciparum* accounts for 97% (94% - 98%) of the parasite species. It is the most virulent of the malaria parasite species and responsible for most reported severe cases. *Plasmodium malariae* accounts for almost 2% of infections, while *Plasmodium ovale* is rare, accounting for approximately 0.2% of all infections. Five parasite species of *Plasmodium* have been documented to cause malaria disease in humans. These include *Plasmodium falciparum* (P.f), *Plasmodium vivax* (P.v), *Plasmodium ovale* (P.o), *Plasmodium malariae* (P.m), *Plasmodium knowlesi* (P.k).

National surveys show that parasite prevalence among children under five declined from 42% in 2010 to 22.6% by microscopy (36.2% by RDT) in 2018. Yet inequities persist, prevalence is nearly five times higher among the poorest households (57%) compared to the richest (11%), and rural prevalence remains disproportionately higher than urban. These disparities highlight how poverty and geography intersect with vulnerability to sustain malaria burden in Nigeria.

3.2.2 Malaria Vector Distribution

Historically, 30 *Anopheles* species have been reported in Nigeria, but recent surveillance across the five ecological zones has confirmed 11 species, with *An. coluzzii*, *An. gambiae*, *An. arabiensis*, and *An. funestus* being the predominant malaria vectors. Species distribution varies geographically and seasonally, with *An. coluzzii* becoming more widespread post-2023 insecticide-treated net (ITN) campaigns. Although *An. stephensi* was confirmed in Gombe in 2022, follow-up surveillance across seven states has not detected its continued presence. Notably, the recent detection of *An. stephensi* in neighbouring Niger Republic is of significant concern.

There is evidence of species switching between wet and dry seasons, complicating malaria control and elimination efforts. From 2018 to 2019, *An. gambiae* s.l. remained the most abundant vector. Surveillance data from 2020 to 2024 revealed fluctuating entomological inoculation rates (EIR), with the highest indoor EIR recorded in Kano (580.85 ib/p/y in 2021). Indoor transmission initially dominated but has since declined due to effective ITN campaigns, while outdoor transmission has



increased, indicating a shift in mosquito behaviour. In 2024, the national average EIR is 9.38 ib/p/y, which is far from the national target of <1 ib/p/y. This dynamic change necessitates a strategic shift from focusing primarily on indoor interventions to both indoor and outdoor interventions.

Fig 3: Annual Entomological Inoculation Rate (EIR)

3.2.3 Dynamics of Malaria Transmission

Malaria transmission remains widespread across the country, with particularly higher intensity in rural areas and communities located near major rivers and water bodies, including irrigation dams in the northern regions. Rainfall patterns strongly influence malaria transmission. In the Mangrove and Rainforest zones, rainfall occurs year-round, while the Guinea and Sudan savannahs experience two peaks of rainfall - typically starting in March or April, pausing in August, and resuming until October. In the Sahel savannah, rainfall usually begins in June or July and lasts for about three to four months. In most ecological zones, the timing of malaria transmission closely aligns with these rainfall patterns.

3.2.4 Morbidity and mortality

Malaria remains a major cause of morbidity and mortality in Nigeria, particularly among children under five years of age and pregnant women. Between 2015 and 2025, malaria prevalence across the 36 states and the Federal Capital Territory (FCT) has shown uneven progress, with some states recording reductions in burden while others experienced stagnation or increases in transmission. Nationally, malaria parasite prevalence among children aged 6-59 months declined from 42% in 2010 to 23% in 2018, then slightly to 22% in 2021, and further decreased to 15.2% in 2025, indicating notable progress in reducing malaria morbidity in recent years (See figure 5).

However, this national average mask substantial subnational variation in malaria burden, reflecting the heterogeneous transmission patterns across the country (See figure 4). Children aged 6-59 months continue to bear the highest burden of infection and severe disease, while pregnant women remain at increased risk of malaria-related complications, including maternal anaemia, low birth weight, and adverse pregnancy outcomes. These findings highlight the need for sustained targeted and data-driven interventions, including subnational tailoring of strategies, to address geographic disparities and accelerate reductions in malaria morbidity and mortality across Nigeria.

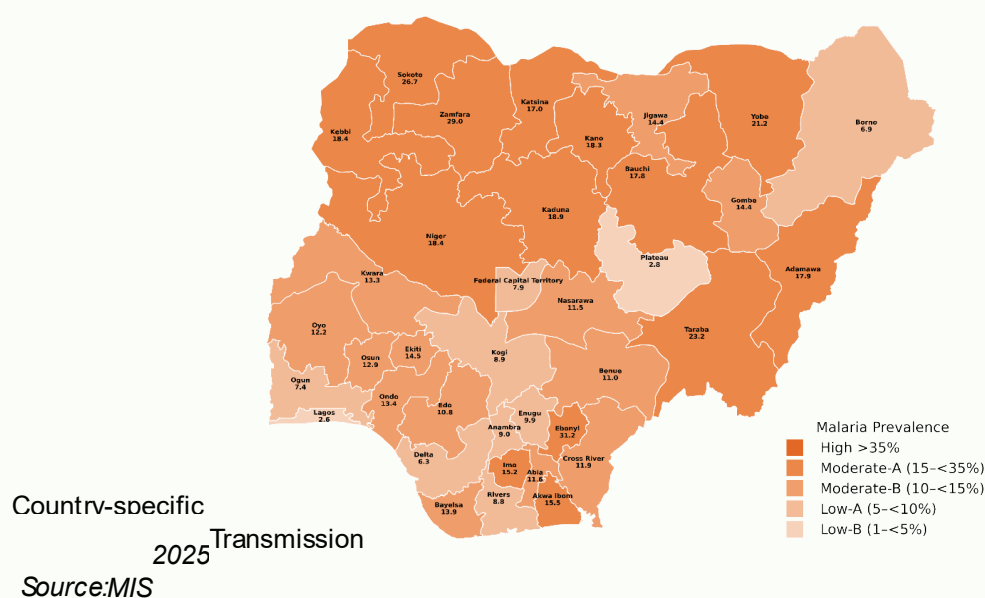


Fig 4: Malaria Prevalence by States; highlighting subnational heterogeneity beyond the national average.

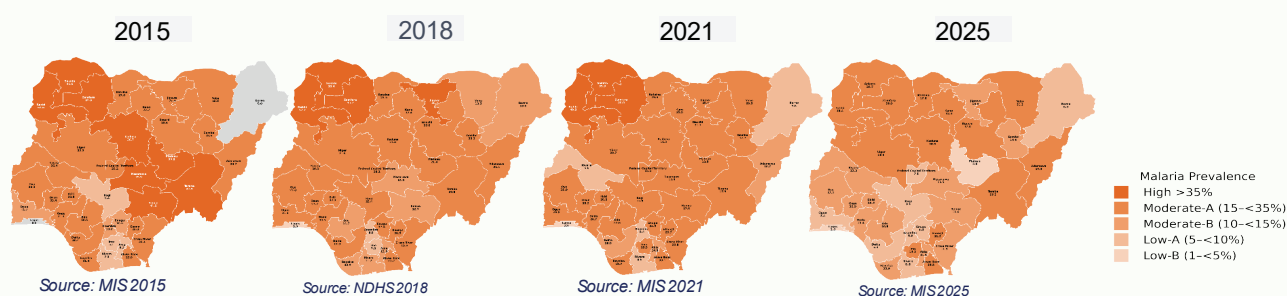


Fig 5: Trends in Malaria Prevalence (2015 - 2025); indicating remarkable national progress, with variable progress across the states.

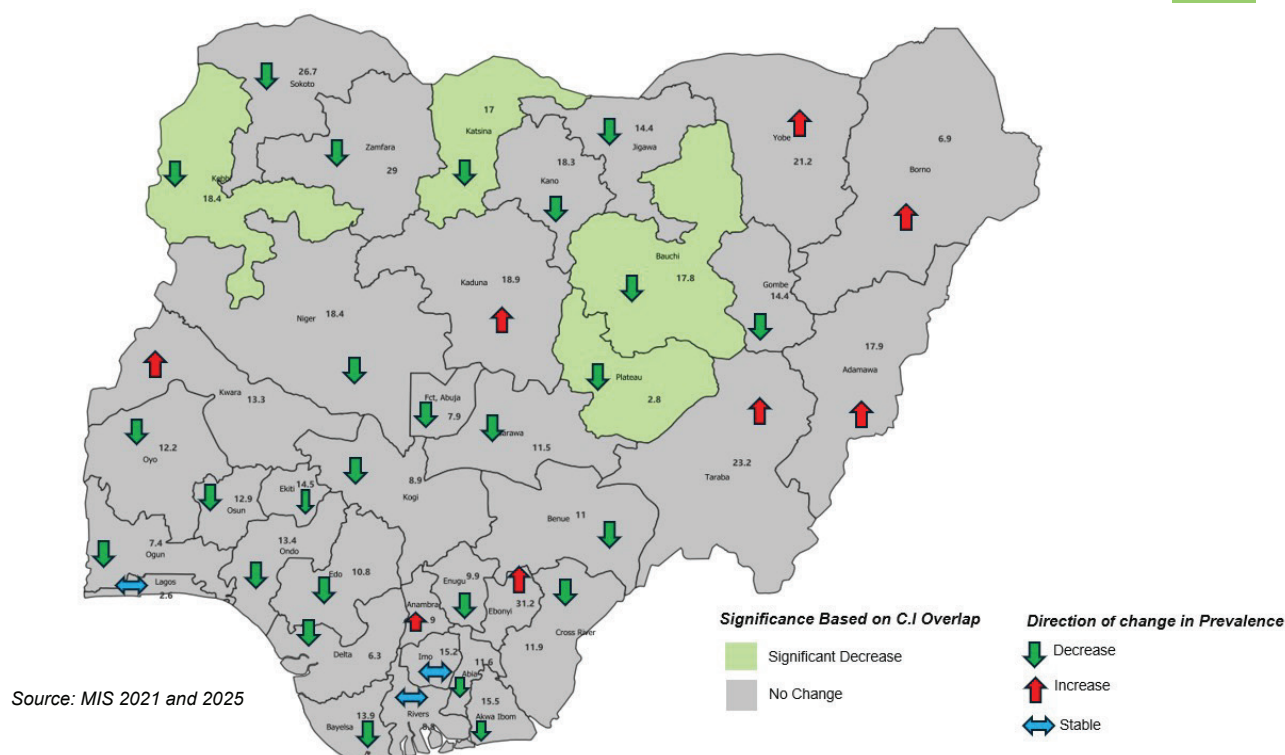


Fig 6: Dynamic changes in state-level malaria prevalence (2021 - 2025) based on confidence interval overlap; this shows a general decrease in prevalence across several states (25 states plus FCT). However, only four of these states (Bauchi, Katsina, Kebbi, and Plateau) show statistically significant decrease in prevalence. Eight states show increase in prevalence, although these changes are not statistically significant; while three states (Lagos, Rivers, and Imo) show little to no change.

3.2.5 Subnational Tailoring (SNT)

3.2.5.1 Background

Malaria transmission is highly heterogeneous across geographical areas and population groups, influenced by ecological, climatic, socioeconomic, and health system factors. This heterogeneity means that applying uniform malaria control strategies across all settings often results in suboptimal allocation of resources and reduced programmatic impact. The World Health Organization (WHO) therefore recommends the use of Subnational Tailoring (SNT), which relies on local epidemiological and contextual data to determine the most appropriate combinations of interventions and strategies for specific locations and populations. Through this approach, malaria programmes are able to prioritize interventions according to local transmission intensity, epidemiological patterns, operational feasibility, and available resources, thereby maximizing the impact of malaria control and elimination efforts.

Nigeria adopted the SNT approach in 2019, shifting from uniform nationwide malaria strategies to targeted interventions based on subnational malaria epidemiology. The process involved structured steps including planning and preparedness, data assembly, situation analysis, malaria risk stratification, tailoring and prioritizing intervention combinations, forecasting impact scenarios, selecting the strategic scenario for the National Malaria Strategic Plan, optimizing strategies within available resources, and guiding implementation with monitoring and evaluation. The initial SNT informed the NMSP 2021-2025, while a revision in 2022 incorporated updated epidemiological and programmatic data.

A further comprehensive update was conducted in 2025-2026 to inform the NMSP 2026-2030. Going forward, Nigeria plans to institutionalize periodic updates of SNT during key programme milestones such as the Mid-Term Review (MTR) and the Malaria Programme Review (MPR) to ensure interventions remain responsive to evolving transmission patterns.

3.2.5.2 Malaria Stratification and Intervention Mixes

Within the SNT framework, core malaria interventions are implemented nationwide to ensure universal access to essential services, including prompt diagnosis and treatment, intermittent preventive treatment in pregnancy (IPTp), and distribution of insecticide-treated nets (ITNs). Additional interventions are deployed based on transmission patterns and contextual suitability. For example, Seasonal Malaria Chemoprevention (SMC) is implemented in states with highly seasonal transmission patterns, while Perennial Malaria Chemoprevention (PMC) is deployed in areas with perennial transmission. The malaria vaccine has also been introduced in selected locations, initially targeting Kebbi and Bayelsa states. Implementation over the past five years has demonstrated the value of using SNT to guide strategic planning and resource prioritization. However, programmatic reviews have also highlighted instances of non-adherence to stratification recommendations, including implementation of SMC in LGAs where it was not recommended and gaps in the implementation of interventions such as integrated Community Case Management (iCCM) in hard-to-reach areas. Addressing these gaps requires stronger alignment between SNT recommendations and state and partner Annual Operational Plans (AOPs) to ensure consistent application of stratification principles.

3.2.5.3 Microstratification and Urban Strategy

While national stratification provides guidance at state and LGA levels, urban settings require more granular analysis due to complex and heterogeneous transmission patterns driven by rapid urbanization, population mobility, informal settlements, and environmental conditions such as poor drainage and urban agriculture. As a result, Nigeria is introducing urban micro-stratification at the ward level as an additional analytical layer within the SNT framework, allowing states to conduct deeper analysis using epidemiological, environmental, and entomological data. One key application of this exercise is the improved targeting of ITN mass campaigns in urban areas, ensuring that vector control interventions are directed to locations with the highest malaria risk rather than uniformly applied across entire urban populations. This approach is consistent with the WHO urban malaria strategy, which emphasizes targeted interventions, improved surveillance, and tailored vector control approaches in rapidly urbanizing settings.

At the sub-national level, a 3-step approach is being utilized to design tailored approaches for effective malaria interventions

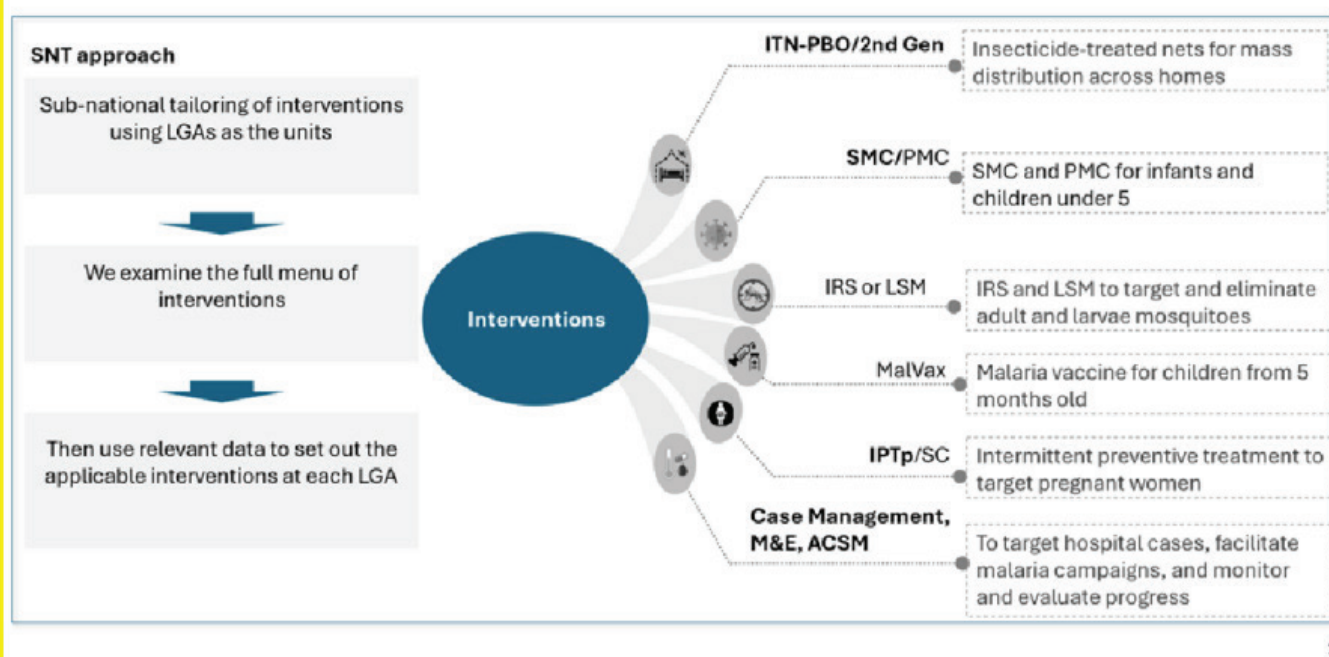


Fig 7: SNT process for delivering sub-nationally targeted malaria interventions.

Malaria transmission exists along a continuum from high to very low transmission settings, and programme responses must evolve accordingly. As transmission declines from moderate to low or very low levels in certain locations, the malaria programme increasingly shifts from broad population-level interventions toward surveillance-driven and targeted responses. This includes identifying and mapping transmission hotspots and deploying focused intervention packages to address pockets of residual transmission. Such targeted approaches enable the programme to sustain gains achieved through large-scale interventions while accelerating progress toward malaria elimination. Through continued refinement of subnational tailoring, including the integration of urban micro-stratification and hotspot mapping, Nigeria aims to strengthen evidence-based planning and ensure that malaria interventions are deployed where they will have the greatest public health impact.

Currently the WHO recommend the use of the transmission intensity for the continuum from control to elimination

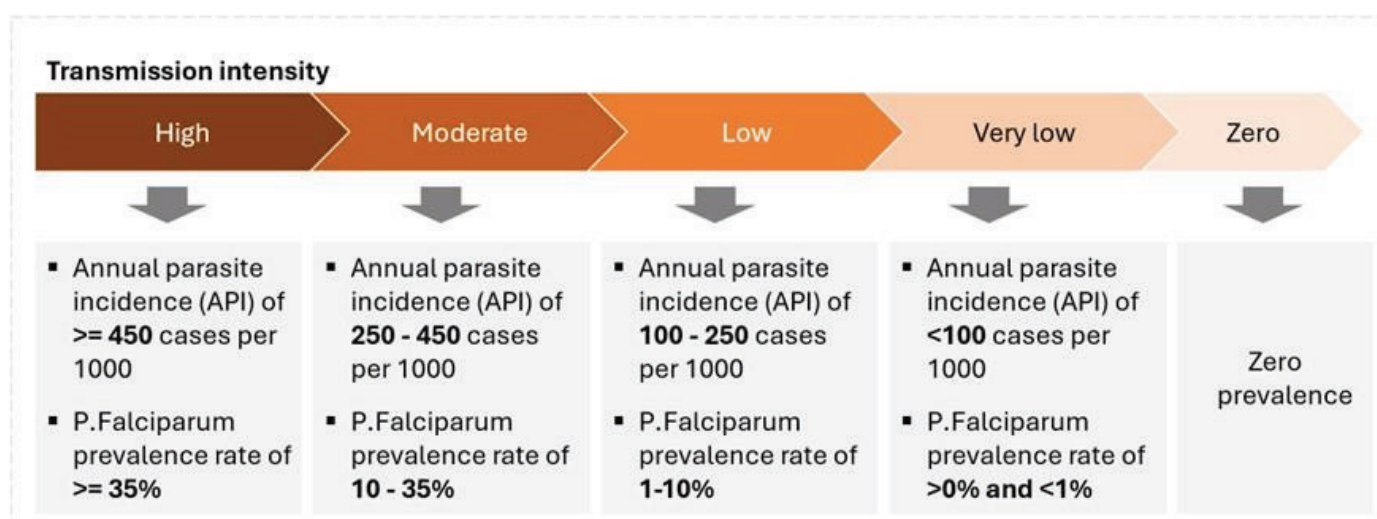


Fig 8: WHO transmission intensity continuum

3.2.6 Impact Projections

The goals, objectives and targets of the National Malaria Strategic Plan (NMSP) 2026–2030 were informed by modelling scenarios developed with technical support from WHO to assess the potential epidemiological impact of different levels of malaria intervention coverage. These scenarios provide an analytical basis for estimating how sustaining current interventions or scaling up coverage of key malaria tools could influence malaria burden over the strategic plan period. The modelling approach allows comparison of different programmatic pathways and helps guide realistic target setting and prioritization of investments.

A baseline scenario representing continuation of current implementation was included in the modelling. Under this Business as Usual (BAU) scenario, the same intervention mixes and effective coverage levels observed in 2024 are assumed to be maintained throughout the 2026–2030 period. This scenario serves as a reference point against which the potential impact of scaling up interventions is assessed. In addition to the BAU scenario, a series of National Strategic Plan (NSP) scale-up scenarios were modelled to examine the incremental impact of increasing effective coverage of key malaria interventions. These interventions include case management (CM), insecticide-treated net (ITN) use, intermittent preventive treatment in pregnancy (IPTp), seasonal malaria chemoprevention (SMC), perennial malaria chemoprevention (PMC), and malaria vaccination where applicable. The scenarios reflect progressive improvements in effective coverage levels based on operational feasibility and recent implementation experience. These range from maintaining current effective coverage levels to gradually increasing coverage to 50%, 60%, 70% and up to 80%, representing the optimal performance scenario for the programme.

Additional funded implementation scenarios were also considered to reflect realistic financing conditions and programmatic constraints. These scenarios include targeted expansion of interventions such as SMC in eligible LGAs and increased ITN coverage, while maintaining IPTp coverage at business-as-usual levels. Such scenarios allow the programme to assess the potential impact of specific intervention packages, including their effects on outcomes such as low birth weight and stillbirths, as well as broader malaria morbidity and mortality.

Together, these modelling scenarios provide an evidence-based foundation for defining the strategic priorities and targets of the NMSP 2026–2030.

3.3 Review of previous NMSP

The Malaria Programme Review (MPR) assessed Nigeria's malaria response under the National Malaria Strategic Plan (NMSP) 2021–2025 across key thematic areas. The review examined epidemiological and entomological trends, effectiveness of programme financing, programme capacity to implement planned activities, effectiveness of the health system in delivering malaria services, and identified priorities to guide the next strategic cycle.

The review showed that *Plasmodium falciparum* accounts for about 97% of infections, transmitted mainly by *An. gambiae* s.l., *An. funestus*, and *An. arabiensis*. Progress in malaria control has varied across states, reflecting the heterogeneous epidemiology and differing transmission dynamics observed across the country. Notably, a substantial proportion of the population seek care from the private sector; about 45% of caregivers seek treatment for febrile children in the private sector (MIS 2021), yet data from the private sector are not systematically captured in routine surveillance systems. In view of this, the MPR emphasized the need to strengthen mechanisms for routine data collection and reporting from the private sector, alongside more frequent surveillance, to ensure comprehensive data for evidence-based and targeted malaria intervention delivery.

The MIS 2025 highlights both progress and persistent gaps in malaria prevention and treatment. While 54% of households own at least one ITN, only 21% have adequate ITN-to-person coverage, indicating that many households do not have enough nets for all members. Utilization also remains suboptimal; 45% of children under five and 54% of pregnant women slept under an ITN the night before the survey. These findings underscore the need for intensified efforts to prioritize access and promote consistent use of ITN, particularly among vulnerable populations.

Similarly, IPTp continues to lag behind national targets. Only 33% of pregnant women received three or more doses of SP for intermittent preventive treatment of malaria in pregnancy, indicating missed opportunities during ANC visits and the need to strengthen IPTp delivery through improved ANC service utilization, consistent availability of SP, and also explore additional delivery channels to expand coverage among pregnant women.

Care-seeking behaviour for childhood fever shows moderate improvement, with 59% of febrile children taken to a health facility or provider. However, diagnostic testing remains low, as only 18% of these children were tested for malaria. Among those who received treatment, 66% were treated with ACT.

3.3.1 MPR Summary and key recommendations across thematic areas

Vector Control

Vector control efforts primarily relied on ITNs distributed through mass campaigns and continuous distribution channels. However, insecticide resistance threatens the effectiveness of nets. Other vector control interventions such as IRS and LSM were implemented only at limited scale, including IRS in IDP camps in Borno State and larviciding pilots in three states. Key recommendations include the following:

-  Expand the deployment of dual-active ingredient ITNs
-  Scale up targeted IRS and LSM interventions
-  Explore integrated delivery of other WHO recommended interventions such as house screening and spatial repellents (spatial emanators)
-  Increase insecticide resistance surveillance monitoring efforts in the sentinel sites
-  Strengthen human resource and research capacity for entomological surveillance and digital entomological data integration and use
-  Continue and upgrade tools for *An. stephensi* surveillance and foster regional collaboration

Chemoprevention and Case Management

SMC expanded significantly from 9 to 21 states, reaching approximately 28 million children aged 3-59 months, and recording optimal coverage (>80%) in all the 21 eligible states; while PMC and IPTsc have been successfully piloted in a few states for future scale-up based on lessons learnt. Therapeutic Efficacy Studies (TES) confirmed that the current first-line antimalarial treatments remain highly effective, with efficacy above 98%. However, sustained effectiveness will require continued monitoring and implementation of resistance prevention measures. These efforts have been accompanied by encouraging reductions in malaria test positivity rates, suggesting improvements in case management, though further improvements are required in quality assurance as well as in ensuring equitable access to case management, particularly for populations in hard-to-reach and underserved communities. Key recommendations include:

-  Scale-up integration with other interventions/programmes to improve cost-effectiveness and deliver interventions innovatively
-  Improve collaboration with other MDAs at National/State levels such as Department of Family Health and NPHCDA, to optimize community IPTp and Community Case Management
-  Private Sector Engagement Expert Group should be established to drive innovation, strengthen capacity, and improve reporting
-  Leverage ongoing government initiatives for local production of malaria medicines to address stock outs
-  Introduce Multiple First-Line Therapies (MFT) to delay the emergence and spread of antimalarial drug resistance
-  Scale-up the nationwide adoption of Rectal Artesunate Suppositories (RAS) for the pre-referral management of severe malaria

Programme Management, Policies and Strategies

The review found that NMEP has made progress in programme management, but institutional capacity gaps remain, particularly in human resource planning, financial oversight, and coordination. State-level coordination is inconsistent, and collaboration with private sector and civil society partners remains suboptimal. While malaria services are included in the BHCPF, coordination with NMEP is inadequate.

Direct government funding for malaria remains relatively low. However, indirect funding through mechanisms such as the IMPACT project and BHCPF provides significant support for the country's malaria response. These alternative financing channels help maintain intervention coverage and sustain programme activities, within the context of limited direct budgetary allocation. Recommendations include:

-  Strengthen governance and sub-national programme leadership; including stronger accountability mechanisms, effective coordination, and more robust programme oversight
-  Enhance multisectoral collaboration by engaging stakeholders across health, environment, education, and other relevant development sectors to explore wider integration for sustainable programming
-  Increase domestic resource mobilization and explore innovative financing mechanisms to ensure sustainable, predictable, and efficient funding.

Malaria Vaccine

Nigeria introduced the R21 malaria vaccine in 2024 through a phased rollout, starting with Bayelsa and Kebbi States as part of the national immunization programme. However, vaccine uptake and dose completion remain low, partly due to inadequate coordination between NMEP and NPHCDA. Recommendations include:

-  Strengthen community engagement to improve awareness, acceptance, and uptake; addressing hesitancy and misinformation
-  Enhance coordination between NMEP and NPHCDA to ensure efficient planning, scale-up, and monitoring of malaria vaccination activities
-  Explore integration of the malaria vaccine with other preventive interventions (e.g., SMC, ITN distribution) to maximize coverage, efficiency, and impact

Surveillance, Monitoring and Evaluation and Operations Research (SMEOR)

Malaria surveillance systems remain suboptimal, capturing only about 47% of malaria cases nationwide, with most reporting from public health facilities. The NMDR provides a platform for centralized storage, management, and visualization of malaria data, supporting the country to make evidence-based programme decisions. However, challenges identified include incomplete data reporting, limited availability of private sector data, limited interoperability with other data systems which constrains integrated analysis and planning, and data quality issues. The review emphasized the following:

-  Institutionalize the use of NMDR to facilitate data use for decision-making especially at sub-national levels
-  Strengthen malaria surveillance system to ensure timely, complete, and high-quality reporting for sustained evidence-based programmatic decisions
-  Leverage advanced analytics to generate actionable insights, regularly identify trends, and strengthen subnational tailoring of interventions at subnational levels
-  Prioritize operational research and strengthen regular research-to-policy engagements to ensure that evidence and findings are effectively translated into programme improvements and policy decisions
-  Continue to engage with the private sector to improve the availability and integration of private-sector data for comprehensive planning and monitoring

- 🔗 Enhance interoperability across data systems to enable seamless data sharing, integration, and coordinated use across national and subnational levels

Emergency Preparedness and Response (EPR)

Although Nigeria has national emergency response structures led by NEMA and disease outbreak management by NCDC, malaria preparedness is not fully integrated into emergency planning. Inadequate intervention coverage across states increases the risk of malaria outbreaks, particularly in humanitarian and displacement settings. Over-reliance on donor support and dependence on donor-supplied commodities also limits rapid response capacity. The review recommended:

- 🔔 Integrate malaria into national emergency preparedness and response (EPR) plans, and ensure adequate buffer stocks of essential malaria commodities are maintained to support timely response during emergencies
- 🔔 Strengthen decentralized planning, including emergency preparedness and response, by enhancing state and LGA capacity for planning, budgeting, and accountability, supported by tailored micro-stratification to guide targeted interventions

Procurement and Supply Chain Management (PSM)

NMEP has an established PSM framework aligned with the broader FMOH system. However, coordination with other government agencies remains inadequate, and there is limited information on domestic market-shaping strategies for malaria commodities. Platforms such as the PVAC provide opportunities to promote local manufacturing and greater private sector participation in the malaria commodity supply chain. Recommendations include:

- 🔗 Strengthen coordination among relevant government agencies to improve alignment in inter-sectoral procurement, regulation, and supply chain management
- 🔗 Promote public-private-philanthropic partnerships to support government efforts in expanding local manufacturing of quality-assured malaria commodities
- 🔗 Develop and implement domestic market-shaping strategies to ensure sustainable supply and affordability of malaria commodities
- 🔗 Improve quality assurance mechanisms across procurement and distribution points
- 🔗 Strengthen commodity tracking and visibility across public and private sectors to enhance accountability, forecasting, and supply chain efficiency

Advocacy Communication and Social Mobilization (ACSM)

There is an established ACSM framework and effective SBC materials that have contributed to increased public awareness and improved practices related to malaria prevention and treatment. However, monitoring of ACSM activities remains constrained by inadequate harmonization of indicators and limited systems for tracking ACSM interventions and outcomes. Recommendations include:

- 📢 Expand and strengthen SBC strategies to sustain community engagement and improve uptake of malaria interventions
- 📢 Scale up support for CSO-led demand generation, citizen monitoring, and feedback loops. Establish indicators that measure community voice, and community accountability

-  Leverage social media and digital platforms to broaden the reach and effectiveness of SBC efforts
-  Strengthen systems for monitoring and evaluating ACSM performance, including harmonizing indicators and improving mechanisms for tracking

Emergency Preparedness and Response (ERP)

Nigeria has a national emergency response programme managed by the National Emergency Management Agency (NEMA); however, disease outbreaks are managed by NCDC. Neither NEMA, NCDC nor NMEP has mainstreamed malaria emergency preparedness in their planning processes and response. Key recommendations include:

-  Integrate malaria emergency preparedness and response into national emergency management frameworks, ensuring adequate coordination between NMEP and relevant MDAs
-  Develop and institutionalize a national malaria emergency preparedness and response plan, including clear protocols for outbreak detection, rapid response, and coordination during humanitarian crises
-  Strengthen surveillance and early warning systems to identify and respond promptly to malaria outbreaks
-  Establish contingency stocks and flexible commodity distribution mechanisms to enable rapid deployment of malaria commodities to emergency and humanitarian settings

Equity, Human Rights and Gender Equality (EHRGE)

The malaria programme has made meaningful strides in identifying priority populations and implementing targeted interventions. Pregnant women, children under five, and low-income households are explicitly prioritized across multiple programme components, and lessons from initiatives such as the BHCPF, NHIA schemes, and the World Bank-funded IMPACT project are increasingly shaping intervention design. Despite these advances in EHRGE, significant gaps persist in protocol design and budgeting. There is inadequate consideration for underserved groups such as IDPs, refugees, mine workers, prisoners, persons with disabilities, and cross-border or migrant workers. Gender-responsive budgeting is yet to be institutionalized. Recommendations include:

-  Strengthen the integration of EHRGE principles across malaria programme planning, implementation, and monitoring. Include refugees, IDPs, mine workers, migrants, prisoners, and persons with disabilities as formally recognized priority groups across all policy, planning, and monitoring instruments
-  Strengthen data disaggregation in routine data systems to highlight EHRGE components; including the incorporation of variables on displacement, disability, incarceration, income quintile (if feasible), and gender identity. Ensure that all malaria services and financing indicators are routinely disaggregated and used for sub-national planning and equity monitoring
-  Introduce gender-responsive budgeting and KPIs; including the allocation of dedicated EHRGE-related budget lines
-  Mainstream EHRGE into programme reviews and planning cycles; ensure that EHRGE considerations are integrated across MPRs, MTRs, and programme planning processes

4.1. Vision

A malaria-free Nigeria

4.2. Mission

To deliver equitable, high-impact malaria interventions, through context-specific, community-owned and collaborative sector-wide approaches that contribute to a resilient health system.

4.3. Strategic directions and policy priorities

This National Malaria Strategic Plan 2026-2030 will align with ongoing sector-wide initiatives and health system reforms to ensure synergy, sustainability, and impact at scale.

Building on the vision of a malaria-free Nigeria, the national response will focus on delivering a robust, multi-stakeholder and multisectoral strategy mix tailored to Nigeria's heterogeneous malaria epidemiology. This approach will be guided by the stratification of the country into very low, low (A and B), moderate (A and B), and high transmission zones, adapted from the Global Technical Strategy (GTS) for Malaria 2016-2030 which envisions "A world free of malaria". The NMSP will incorporate the three pillars and two supporting elements of the GTS, aligning national and subnational efforts with global best practices to accelerate progress towards a malaria-free Nigeria.

The overarching purpose is to accelerate the reduction of malaria burden and deaths in alignment with the re-thinking malaria agenda, while ensuring consistency with the principles and strategic pillars of the Health Sector Strategic Blueprint (HSSB), particularly Pillar One: Effective Governance, and Pillar Two: Efficient, Equitable, and Quality Health Systems, under which malaria core interventions are anchored.

Implementation of prioritized strategies and key activities will be anchored on the High Burden to High Impact (HBHI) approach/Big Push initiative, emphasizing the following: Strong political commitment and leadership; Use of strategic information to drive targeted action; Evidence-based guidance for policies and strategies; well-coordinated, nationally led malaria response.

Figure 10 below shows the alignment of the NMSP with national policies, global strategies, and emerging priorities. Similarly, figure 11 specifically shows the linkage between the strategic objectives of the NMSP and the pillars and enablers of the HSSB, highlighting that achieving malaria programme targets relies on strengthening key health system components such as governance, surveillance, data systems, financing, and service delivery.

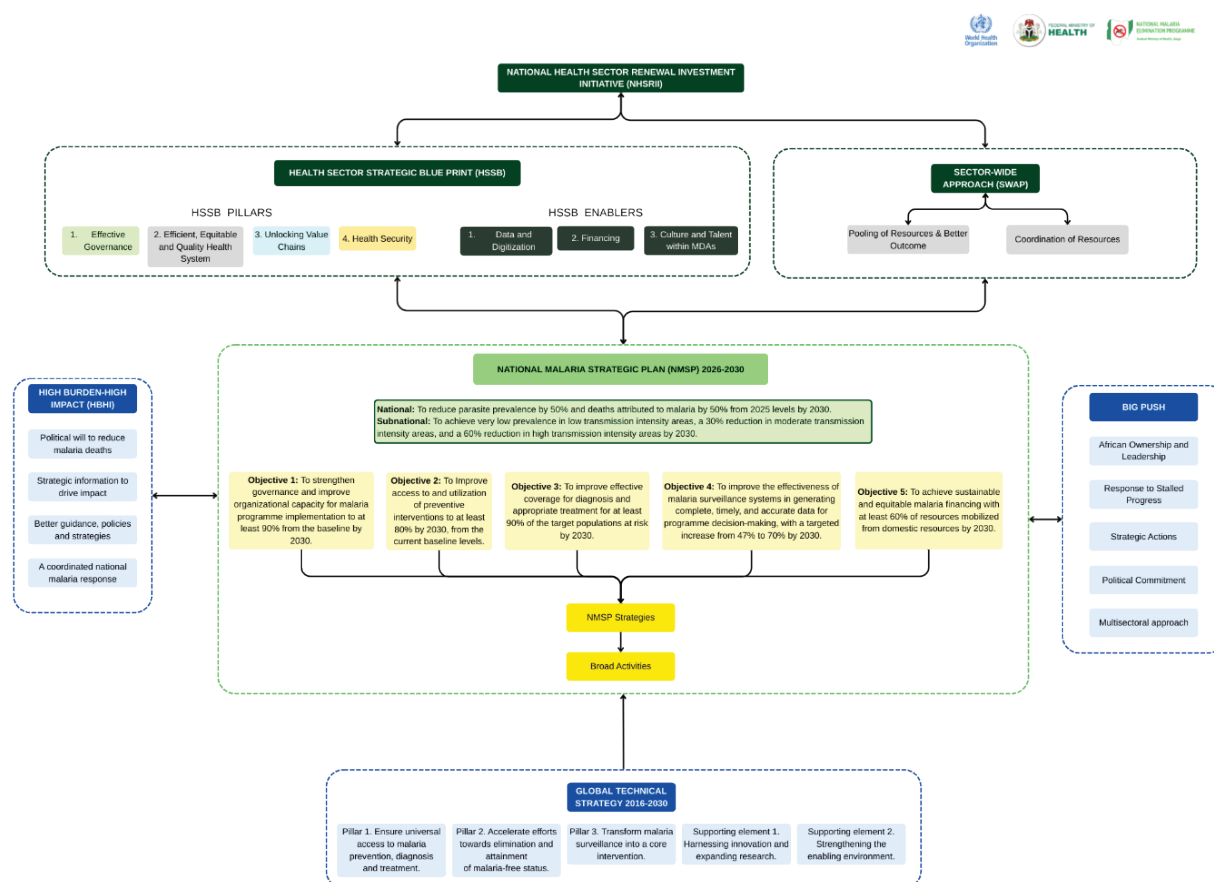


Fig 9. Alignment of the NMSP with National and Global Strategies

HSSB PILLARS AND ENABLERS

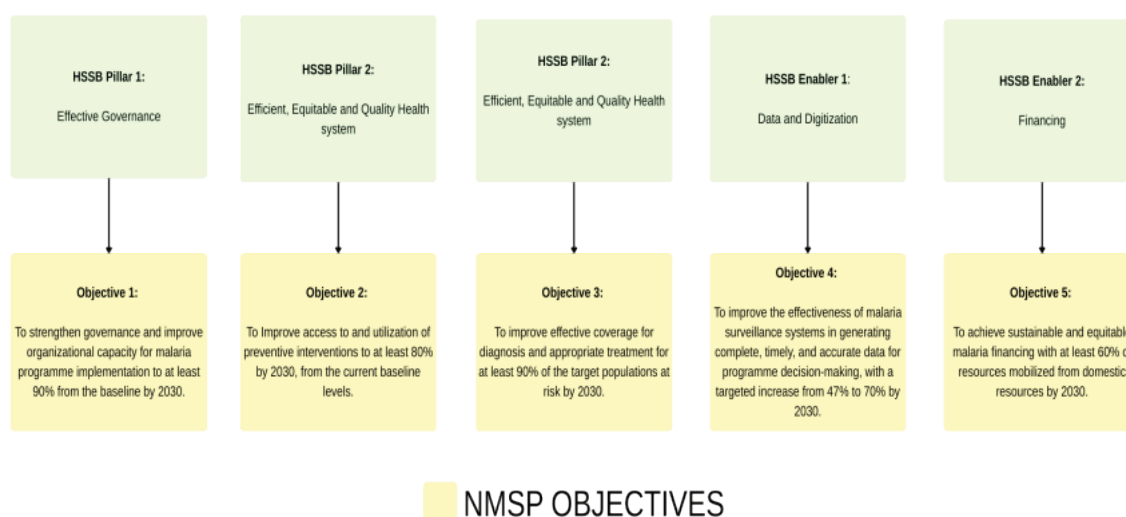


Fig 10. Linkages between NMSP Objectives and HSSB Pillars and Enablers.

4.4. Goals and objectives

4.4.1. Goals

National: To reduce parasite prevalence by 50% and deaths attributed to malaria by 50% from 2025 levels by 2030.

Subnational: To achieve very low prevalence in low transmission intensity areas, a 30% reduction in prevalence in moderate transmission intensity areas, and a 60% reduction in prevalence in high transmission intensity areas from 2025 levels, by 2030.

4.4.2. Objectives of NMSP, 2026-2030

-  To strengthen governance and improve organizational capacity for malaria programme implementation to at least 90% from the baseline by 2030.
-  To Improve access to and utilization of preventive interventions to at least 80% by 2030, from the current baseline levels.
-  To improve effective coverage for diagnosis and appropriate treatment for at least 90% of the target populations at risk by 2030.
-  To improve the effectiveness of malaria surveillance systems in generating complete, timely, and accurate data for programme decision-making, with a targeted increase from 47% to 70% by 2030.
-  To achieve sustainable and equitable malaria financing with at least 60% of resources mobilized from domestic resources by 2030.

4.4.3. Supportive Cross-cutting priority areas

Beyond the strategic objectives, there are cross-cutting priority areas that are fundamental to the achievement of the NMSP goal. These priority areas include;

Advocacy, Communication and Social Mobilization (ACSM)

ACSM is a fundamental strategy that cuts across all the objectives of the NMSP. It remains the component that consistently educates and promotes desired positive behavioural change for the prevention, diagnosis and treatment and all manners of malaria interventions at all levels.

Effective ACSM strategy is central to generating the political will needed for malaria elimination in Nigeria. In other words, ACSM is a strategic driver for ensuring adequate political will at all tiers as stipulated in Pillar 1 of the High Burden High Impact (HBHI) approach.

ACSM interventions make crucial contributions to the implementation of the outcome indicators of the NMSP strategic objectives such as governance, vector control, chemoprevention, diagnosis and treatment, financing and the M&E performance framework that involves behavioural change and enlightenment.

ACSM is not treated as a stand-alone component, but it is fully integrated, resourced, and aligned with all the strategic objectives. However, it is imperative to mainstream ACSM in all thematic planning and budgets, develop integrated communication strategies by thematic areas, and designate an ACSM focal point for the various objectives. The ACSM focus areas include:

1. Provider-based initiative
2. Utilization of multiple channels, with a focus on new media platforms
3. Community mobilization (enhancing accountability, engagement, and ownership)
4. Improving coverage of SBC activities
5. Standardization of planning and implementation, along with the introduction of uniform tools for reporting

The ACSM strategies of this NMSP will focus on achieving objectives 1 to 5 by influencing behaviours of people at 4 different levels which are: Policy; Services or Systems; Community; Household and Individual. ACSM supports the programme in strengthening coordination, planning, networking, data management, resource mobilization and also drives effective delivery of SBC interventions at all levels. It will also support the development of advocacy tools to generate more funds at national and sub-national levels, as well as those to increase coordination between service delivery and SBC to align demand and supply factors and efforts.

Behaviour changes at each level include:

- 1) Policy: Increased political commitment through budget allocation and improved release of funds for malaria as well as policy reviews/adoption based on evidence. Advocacy will drive these expected results through the provision of facts on malaria control interventions and funding, including scorecards. More collaboration and commitment of the private sector –through consistent and outcome/result-driven advocacy.
- 2) Services or Systems: Improved providers' knowledge, attitude and behaviours; service communication; relevant stakeholders' engagement; buy-in and enabling environment (including accessibility, affordability and availability). Improved demand for testing and ANC for IPTp.
- 3) Community: Increased commitment and ownership through community groups and associations, Community Health Workers. Promotion of SMC and positive norms for malaria control
- 4) Household and Individuals: Increased knowledge, change in social norms or beliefs and increased demand and use for products and services, intensify the promotion of early ANC attendance among pregnant women, which includes uptake of 3 or more doses of IPTp.

Product and Supply Chain Management (PSM)

Procurement and Supply Chain Management (PSM) is a cross-cutting facilitator of all strategic objectives under the NMSP 2026–2030. The strategy specifically leverages PSM interventions that use institutional strengths and existing linkages between the National Malaria Elimination Programme (NMEP) and key health and regulatory agencies through active participation in national coordination platforms, including DFDS, NPSCMP, the National Primary Health Care Development Agency (NPHCDA), and the National Agency for Food and Drug Administration and Control (NAFDAC). This intentional alignment is designed to improve planning, harmonize standards, and unlock efficiencies across the malaria commodity ecosystem.

A high-performing PSM system that guarantees the availability of the right commodities, in the right quantities and quality, at the right place and time is crucial to the success of the NMSP.

Interventions will prioritize actions that reduce stock-outs, wastage, and expiries; strengthening quality assurance and regulatory compliance; incentivizing local manufacturing; and optimizing last-mile delivery through public–private collaboration. Together, these measures present a compelling investment opportunity for government, donors, and the private sector to drive measurable impact, value for money, and sustained malaria burden reduction.

Key PSM functions include the following:

-  Ensuring commodity availability and access
-  Aligning forecasting and quantification with programme needs
-  Driving efficiency in PSM
-  Improving last mile delivery and Equity, Human Rights, Gender considerations
-  Supporting surveillance and decision making
-  Ensuring Quality Assurance and Regulatory Compliance
-  Promoting sustainability and transition from donor dependency
-  Strengthen national and sub-national supply chain systems to reduce reliance on parallel donor-funded systems.
-  Incorporate initiatives to improve health facility logistics reporting efficiency by leveraging innovative relevant applications and digital tools like Supply to automate the process.
-  Enhance procurement and supply chain outcomes by aligning the malaria programme with new resources like the Rethinking Malaria and PVAC initiatives

Equity, Human Rights, and Gender Equality (EHRGE)

The previous NMSP focused its targeting to key vulnerable populations like women, children, the poor, IDPs and refugees. Through consultations during the NMSP development process and as part of MPR, it has been agreed that Nigeria will expand its targeting to additional priority population groups, while continuing to strengthen the groups identified in the previous NMSP. Key groups identified for the expanded targeting include populations displaced by natural and manmade disasters - (IDPs and refugees), People with Disabilities (PWDs), incarcerated populations, youth living in hostels, and miners.

As part of the MPR and NMSP development process, the stakeholders have agreed that the 2026–2030 malaria strategy will mainstream the Equity, Human Rights, and Gender Equality (EHRGE) as a cross-cutting theme. These perspectives have been woven into the strategic framework, financing considerations, and monitoring indicators, ensuring inclusivity in both design, data systems, and implementation.

EHRGE is at the core of Nigeria’s health sector strategic blueprint and the malaria response. Malaria continues to exact a disproportionate toll on Nigeria’s most vulnerable populations, with children under five and pregnant women accounting for nearly 75% of malaria out-patient consultations in the country. Therefore, EHRGE strategies intentionally cut across the strategic objectives of the NMSP.

Despite policy progress, out-of-pocket expenditures (OOPE) on malaria-related care remains unsustainably high, rising from 71% in 2018 to 84% in 2024, highlighting weak financial risk protection and insufficient uptake of mechanisms like the Basic Health Care Provision Fund (BHC PF) and the National Health Insurance Authority (NHIA). These are further complicated by other systemic and operational challenges that persist, including:

-  Limited data disaggregation: Routine systems (e.g., DHIS2) lack variables for displacement, disability, income, and incarceration, making inequities poorly visible and difficult to manage.
-  Some underserved populations (including IDPs, mine workers, migrants, prisoners, and people with disability) are often not fully recognized in planning, data systems, and budgeting.
-  Gender barriers persist and require intentionality to address. Some of the barriers faced by women in some settings include spousal permission, financial dependence, and safety concerns, impacting timely care-seeking and uptake of malaria preventive tools.
-  Financial burden remains high as OOPE has increased significantly over the years, with inadequate weak linkages between malaria services and social health protection schemes.

For the NMSP 2026-2030, key enablers and opportunities for EHRGE include: Strong legal and policy frameworks (such as NHIA Act, BHC PF), strong technical platforms (DHIS2, NDHS, MIS, Matchbox equity scan), pilot experiences with malaria delivery in humanitarian contexts, renewed national commitment under NHSRII.

Specifically, efforts will be made to embed explicit commitments to underserved populations, strengthen data systems, institutionalize gender-responsive budgeting, ensure financial protection, and prioritize institutional partnerships.

Malaria in Humanitarian Settings

While the EHRGE-focused malaria response seeks to ensure that no vulnerable population is left behind, worsening humanitarian crises on the other hand, continue to forcibly displace populations and further exacerbate vulnerability with increased risk of malaria and other diseases. Managing this requires intense collaborations and leveraging multi-sectoral programmes.

4.5. Strategies and Broad Activities.

To consolidate recent gains and accelerate progress towards malaria elimination, Nigeria will maximize the impact of WHO-recommended strategies through context-specific deployment, reflecting the country's heterogeneous malaria epidemiology. These strategies, with the identified broad activities, will be implemented to strengthen the effectiveness of the country's malaria response at both national and subnational levels.

The broad activities under each of the five NMSP Objectives (Objectives 1-5), have been mapped to align with the national HSSB structure. This alignment ensures coherence between malaria strategies and the broader health sector reform agenda. It also facilitates the integration of malaria interventions into national planning and budgeting processes, while enabling malaria programme activities to be systematically coordinated and monitored through the Annual Operational Plan (AOP) framework of the FMOH&SW.

The HSSB coding structure assigns specific numbers (identifiers) that correspond to the pillars/enablers, strategic objectives, priority initiatives, and interventions or activities. Therefore, mapping the NMSP broad activities to the relevant HSSB pillars or health system enablers ensures that malaria programming contributes directly to national health sector priorities and reforms.

For example, the first broad activity for NMSP Objective 1, “Integrate malaria elimination activities into national and subnational health and economic plans”, is mapped to P1.2.2.1, which denotes:

- 1 - Pillar 1 of the HSSB (Effective Governance)
- 2 - Strategic Objective 2 under pillar 1
- 2 - Priority Initiative 2 under the strategic objective
- 1 - Specific Intervention (or Activity) 1 for implementation

In some instances, where appropriate, the Pillar (P) is replaced with Enabler (E) to indicate that the broad activity in the NMSP aligns more closely with a Health System Enabler rather than a Pillar.

4.5.1. Objective 1: To strengthen governance and improve organizational capacity for malaria programme implementation to at least 90% from the baseline by 2030.

Leveraging the Federal Ministry of Health’s Sector-Wide Approach (SWAp), NMEP will prioritize governance and organizational capacity as critical elements of the country’s malaria elimination efforts. This strategic objective aims to ensure that leadership structures, coordination platforms, partnerships, and accountability mechanisms are operating at optimal levels. Strengthening governance will foster improved leadership, policy environment, and effective coordination among stakeholders, while enhancing organizational capacity will empower NMEP to build and sustain strategic partnerships, effectively plan and implement interventions, and robustly monitor and evaluate progress. By aligning with the SWAp initiative, this approach promotes integration, efficiency, and sustainability across malaria elimination efforts and the wider health sector.

Table 1: Objective 1 will be implemented through the following Priority Areas, Strategies, and Broad Activities

Priority Areas	Core Strategies	Broad Activities	HSSB Code
Sustained political commitment and multisectoral collaboration	1.1 Strengthen the commitment, leadership, and sustained support from government at all levels.	1.1.1 Integrate malaria elimination activities into national and subnational health and economic plans	P1.2.2.1
		1.1.2 Deploy African Leaders Malaria Alliance (ALMA) scorecard and accountability framework at the national and subnational levels to strengthen political commitment, leadership accountability, and performance monitoring.	P1.2.2.1
	1.2 Bolster mechanisms to coordinate malaria activities at the national and subnational levels, and across MDAs.	1.2.1 Strengthen external coordination platforms at Federal level and 36 states plus FCT.	P1.4.5.2
		1.2.2 Strengthen internal coordination platforms at Federal level and 36 states plus FCT. Revise ToR and membership of all existing committees and working groups to ensure EHRGE inclusion as per the national coordination framework.	P1.4.5.2

		1.2.3 Establish multi-sectoral collaborative platforms at the national and subnational levels (MDAs / SWAp / PVAC). Ensure the inclusion of EHRGE dimensions in the OCA tool.	P1.4.5.2
	1.3 Strengthen strategic partnerships across service delivery, supply chain, and social and behaviour change (SBC) stakeholders by fostering collaboration among relevant MDAs and partner organizations	1.3.1 Improve collaboration and integration between SBC and service delivery stakeholders to ensure synchronized malaria prevention, diagnosis, and treatment efforts.	P2.5.6.9
		1.3.2 Foster collaboration with national supply chain bodies, procurement agencies, and development partners to ensure efficient forecasting, procurement, and distribution of malaria commodities (including NPSCMP, NAFDAC, NPHCDA, PVAC etc).	P1.4.5.2
Active Private Sector Engagement	1.4 Strengthen collaborative platforms and partnerships with private sector stakeholders at National and Subnational levels to increase coverage of targeted interventions	1.4.1 Facilitate regular private sector coordination mechanisms to provide an enabling environment for private sector participation in decision making and co-creation of strategic interventions.	P2.7.11.5
		1.4.2 Engage regulatory bodies to strengthen partnerships with the private sector and ensure compliance with standard regulations.	P1.3.3.3
Policy and technical guidance	1.5 Provide evidence-based policies and ongoing guidance for the deployment of malaria interventions, adapting global policies to local context and fostering innovation (across the various thematic areas)	1.5.1 Develop/disseminate national policies and guidelines ensuring they are effectively communicated, adopted, and implemented at the state level.	P2.7.11.2
		1.5.2 Establish consultative meetings to review existing mechanisms and status of compliance to national policies, strategies, and regulatory framework.	P2.7.11.2
		1.5.3 Conduct EHRGE vulnerability assessment using Malaria Matchbox methodology covering at the least the following groups: populations affected by natural disasters, incarcerated populations (institutionalized populations), mine workers and mining communities, and youths living in educational hostels	P2.7.11.2
Evidence-based Planning	1.6 Strengthen evidence-based planning with subnational inputs that align with Country Fiscal Frameworks	1.6.1 Scale-up mechanisms for periodic malaria programme progress and performance reviews at the federal and state levels. Establish coordination mechanisms (including data sharing) with BHCPF (Basic Healthcare Provision Fund) and NHEA for sharing data on priority EHRGE commitments.	P1.4.4.1

		1.6.2 Develop/support annual operational plan for malaria programme at the federal and in 36 states plus FCT. Embed Grievance Redressal Mechanisms into AOPs, covering all malaria interventions at community and facility levels.	P1.4.4.2
		1.6.3 Conduct Mid-term and End-term reviews of the NMSP and development of the next NMSP	P1.4.4.1
		1.6.4 Develop a pragmatic costed plan to prioritize key interventions, guide evidence-based allocations, and support resource mobilization.	P1.4.4.1
Capacity for Malaria Programme Implementation	1.7 Strengthen the capacity of NMEP to provide technical support and coordinate all malaria programme priorities at national and state levels	1.7.1 Develop tools and establish mechanisms to regularly assess NMEP/SMEP capacity to implement the NMSP priority interventions.	P2.9.15.6
		1.7.2 Develop a capacity building plan to enhance individual skills and organizational resources for improving programme delivery.	P2.9.15.6

4.5.2 Objective 2: To improve access to and utilization of malaria preventive interventions to at least 80% by 2030, from current baseline levels.

This objective commits Nigeria to raise both access to, and correct use of, proven preventive measures. These include vector control tools such as insecticide-treated nets (ITNs), indoor residual spraying (IRS) where appropriate, larval source management (LSM) in appropriate settings, evidence-based chemoprevention interventions, and malaria vaccine. Achieving optimal impact from these interventions requires not only ensuring availability but also strengthening social and behaviour change approaches to promote correct, consistent, and sustained use of preventive tools at household and community levels. Additionally, this strategic objective will prioritize insecticide resistance monitoring and vector surveillance with tailored approaches for urban and complex environments. The focus includes getting the right tool to the right place, guided by current evidence and lessons, including insecticide-resistance as well as entomological data. Entomological findings will inform the selection and targeting of vector control interventions, including ITNs, ensuring that deployment is aligned with the local transmission context, vector behaviour, and ecological characteristics. The principles guiding vector control deployment will emphasize context-appropriate intervention selection, stratification-informed targeting, and efficient use of resources to maximize impact. Equity is central to optimizing this objective, therefore micro-plans will prioritize underserved wards, humanitarian and mobile populations, emergencies and private-sector outlets. There will be priority strategies for efficient product supply chain management and innovative social and behaviour change interventions. Geographic Information Systems (GIS) will be leveraged to map high-risk areas, mosquito breeding sites, population distribution, and environmental risk factors. This will enhance decision-making for microplanning, enable real-time monitoring, and improve resource allocation, thereby increasing the precision and effectiveness of preventive interventions.

Table 2: Objective 2 will be implemented through the following Priority Areas, Strategies, and Broad Activities

Priority Areas	Core Strategies	Broad Activities	HSSB Code
Stratified and tailored deployment of WHO-recommended vector control interventions.	2.1 Deploy safe and effective integrated vector control interventions based on malaria transmission intensity, epidemiological stratification, and contextual factors.	2.1.1 High transmission settings (malaria prevalence $\geq 35\%$). Deploy the following: 1. ITN mass distribution 2. ITN continuous distribution 3. Targeted IRS in eligible hotspots 4. LSM where feasible, in urban and semi-urban areas	P2.6.10.5
		2.1.2 Moderate transmission settings; category A (malaria prevalence 15 to $<35\%$). Deploy the following: 1. ITN mass distribution 2. ITN continuous distribution 3. Targeted IRS in eligible hotspots 4. LSM where feasible, in urban and semi-urban areas	P2.6.10.5
		2.1.3 Moderate transmission settings; category B (malaria prevalence 10 to $<15\%$). Deploy the following: 1. ITN mass distribution 2. ITN continuous distribution 3. Targeted IRS in eligible hotspots 4. LSM where feasible, in urban and semi-urban areas	P2.6.10.5
		2.1.4 Low transmission settings; category A (malaria prevalence 5 to $<10\%$). Deploy the following: 1. Targeted ITN mass distribution 2. ITN continuous distribution 3. Targeted IRS in eligible hotspots 4. LSM where feasible, in urban and semi-urban areas	P2.6.10.5
		2.1.5 Low transmission settings; category B (malaria prevalence 1 to $<5\%$). Deploy the following: 1. ITN continuous distribution focusing on population groups at risk 2. Targeted IRS in eligible hotspots 3. LSM where feasible, in urban and semi-urban areas	P2.6.10.5

		2.1.6 Very low transmission settings (malaria prevalence 0 to <1%). Deploy the following: 1. ITN continuous distribution focusing on population groups at risk 2. Targeted IRS in active foci, and during outbreak response 3. LSM where feasible	P2.6.10.5
	2.2 Deploy innovative vector control tools in targeted areas to complement mainstream vector control interventions.	2.2.1 Implement innovative vector control tools such as house screening, insecticide-treated paints and clothes, spatial repellents (spatial emanators), attractive sugar baits (ATSB) etc.	P2.6.10.5
	2.3 Deploy malaria preventive measures in humanitarian settings and complex operating environments.	2.3.1 Develop an emergency preparedness plan and revise existing implementation strategies and protocols to ensure they reflect EHRGE priority groups.	P2.6.10.5
		2.3.2 Provide ITNs and other appropriate preventive interventions for populations in humanitarian settings and other complex operating environments, including people in prisons, students in hostels, miners, unregistered migrants, and internally displaced persons/returnees.	P2.6.10.5
Leverage entomological data for evidence-based programme decisions	2.4 Establish a sustainable decision-making mechanism for deployment of IVM interventions using entomological surveillance evidence (insecticide resistance monitoring and vector surveillance).	2.4.1 Sustain vector sentinel surveillance to generate evidence for informed vector control decision-making.	P2.6.10.5
		2.4.2 Sustain insecticide resistance monitoring to generate evidence for informed vector control decision-making.	P2.6.10.5
		2.4.3 Strengthen capacity of NMEP and key stakeholders for planning, implementation, monitoring, and evaluation of vector control interventions.	P2.6.10.5
Stratified and tailored deployment of WHO-recommended chemopreventive interventions.	2.5 Deploy Chemo-preventive interventions to eligible populations (IPTp, SMC, PMC, IPTsc).	2.5.1 Provide Seasonal Malaria Chemoprevention (SMC) services to eligible populations in LGAs where more than 60% of rainfall occurs within four to five consecutive months.	P2.6.10.7

		2.5.2 Scale up Perennial Malaria Chemoprevention (PMC) services to eligible populations in the eligible LGAs.	P2.6.10.7
		2.5.3 Provide Intermittent Preventive Treatment in pregnancy (IPTp) to all pregnant women across the country at ANC facilities and at community levels.	P2.6.10.7
		2.5.4 Deploy IPTsc services to eligible populations in the eligible LGAs.	P2.6.10.7
		2.5.5 Pilot Post Discharge Malaria Chemoprevention (PDMC) amongst patients recently discharged from hospitals.	P2.6.10.7
		2.5.6 Provide Chemoprophylaxis for Special groups, especially in individuals with Sick Cell Anaemia and non-immune travellers.	P2.6.10.7
Scale up of Malaria Vaccine to eligible populations	2.6 Support the deployment of Malaria Vaccine to eligible populations.	2.6.1 Scale up the delivery of malaria vaccine to eligible populations, ensuring equitable access and high coverage.	P2.6.10.7
		2.6.2 Strengthen the coordination between NMEP and NPHCDA for effective scale-up of malaria vaccine.	P2.6.10.7
		2.6.3 Integrate malaria vaccine uptake with other malaria prevention campaigns (ITN, SMC) for a more comprehensive protection.	P2.6.10.7
Effective waste management	2.7 Deploy safe, sustainable, and effective management of medical and chemical wastes.	2.7.1 Strengthen waste management systems and create awareness on effective waste management.	P2.6.10.5
		2.7.2 Build capacity of health workers on safe handling of materials, waste segregation and appropriate waste disposal.	P2.6.10.5

Table 3: Supportive PSM Strategies (Objective 2 continued).

	Strategies	Broad Activities	HSSB Code
Institutionalized supply chain resilience and market-shaping capacity	2.8 Strengthen systems for continuous availability of, and access to health products for the prevention of malaria through vector control, chemoprevention, and malaria vaccine.	2.8.1 Strengthen systems and processes to reliably quantify malaria commodities used in prevention interventions, including vector control, chemoprevention, and malaria vaccination.	P3.13.19.2
		2.8.2 Strengthen and harmonize procurement processes to ensure timely and cost-effective acquisition of malaria prevention commodities.	P3.13.19.2
		2.8.3 Promote the integrated procurement framework and its benefits to stakeholders, including policymakers, and communities.	P3.13.19.2
		2.8.4 Leverage technology to strengthen inventory management, monitor stockouts, and improve demand forecasting for malaria commodities at all levels of the health system.	P3.13.19.3
		2.8.5 Carry out effective last-mile delivery of malaria preventive commodities by implementing equitable and practical costing and resource allocation methods that prioritize access for vulnerable and underserved populations.	P3.13.19.4

Table 4: Supportive ACSM Strategies (Objective 2 continued).

	ACSM Strategies	Broad Activities	HSSB Code
Effective coverage and use of preventive interventions	2.9 Sustain and increase public awareness and understanding of malaria prevention to enhance demand, access, and proper use of malaria preventive measures, especially among vulnerable and hard-to-reach populations.	2.9.1 Conduct studies on awareness, ownership and use of malaria control interventions.	P1.16.22.5
		2.9.2 Develop/adapt and deploy tools for provider and client behaviour change to enhance client-provider engagement.	P2.5.6.8
		2.9.3 Promote access to, and utilization of malaria prevention interventions through electronic/mass/new media.	P2.5.6.8
	2.10 Leverage the influence of trusted community figures and public personalities to promote malaria prevention behaviours and drive access, uptake, and proper use of malaria interventions.	2.10.1 Design, implement, and sustain a malaria champion and brand ambassador programme, especially in hard-to-reach areas and other high-risk populations, to improve ownership and utilization of malaria prevention interventions.	P2.5.6.8

4.5.3 Objective 3: To improve effective coverage for diagnosis and appropriate treatment for at least 90% of the target population at risk by 2030.

This objective for the strategic plan adopts a dual-pronged approach. First, to prioritize the deployment and routine use of reliable parasitological diagnostics, ensuring that every suspected malaria case is tested before treatment. Second, it aims to ensure that all confirmed cases are managed with effective antimalarial medicines in line with national guidelines and WHO standards.

In recent years, the emergence and evolution of partial resistance to antimalarial medicines have reinforced the need for a strengthened antimalarial resistance (AMR) response within malaria case management strategies. In line with global recommendations and evidence highlighted in the World Malaria Report 2025 on malaria resistance, Nigeria will adopt a proactive treatment strategy that includes the deployment of Multiple First-Line Therapies (MFT), exploration of triple artemisinin-based combination therapies (3xACTs) where appropriate, and the use of single low-dose primaquine (SLDPQ) alongside ACTs in selected low-transmission settings to interrupt transmission. These interventions will be implemented in accordance with national treatment guidelines and other relevant policy and technical guidance.

Achieving this objective will require scaling up diagnostic coverage at community, facility, and private sector levels; strengthening supply chain systems to ensure uninterrupted availability of rapid diagnostic tests (RDTs) and antimalarials; training and mentoring health workers for quality service delivery; and reinforcing community awareness to drive timely care-seeking. These efforts will be embedded within national and sub-national systems, monitored through robust surveillance and reporting mechanisms, and supported by sustained partnerships to secure progress towards the 2030 goal. The target defined under this objective will be achieved through the implementation of the following strategies:

Table 5: Objective 3 will be implemented through the following Priority Areas, Strategies, and Broad Activities

Priority Areas	Strategies	Broad Activities	HSSB Code
Parasitological confirmation of malaria in both public and private health facilities before treatment.	3.1 Deployment of effective parasitological diagnostics for testing care-seeking persons with suspected malaria	3.1.1 Build capacity of personnel in public health facilities on basic malaria microscopy.	P2.7.11.3
		3.1.2 Support the expansion of malaria microscopy certification programmes to build a larger pool of certified malaria microscopists across all states.	P2.7.11.3
		3.1.3 Build capacity of personnel in private health facilities at all levels and among private medical retailers (Community Pharmacists and PPMVs) for parasitological confirmation of malaria.	P2.7.11.3
		3.1.4 Provide rapid diagnostic testing and microscopy for parasitological confirmation of malaria in public and private health facilities and at the community level.	P2.6.10.7

		3.1.5 Scale up of quality assurance and quality control systems for malaria diagnosis.	P2.6.10.7
		3.1.6 Conduct operational research on the deployment and acceptability of existing and emerging parasitological confirmation tests, including the Urine Malaria Test and AI-assisted and automated diagnosis.	P3.10.16.3
		3.1.7 Strengthen prompt malaria diagnosis in humanitarian emergencies (including internally displaced populations - IDPs, prisoners, miners etc).	P2.6.10.7
Quality-assured treatment of confirmed malaria cases in accordance with the national guideline and WHO recommendations.	3.2 Ensure appropriate treatment for individuals with confirmed malaria using effective antimalarial medicines.	3.2.1 Provision of treatment services for uncomplicated malaria at health facilities and the community levels.	P2.6.10.7
		3.2.2 Strengthen the management of severe malaria in public and private health facilities (including capacity building, increasing access to pre-referral treatment using Rectal Artesunate at primary healthcare facilities, and Injection Artesunate at secondary and tertiary healthcare facilities).	P2.6.10.7
		3.2.3 Scale-up community case management of malaria as a component of integrated community case management (iCCM) through the Community-Based Health Workforce programme, especially in hard-to-reach areas	P2.8.12.36
		3.2.4 Ensure compliance to National Malaria Treatment Guidelines and the National Quality of Care Guideline on malaria case management.	P2.6.10.7
		3.2.5 Strengthen prompt malaria treatment in humanitarian emergencies (including internally displaced populations – IDPs, prisoners, miners etc).	P2.6.10.7
		3.2.6 Strengthen malaria surveillance activities (Antimalarial drug therapeutic efficacy test - DTET)	P2.6.10.7
		3.2.7 Strengthen Pharmacovigilance activities in collaboration with NAFDAC.	P2.6.10.7
		3.2.8 Pilot the implementation strategy of Multiple First Line Therapy (MFT) to generate evidence on model of delivery for scale-up, to delay the emergence of resistance.	P2.6.10.7

		3.2.9 Scale up of MFT by incorporating initial lessons learnt from the implementation strategy pilot.	P2.6.10.7
		3.2.10 Introduce the use of Single Low-Dose Primaquine (SLDPQ) alongside ACTs for treatment of confirmed Plasmodium falciparum malaria cases in low transmission (B) settings to reduce onward transmission, in line with WHO recommendations. The recommended dose is a single 0.25 mg/kg body weight administered with ACT.	P2.6.10.7
Active case detection in Low B and Very low transmission areas.	3.3 Deploy active malaria case detection strategies to identify and respond to residual transmission foci in low and very low transmission settings.	3.3.1 Implement proactive and reactive case detection approaches, conducting community-based screening in high-risk areas and investigating all confirmed cases to identify secondary infections.	P2.6.10.7

Table 6: Supportive PSM Strategies (Objective 3 continued).

Priority Areas	Strategies	Broad Activities	HSSB Code
Robust supply chain ensuring timely access to quality antimalarials and diagnostics.	3.4 Strengthen systems for continuous availability of, and access to health products for the diagnosis and treatment of malaria.	3.4.1 Strengthen systems and processes to reliably quantify malaria commodities used for diagnosis and treatment.	P3.13.19.2
		3.4.2 Strengthen and harmonize procurement processes to ensure timely and cost-effective acquisition of malaria commodities for diagnosis and treatment.	P3.13.19.2
		3.4.3 Carry out effective last-mile delivery of malaria diagnosis and treatment commodities by implementing equitable and practical costing and resource allocation methods that prioritize access for vulnerable and underserved populations.	P3.13.19.4

Table 7: Supportive ACSM Strategies (Objective 3 continued).

Priority Areas	Strategies	Broad activities	HSSB Code
Effective coverage and utilization of diagnostic and treatment interventions.	3.5 Deploy an integrated ACSM campaign that combines mass media, digital platforms, and interpersonal communication through trusted structures to increase awareness, demand, and correct use of diagnostic and treatment services.	3.5.1 Promote access to, and utilization of malaria diagnosis and treatment interventions through electronic/mass/new media.	P2.5.6.8
	3.6 Establishment of accountability (social) mechanism to improve quality of community level malaria /ACSM activities.	3.6.1 Design, implement, and sustain a malaria champion and brand ambassador programme, especially in hard-to-reach areas and other high-risk populations, to improve ownership and utilization of malaria diagnosis and treatment interventions.	P2.5.6.8

4.5.4 Objective 4: To improve the effectiveness of malaria surveillance systems in generating complete, timely, and accurate data for programme decision-making, with a targeted increase from 47% to 70% by 2030.

The surveillance objective seeks to improve the comprehensiveness of the malaria surveillance system from a baseline of 47% in 2022 to 70% by 2030 through improving data quality approaches, mapping and digitalizing integrated malaria data reporting, improving the capacity of human resources for SMEOR at all levels, strengthening entomological surveillance system, strengthening data governance and coordination, expanding operational research for malaria surveillance, adaptive surveillance to the trends of disease burden, and strengthening drugs and diagnostics surveillance for evidence-based decision-making.

Improving the performance and comprehensiveness of malaria surveillance is central to Nigeria's 2026-2030 goal, as part of the broader malaria elimination agenda, which emphasizes data-driven decision-making, accountability, and the tailoring of interventions at the sub-national level. This aligns with global commitments under the WHO Global Technical Strategy for Malaria 2016-2030, which underscores surveillance as a core intervention for elimination. By leveraging digital health platforms such as DHIS2 and the Nigeria Malaria Data Repository (NMDR), investments will ensure integrated, real-time, and interoperable data systems that consolidate routine, entomological, and drug surveillance data for rapid use.

Furthermore, capacity development at all levels will foster sustainability and ownership, while stratification of states based on transmission intensity will enable precision-targeting of interventions, ensuring resources are deployed where they are most needed. Ultimately, this objective will contribute to accelerating the trajectory towards malaria elimination, improving accountability, and innovation.

Table 8: Objective 4 will be implemented through the following Priority Areas, Strategies, and Broad Activities

Priority Areas	Strategies	Broad activities	HSSB Code
Enhance data quality and use through expanded coverage and digital reporting systems.	4.1. Improve the quality and coverage of data generation, analysis, use, and feedback mechanisms	4.1.1 Strengthen routine malaria data generation across public, private, and community platforms leveraging the existing health information system (CBHMIS, NMDR, NHMIS, NHLMIS)	E1.16.22.3
		4.1.2 Institutionalize routine malaria data review and data-to-action platforms at national, state, and LGA levels	E1.16.22.5
		4.1.3 Strengthen feedback mechanisms across all levels of the health system	E1.16.22.3
		4.1.4 Strengthen the use of geospatial and stratification data for malaria programme planning	E1.16.23.2
	4.2 Improve data quality, analysis and feedback loops	4.2.1 Develop/maintain dashboards and automated alerts to track anomalies or missing reports.	P2.6.10.6
		4.2.2 Improve the generation of evidence for decision-making and impact through reporting of quality malaria data and information from the health facilities.	P2.6.10.6
	4.3 Mapping and digitalizing integrated malaria data reporting	4.3.1 Expand digital reporting and support the standardization of malaria data elements for Electronic Medical Record (EMR).	E1.16.22.3
		4.3.2 Strengthen the integration of all data sources with NMDR. Revise SMEOR strategy and document data collection mechanisms to ensure availability of disaggregated data for all NMSP priority groups for all interventions.	E1.16.22.6
		4.3.3 Strengthen data sharing and dissemination of health information for evidence-based decision making	E1.16.22.8

		4.3.4 Support the interoperability between NHMIS and NHLMIS data systems. Regularly share disaggregated data analysis with decision makers and technical forums for course correction at national and state levels.	E1.16.22.6
		4.3.5 Improve private sector data reporting.	P2.8.13.27
Strengthen SMEOR capacity at various levels.	4.4 Improving capacity of Human Resources for SMEOR at all levels.	4.4.1 Strengthen the capacity of healthcare providers on HMIS to optimize data collection and reporting.	E1.16.23.5
		4.4.2 Build the capacity of SMEP and LGA Malaria Focal Persons on data analysis, interpretation, and use for evidence-based decision making.	E1.16.23.5
Scale up Entomological Surveillance System.	4.4 Strengthen Entomological surveillance	4.4.1 Expand entomological sites across the country for data generation.	P2.6.10.5
		4.4.2 Support expansion of Molecular analysis laboratories.	P2.6.10.6
		4.4.3 Monitor emerging vectors such as <i>Anopheles Stephensi</i>	P4.15.21.4
Leverage TES to prevent drug resistance.	4.5 Strengthen drugs and diagnostics surveillance through the conduct of TES and evidence-based decision making	4.5.1 Conduct regular TES across the study sites in the country	P3.13.19.6
		4.5.2 Monitor molecular markers of antimalarial resistance.	P3.13.19.6
		4.5.3 Conduct implementation research on HRP2/3 antigen deletions to generate evidence that will guide informed decision-making on the deployment of appropriate mRDTs in the country.	P3.13.19.6
Institutionalize research to strengthen surveillance	4.6 Expand research for Malaria Surveillance.	4.6.1 Strengthen Operations Research (OR) through enhanced collaboration with tertiary institutions, engagement with the academia, and consistent generation of evidence for programme decision making.	P3.10.16.3
		4.6.2 Support the coordination, design, and implementation of malaria-related surveys.	E1.16.22.5

Active surveillance for rapid case notification, follow-up, and response in Low B and Very low transmission areas.	4.7 Strengthen surveillance systems to support case notification, follow-up, and timely response in pre-elimination settings	4.7.1 Integrate community health workers and private providers into active surveillance networks to expand reach and ensure prompt case identification.	E1.16.22.8
		4.7.2 Utilize digital tools for real-time data reporting, geo-mapping of cases, and monitoring of intervention impact.	E1.16.23.2

Table 9: Supportive PSM Strategies (Objective 4 continued).

Priority Areas	Strategies	Broad Activity	HSSB Code
Enhance Health Facility Logistics Reporting	4.8 Significantly improve Health Facility logistics reporting efficiency for optimal utilization of commodities, wider coverage and evidence-based supply chain decisions	4.8.1 Enhance the generation of quality logistics data by leveraging innovative relevant applications and digital tools	P3.13.19.3
		4.8.2 Build capacity for analysis and use of logistics data	P3.13.19.3
		4.8.3 Conduct Regular data quality assessments and feedback	P3.13.19.3
Strengthen PSM Performance Monitoring & Accountability	4.9 Periodic review and feedback on outcome measurements	4.9.1 Establish performance metrics and monitoring systems to assess (PSM) performance; including the use of stakeholder feedback mechanism to identify areas for improvement	P3.13.19.3

4.5.5 Objective 5: To achieve sustainable and equitable malaria financing with at least 60% of resources mobilized from domestic resources by 2030.

This Financial Resource Management builds on the National Malaria Strategic Plan 2026–2030 and the implementation matrix developed under the eight strategic financing pillars. It reflects lessons from the 2021–2025 plan, where funding was highly dependent on external donors and government allocations were vulnerable to oil price fluctuations. This also considers the potential advocacy of making the National programme an agency. The FRMP aims to diversify revenue streams, institutionalize accountability, and ensure sustainability through the National Malaria Financing Facility (NMFF), domestic revenue measures, private sector engagement, and equity-focused protection mechanisms.

Table 10: Objective 5 will be implemented through the following Priority Areas, Strategies, and Broad Activities

Priority Areas	Strategies	Broad activities	HSSB Code
Strengthen Sustainable Financing	5.1 Enhance capacity to generate, manage and utilize financial resources equitably and efficiently for malaria	5.1.1 Strengthen financial resource mapping, evidence generation, and expenditure tracking processes.	E2.17.24.4
		5.1.2 Develop tools/facilitate allocative efficiency in the disbursement of funds for malaria subnationally tailored interventions.	E2.17.24.7
		5.1.3 Organize high-level annual malaria financing roundtable events to galvanize political commitment and mobilize resources.	E2.17.24.6
Mobilize and Optimize External Funding	5.2 Attract and optimize external funding through development partners and global health initiatives	5.2.1 Initiate/Support joint regional initiatives for domestic resource mobilization.	E2.17.24.6
Scale up Innovative Financing and Private Sector Engagement	5.3 Deploy innovative financing mechanisms	5.3.1 Promote innovative resource mobilization initiatives targeting individuals, corporate organizations, philanthropic organizations and End Malaria Council (EMC).	E2.17.24.6
		5.3.2 Promote private sector engagement by supporting 3-5 malaria-focused startups annually, strengthening PPPs for local manufacturing of malaria commodities, and leveraging private sector platforms to build the business case for malaria investment.	E2.17.24.6
Engagement plan to secure more funding	5.4 Secure greater health allocations from national and subnational governments	5.4.1 Develop an engagement plan to ensure ring-fenced funds for malaria from statutory allocations. (engagement with Legislature, NDDC, SEDC, NEDC etc).	E2.17.24.3

		5.4.2 Position the malaria programme as part of constituency empowerment projects.	E2.17.24.3
		5.4.3 Allocate funds to deploy interventions and operations in COE and emergency settings.	E2.17.24.3

Table 11: Supportive PSM Strategies (Objective 5 continued).

Priority Areas	Strategies	Broad Activities	HSSB Code
Leverage Private Capital for Malaria Commodities and Boost Domestic Financing	5.5 Leverage private capital and contributions for domestic resourcing of malaria commodities	5.5.1 Establish a co-payment mechanism for malaria commodities and an enabling environment for local manufacturing of malaria commodities in Nigeria.	E2.17.24.6

Table 12: Supportive ACSM Strategies (Objective 5 continued).

Priority Areas	Strategies	Broad activities	HSSB Code
Intensify Advocacy for Malaria Financing	5.6 Engage policy makers to generate increased political will for malaria funding	5.6.1 Deploy advocacy intervention tools and packages targeted at policy makers at the national and state levels.	P2.8.13.6
Strengthen Community Led Monitoring and Accountability	5.7 Mobilize Civil Society Organizations for improved transparency and accountability	5.7.1 Strengthen the role of Civil Society Organizations in tracking malaria programme implementation, financing, and results at the national and subnational level.	P2.5.6.6

4.6. Banding and Stratification

Given Nigeria's complexity and epidemiological diversity, the various states are currently progressing towards malaria elimination at different rates. Therefore, each state is required to intensify efforts through combinations of interventions tailored to its specific local context, aligned with the country's transmission stratification and sub-stratification (transmission bands).

In view of this, a country-tailored stratification approach is essential to optimize the delivery and impact of malaria interventions. Overall, Nigeria's journey towards a malaria-free status is continuous and dynamic, with the states positioned at different points along the elimination pathway. This heterogeneity informs the planning and deployment of interventions as recommended for each transmission intensity band (See figure 12). Consequently, state malaria programmes will align with the specific band that is appropriate for their context. This targeted approach will further strengthen and optimize the malaria control response across the country.

Transmission Intensity	Basic Interventions for the various Transmission Bands									Additional Considerations (Dynamic Trend)	Optional Interventions				
	ITN (MC)	ITN (CD)	Diagnosis	Treatment (UM/SM)	Treatment (S/Low Dose Primaquine)	IPTp	SMC	Surveillance	EPR		IRS	LSM	Vaccine	PMC	IPTSC
Moderate - A	XXX	XXX	XXX	XXX		XXX		XX		RETROGRESS	XXX	XXX	XXX	XXX	XXX
	XXX	XXX	XXX	XXX		XXX	XXX	XX		PROGRESS	XX	XXX	XX		XXX
	XXX	XXX	XXX	XXX		XXX	XXX	XX		PROGRESS	XX	XXX	XX		XXX
	XXX	XXX	XXX	XXX		XXX	XXX	XX		RETROGRESS	XXX	XXX	XXX		XXX
	XXX	XXX	XXX	XXX		XXX	XXX	XX		RETROGRESS	XXX	XXX	XXX		XXX
	XXX	XXX	XXX	XXX		XXX	XXX	XX		PROGRESS	XX	XXX	XX		XXX
	XXX	XXX	XXX	XXX		XXX	XXX	XX		PROGRESS	XX	XXX	XX		XXX
	XXX	XXX	XXX	XXX		XXX	XXX	XX		PROGRESS	XX	XXX	XX		XXX
	XXX	XXX	XXX	XXX		XXX	XXX	XX		PROGRESS	XX	XXX	XX		XXX
	XXX	XXX	XXX	XXX		XXX	XXX	XX		PROGRESS	XX	XXX	XX		XXX
Moderate - B	XXX	XXX	XXX	XXX		XXX	XXX	XX		STAGNANT	XXX	XXX	XXX	XXX	XXX
	XXX	XXX	XXX	XXX		XXX	XXX	XX		PROGRESS	X	X	X		X
	XXX	XXX	XXX	XXX		XXX	XXX	XX		PROGRESS	X	X	X	XXX	X
	XXX	XXX	XXX	XXX		XXX	XXX	XX		PROGRESS	X	X	X		X
	XXX	XXX	XXX	XXX		XXX	XXX	XX		PROGRESS	X	X	X	XXX	X
	XXX	XXX	XXX	XXX		XXX	XXX	XX		PROGRESS	X	X	X	XXX	X
	XXX	XXX	XXX	XXX		XXX	XXX	XX		PROGRESS	X	X	X	XXX	X
	XXX	XXX	XXX	XXX		XXX	XXX	XX		PROGRESS	X	X	X	XXX	X
	XXX	XXX	XXX	XXX		XXX	XXX	XX		PROGRESS	X	X	X	XXX	X
	XXX	XXX	XXX	XXX		XXX	XXX	XX		PROGRESS	X	X	X	XXX	X
Low - A	X	XXX	XXX	XXX	XX	XXX		XXX	XX	RETROGRESS	XX	X		XXX	X
	X	XXX	XXX	XXX	XX	XXX	XXX	XXX	XX	PROGRESS	X	X		XXX	X
	X	XXX	XXX	XXX	XX	XXX		XXX	XX	STAGNANT	X	X		XXX	X
	X	XXX	XXX	XXX	XX	XXX	XXX	XXX	XX	PROGRESS	X	X		XXX	X
	X	XXX	XXX	XXX	XX	XXX		XXX	XX	PROGRESS	X	X		XXX	X
	X	XXX	XXX	XXX	XX	XXX	XXX	XXX	XX	RETROGRESS	XX	X		XXX	X
	X	XXX	XXX	XXX	XX	XXX		XXX	XX	PROGRESS	X	X		XXX	X
	X	XXX	XXX	XXX	XX	XXX	XXX	XXX	XX	PROGRESS	XXX	XXX		X	X
	X	XXX	XXX	XXX	XX	XXX		XXX	XX	PROGRESS	XXX	XXX		X	X
	X	XXX	XXX	XXX	XX	XXX	XXX	XXX	XX	STAGNANT	XXX	XXX		X	X

Key	Transmission Intensity
High>35	
Moderate-A (15<35)	
Moderate-B 10<15)	
Low-A (5<10)	
Low-B (1<5)	

Key	Recommendation Scale
XXX	Very Highly Recommended (Indispensable)
XX	Highly Recommended
X	Recommended

Strategic Rationale for Sub-stratification	
GTS Transmission strata have been sub-stratified to ensure more precise targeting of interventions considering Nigeria's complex epidemiological setting.	

Fig 11: Banding and Stratification

5.1. MSP Work Plan

To achieve the goal and objectives of the NMSP, the work plan below articulates the relevant strategies, broad activities, implementation timelines and responsible entities.

Table 13: Objective 1; Strategies, Broad Activities, Implementation timelines and Responsible Entities

Objective 1: To strengthen governance and improve organizational capacity for malaria programme implementation to at least 90% from the baseline by 2030.							
Strategy	Broad Activity	Implementation Timeline					Key Responsible
		2026	2027	2028	2029	2030	
1.1 Strengthen the commitment, leadership, and sustained support from government at all levels.	1.1.1 Integrate malaria elimination activities into national and subnational health and economic plans	X	X	X	X	X	NMEP PM/Partners
	1.1.2 Deploy African Leaders Malaria Alliance (ALMA) scorecard and accountability framework at the national and subnational levels to strengthen political commitment, leadership accountability, and performance monitoring.	X	X	X	X	X	NMEP PM/Partners
1.2 Bolster mechanisms to coordinate malaria activities at the national and subnational levels, and across MDAs.	1.2.1 Strengthen external coordination platforms at Federal level and 36 states plus FCT.	X	X	X	X	X	NMEP PM/Partners
	1.2.2 Strengthen internal coordination platforms at Federal level and 36 states plus FCT. Revise ToR and membership of all existing committees and working groups to ensure EHRGE inclusion as per the national coordination framework.	X	X	X	X	X	NMEP PM/Partners
	1.2.3 Establish multi-sectoral collaborative platforms at the national and subnational levels (MDAs / SWAp / PVAC). Ensure the inclusion of EHRGE dimensions in the OCA tool.	X					NMEP PM/Partners

1.3 Strengthen strategic partnerships across service delivery, supply chain, and social and behaviour change (SBC) stakeholders by fostering collaboration among relevant MDAs and partner organizations	1.3.1 Improve collaboration and integration between SBC and service delivery stakeholders to ensure synchronized malaria prevention, diagnosis, and treatment efforts.	X	X	X	X	X	NMEP PM/Partners
	1.3.2 Foster collaboration with national supply chain bodies, procurement agencies, and development partners to ensure efficient forecasting, procurement, and distribution of malaria commodities (including NPSCMP, NAFDAC, NPHCDA, PVAC etc).	X	X	X	X	X	NMEP PM/Partners
1.4 Strengthen collaborative platforms and partnerships with private sector stakeholders at National and Subnational levels to increase coverage of targeted interventions	1.4.1 Facilitate regular private sector coordination mechanisms to provide an enabling environment for private sector participation in decision making and co-creation of strategic interventions.	X	X	X	X	X	NMEP PM/Partners
	1.4.2 Engage regulatory bodies to strengthen partnerships with the private sector and ensure compliance with standard regulations.	X	X	X	X	X	NMEP PM/Partners
1.5 Provide evidence-based policies and ongoing guidance for the deployment of malaria interventions, adapting global policies to local context and fostering innovation (across the various thematic areas)	1.5.1 Develop/disseminate national policies and guidelines ensuring they are effectively communicated, adopted, and implemented at the state level.	X	X	X	X	X	NMEP PM/Partners
	1.5.2 Establish consultative meetings to review existing mechanisms and status of compliance to national policies, strategies, and regulatory framework.	X	X	X	X	X	NMEP PM/Partners
	1.5.3 Conduct EHRGE vulnerability assessment using						

	Malaria Matchbox methodology covering at the least the following groups: populations affected by natural disasters, incarcerated populations (institutionalized populations), mine workers and mining communities, and youths living in educational hostels		X				NMEP PM/Partners
1.6 Strengthen evidence-based planning with subnational inputs that align with Country Fiscal Frameworks	1.6.1 Scale-up mechanisms for periodic malaria programme progress and performance reviews at the federal and state levels. Establish coordination mechanisms (including data sharing) with BHCPF (Basic Healthcare Provision Fund) and NHEA for sharing data on priority EHRGE commitments.	X	X	X	X	X	NMEP PM/Partners
	1.6.2 Develop/support annual operational plan for malaria programme at the federal and in 36 states plus FCT. Embed Grievance Redressal Mechanisms into AOPs, covering all malaria interventions at community and facility levels.	X	X	X	X	X	NMEP PM/Partners
	1.6.3 Conduct Mid-term and End-term reviews of the NMSP and development of the next NMSP	X	X	X	X	X	NMEP PM/Partners
	1.6.4 Develop a pragmatic costed plan to prioritize key interventions, guide evidence-based allocations, and support resource mobilization.					X	
1.7 Strengthen the capacity of NMEP to provide technical support and coordinate all malaria programme priorities at national and state levels	1.7.1 Develop tools and establish mechanisms to regularly assess NMEP/SMEP capacity to implement the NMSP priority interventions.	X	X	X	X	X	NMEP PM/Partners
	1.7.2 Develop a capacity building plan to enhance individual skills and organizational resources for improving programme delivery.	X	X	X	X	X	NMEP PM/Partners

Table 14: Objective 2; Strategies, Broad Activities, Implementation timelines and Responsible Entities

Objective 2: To Improve access to and utilization of preventive interventions to at least 80% by 2030, from the current baseline levels.							
Strategy	Broad Activity	Implementation Timeline				Key Responsible	
		2026	2027	2028	2029	2030	
2.1 Deploy safe and effective integrated vector control interventions based on malaria transmission intensity, epidemiological stratification, and contextual factors.	2.1.1 High transmission settings (malaria prevalence $\geq 35\%$). Deploy the following: 1. ITN mass distribution 2. ITN continuous distribution 3. Targeted IRS in eligible hotspots LSM where feasible, in urban and semi-urban areas	X	X	X	X	X	NMEP/IV M/SM EP
	2.1.2 Moderate transmission settings; category A (malaria prevalence 15 to $<35\%$). Deploy the following: 1. ITN mass distribution 2. ITN continuous distribution 3. Targeted IRS in eligible hotspots LSM where feasible, in urban and semi-urban areas	X	X	X	X	X	NMEP/IV M/SM EP
	2.1.3 Moderate transmission settings; category B (malaria prevalence 10 to $<15\%$). Deploy the following: 1. ITN mass distribution 2. ITN continuous distribution 3. Targeted IRS in eligible hotspots LSM where feasible, in urban and semi-urban areas	X	X	X	X	X	NMEP/IV M/SM EP

	2.1.4 Low transmission settings; category A (malaria prevalence 5 to <10%). Deploy the following: 5. Targeted ITN mass distribution 6. ITN continuous distribution 7. Targeted IRS in eligible hotspots LSM where feasible, in urban and semi-urban areas	X	X	X	X	X	NMEP/IV M/SM EP
	2.1.5 Low transmission settings; category B (malaria prevalence 1 to <5%). Deploy the following: 4. ITN continuous distribution focusing on population groups at risk 5. Targeted IRS in eligible hotspots LSM where feasible, in urban and semi-urban areas	X	X	X	X	X	NMEP/IV M/SM EP
	2.1.6 Very low transmission settings (malaria prevalence 0 to <1%). Deploy the following: 1. ITN continuous distribution focusing on population groups at risk 2. Targeted IRS in active foci, and during outbreak response LSM where feasible	X	X	X	X	X	NMEP/IV M/SM EP
2.2 Deploy innovative vector control tools in targeted areas to complement mainstream vector control interventions.	2.2.1 Implement innovative vector control tools such as house screening, insecticide-treated paints and clothes, spatial repellents, (spatial emanators) attractive sugar baits (ATSB) etc.	X	X	X	X	X	NMEP/IV M/SM EP
2.3 Deploy malaria preventive measures in humanitarian settings and complex operating environments.	2.3.1 Develop an emergency preparedness plan and revise existing implementation strategies and protocols to ensure they reflect EHRGE priority groups.	X	X	X	X	X	NMEP/IV M/SM EP

	2.3.2 Provide ITNs and other appropriate preventive interventions for populations in humanitarian settings and other complex operating environments, including people in prisons, students in hostels, miners, unregistered migrants, and internally displaced persons/returnees.	X	X	X	X	X	NMEP/IV M/SM EP
2.4 Establish a sustainable decision-making mechanism for deployment of IVM interventions using entomological surveillance evidence (insecticide resistance monitoring and vector surveillance).	2.4.1 Sustain vector sentinel surveillance to generate evidence for informed vector control decision-making.	X	X	X	X	X	NMEP/IV M/SM EP
	2.4.2 Sustain insecticide resistance monitoring to generate evidence for informed vector control decision-making.	X	X	X	X	X	NMEP/IV M/SM EP
	2.4.3 Strengthen capacity of NMEP and key stakeholders for planning, implementation, monitoring, and evaluation of vector control interventions.	X	X	X	X	X	NMEP/IV M/SM EP
2.5 Deploy Chemo-preventive interventions to eligible populations (IPTp, SMC, PMC, IPTsc).	2.5.1 Provide Seasonal Malaria Chemoprevention (SMC) services to eligible populations in LGAs where more than 60% of rainfall occurs within four to five consecutive months.	X	X	X	X	X	NMEP/IV M/SM EP
	2.5.2 Scale up Perennial Malaria Chemoprevention (PMC) services to eligible populations in the eligible LGAs.	X	X	X	X	X	NMEP/IV M/SM EP
	2.5.3 Provide Intermittent Preventive Treatment in pregnancy (IPTp) to all pregnant women across the country at ANC facilities and at community levels.	X	X	X	X	X	NMEP/IV M/SM EP
	2.5.4 Deploy IPTsc services to eligible populations in the eligible LGAs.	X	X	X	X	X	NMEP/IV M/SM EP
	2.5.5 Pilot Post Discharge Malaria Chemoprevention (PDMC) amongst patients recently discharged from hospitals.	X	X	X	X	X	NMEP/IV M/SM EP
	2.5.6 Provide Chemoprophylaxis for Special groups, especially in individuals with Sick Cell Anaemia and non-immune travellers.	X	X	X	X	X	NMEP/IV M/SM EP

2.6 Support the deployment of Malaria Vaccine to eligible populations.	2.6.1 Scale up the delivery of malaria vaccine to eligible populations, ensuring equitable access and high coverage.	X	X	X	X	X	NMEP/IV M/SM EP
	2.6.2 Strengthen the coordination between NMEP and NPHCDA for effective scale-up of malaria vaccine.	X	X	X	X	X	NMEP/IV M/SM EP
	2.6.3 Integrate malaria vaccine uptake with other malaria prevention campaigns (ITN, SMC) for a more comprehensive protection.	X	X	X	X	X	NMEP/IV M/SM EP
2.7 Deploy safe, sustainable, and effective management of medical and chemical wastes.	2.7.1 Strengthen waste management systems and create awareness on effective waste management.	X	X	X	X	X	NMEP/IV M/SM EP
	2.7.2 Build capacity of health workers on safe handling of materials, waste segregation and appropriate waste disposal.	X	X	X	X	X	NMEP/IV M/SM EP
2.8 Strengthen systems for continuous availability of, and access to health products for the prevention of malaria through vector control, chemoprevention, and malaria vaccine.	2.8.1 Strengthen systems and processes to reliably quantify malaria commodities used in prevention interventions, including vector control, chemoprevention, and malaria vaccination.	X	X	X	X	X	NMEP/IV M/SM EP
	2.8.2 Strengthen and harmonize procurement processes to ensure timely and cost-effective acquisition of malaria prevention commodities.	X	X	X	X	X	NMEP/IV M/SM EP
	2.8.3 Promote the integrated procurement framework and its benefits to stakeholders, including policymakers, and communities.	X	X	X	X	X	NMEP/IV M/SM EP
	2.8.4 Leverage technology to strengthen inventory management, monitor stockouts, and improve demand forecasting for malaria commodities at all levels of the health system.	X	X	X	X	X	NMEP/IV M/SM EP

	2.8.5 Carry out effective last-mile delivery of malaria preventive commodities by implementing equitable and practical costing and resource allocation methods that prioritize access for vulnerable and underserved populations.	X	X	X	X	X	NMEP/TV M/SM EP
2.9 Sustain and increase public awareness and understanding of malaria prevention to enhance demand, access, and proper use of malaria preventive measures, especially among vulnerable and hard-to-reach populations.	2.9.1 Conduct studies on awareness, ownership and use of malaria control interventions.	X	X	X	X	X	NMEP/PS M/SMEP/P artners
	2.9.2 Develop/adapt and deploy tools for provider and client behaviour change to enhance client-provider engagement.	X	X	X	X	X	NMEP/PS M/SMEP/P artners
	2.9.3 Promote access to, and utilization of malaria prevention interventions through electronic/mass/new media.	X	X	X	X	X	NMEP/PS M/SMEP/P artners
2.10 Leverage the influence of trusted community figures and public personalities to promote malaria prevention behaviours and drive access, uptake, and proper use of malaria interventions.	2.10.1 Design, implement, and sustain a malaria champion and brand ambassador programme, especially in hard-to-reach areas and other high-risk populations, to improve ownership and utilization of malaria prevention interventions.	X	X	X	X	X	NMEP/AC SM/SMEP/ Partners

Table 15: Objective 3; Strategies, Broad Activities, Implementation timelines and Responsible Entities

Objective 3: To improve effective coverage for diagnosis and appropriate treatment for at least 90% of target populations at risk by 2030.							
Strategy	Broad Activity	Implementation Timeline					Key Responsible
		2026	2027	2028	2029	2030	
3.1 Deployment of effective parasitological diagnostics for testing care-seeking persons with suspected malaria	Build capacity of personnel in public health facilities on basic malaria microscopy.	X	X	X	X	X	NMEP/CM/SMEP /Partners

	3.1.2 Support the expansion of malaria microscopy certification programmes to build a larger pool of certified malaria microscopists across all states.	X	X	X	X	X	NMEP/CM/SMEP /Partners
	3.1.3 Build capacity of personnel in private health facilities at all levels and among private medical retailers (Community Pharmacists and PPMVs) for parasitological confirmation of malaria.	X	X	X	X	X	NMEP/CM/SMEP /Partners
	3.1.4 Provide rapid diagnostic testing and microscopy for parasitological confirmation of malaria in public and private health facilities and at the community level.	X	X	X	X	X	NMEP/CM/SMEP /Partners
	3.1.5 Scale up of quality assurance and quality control systems for malaria diagnosis.	X	X	X	X	X	NMEP/CM/SMEP /Partners
	3.1.6 Conduct operational research on the deployment and acceptability of existing and emerging parasitological confirmation tests, including the Urine Malaria Test and AI-assisted and automated diagnosis.	X	X	X	X	X	NMEP/CM/SMEP /Partners
	3.1.7 Strengthen prompt malaria diagnosis in humanitarian emergencies (including internally displaced populations - IDPs, prisoners, miners etc).	X	X	X	X	X	NMEP/CM/SMEP /Partners
3.2 Ensure appropriate treatment for individuals with confirmed malaria using effective antimalarial medicines.	Provision of treatment services for uncomplicated malaria at health facilities and the community levels.	X	X	X	X	X	NMEP/CM/SMEP /Partners
	3.2.2 Strengthen the management of severe malaria in public and private health facilities (including capacity building, increasing access to pre-referral treatment using Rectal Artesunate at primary healthcare facilities, and Injection Artesunate at secondary and tertiary healthcare facilities).	X	X	X	X	X	NMEP/CM/SMEP /Partners

	3.2.3 Scale-up community case management of malaria as a component of integrated community case management (iCCM) through the Community-Based Health Workforce programme, especially in hard-to-reach areas						
	3.2.4 Ensure compliance to National Malaria Treatment Guidelines and the National Quality of Care Guideline on malaria case management.	X	X	X	X	X	NMEP/CM/SMEP /Partners
	3.2.5 Strengthen prompt malaria diagnosis in humanitarian emergencies (including internally displaced populations – IDPs, prisoners, miners etc).	X	X	X	X	X	NMEP/CM/SMEP /Partners
	3.2.6 Strengthen malaria surveillance activities (Antimalarial drug therapeutic efficacy test - DTET)	X	X	X	X	X	NMEP/CM/SMEP /Partners
	3.2.7 Strengthen Pharmacovigilance activities in collaboration with NAFDAC.	X	X	X	X	X	NMEP/CM/SMEP /Partners
	3.2.8 Pilot the implementation strategy of Multiple First Line Therapy (MFT) to generate evidence on model of delivery for scale-up, to delay the emergence of resistance.	X	X	X	X	X	NMEP/CM/SMEP /Partners
	3.2.9 Scale up of MFT by incorporating initial lessons learnt from the implementation strategy pilot.	X	X	X	X	X	NMEP/CM/SMEP /Partners
	3.2.10 Introduce the use of Single Low-Dose Primaquine (SLDPQ) alongside ACTs for treatment of confirmed Plasmodium falciparum malaria cases in low transmission (B) settings to reduce onward transmission, in line with WHO recommendations. The recommended dose is a single 0.25 mg/kg body weight administered with ACT.	X	X	X	X	X	NMEP/CM/SMEP /Partners

3.3 Deploy active malaria case detection strategies to identify and respond to residual transmission foci in low and very low transmission settings.	3.3.1 Implement proactive and reactive case detection approaches, conducting community-based screening in high-risk areas and investigating all confirmed cases to identify secondary infections.	X	X	X	X	X	NMEP/CM/SMEP /Partners
3.4 Strengthen systems for continuous availability of, and access to health products for the diagnosis and treatment of malaria.	3.4.1 Strengthen systems and processes to reliably quantify malaria commodities used for diagnosis and treatment.	X	X	X	X	X	NMEP/PSM/SME P/Partners
	3.4.2 Strengthen and harmonize procurement processes to ensure timely and cost-effective acquisition of malaria commodities for diagnosis and treatment.	X	X	X	X	X	NMEP/PSM/SME P/Partners
	3.4.3 Carry out effective last-mile delivery of malaria diagnosis and treatment commodities by implementing equitable and practical costing and resource allocation methods that prioritize access for vulnerable and underserved populations.	X	X	X	X	X	NMEP/PSM/SME P/Partners
3.5 Deploy an integrated ACSM campaign that combines mass media, digital platforms, and interpersonal communication through trusted structures to increase awareness, demand, and correct use of diagnostic and treatment services.	3.5.1 Promote access to, and utilization of malaria diagnosis and treatment interventions through electronic/mass/new media.	X	X	X	X	X	NMEP/ACSM/SM EP/Partners
3.6 Establishment of accountability (social) mechanism to improve quality of community level malaria /ACSM activities.	3.6.1 Design, implement, and sustain a malaria champion and brand ambassador programme, especially in hard-to-reach areas and other high-risk populations, to improve ownership and utilization of malaria diagnosis and treatment interventions.	X	X	X	X	X	NMEP/ACSM/SM EP/Partners

Table 16: Objective 4; Strategies, Broad Activities, Implementation timelines and Responsible

Objective 4: To improve the effectiveness of malaria surveillance systems in generating complete, timely, and accurate data for programme decision-making, with a targeted increase from 47% to 70% by 2030.

Entities

Strategy	Broad Activity	Implementation Timeline					Key Responsible
		2026	2027	2028	2029	2030	
4.1. Improve the quality and coverage of data generation, analysis, use, and feedback mechanisms	4.1.1 Strengthen routine malaria data generation across public, private, and community platforms leveraging the existing health information system (CBHMIS, NMDR, NHMIS, NHLMIS)	X	X	X	X	X	NMEP/SMEOR/SME P/Partners
	4.1.2 Institutionalize routine malaria data review and data-to-action platforms at national, state, and LGA levels	X	X	X	X	X	NMEP/SMEOR/SME P/Partners
	4.1.3 Strengthen feedback mechanisms across all levels of the health system	X	X	X	X	X	NMEP/SMEOR/SME P/Partners
	4.1.4 Strengthen the use of geospatial and stratification data for malaria programme planning	X	X	X	X	X	NMEP/SMEOR/SME P/Partners
4.2 Improve data quality, analysis and feedback loops	4.2.1 Develop/maintain dashboards and automated alerts to track anomalies or missing reports.	X	X	X	X	X	NMEP/SMEOR/SME P/Partners
	4.2.2 Improve the generation of evidence for decision-making and impact through reporting of quality malaria data and information from the health facilities.						

4.3 Mapping and digitalizing integrated malaria data reporting	4.3.1 Expand digital reporting and support the standardization of malaria data elements for Electronic Medical Record (EMR).	X	X	X	X	X	NMEP/SMEOR/SME P/Partners
	4.3.2 Strengthen the integration of all data sources with NMDR. Revise SMEOR strategy and document data collection mechanisms to ensure availability of disaggregated data for all NMSP priority groups for all interventions.	X	X	X	X	X	NMEP/SMEOR/SME P/Partners
	4.3.3 Strengthen data sharing and dissemination of health information for evidence-based decision making	X	X	X	X	X	NMEP/SMEOR/SME P/Partners
	4.3.4 Support the interoperability between NHMIS and NHLMIS data systems. Regularly share disaggregated data analysis with decision makers and technical forums for course correction at national and state levels.	X	X	X	X	X	NMEP/SMEOR/SME P/Partners
	4.3.5 Improve private sector data reporting.	X	X	X	X	X	NMEP/SMEOR/SME P/Partners
4.4 Improving capacity of Human Resources for SMEOR at all levels.	4.4.1 Strengthen the capacity of healthcare providers on HMIS to optimize data collection and reporting.	X	X	X	X	X	NMEP/SMEOR/SME P/Partners
	4.4.2 Build the capacity of SMEP and LGA Malaria Focal Persons on data analysis, interpretation, and use for evidence-based decision making.	X	X	X	X	X	NMEP/SMEOR/SME P/Partners

4.4 Strengthen Entomological surveillance	4.4.1 Expand entomological sites across the country for data generation.	X	X	X	X	X	NMEP/SMEOR/SME P/Partners
	4.4.2 Support expansion of Molecular analysis laboratories.	X	X	X	X	X	NMEP/SMEOR/SME P/Partners
	4.4.3 Monitor emerging vectors such as <i>Anopheles Stephensi</i>	X	X	X	X	X	NMEP/SMEOR/SME P/Partners
4.5 Strengthen drugs and diagnostics surveillance through the conduct of TES and evidence-based decision making	4.5.1 Conduct regular TES across the study sites in the country	X	X	X	X	X	NMEP/SMEOR/SME P/Partners
	4.5.2 Monitor molecular markers of antimalarial resistance.	X	X	X	X	X	NMEP/SMEOR/SME P/Partners
	4.5.3 Conduct implementation research on HRP2/3 antigen deletions to generate evidence that will guide informed decision-making on the deployment of appropriate mRDTs in the country.	X	X	X	X	X	NMEP/SMEOR/SME P/Partners
4.6 Expand research for Malaria Surveillance.	4.6.1 Strengthen Operations Research (OR) through enhanced collaboration with tertiary institutions, engagement with the academia, and consistent generation of evidence for programme decision making.	X	X	X	X	X	NMEP/SMEOR/SME P/Partners
	4.6.2 Support the coordination, design, and implementation of malaria-related surveys.	X	X	X	X	X	NMEP/SMEOR/SME P/Partners

4.7 Strengthen surveillance systems to support case notification, follow-up, and timely response in pre-elimination settings	4.7.1 Integrate community health workers and private providers into active surveillance networks to expand reach and ensure prompt case identification.	X	X	X	X	X	NMEP/SMEOR/SMEP/Partners
	4.7.2 Utilize digital tools for real-time data reporting, geo-mapping of cases, and monitoring of intervention impact.	X	X	X	X	X	NMEP/SMEOR/SMEP/Partners
4.8 Significantly improve Health Facility logistics reporting efficiency for optimal utilization of commodities, wider coverage and evidence-based supply chain decisions	4.8.1 Enhance the generation of quality logistics data by leveraging innovative relevant applications and digital tools	X	X	X	X	X	NMEP/PSM/SMEP/Partners
	4.8.2 Build capacity for analysis and use of logistics data	X	X	X	X	X	NMEP/PSM/SMEP/Partners
	4.8.3 Conduct Regular data quality assessments and feedback	X	X	X	X	X	NMEP/PSM/SMEP/Partners
4.9 Periodic review and feedback on outcome measurements	4.9.1 Establish performance metrics and monitoring systems to assess (PSM) performance; including the use of stakeholder feedback mechanism to identify areas for improvement	X	X	X	X	X	NMEP/PSM/SMEP/Partners

Table 17: Objective 5; Strategies, Broad Activities, Implementation timelines and Responsible Entities

Objective 5: To achieve sustainable malaria financing with at least 60% of resources mobilized from domestic resources by 2030							
Strategy	Broad Activity	Implementation Timeline					Key Responsible
		2026	2027	2028	2029	2030	
5.1 Enhance capacity to generate, manage and utilize financial resources equitably and efficiently for malaria	5.1.1 Strengthen financial resource mapping, evidence generation, and expenditure tracking processes.	X	X	X	X	X	NMEP/PM /SMEP/ Partners
	5.1.2 Develop tools/facilitate allocative efficiency in the disbursement of funds for malaria sub-nationally tailored interventions.	X	X	X	X	X	NMEP/PM /SMEP/ Partners
	5.1.3 Organize high-level annual malaria financing roundtable events to galvanize political commitment and mobilize resources.	X	X	X	X	X	NMEP/PM /SMEP/ Partners
5.2 Attract and optimize external funding through development partners and global health initiatives	5.2.1 Initiate/Support joint regional initiatives for domestic resource mobilization.	X	X	X	X	X	NMEP/PM /SMEP/ Partners
5.3 Deploy innovative financing mechanisms	5.3.1 Promote innovative resource mobilization initiatives targeting individuals, corporate organizations, philanthropic organizations and End Malaria Council (EMC).	X	X	X	X	X	NMEP/PM /SMEP/ Partners
	5.3.2 Promote private sector engagement by supporting 3-5 malaria-focused startups annually, strengthening PPPs for local manufacturing of malaria commodities, and leveraging private sector platforms to build the business case for malaria investment.	X	X	X	X	X	NMEP/PM /SMEP/ Partners
5.4 Secure greater health allocations from national and subnational governments	5.4.1 Develop an engagement plan to ensure ring-fenced funds for malaria from statutory budget allocations. (e.g. engagement with the Legislature, engagement with Regional Development Commissions such as NDDC, SEDC, NEDC etc).	X	X	X	X	X	NMEP/PM /SMEP/ Partners

	5.4.2 Position the malaria programme as part of constituency empowerment and address malaria issues as a constituency development issue.	X	X	X	X	X	NMEP/PM /SMEP/ Partners
	5.4.3 Allocate Financial Resources for NMEP Capacities to ensure adequate Targeting, ability to work in Complex Operating Environments, and respond to Emergencies						
5.5 Leverage private capital and contributions for domestic resourcing of malaria commodities	5.5.1 Establish a co-payment mechanism for malaria commodities and an enabling environment for local manufacturing of malaria commodities in Nigeria.	X	X	X	X	X	NMEP/PS M/SMEP/ Partners
5.6 Engage policy makers to generate increased political will for malaria funding	5.6.1 Deploy advocacy intervention tools and packages targeted at public policy makers at the national and state levels.	X	X	X	X	X	NMEP/AC SM/SMEP/ Partners
5.7 Mobilize Civil Society Organizations for improved transparency and accountability	5.7.1 Strengthen the role of Civil Society Organizations in tracking malaria programme implementation, financing, and results at the national and subnational level.	X	X	X	X	X	NMEP/AC SM/SMEP/ Partners

5.2. Implementation arrangements

Implementation Arrangements for the NMSP 2026-2030 will leverage the Sector-Wide Approach (SWAp) to ensure coordinated planning, financing, risk management, procurement and supply chain management, partnership coordination, and effective implementation across all levels of government, development partners, and private sector. This approach will align resources and activities with national priorities, promote joint accountability, minimize duplication, and strengthen the integration of malaria interventions into broader health system functions, while enabling flexible, evidence-based, and locally responsive implementation. This will build on the recent successes, while addressing the challenges and also incorporating the recommendations from the review of the NMSP 2021-2025. It will leverage the High Burden, High Impact (HBHI) approach and apply lessons learned from the implementation of subnational tailoring (SNT) intervention mixes, while taking into account the technical and operational needs of decentralized malaria programmes across states.

Achieving the NMSP targets will require coordinated efforts from multiple stakeholders, strengthened multi-sectoral coordination, and sustained collaboration at the federal, state, LGA, community, and household levels to effectively deliver on the strategies, priorities, and timelines of the plan. A synergy of bilateral and multilateral agencies, implementing partners, Civil Society groups, Research

Institutions, Academia and the private sector will be a catalyst to the achievement of the goal and objectives of the NMSP.

While NMEP and Federal MDAs provide policy and guidelines for key malaria control/elimination strategies, implementation will be integrated and decentralized to the States and the LGAs, managed by the State Malaria Elimination Programmes (SMEPs) through their Annual Operation Plan (AOP) development and periodic reviews to check implementation progress. Critical state-level stakeholders include the State Primary Health Care Development Agencies (SPHCDA), Hospital Management Boards (HMBs), State Logistics Management Coordination Units (LMCUs), Department of Planning Research & Statistics/Health Management Information System (DPRS/HMIS), State Health Insurance Agencies, LGA malaria focal persons, PHC facilities, private health facilities, community health workers and the new CBHWP initiative.

Guiding Principles for the NMSP 2026-2030

The implementation of this NMSP will be guided by the following:

-  **Subnational Tailoring (SNT):** The implementation of the NMSP 2026-2030 will be guided by subnational tailoring of interventions as one of its core principles. This strategic approach acknowledges Nigeria's heterogeneous malaria epidemiology, diverse transmission patterns, evolving entomology, and varied contextual realities across different settings. By aligning appropriate interventions with local needs, subnational tailoring ensures that resources are used more efficiently, interventions are more effective, and local ownership is strengthened. States will be supported to develop and regularly update their malaria operational plans based on their specific transmission dynamics and disease burden. This approach is expected to enhance responsiveness, improve impact, and accelerate progress towards malaria elimination in Nigeria
-  **Leveraging SWAp to improve the effectiveness of donor support:** Malaria partners will align their support with national priorities under the Sector Wide Approach (SWAp) framework to enhance coordination, efficiency, and impact. Partners activities should be harmonized and overseen by NMEP for results, ensuring that resources are deployed in line with the country's strategic direction
-  **Multi-stakeholder and Multisectoral Approach:** Successful implementation of the NMSP strategies and broad activities will most times require the involvement of staff from different branches of NMEP, departments of FMOH and other line Ministries and Agencies e.g., Family Health, NPHCDA, SPHCDA, NHIA, SHIA, NPSCMP, NCDC, NEMA, SEMA, Private Sector, partners etc
-  **Equity, Human Rights, and Gender Equality (EHRGE):** EHRGE will be a central pillar of the NMSP 2026-2030, ensuring that malaria interventions are inclusive, and responsive to the needs of all populations especially the most vulnerable.

High priority must be given to groups disproportionately affected by malaria, including the rural poor, women, children under five, mobile and migrant populations, internally displaced persons, and refugees. These groups often face systemic barriers to accessing healthcare services. Integrating EHRGE into malaria programming means deliberately identifying and addressing these barriers, and a strong focus on EHRGE will enhance the reach and inclusiveness of malaria interventions across the country

-  **Efficiency:** Implementation of the NMSP 2026-2030 will be guided by the principle of efficiency, ensuring that all available and prospective resources are optimally allocated and utilized to deliver maximum value for money. The NMSP will emphasize evidence-based resource allocation, programme efficiency, integration and synergy of interventions, and robust monitoring and accountability mechanisms
-  **Partnerships Coordination:** Strengthen collaboration with relevant sectors such as education, environment, and water resources, and with key stakeholders, including the private sector, civil society, and development partners. Coordination platforms will be operationalized at national and sub-national levels to foster effective integration and collaboration. Business processes will be clearly defined, with responsibilities assigned according to institutional mandates to enhance coordinated implementation
-  **Mechanisms for Performance Tracking:** NMEP and partners will institutionalize robust systems for monitoring implementation progress, financial performance, and commodity management. These mechanisms will support real-time data analysis, accountability, and adaptive programme management to enhance effectiveness and ensure results are achieved
-  **Leveraging Community Health Services:** At the subnational level, implementation of malaria-related activities will build on existing community and social structures rather than creating new tiers of workstreams. The plan will leverage existing systems such as the Civil Society network, the Community Health Workers Programme, and other community-based platforms to enhance reach, ownership, and sustainability of interventions
-  **Risk Management:** Potential risks and assumptions associated with malaria programme implementation will be proactively identified, assessed, and mitigated. A structured risk management framework will address issues related to programme standards, internal controls, and quality assurance to safeguard efficiency, accountability, and sustainability of interventions

5.2.1. Programme Planning:

NMEP, SMEP and Partners will develop Annual Operational Plans (AOPs) that will highlight implementation activities and budget breakdown for malaria programmes, as well as articulate the investments of malaria partners within the fiscal year that are consistent with the priorities set in the NMSP. This is in line with the Partnership coordination system, guided by the practice directive from the Federal Ministry of Finance, Budget and National Planning, where the FMoH and MDAs develop AOP in alignment with the HSSB tool. The planning cycle aligns with the fiscal policy and budget cycle of January to December each year.

5.2.2. Partnership coordination framework

Effective implementation of the NMSP requires strong coordination among government institutions, development partners, and other stakeholders involved in malaria control and elimination across the country. The Federal Ministry of Health and Social Welfare (FMoH&SW) provides overall leadership for the national malaria response through NMEP, which is responsible for strategic direction, policy guidance, and coordination of malaria control and elimination efforts.

The Malaria Technical Working Group (TWG) serves as the primary national platform for technical coordination. The TWG brings together representatives from government agencies, development partners, implementing partners, civil society organizations, academia, and the private sector to support the planning, implementation, and monitoring of malaria interventions. It also provides a structured framework for coordination of the in-country RBM Partnership, ensuring alignment of partner activities with national malaria priorities. To strengthen technical oversight and provide specialized guidance, the TWG operates through six thematic subcommittees aligned with the key technical areas of the malaria elimination strategy. These subcommittees provide detailed technical support, facilitate evidence-based decision-making, and support the development of policies, guidelines, and Annual Operational Plans (AOPs) necessary for effective programme implementation.

At the subnational level, coordination is facilitated through state-level structures including Partners Forum, Malaria Control Advisory Committees, and other established state-specific malaria coordination platforms. These coordination mechanisms support the State Malaria Elimination Programmes (SMEPs) in harmonizing partner activities, promoting information sharing, and ensuring that malaria interventions are implemented in line with national guidelines while addressing state-specific priorities.

In addition to internal programme coordination, NMEP maintains strong collaboration with relevant Ministries, Departments, and Agencies (MDAs) (see figure 13 below) to promote a multisectoral response to malaria. Engagement with sectors such as Environment, Education, Agriculture, Water Resources, and Defence supports the integration of malaria prevention and control interventions into broader sectoral strategies and programmes. These partnerships strengthen efforts related to environmental management, school-based malaria interventions, improved water infrastructures, and the provision of security support by the military and para-military to facilitate service delivery in security-challenged communities. This partnership coordination framework ensures that all stakeholders operate within a harmonized structure that promotes efficiency, accountability, and collective action towards achieving the national malaria elimination goals.

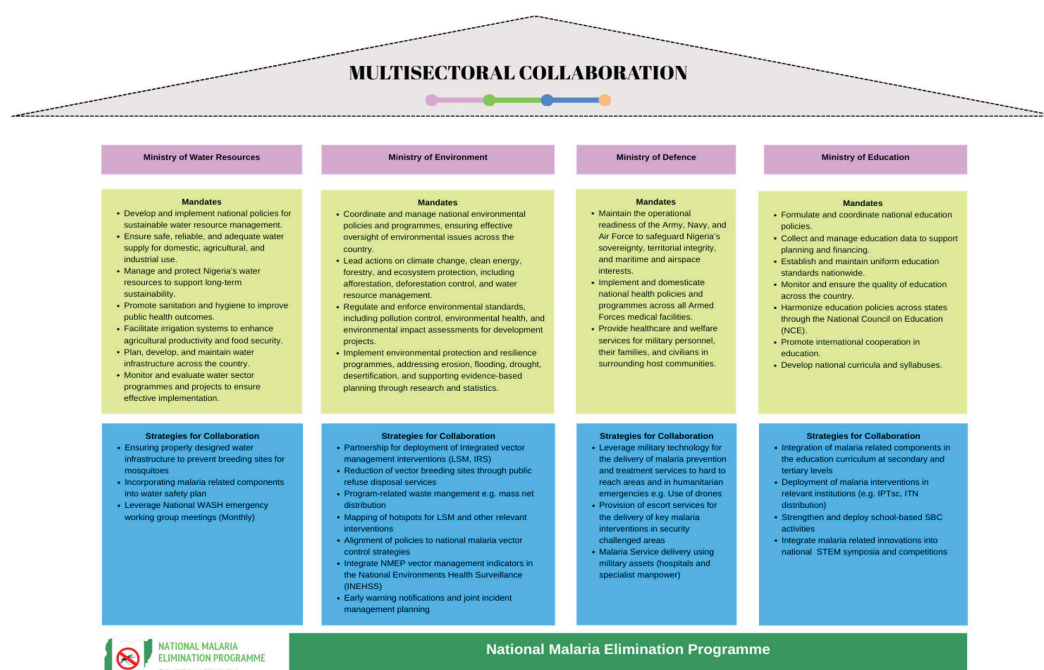


Fig 12: Framework for Multisectoral Collaboration.

5.2.3. Procurement and supply management (PSM) system

The National Supply Chain system for the malaria programme in Nigeria is a complex and multi-tiered system, coordinated by the Procurement and Supply Chain Management (PSM) branch of the National Malaria Elimination Programme (NMEP). The PSM branch is responsible for forecasting and quantifying the country's malaria health product needs, which serves as the basis for procurement by the government and donors/implementing partners.

The procurement process is informed by the national quantification outcome, and donor commitment to specific states is taken into account. Where there are gaps between the forecast and donor commitment for each state, the Government of Nigeria (GoN) takes responsibility to bridge the gaps. This largely ensures that the country usually has a steady supply of malaria health products to meet the needs of the citizens.

The malaria supply chain in Nigeria has three storage levels: national warehouses, axial or zonal warehouses, and state warehouses. The national warehouses, located in Lagos and Abuja, serve as the primary entry points for all malaria health products imported into the country. From these national warehouses, products are transported to the zonal warehouses, which are strategically located in six zones across the country, namely: Lagos (South-West), Gombe (North-East), Sokoto (North-West), Abuja (North Central), Cross River (South-South), and Anambra (South-East).

The zonal warehouses then serve as the hubs for distributing malaria health products to the states within their respective zones. At the state level, the Logistics Management Coordination Unit (LMCU) plays a critical role in aggregating the health product needs of each health facility, based on the Bimonthly Facility Stock Report (BFSR) generated at the facility level. The aggregated needs are used to generate the Last Mile Delivery (LMD) Plan for each health facility,

which outlines the specific quantities of malaria health products required by each facility.

The LMD plan is reviewed by the national programme and sent back to the LMCU for approval by the relevant authority. Once approved, the LMD plan is sent to the axial warehouse for Last Mile delivery to the health facilities. At the health facility level, the health products are received, and the Proof of Delivery (POD) is signed off, confirming receipt of the quantities issued from the axial warehouses.

Each health facility has Logistics Management Information System (LMIS) tools for reporting and recording transactions. The BFSR is used to generate logistics reports at the health facility level every two months, which are collected by the Local Government Area (LGA) LMCU and transmitted to the state LMCU. The state LMCU then enters the data into the National Health Logistics Management Information System (NHLMIS), which generates the malaria logistics dashboard and informs the LMD plan. The LMD plan drives the bimonthly re-supply of malaria health products to the facilities, ensuring that necessary products are available.

The system's effectiveness relies on the collaboration and coordination among various stakeholders, including the government, donors, implementing partners, and healthcare providers. The system leverages LMIS tools and the NHLMIS to track inventory levels, generate accurate forecasts, and ensure that malaria health products are delivered to where they are needed most.

However, MPR observes the occasional challenge with reconciliation of product quantities at the last mile of distribution attributable to previously noted varying degrees of controversial practices including dumping and proxy delivery. Again weak linkages noted between the National Malaria Programme (NMP) and relevant MDAs resulted in the little evidence of Post Marketing Surveillance (PMS); also there was insufficient clarity of information flow across relevant MDAs involved in Supply Chain Management with non-definition of baseline data and periodic (annual) targets for PSM; furthermore, the clarity on Domestic Market Shaping strategies for malaria commodities and indicators to monitor domestic supply side activities, production or delivery performance.

The strategic plan (2026-2030) is an opportunity to:

-  Strengthen the connection between the National Malaria Programme (NMP) by ensuring active participation in relevant working groups with the DFDS, NPSCMP, National Primary Health Care Development Agency (NPHCDA), and National Agency for Food and Drug Administration and Control (NAFDAC)
-  Incorporate initiatives to improve health facility logistics reporting efficiency by leveraging innovative relevant applications and digital tools like mSupply to automate the process.
-  Enhance procurement and supply chain outcomes by aligning the malaria programme with new resources like the Rethinking Malaria and PVAC initiatives
-  Strengthen and ensure comprehensiveness of the QA/QC sampling protocol for malaria commodities as well as specifically define baseline values and annual targets for all PSM indicators

5.2.4. Financial Resource Management

Sustainable financing is a critical component of the NMSP 2026-2030, particularly in the context of evolving donor landscape and shifting funding dynamics. To demonstrate financial resilience in the next five years, the country will prioritize long-term domestic sustainability strategies focusing on efficiency, equity, accountability, and equally explore more private sector partnerships, subnational financing, and diverse innovative opportunities. This approach aims to diversify revenue streams, institutionalize accountability, and ensure sustainability through domestic revenue measures, private sector engagement, and equity-focused protection mechanisms. It incorporates key lessons learned from the malaria programme review to ensure more effective resource allocation and improved outcomes in the new planning cycle.

The End Malaria Council (EMC) is positioned to play a crucial role in leading high-level advocacy and intensified resource mobilization efforts, working closely with NMEP and SMEPs. It is imperative to mobilize political commitment at the highest levels to ensure that malaria remains a national priority, through effective collaboration and partnerships between governments and the private sector. These collaborative efforts will leverage innovations, technology, and equally strengthen operational capacity for resource mobilization and sustainable financing.

The major financing sources for NMSP 2026–2030 will include:

-  Federal & State Budgetary Allocations (via the proposed Malaria Financing Act, BHCPF, State Health Insurance, HOPE-PHC Programme etc.)
-  National Malaria Financing Facility (NMFF): Pooled contributions from government, private sector, End Malaria Council and philanthropy
-  Private Sector and Community Contributions: CSR, fintech-driven micro-donations, malaria diaspora and corporate bonds, cooperative savings, other innovative domestic revenue sources
-  Donor Resources: Global Fund, Gates Foundation, World Bank, Islamic Development Bank, Philanthropic donors, etc.

Some of the financial mechanisms for increasing indirect resource allocation to malaria elimination efforts include:

National Health Insurance Agency (NHIA): This is Nigeria's health financing strategy to attain Universal Health Coverage, though the scheme currently covers less than 10% of the population, which is more of the formal working class. Nonetheless, NHIA offers a strategic opportunity to increase access, sustainability, and financial protection for malaria services. Integration of malaria services into NHIA benefit packages provides an opportunity to ensure that essential malaria services are covered, reducing out-of-pocket costs, especially for vulnerable populations such as pregnant women and children under 5.

Basic Healthcare Provision Fund (BHCPF): States have commenced to draw down the 1% Consolidated Revenue Fund allocated to the BHCPF each year in accordance with the provisions of the National Health Act 2014. This will aid the implementation of the Basic Minimum Package of Health Services which includes Malaria.

Drug Revolving Fund (DRF) Schemes: The State and LGA DRF initiatives are opportunities for financing Malaria medicines and other commodities at the sub-national levels. This also holds the key for the sustainability strategy of the NMEP.

RMNCHAH Week: Malaria interventions remain a major component of the week-long bi-annual implementation of integrated reproductive, maternal, neonatal, child and adolescent health. The intervention provides opportunity for scaling up priority health services particularly in hard-to-reach areas with support from the State Governments via the Hospital Management Boards, UNICEF, UNDP, WHO, etc.

Public Private Partnership (PPP): Leveraging the corporate social responsibility (CSR) of private companies and organizations to fund malaria related interventions and galvanizing private sector support for malaria through CAMA. Private sector engagement will be guided by the direction provided in the HSSB.

5.2.5. Risk Management and Mitigation.

The risks likely to be associated with the implementation of the NMSP 2026-2030 and the mitigating actions are shown in the table below:

Table 18: Risk categories and mitigation actions

Risk Category	Key Risk	Risk Rating	Mitigation Actions
Financing	Reduced external funding and inadequate domestic financing may create coverage gaps in malaria interventions and surveillance activities	4	Strengthen and diversify malaria financing mechanisms to ensure sustainable and resilient funding: - Leverage domestic funding (including the BHCPF, federal, state, and LGA budget lines, and co-financing arrangements) - Engage the private sector through partnerships and corporate social responsibility initiatives to ensure sustainable and predictable funding.
Security and Humanitarian Access	Worsening insecurity and population displacement continues to limit access to affected areas, hinder the movement of commodities, and threaten staff safety, resulting in gaps and	4	- Integrate security analysis and flexible planning into the malaria programme
	disruptions of malaria service delivery.		- Use community-based platforms and personnel to sustain service delivery in hard-to-reach areas - Strengthen remote monitoring using digital tools - Maintain strong coordination with NEMA and partners working in security-challenged areas, and ensure security protocols are updated regularly
Supply Chain and Logistics	Foreign exchange volatility, supplier delays, port congestion, road insecurity, and limited warehousing capacity may disrupt the supply chain, leading to delayed distribution and stockouts of malaria commodities.	3	- Strengthen supply chain resilience through early procurement planning, diversification of suppliers, and improved warehousing - Enhance coordination with partners, donor agencies, and authorities

			- Monitor stock levels using digital tools such as mSupply - Prioritize local procurement where feasible
Climate change	Increasing climate variability and severe flooding may displace populations, damage health infrastructure, disrupt malaria service delivery, and alter transmission patterns. Additionally, concurrent outbreak of climate-related diseases may put strain on available resources and response capacity.	4	- Coordinate with disaster management, humanitarian partners, and relevant agencies such as the Nigeria Meteorological Agency (NiMet) and the Nigeria Hydrological Services Agency (NIHSA) for forecasting and management of water-related hazards - Enhance early warning and surveillance to anticipate any shifts - Engage communities on malaria prevention and safe access to services during climate-related disruptions
Private Sector Engagement	Limited private sector engagement may result in inadequate buy-in, fragmented service delivery, and insufficient data reporting, potentially undermining the effectiveness of the national malaria response.	3	- Engage private sector stakeholders through regular consultations, capacity building, and inclusion in the malaria programme planning activities - Use professional associations to maintain active and coordinated private sector involvement in the national malaria response
Coordination and Collaboration	Weak coordination and collaboration among the MDAs, partners, and other stakeholders may lead to duplication of efforts, inefficient resource use, and coverage gaps.	2	- Establish and sustain regular multi-stakeholder coordination platforms - Align malaria activities with national health strategies and humanitarian response mechanisms - Monitor collaboration outcomes to identify gaps and improve efforts

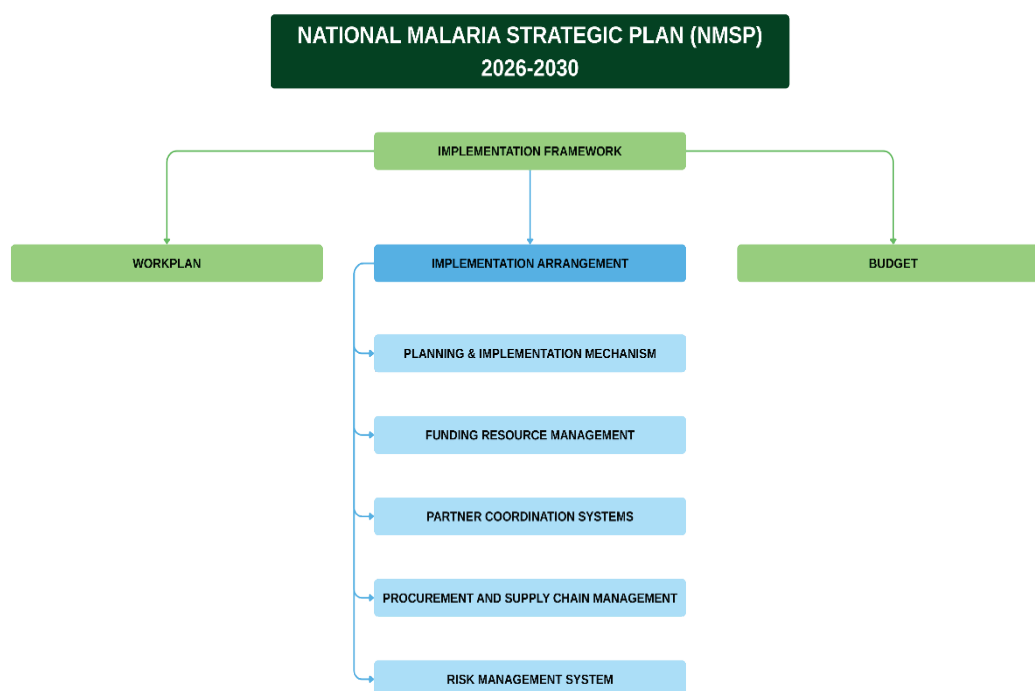


Fig 13: Structure of the NMSP Implementation Framework; shows the operational architecture of the NMSP, including the interaction between governance, partnerships, and operational elements involved in achieving the NMSP targets.

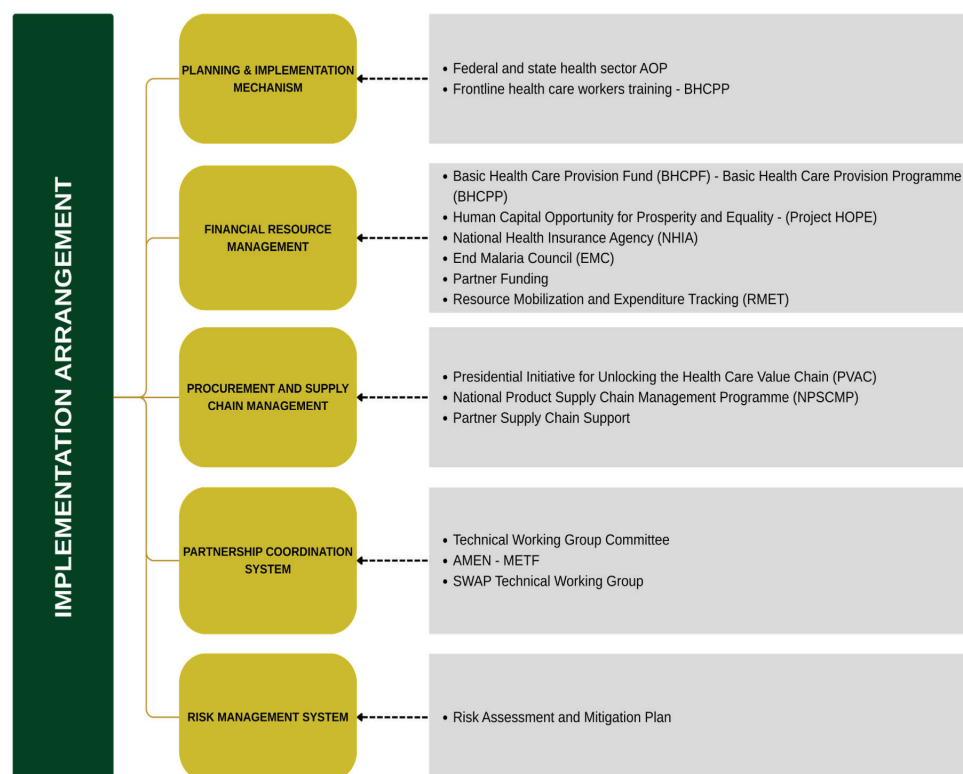


Fig 14: Overview of the Implementation Arrangements; outlines the coordination mechanisms, operational processes, and responsible entities that will ensure accountability and effective implementation of the NMSP 2026-2030.

5.3. NMSP Budget

Total estimated budget (2026 - 2030)

The total budget for the NMSP 2026-2030 is six trillion, four hundred and seventy-six billion, six hundred and seventy-two million, seven hundred and ninety-eight thousand, six hundred and nine Naira (₦6,476,672,798,609). This is equivalent to four billion, three hundred and seventeen million, seven hundred and eighty-one thousand, eight hundred and sixty-six US dollars (USD4,317,781,866), using an exchange rate of ₦1,500 per USD1.

Objective 2 which has Preventive Interventions such as vector control, chemoprevention, and malaria vaccine account for over 75% of the total budget (See Table 20 and Figure 14). This significant allocation underscores the strategic emphasis on prevention as a cost-effective approach to reducing malaria transmission and disease burden in this planning cycle. However, within Objective 2, vector control interventions represent the largest cost driver, accounting for almost half (49%) of the total budget (see Table 21 and Figure 15). This reflects the central role of interventions such as ITNs, LSM, IRS, and other integrated vector management strategies in achieving the overall goals of the NMSP.

Table 19: Summary of NMSP Budget by Objectives

NMSP Objectives	2026	2027	2028	2029	2030	2026-2030 (Total Budget)
Objective 1: To strengthen governance and improve organizational capacity for malaria programme implementation to at least 90% from the baseline by 2030.	8,885,103,620	6,709,918,380	7,018,956,900	6,835,387,580	7,144,426,100	36,593,792,580
Objective 2: To Improve access to and utilization of preventive interventions to at least 80% by 2030, from the current baseline levels.	903,227,123,364	1,162,495,574,207	1,041,553,881,964	741,932,753,095	1,061,044,948,161	4,910,254,280,791
Objective 3: To improve effective coverage for diagnosis and appropriate treatment for at least 90% of the target populations at risk by 2030.	220,649,826,024	223,483,001,182	226,944,778,096	230,209,593,443	233,722,509,402	1,135,009,708,148
Objective 4: To improve the effectiveness of malaria surveillance systems in generating complete, timely, and accurate data for programme decision-making, with a targeted increase from 47% to 70% by 2030.	25,488,607,957	25,429,341,637	25,816,997,847	25,471,939,937	27,019,591,637	129,226,479,015
Objective 5: To achieve sustainable and equitable malaria financing with at least 60% of resources mobilized	7,650,524,895	121,375,228,355	7,601,337,215	121,375,228,355	7,586,219,255	265,588,538,075

from domestic resources by 2030.						
Annual Budget (NGN)	1,165,901,185,860	1,539,493,063,761	1,308,935,952,022	1,125,824,902,411	1,336,517,694,555	6,476,672,798,609
Annual Budget (USD)	777,267,457	1,026,328,709	872,623,968	750,549,935	891,011,796	4,317,781,866

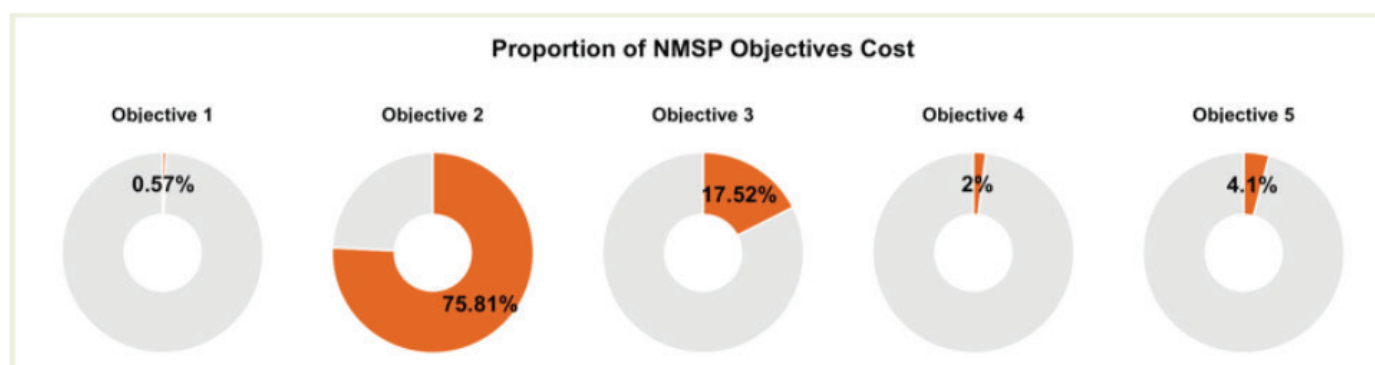


Figure 15: Summary of NMSP budget by Objectives.

Annual funding requirements range from ₦1.17 trillion (USD777.3 million) in 2026 to ₦1.31 trillion (USD872.6 million) in 2028, with the highest spend of ₦1.54 trillion (USD1.03 billion) expected in 2027. Year-on-year budget variations are attributed to changes in projected target populations and planned timelines for specific programmatic activities e.g. More states are scheduled for ITN distribution in 2027 compared to other years and IPTSC is scheduled to commence in 2027.

Table 20: Summary of NMSP Budget by Intervention Areas

Intervention Area	Annual Budget					2026-2030 Budget	% of Total
	2026	2027	2028	2029	2030	2026 – 2030 (Total)	
Vector Control: ITN	196,013,179,163	457,889,172,352	318,905,499,461	224,451,278,844	513,279,822,456	1,710,538,952,277	26.05
Vector Control: IRS	156,536,488,348	156,536,488,348	156,536,488,348	156,536,488,348	156,536,488,348	782,682,441,741	11.92
Vector Control: LSM	227,698,430,454	227,698,430,454	227,698,430,454	0	0	683,095,291,362	10.40
Vector Control: Entomological surveillance	640,121,460	640,121,460	640,121,460	640,121,460	640,121,460	3,200,607,300	0.05
Vector Control: Other Interventions	90,016,110	12,422,539,470	79,185,450	79,185,450	79,185,450	12,750,111,930	0.19
Specific Prevention Interventions (SPI): SP for IPTp	20,147,733,855	21,294,738,135	22,530,275,495	23,863,229,841	25,303,537,726	113,139,515,052	1.72
Specific Prevention Interventions (SPI): SP for PMC	35,697,977,178	36,818,278,360	37,974,123,443	39,166,673,719	40,397,115,967	190,054,168,667	2.89

Specific Prevention Interventions (SPI): SP for IPTsc	0	85,037,932,309	94,645,523,314	108,373,708,229	129,462,470,790	417,519,634,641	6.36
Specific Prevention Interventions (SPI): Malaria Vaccine	35275240	240,008,900,017	20157280	20157280	20157280	240,104,647,097	3.66
Specific Prevention Interventions (SPI): Seasonal Malaria Intervention (SMC)	157,971,782,071	163,374,620,899	168,986,615,623	174,817,890,288	180,879,257,022	846,030,165,903	12.88
Malaria preventive measures in humanitarian settings and complex operating environments (EHRGE)	1,170,514,240	117,728,960	117,728,960	117,728,960	117,728,960	1,641,430,080	0.02
Case Management: Diagnosis	44,243,141,491	45,383,368,591	46,815,794,535	48,296,832,709	49,828,335,832	234,567,473,158	3.57
Case Management: Treatment	176,404,184,533	178,099,632,591	179,981,822,362	181,912,760,735	183,894,173,570	900,292,573,790	13.71
RSSH: PSM	12,598,928,349	12,555,133,449	13,028,370,259	12,579,133,449	12,567,133,449	63,328,698,955	0.96
RSSH: SMEOR	13,004,838,173	12,951,571,853	13,013,152,453	12,970,170,153	14,529,821,853	66,469,554,485	1.01
RSSH: ACSM	5,952,994,050	119,675,188,590	5,901,297,450	119,675,188,590	5,886,179,490	257,090,848,170	3.91
Programme Management	10,555,707,570	8,336,373,970	8,645,412,490	8,461,843,170	8,770,881,690	44,770,218,890	0.68
Annual Intervention Budget (NGN)	1,058,761,312,286	1,778,840,219,809	1,295,519,998,837	1,111,962,391,224	1,322,192,411,344	6,476,672,798,609	100
Annual Intervention Budget (USD)	705,840,875	1,185,893,480	863,679,999	741,308,261	881,461,608	4,317,781,866	

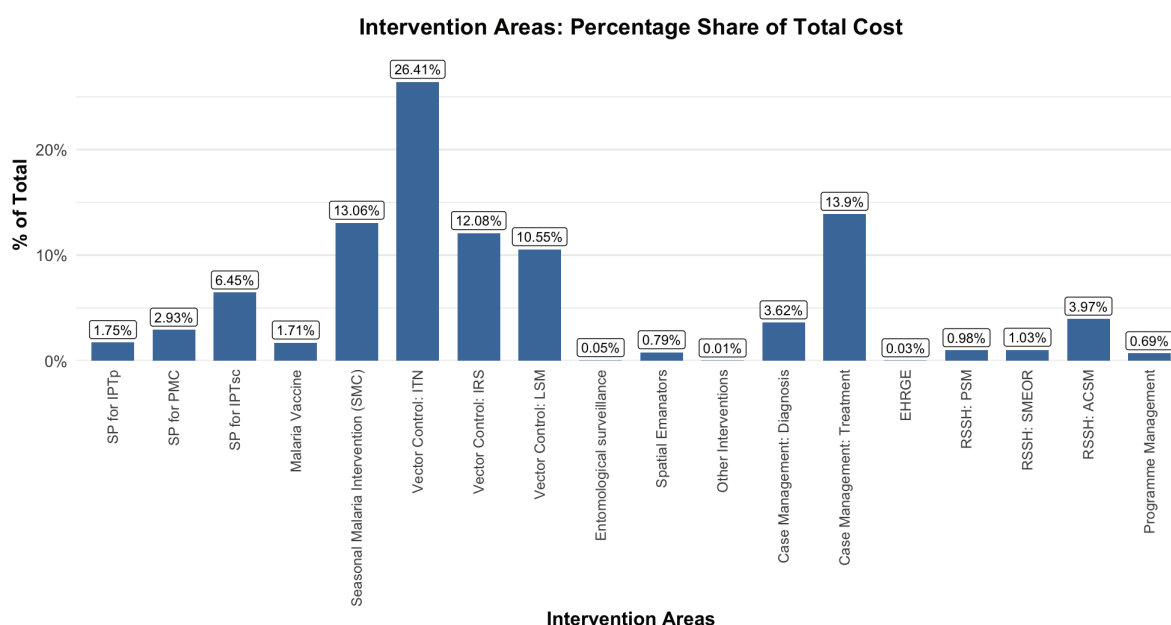


Figure 16: Summary of NMSP budget by Intervention Areas

Table 21: Malaria Commodity Needs for 2026 - 2030

Commodity	Annual Needs					2026 -2030 Needs
	2026	2027	2028	2029	2030	
ACT doses (Public sector)	69,147,382	69,851,866	70,575,018	71,317,518	72,080,081	283,119,999
ACT doses (Private sector)	93,056,667	93,975,990	94,904,395	95,841,972	96,788,812	474,567,836
RDT quantity (Public sector)	61,812,317	63,804,581	65,864,226	67,993,802	70,195,977	329,670,903
RDT quantity (Private sector)	83,301,891	86,083,006	88,956,971	91,926,887	94,995,956	445,264,711
Microscopy needs (Public sector)	16,613,315	17,167,967	17,741,137	18,333,442	18,945,522	88,801,383
Microscopy needs (Private sector)	26,901,251	27,799,376	28,727,486	29,686,581	30,677,697	143,792,391
ITN quantity (Mass Campaign)	18,700,002	88,862,475	36,269,768	20,734,862	97,400,751	261,967,858
ITN quantity (Routine)	18,114,590	19,141,217	20,244,005	21,430,024	22,707,103	101,636,939

Artesunate Injection doses (Public)	6,698,653	6,766,898	6,836,951	6,908,879	6,982,750	20,518,354
Rectal Artesunate Suppositories (Public)	535,893	541,347	546,946	552,694	558,598	2,735,478
SPAQ need	113,367,119	117,397,678	121,596,187	125,971,639	130,533,688	608,866,311
SP need (Public sector)	136,351,121	141,289,343	146,451,240	151,851,850	157,507,651	733,451,205
SP need (Private sector)	12,549,629	13,195,464	13,882,784	14,615,010	15,395,916	69,638,803
Malaria Vaccine need	6,616,028	6,837,276	7,066,696	7,304,660	7,551,556	35,376,216

Table 22 shows the commodity needs for the period 2026-2030, presenting a comprehensive overview of the projected annual requirements for key malaria commodities alongside the capacity of both public and private sector systems to meet these needs.

Overall, the cost of the NMSP 2026-2030 represents a 20% increase from the previous strategic plan, which can be attributed to the scale up of current interventions and introduction of new approaches. Specifically, the increase reflects a strategic shift towards, expanding access to quality care, improved surveillance, and greater emphasis on sustainable financing mechanisms; Surveillance-related investments increased from 0.7% of the total cost in 2021-2025 to 1.97% in 2026-2030 due to the increased investments in strengthening routine data systems and active surveillance for areas of low transmission, while malaria financing and sustainability rose from 0.1% to 4.04% representing a broader and more deliberate investment in health system stewardship, strengthening partnerships, and domestic resource mobilization.

This Monitoring and Evaluation (M&E) Framework serves as a critical roadmap for ensuring the effective implementation, tracking, and assessment of the NMSP 2026–2030. It provides a structured approach for measuring progress, identifying implementation gaps, and promoting accountability across all programmatic areas. The framework is composed of three core components: the Performance Framework (PF), which outlines key indicators, targets, and milestones for monitoring results; the Data Management System which details data flow, sources, and quality assurance mechanisms across all levels of the health system; M&E Feedback Mechanisms which represent structured data reviews and communication channels for continuous learning and data improvements; and the M&E Coordination Mechanisms which define roles, responsibilities, and collaboration structures among stakeholders at federal, state, and LGA levels.

The Surveillance, Monitoring, Evaluation, and Operations Research (SMEOR) Branch of NMEP provides leadership for the design, implementation, and continuous improvement of malaria data systems. The branch ensures that high-quality, timely, and reliable data inform decision-making, policy development, and resource allocation. Under the NMSP 2026–2030, data systems will be further strengthened through integration, digital innovations, and enhanced capacity-building initiatives to improve data use at all levels.

The monitoring of the NMSP 2026–2030 will apply an equity, vulnerability, and gender lens to ensure that programme performance reflects the needs of populations disproportionately affected by malaria. Routine data systems will progressively integrate relevant disaggregation (e.g., sex, age, geographic vulnerability, displacement or mobility status) where feasible, and states will be supported to analyse coverage gaps affecting groups such as the rural poor, women, children under five, mobile and migrant populations, IDPs and refugees.

Performance reviews, DHIS2/NMDR dashboards, and quarterly/state review meetings will be used to track equity-related gaps in access and utilization, and to guide corrective actions through existing decision-making forums. This approach ensures that EHRGE considerations remain embedded within programme monitoring and accountability processes without creating parallel reporting systems.

6.1 Performance Framework

The performance framework (PF) provides a structured approach for systematically tracking the implementation, outcomes, and impact of the NMSP 2026–2030. It serves as a key management tool for measuring progress, assessing the effectiveness of interventions, and identifying areas that require course correction. Through defined performance indicators, the framework enables programme managers and stakeholders to determine when implementation is on track and when adjustments are needed to achieve desired results.

The indicators outlined in the Performance Framework (Table 23) have data sources, targets, frequency of measurement, and designated responsible entities across the malaria programme. This ensures consistency in data collection, facilitates comparability, and also supports evidence-based decision-making throughout the implementation period.

Table 22: Performance Framework for the NMSP 2026-2030

Goals and Objectives	Indicators	Baseline		Annual Target					Data Source
		Value	Year	2026	2027	2028	2029	2030	
Goals	Impact Indicators								
National To reduce malaria parasite prevalence by 50% and deaths attributed to malaria by 50% from 2025 levels by 2030. Subnational To achieve very low prevalence in low transmission intensity areas, a 30% reduction in prevalence in moderate transmission intensity areas, and a 60% reduction in prevalence in high transmission intensity areas by 2030.	Parasite prevalence in U5 (slide)	15.2%	2025	13.2 %	11.5%	10.0%	8.7%	7.6%	NMIS
	Entomological inoculation rate (indoor/outdoor)	9.0	2024	7.2	5.9	4.5	3.6	2.7	Ento-surveillance report
	Annual parasite incidence per 1,000 population	289	2024	216	186	161	139	120	WMR
	Malaria mortality per 100,000 population	62	2024	49	43	38	34	30	WMR
	All-cause U5 mortality per 1,000 population	110	2024	100	90	81	72	63	NDHS
Objective 1	Outcome Indicators								
1. To strengthen governance and improve organizational capacity to at least 90% from baseline by 2030	1.1 Proportion of the planned activities fully implemented at >=80% (federal & state)	62%	2025	68%	74%	80%	86%	90%	MPR
	1.2 Organizational Capacity Assessment (OCA) score at all levels (federal, state, LGA)	60%	2024	70%	75%	80%	86%	90%	OCA report
Objective 2		Outcome Indicators							
2. To improve access to and utilization of preventive interventions to at least 80% of the target population by 2025	2.1 % of households with at least 1 ITN	53.7%	2025	58.2 %	63%	68%	74%	80%	NMIS/DHS
	2.2 % of households with at least 1 ITN for every 2 persons	21.1%	2025	26.0 %	32.0%	40.0%	50.0%	60.0%	NMIS/DHS

	2.3 % of population with access to an ITN in the household	40.0%	2025	45.4 %	51.4%	58.3%	66.1%	75.0%	NMIS/DHS
	2.4 % of household residents who slept under ITN the previous night	64.3%	2025	67.2 %	70.2%	73.3%	76.6%	80.0%	NMIS/DHS
	2.5 % of under-5 children who slept under ITN previous night	44.9%	2025	49.8 %	55.1%	61.1%	67.7%	75.0%	NMIS/DHS
	2.6 % of pregnant women who slept under ITN previous night	54.0%	2025	57.7 %	61.6%	65.8%	70.2%	75.0%	NMIS/DHS
	2.7 % of population protected by IRS in the last 12 months	3%	2024	5%	7%	10%	12%	15% (focal)	Activity report
	2.8 Proportion of larval habitats with no larvae post-implementation in targeted areas	0%	2024	40%	55%	65%	75%	85% (focal)	Activity report
	2.9 % of women who received ≥3 doses of IPTp	33%	2025	39%	46%	54%	64%	75%	NDHS/NMIS
	2.10 % of targeted children receiving all SMC cycles (cohort tracking)	88%	2024	90%	91%	92%	93%	95%	Activity report
	2.11 % of eligible under-2 children receiving all 4 doses of SP for PMC	10%	2025	25%	40%	55%	70%	80%	Activity report
	2.12 % of eligible (targeted) under-2 children receiving all 4 doses of malaria vaccine	34%	2025	45%	55%	65%	75%	85%	Routine report
Objective 3				Outcome Indicators					
3. To improve effective coverage for diagnosis and appropriate treatment for at least 90% of the target populations at risk by 2030	3.1 % of persons with suspected malaria receiving a diagnostic test (RDT and/or microscopy) according to national guideline	94%	2024	95%	96%	97%	98%	99%	NMDR (DHIS2)

	3.2 % of confirmed malaria cases who received first line antimalarial treatment according to national guideline	98%	2024	98%	99%	99%	99%	100%	NMDR (DHIS2)
	3.3 % of U5 children with fever for whom advice was sought within 24h	60%	2024	65%	70%	75%	80%	85%	NDHS/NMIS
	3.4 % receiving ACT, among U5 children with fever in the last two weeks who received any antimalarial drug	57%	2024	65%	70%	75%	80%	85%	NDHS/NMIS
	3.5 % of health facilities without stock out of ACTs for 7 consecutive days in a month	60%	2024	70%	75%	80%	85%	90%	e-NHLMIS
	3.6 Malaria Test Positivity Rate	70%	2024	65%	60%	55%	50%	45%	NMDR (DHIS2)
	3.7 % of healthcare providers who ensure confirmation of malaria with a test before treatment	80%	2024	85%	90%	93%	95%	97%	TBD
	3.8 Order Fill Rate / OTIF: % of malaria product orders fulfilled in full and on time	75%	2024	80%	85%	88%	92%	95%	Programme Reports

	3.9 % of malaria medicines/products that met quality specifications during post-marketing surveillance	95%	2024	96%	97%	98%	98%	99%	Programme Reports
Objective 4	Outcome Indicators								
4. To improve the effectiveness of malaria surveillance systems in generating complete, timely, and accurate data, with a targeted increase from 47% to 70% by 2030	4.1 % of expected HF reports received & complete	93%	2024	94%	95%	96%	97%	98%	NMDR (DHIS2)
	4.2 % of HF assessed that met the national data-quality threshold ($\geq 80\%$)	83%	2024	85%	87%	90%	93%	95%	NMDR (Power BI)
	4.3 % of HFs with $\leq 5\%$ variance between NHMIS & NHLMIS	50%	2024	60%	70%	75%	80%	85%	e-NHLMIS
	4.4 % of operational decisions guided by routine/surveillance data	40%	2024	55%	60%	65%	70%	80%	Programme Reports
	4.5 % of designated TES sites completing full therapeutic assessment	100%	2024	100%	100%	100%	100%	100%	Programme Reports
	4.6 % of OR findings translated into policy	25%	2024	35%	45%	55%	65%	75%	Programme Reports
	4.7 % of malaria cases detected by surveillance system	60%	2024	65%	70%	75%	78%	80%	Programme Reports
Objective 5	Outcome Indicators								

5. To achieve sustainable malaria financing with at least 60% of resources mobilized from domestic resources	5.1 % of states funding $\geq 40\%$ of MOP from domestic sources	10%	2024	18%	25%	35%	48%	60%	AOP Report
	5.2 % of malaria expenditure that is out-of-pocket	84%	2022	70%	65%	60%	55%	50%	NHA
	5.3 % of total malaria expenditure contributed by Government (federal, states + FCT)	20%	2024	28%	35%	42%	50%	60%	Annual Prog Report

6.2 Data Management System

The Surveillance, Monitoring, Evaluation, and Operational Research (SMEOR) policy and system constitute a core component of the country's malaria response, providing the framework for evidence-based planning, implementation, and performance monitoring across all levels of the malaria programme. The SMEOR system is guided by several strategic documents and operational tools, including the National Malaria Operations Research Agenda (NMORA), the M&E Plan, SOPs for Data Management, and guidelines for Data Quality Assurance (DQA) as well as integrated Monitoring and Supportive Supervision (iMSV) protocols. Other key components include the Model Health Facility (MHF) initiative designed to promote best practices in malaria data management and service delivery, and comprehensive M&E Training Manuals aimed at strengthening capacity among programme officers at all levels. It is important to note that PHCs in Nigeria are using the 2019 version of the National Health Management Information System (NHMIS) tool for data collection. However, the 2024 version is being finalized and is anticipated to be rolled out during the lifespan of the current NMSP.

At the national level, the NMEP/SMEOR branch conducts monthly malaria data analyses using data in the National Malaria Data Repository (NMDR), including routine service data added from the DHIS2 platform. These analyses help identify trends, data gaps (including outliers), and performance bottlenecks. NMEP and its partners disseminate feedback reports through the SMEOR Subcommittee, biannual M&E Review Meetings and other platforms, highlighting facilities or states with data quality concerns and providing recommendations for corrective action. Additionally, the National Health Logistics Management Information System (NHLMIS) serves as a complementary platform for managing and monitoring malaria commodity logistics data. It is imperative for NMEP and partners to ensure that service data and logistics data are effectively linked and triangulated, to support decisions on forecasting, procurement, and distribution of malaria health products such as RDTs, ACTs, ITNs, SPAQ, and SP.

At the State level, dedicated malaria M&E officers oversee the implementation of SMEOR activities. They work closely with the State HMIS officers within the Department of Health Planning, Research, and Statistics (DHPRS) to ensure data accuracy, consistency, and timely submission of service data to the DHIS2 platform. Similarly, the State Coordinators for the Logistics Management Coordination Unit (LMCU) are responsible for the management of the malaria logistics data.

At the LGA level, the LGA malaria focal persons, along with the LGA M&E officers, are responsible for data validation, quality assurance, and timely reporting of malaria service data using the standard indicators. While the LGA M&E officer is responsible for uploading the service delivery data into the DHIS2 platform, the LGA LMCU Coordinator is responsible for reporting the logistics data to the NHLMIS platform. The SMEPs use data from the DHIS2 and NMDR to produce a quarterly malaria bulletin.

As Nigeria progresses toward malaria burden reduction and low transmission setting, during the course of this strategic plan, strengthening data systems will become increasingly critical. Surveillance systems will need to transition from aggregate reporting to more sensitive and timely systems capable of detecting and responding to individual cases and localized transmission foci. This will require strengthening case-based surveillance, improving digital reporting platforms, and enhancing interoperability between malaria data systems. In low-transmission settings, closer collaboration with Disease Surveillance and Notification Officers (DSNOs) under the IDSR framework will be essential to ensure prompt case notification, investigation, and rapid response. Strengthening these surveillance and data systems will support early detection of residual transmission and enable more targeted malaria control and elimination efforts.

The flow of data follows a hierarchical structure from the health facility level through the LGA and State levels, culminating at the national level, as illustrated in figure 10 below. Although the community data flow is depicted on the data flow chart, it's relatively weak. Continued efforts towards achieving interoperability between the DHIS2 and NHLMIS platforms will further enhance data integration, accountability, and availability of high-quality data, for programme decision-making.

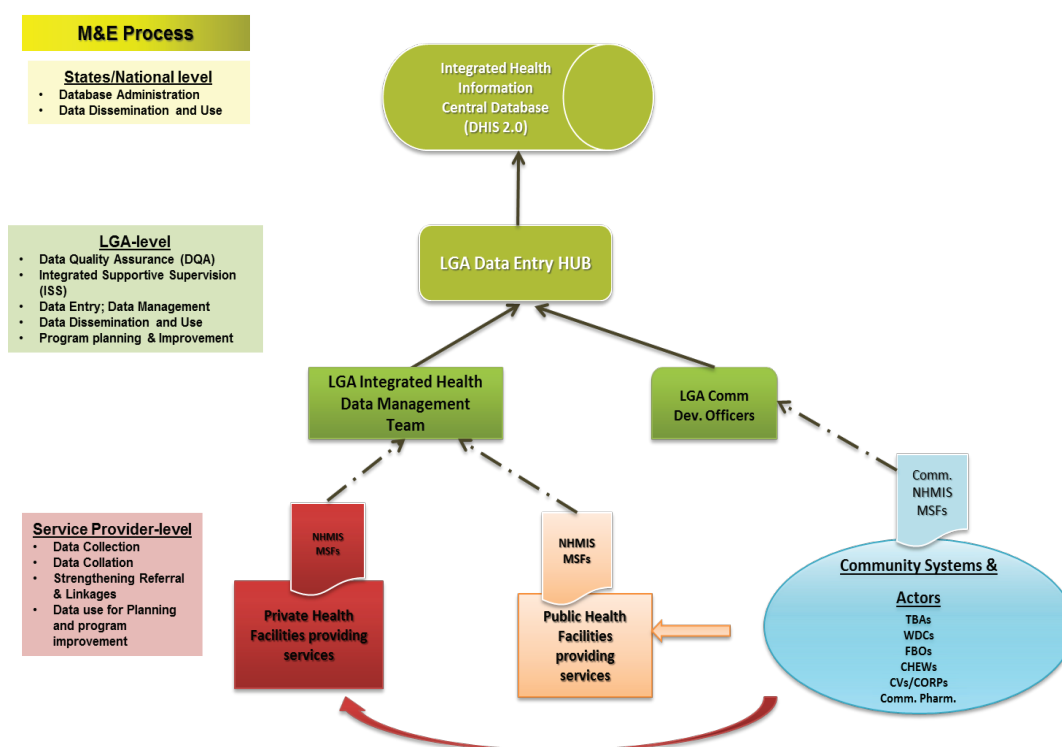


Fig 17: National Malaria data flow

6.3 M&E Feedback, Complaint, and Response Mechanism (FCRM)

To ensure that data within the DHIS2/NMDR remains accurate, reliable, and responsive to programmatic needs, a structured Feedback, Complaint, and Response Mechanism (FCRM) has been established. This mechanism enables Monitoring and Evaluation (M&E) personnel and other data users at national, state, and local government levels to provide timely feedback on data quality, system functionality, and overall usability.

The FCRM establishes structured channels for collecting, reviewing, and addressing feedback on the data platform/repository, enhancing accountability and promoting continuous improvement in data quality and decision-making. Feedback is provided by stakeholders at all levels, including National, State, and LGA M&E Officers, among other users who identify data issues whilst interacting with the DHIS2/NMDR platform. Current feedback channels include meetings, review sessions, WhatsApp groups, phone calls, and field visits, enabling real-time reporting and communication between data users and system managers.

Once feedback is received, DHIS2/NMDR system managers and the M&E leadership at national and state levels review and categorize submissions, determine corrective actions (e.g., data validation, troubleshooting, or escalation), and provide timely responses to submitters through appropriate channels. This process maintains a closed feedback loop, promoting transparency and collaboration between data users and managers.

Currently, feedback is not formally logged in the DHIS2/NMDR, but the long-term goal is to adopt a structured digital tracking system (e.g., an integrated ticketing or issue-tracking platform). Insights from this mechanism further support data quality assurance, staff capacity building, and system improvement, ultimately fostering a culture of data ownership, responsiveness, and continuous learning within the health information system.

Feedback, Complaint, and Response Mechanism (FCRM) For DHIS2/NMDR Data Quality and Use

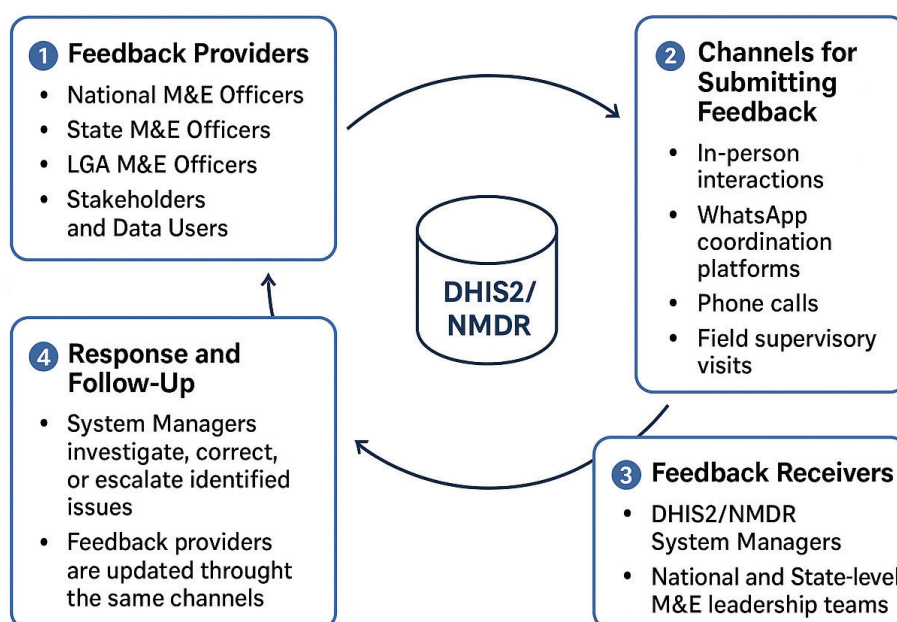


Fig. 18: Feedback, Complaint, and Response Mechanism

6.4 M&E Coordination Mechanisms

The coordination of SMEOR activities will be guided by well-defined mechanisms at both national and sub-national levels to strengthen collaboration, ensure data quality, and promote evidence-based decision-making across all programmatic areas. This coordination will be undertaken in close collaboration with the Department of Health Planning, Research and Statistics (DHPRS) at both national and state levels, given its central role in the management and oversight of the National Health Management Information System (NHMIS) and the broader health information system. Different layers of Data Quality Assessments (DQAs) will be implemented by NMEP and partners at national, state, and LGA levels to support continuous performance improvement, while integrated Monitoring and Supportive Supervision (iMSV) will be conducted in collaboration with disease programme areas to improve the completeness, accuracy, and timeliness of malaria data reporting.

The SMEOR branch will also leverage existing coordination platforms and partnerships with key stakeholders, including MDAs and implementing partners, to enhance data sharing, resource mobilization, and the use of evidence for programme planning and policy formulation. Key platforms include the Data Management Expert Group (DMEG), the Malaria Operations Research Expert Group (MOREG), the SMEOR Sub-committee, and other technical task teams.

At the sub-national level, coordination mechanisms include regular data review meetings and data control rooms that serve as platforms for monitoring data quality, addressing reporting challenges, facilitating timely decision-making, and strengthening feedback loops between state, LGA, and health facility levels. These platforms will also involve close engagement with DHPRS units at state level to ensure alignment between malaria programme data and the broader national health information system.

Annex 1: Banding of states by Malaria Transmission Intensity

Banding by transmission Intensity

Transmission Category	States (Prevalence %)
High (>35%)	—
Moderate A (15–<35%)	Niger (18.4), Adamawa (17.9), Bauchi (17.8), Taraba (23.2), Yobe (21.2), Kaduna (18.9), Kano (18.3), Katsina (17.0), Kebbi (18.4), Sokoto (26.7), Zamfara (29.0), Ebonyi (31.2), Imo (15.2), Akwa Ibom (15.5)
Moderate B (10–<15%)	Benue (11.0), Kwara (13.3), Nasarawa (11.5), Gombe (14.4), Jigawa (14.4), Abia (11.6), Bayelsa (13.9), Cross River (11.9), Edo (10.8), Ekiti (14.5), Ondo (13.4), Osun (12.9), Oyo (12.2)
Low A (5–<10%)	FCT (7.9), Kogi (8.9), Borno (6.9), Anambra (9.0), Enugu (9.9), Rivers (8.8), Delta (6.3), Ogun (7.4)
Low B (1–<5%)	Plateau (2.8), Lagos (2.6)
Very Low (0–<1%)	—

Demographics		Epidemiological Stratification		Intervention mixes
State	LGA	PfPR_inl a	LGA_Bur den	
Abia	aba_north	11.54	Moderate	CM + IPTp + Dual AI + PMC + Vac
Abia	aba_south	11.72	Moderate	CM + IPTp + Dual AI + PMC + Vac + LSM
Abia	arochukwu	13.02	Moderate	CM + IPTp + Dual AI + PMC + Vac
Abia	bende	8.1	Low	CM + IPTp + Dual AI + PMC
Abia	ikwuano	7.99	Low	CM + IPTp + Dual AI + PMC
Abia	isiala_ngwa_north	11.47	Moderate	CM + IPTp + Dual AI + PMC + Vac
Abia	isiala_ngwa_south	8.29	Low	CM + IPTp + Dual AI + PMC
Abia	isuikwato	6.07	Low	CM + IPTp + Dual AI + PMC + LSM
Abia	obi_nwa	12.87	Moderate	CM + IPTp + Dual AI + PMC + Vac
Abia	ohafia	8.98	Low	CM + IPTp + Dual AI + PMC
Abia	osisioma_ngwa	10.48	Moderate	CM + IPTp + Pyr + PMC + Vac
Abia	ugwunagbo	17.63	Moderate	CM + IPTp + Dual AI + PMC + Vac
Abia	ukwa_east	21.11	Moderate	CM + IPTp + Dual AI + PMC + Vac
Abia	ukwa_west	17.23	Moderate	CM + IPTp + Dual AI + PMC + Vac
Abia	umu_neochi	7.83	Low	CM + IPTp + Dual AI + PMC
Abia	umuahia_north	3.66	Low	CM + IPTp + Dual AI + PMC
Abia	umuahia_south	4.06	Low	CM + IPTp + Dual AI + PMC
Adamawa	demsa	9.68	Low	CM + IPTp + Dual AI + SMC + iCCM
Adamawa	fufore	14.84	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Adamawa	ganaye	12.33	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Adamawa	gireri	9.27	Low	CM + IPTp + Dual AI + SMC + iCCM
Adamawa	gombi	8.11	Low	CM + IPTp + Dual AI + SMC + iCCM
Adamawa	guyuk	12.13	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Adamawa	hong	6.25	Low	CM + IPTp + Dual AI + SMC + iCCM
Adamawa	jada	10.11	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Adamawa	lamurde	9.33	Low	CM + IPTp + Dual AI + SMC + iCCM
Adamawa	madagali	2.98	Low	CM + IPTp + Dual AI + SMC + iCCM
Adamawa	maiha	8.45	Low	CM + IPTp + Dual AI + SMC + iCCM
Adamawa	mayo_belwa	7.29	Low	CM + IPTp + Dual AI + SMC + iCCM

Adamawa	michika	2.93	Low	CM + IPTp + Dual AI + SMC + iCCM
Adamawa	mubi_north	4.06	Low	CM + IPTp + Dual AI + SMC + iCCM
Adamawa	mubi_south	4.26	Low	CM + IPTp + Dual AI + SMC + iCCM
Adamawa	numan	8.83	Low	CM + IPTp + Dual AI + SMC + iCCM
Adamawa	shelleng	10.7	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Adamawa	song	6.87	Low	CM + IPTp + Dual AI + SMC + iCCM
Adamawa	toungo	15.02	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Adamawa	yola_north	9.22	Low	CM + IPTp + Dual AI + SMC + iCCM
Adamawa	yola_south	5.02	Low	CM + IPTp + Dual AI + SMC + iCCM
Akwa_Ibom	abak	16.1	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Akwa_Ibom	eastern_obolo	41.26	High	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa_Ibom	eket	34.04	Moderate	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa_Ibom	esit_eket	31.14	Moderate	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa_Ibom	essien_udim	15.9	Moderate	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa_Ibom	etim_ekpo	15.7	Moderate	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa_Ibom	etinan	23.53	Moderate	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa_Ibom	ibeno	32.39	Moderate	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa_Ibom	ibesikpo_asutan	11.41	Moderate	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa_Ibom	ibiono_ibom	13.63	Moderate	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa_Ibom	ika	15.32	Moderate	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa_Ibom	ikono	14.01	Moderate	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa_Ibom	ikot_abasi	43.06	High	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa_Ibom	ikot_ekpene	13.75	Moderate	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa_Ibom	ini	14.59	Moderate	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa_Ibom	itu	8.77	Low	CM + IPTp + Dual AI + PMC + iCCM

Akwa Ibom	mbo	49.15	High	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa Ibom	mkpat_enin	30.91	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Akwa Ibom	nsit_atai	21.3	Moderate	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa Ibom	nsit_ibom	18.79	Moderate	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa Ibom	nsit_ubium	29.22	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Akwa Ibom	obot_akara	13.3	Moderate	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa Ibom	okobo	21.37	Moderate	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa Ibom	onna	39.18	High	CM + IPTp + Dual AI + PMC + Vac + iCCM
Akwa Ibom	oron	29.67	Moderate	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa Ibom	oruk_anam	24.89	Moderate	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa Ibom	udung_uko	28.87	Moderate	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa Ibom	ukanafun	17.35	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Akwa Ibom	uruan	14.22	Moderate	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa Ibom	urue_offong_oruko	40.8	High	CM + IPTp + Pyr + PMC + Vac + iCCM
Akwa Ibom	uyo	6.57	Low	CM + IPTp + Pyr + PMC
Anambra	aguata	5.62	Low	CM + IPTp + PBO + PMC
Anambra	anambra_east	4.86	Low	CM + IPTp + PBO + PMC
Anambra	anambra_west	5.03	Low	CM + IPTp + PBO + PMC
Anambra	anaocha	6.54	Low	CM + IPTp + PBO + PMC
Anambra	awka_north	8.82	Low	CM + IPTp + PBO + PMC
Anambra	awka_south	4.54	Low	CM + IPTp + PBO + PMC
Anambra	ayamelum	4.37	Low	CM + IPTp + PBO + PMC
Anambra	dunukofia	2.9	Low	CM + IPTp + PBO + PMC
Anambra	ekwusigo	5.1	Low	CM + IPTp + PBO + PMC
Anambra	idemili_north	4.7	Low	CM + IPTp + PBO + PMC
Anambra	idemili_south	4.85	Low	CM + IPTp + PBO + PMC
Anambra	ihiala	7.36	Low	CM + IPTp + PBO + PMC
Anambra	njikoka	3.09	Low	CM + IPTp + PBO + PMC

Anambra	nnewi_north	4.6	Low	CM + IPTp + PBO + PMC
Anambra	nnewi_south	6.13	Low	CM + IPTp + PBO + PMC
Anambra	ogbaru	3.99	Low	CM + IPTp + PBO + PMC
Anambra	onitsha_north	2.64	Low	CM + IPTp + PBO + PMC
Anambra	onitsha_south	2.38	Low	CM + IPTp + PBO + PMC
Anambra	orumba_north	9.53	Low	CM + IPTp + PBO + PMC
Anambra	orumba_south	7.22	Low	CM + IPTp + PBO + PMC
Anambra	oyi	3.53	Low	CM + IPTp + PBO + PMC
Bauchi	alkaleri	8.42	Low	CM + IPTp + PBO + SMC
Bauchi	bauchi	5.15	Low	CM + IPTp + Dual AI + SMC
Bauchi	bogoro	7.48	Low	CM + IPTp + PBO + SMC
Bauchi	damban	9.29	Low	CM + IPTp + PBO + SMC
Bauchi	darazo	15.81	Moderate	CM + IPTp + Dual AI + SMC + Vac
Bauchi	dass	8.95	Low	CM + IPTp + Dual AI + SMC
Bauchi	gamawa	8.04	Low	CM + IPTp + PBO + SMC
Bauchi	ganjuwa	10.16	Moderate	CM + IPTp + PBO + SMC + Vac
Bauchi	giade	15.65	Moderate	CM + IPTp + PBO + SMC + Vac
Bauchi	itas_gadai	15.13	Moderate	CM + IPTp + Dual AI + SMC + Vac
Bauchi	jama_are	23.72	Moderate	CM + IPTp + PBO + SMC + Vac
Bauchi	katagum	12.5	Moderate	CM + IPTp + Dual AI + SMC + Vac
Bauchi	kirfi	10	Moderate	CM + IPTp + PBO + SMC + Vac
Bauchi	misau	15.15	Moderate	CM + IPTp + PBO + SMC + Vac
Bauchi	ningi	15.68	Moderate	CM + IPTp + Dual AI + SMC + Vac
Bauchi	shira	18.8	Moderate	CM + IPTp + PBO + SMC + Vac
Bauchi	tafawa_balewa	9.38	Low	CM + IPTp + PBO + SMC
Bauchi	toro	7.3	Low	CM + IPTp + Dual AI + SMC
Bauchi	warji	11.06	Moderate	CM + IPTp + PBO + SMC + Vac
Bauchi	zaki	7.12	Low	CM + IPTp + PBO + SMC
Bayelsa	brass	31.95	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Bayelsa	ekeremor	29.05	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Bayelsa	kolokuma_opoku ma	8.01	Low	CM + IPTp + PBO + PMC + iCCM
Bayelsa	nembe	18.64	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Bayelsa	ogbia	17.31	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Bayelsa	sagbama	11.16	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM

Bayelsa	southern_ijaw	26.3	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Bayelsa	yenegoa	7.19	Low	CM + IPTp + PBO + PMC + iCCM
Benue	ado	21.89	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Benue	agatu	13.35	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Benue	apa	13.75	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Benue	buruku	2.9	Low	CM + IPTp + PBO + PMC + iCCM
Benue	gboko	2.71	Low	CM + IPTp + PBO + PMC + iCCM
Benue	guma	5.71	Low	CM + IPTp + PBO + SMC + iCCM
Benue	gwer_east	3.95	Low	CM + IPTp + Dual AI + PMC + iCCM
Benue	gwer_west	6.24	Low	CM + IPTp + PBO + SMC + iCCM
Benue	katsina_ala	3.78	Low	CM + IPTp + PBO + PMC + iCCM
Benue	konshisha	2.27	Low	CM + IPTp + PBO + PMC + iCCM
Benue	kwande	5.39	Low	CM + IPTp + PBO + PMC + iCCM
Benue	logo	3.4	Low	CM + IPTp + PBO + SMC + iCCM
Benue	makurdi	3.12	Low	CM + IPTp + PBO + SMC + iCCM
Benue	obi_1	9.15	Low	CM + IPTp + Dual AI + PMC + iCCM
Benue	ogbadibo	11.29	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Benue	ohimini	15.9	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Benue	oju	9.22	Low	CM + IPTp + Pyr + PMC + iCCM
Benue	okpokwu	19.06	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Benue	oturkpo	9.42	Low	CM + IPTp + PBO + PMC + iCCM
Benue	tarka	2.98	Low	CM + IPTp + Dual AI + SMC + iCCM
Benue	ukum	3.36	Low	CM + IPTp + Dual AI + SMC + iCCM
Benue	ushongo	1.83	Low	CM + IPTp + PBO + PMC + iCCM
Benue	vandeikya	2.87	Low	CM + IPTp + Dual AI + PMC + iCCM
Borno	abadam	4.7	Low	CM + IPTp + PBO + SMC + iCCM
Borno	askira_uba	4.02	Low	CM + IPTp + PBO + SMC + iCCM
Borno	bama	9.53	Low	CM + IPTp + PBO + SMC + iCCM
Borno	bayo	25.83	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Borno	biu	8.3	Low	CM + IPTp + PBO + SMC + iCCM
Borno	chibok	6.43	Low	CM + IPTp + PBO + SMC + iCCM
Borno	damboa	7.62	Low	CM + IPTp + PBO + SMC + iCCM

Borno	dikwa	8	Low	CM + IPTp + PBO + SMC + iCCM
Borno	gubio	10.67	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Borno	guzamala	4.32	Low	CM + IPTp + PBO + SMC + iCCM
Borno	gwoza	4.4	Low	CM + IPTp + PBO + SMC + iCCM
Borno	hawul	7.26	Low	CM + IPTp + PBO + SMC + iCCM
Borno	jere	2.99	Low	CM + IPTp + PBO + SMC + iCCM + LSM
Borno	kaga	11.46	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Borno	kala_balge	5.62	Low	CM + IPTp + PBO + SMC + iCCM
Borno	konduga	5.94	Low	CM + IPTp + PBO + SMC + iCCM
Borno	kukawa	6.92	Low	CM + IPTp + PBO + SMC + iCCM
Borno	kwaya_kusar	19.65	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Borno	mafa	9.05	Low	CM + IPTp + PBO + SMC + iCCM
Borno	magumeri	10.28	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Borno	maiduguri	1.46	Low	CM + IPTp + PBO + SMC + LSM
Borno	marté	9.08	Low	CM + IPTp + PBO + SMC + iCCM
Borno	mobbar	4.98	Low	CM + IPTp + PBO + SMC + iCCM
Borno	monguno	7.9	Low	CM + IPTp + PBO + SMC + iCCM
Borno	ngala	8.77	Low	CM + IPTp + PBO + SMC + iCCM
Borno	nganzai	8.31	Low	CM + IPTp + PBO + SMC + iCCM
Borno	shani	16.76	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Cross_River	abi	10.25	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Cross_River	akamkpa	14.88	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Cross_River	akpabuyo	27.77	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Cross_River	bakassi	0.52	Very low	CM + IPTp + PMC + iCCM
Cross_River	bekwara	3.31	Low	CM + IPTp + Dual AI + PMC + iCCM
Cross_River	biase	18.23	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Cross_River	boki	10.97	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Cross_River	calabar_south	14.94	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM

Cross_River	calabar_municipal	12.31	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Cross_River	etung	15.12	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Cross_River	ikom	11.18	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Cross_River	obanliku	10.99	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Cross_River	obubra	17.95	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Cross_River	obudu	7.29	Low	CM + IPTp + Dual AI + PMC + iCCM
Cross_River	odukpani	12.34	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Cross_River	ogoja	4.66	Low	CM + IPTp + Dual AI + PMC + iCCM
Cross_River	yakurr	10.04	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Cross_River	yala	3.74	Low	CM + IPTp + Dual AI + PMC + iCCM
Delta	aniocha_north	7.83	Low	CM + IPTp + PBO + PMC + iCCM
Delta	aniocha_south	6.51	Low	CM + IPTp + Dual AI + PMC + iCCM
Delta	bomadi	12.61	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Delta	burutu	22.41	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Delta	ethiope_east	12.32	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Delta	ethiope_west	14.41	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Delta	ika_north_east	10.47	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Delta	ika_south	7.58	Low	CM + IPTp + PBO + PMC + iCCM
Delta	isoko_north	7.35	Low	CM + IPTp + Dual AI + PMC + iCCM
Delta	isoko_south	6.5	Low	CM + IPTp + PBO + PMC + iCCM
Delta	ndokwa_east	8.11	Low	CM + IPTp + PBO + PMC + iCCM
Delta	ndokwa_west	5.03	Low	CM + IPTp + PBO + PMC + iCCM
Delta	okpe	14.53	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Delta	oshimili_north	4.57	Low	CM + IPTp + PBO + PMC + iCCM
Delta	oshimili_south	3.16	Low	CM + IPTp + PBO + PMC + iCCM
Delta	patani	8.41	Low	CM + IPTp + PBO + PMC + iCCM
Delta	sapele	10.82	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Delta	udu	5.11	Low	CM + IPTp + PBO + PMC + iCCM

Delta	ughelli_north	8.02	Low	CM + IPTp + PBO + PMC + iCCM
Delta	ughelli_south	7.51	Low	CM + IPTp + PBO + PMC + iCCM
Delta	ukwuani	8.61	Low	CM + IPTp + Dual AI + PMC + iCCM
Delta	uvwie	6.97	Low	CM + IPTp + PBO + PMC + iCCM
Delta	warri_north	25.21	Moderate	CM + IPTp + PBO + PMC + Vac
Delta	warri_south	5.7	Low	CM + IPTp + PBO + PMC
Delta	warri_south_west	15.79	Moderate	CM + IPTp + PBO + PMC + Vac
Ebonyi	abakaliki	16.34	Moderate	CM + IPTp + PBO + PMC + Vac
Ebonyi	afikpo_north	10.58	Moderate	CM + IPTp + PBO + PMC + Vac
Ebonyi	afikpo_south	8.41	Low	CM + IPTp + PBO + PMC
Ebonyi	ebonyi	20.36	Moderate	CM + IPTp + PBO + PMC + Vac
Ebonyi	ezza_north	29.34	Moderate	CM + IPTp + PBO + PMC + Vac
Ebonyi	ezza_south	19.65	Moderate	CM + IPTp + PBO + PMC + Vac
Ebonyi	ikwo	14.24	Moderate	CM + IPTp + PBO + PMC + Vac
Ebonyi	ishielu	37.67	High	CM + IPTp + PBO + PMC + Vac
Ebonyi	ivo	10.93	Moderate	CM + IPTp + PBO + PMC + Vac
Ebonyi	izzi	13.96	Moderate	CM + IPTp + PBO + PMC + Vac
Ebonyi	ohaozara	22.17	Moderate	CM + IPTp + PBO + PMC + Vac
Ebonyi	ohaukwu	24.68	Moderate	CM + IPTp + PBO + PMC + Vac
Ebonyi	onicha	24.23	Moderate	CM + IPTp + PBO + PMC + Vac
Edo	akoko_edo	8.88	Low	CM + IPTp + PBO + PMC
Edo	egor	12.36	Moderate	CM + IPTp + PBO + PMC + Vac
Edo	esan_central	10.83	Moderate	CM + IPTp + PBO + PMC + Vac
Edo	esan_north_east	6.92	Low	CM + IPTp + PBO + PMC
Edo	esan_south_east	10.35	Moderate	CM + IPTp + PBO + PMC + Vac
Edo	esan_west	7.36	Low	CM + IPTp + PBO + PMC
Edo	etsako_central	5.14	Low	CM + IPTp + PBO + PMC
Edo	etsako_east	6.13	Low	CM + IPTp + PBO + PMC
Edo	etsako_west	7.63	Low	CM + IPTp + PBO + PMC
Edo	igubeben	11.39	Moderate	CM + IPTp + PBO + PMC + Vac
Edo	ikpoba_okha	11.31	Moderate	CM + IPTp + PBO + PMC + Vac
Edo	oredo	8.49	Low	CM + IPTp + PBO + PMC
Edo	orhionmwon	11.24	Moderate	CM + IPTp + PBO + PMC + Vac
Edo	ovia_north_east	11.38	Moderate	CM + IPTp + PBO + PMC + Vac
Edo	ovia_south_west	16.89	Moderate	CM + IPTp + PBO + PMC + Vac
Edo	owan_east	9.15	Low	CM + IPTp + PBO + PMC
Edo	owan_west	13.02	Moderate	CM + IPTp + PBO + PMC + Vac
Edo	uhunmwonde	10.66	Moderate	CM + IPTp + PBO + PMC + Vac
Ekiti	ado_ekiti	4.55	Low	CM + IPTp + PBO + PMC

Ekiti	efon_alayee	11.52	Moderate	CM + IPTp + PBO + PMC + Vac
Ekiti	ekiti_east	9.63	Low	CM + IPTp + PBO + PMC + LSM
Ekiti	ekiti_south_west	10.23	Moderate	CM + IPTp + PBO + PMC + Vac
Ekiti	ekiti_west	14.13	Moderate	CM + IPTp + PBO + PMC + Vac
Ekiti	emure	7.51	Low	CM + IPTp + PBO + PMC
Ekiti	gboyin	10.16	Moderate	CM + IPTp + PBO + PMC + Vac
Ekiti	idosi_osi	8.86	Low	CM + IPTp + PBO + PMC
Ekiti	ijero	14.09	Moderate	CM + IPTp + PBO + PMC + Vac
Ekiti	ikere	6.16	Low	CM + IPTp + PBO + PMC + LSM
Ekiti	ikole	9.72	Low	CM + IPTp + PBO + PMC
Ekiti	ilemeji	13.4	Moderate	CM + IPTp + PBO + PMC + Vac
Ekiti	irepodun_ifelodun	9.03	Low	CM + IPTp + PBO + PMC
Ekiti	ise_orun	5.85	Low	CM + IPTp + PBO + PMC
Ekiti	moba	14.71	Moderate	CM + IPTp + PBO + PMC + Vac
Ekiti	oye	11	Moderate	CM + IPTp + PBO + PMC + Vac
Enugu	aninri	13.49	Moderate	CM + IPTp + PBO + PMC + Vac
Enugu	awgu	5.28	Low	CM + IPTp + Dual AI + PMC
Enugu	enugu_east	7.65	Low	CM + IPTp + Dual AI + PMC
Enugu	enugu_north	3.47	Low	CM + IPTp + PBO + PMC
Enugu	enugu_south	4.57	Low	CM + IPTp + Dual AI + PMC
Enugu	ezeagu	8.97	Low	CM + IPTp + PBO + PMC
Enugu	igbo_etiti	7.47	Low	CM + IPTp + PBO + PMC
Enugu	igbo_eze_north	12.14	Moderate	CM + IPTp + Dual AI + PMC + Vac
Enugu	igbo_eze_south	14.44	Moderate	CM + IPTp + PBO + PMC + Vac
Enugu	isi_uzo	16.84	Moderate	CM + IPTp + PBO + PMC + Vac
Enugu	nkanu_east	24.9	Moderate	CM + IPTp + PBO + PMC + Vac
Enugu	nkanu_west	12.34	Moderate	CM + IPTp + PBO + PMC + Vac
Enugu	nsukka	7.23	Low	CM + IPTp + PBO + PMC
Enugu	oji_river	8.6	Low	CM + IPTp + PBO + PMC
Enugu	udenu	9.78	Low	CM + IPTp + PBO + PMC
Enugu	udi	3.88	Low	CM + IPTp + PBO + PMC
Enugu	uzo_uwani	7.85	Low	CM + IPTp + PBO + PMC
Federal Capital Territory	abaji	6.83	Low	CM + IPTp + PBO + SMC
Federal Capital Territory	abuja_municipal	6.14	Low	CM + IPTp + PBO + SMC
Federal Capital Territory	bwari	5.37	Low	CM + IPTp + PBO + SMC
Federal Capital Territory	gwagwalada	5.63	Low	CM + IPTp + PBO + SMC

Federal Capital Territory	kuje	7.11	Low	CM + IPTp + PBO + SMC
Federal Capital Territory	kwali	5.65	Low	CM + IPTp + PBO + SMC
Gombe	akko	9.41	Low	CM + IPTp + Dual AI + SMC
Gombe	balanga	11.36	Moderate	CM + IPTp + Dual AI + SMC + Vac
Gombe	billiri	5.43	Low	CM + IPTp + Dual AI + SMC
Gombe	dukku	13.12	Moderate	CM + IPTp + PBO + SMC + Vac
Gombe	funakaye	18.33	Moderate	CM + IPTp + Dual AI + SMC + Vac
Gombe	gombe	5.56	Low	CM + IPTp + Dual AI + SMC
Gombe	kaltungo	4.83	Low	CM + IPTp + PBO + SMC
Gombe	kwami	18.93	Moderate	CM + IPTp + PBO + SMC + Vac
Gombe	nafada	11.8	Moderate	CM + IPTp + PBO + SMC + Vac
Gombe	shomgom	6.13	Low	CM + IPTp + PBO + SMC
Gombe	yamaltu deba	23.04	Moderate	CM + IPTp + Dual AI + SMC + Vac
Imo	aboh_mbaise	8.6	Low	CM + IPTp + PBO + PMC
Imo	ahiazu mbaise	7.31	Low	CM + IPTp + PBO + PMC
Imo	ehime_mbano	5.57	Low	CM + IPTp + PBO + PMC
Imo	ezinihitte	6.82	Low	CM + IPTp + PBO + PMC
Imo	ideato_north	7.67	Low	CM + IPTp + PBO + PMC
Imo	ideato_south	8.14	Low	CM + IPTp + PBO + PMC
Imo	ihitte_uboma	6.48	Low	CM + IPTp + PBO + PMC
Imo	ikeduru	7.8	Low	CM + IPTp + PBO + PMC
Imo	isiala_mbano	6.68	Low	CM + IPTp + PBO + PMC
Imo	isu	8.22	Low	CM + IPTp + PBO + PMC
Imo	mbaitoli	9.47	Low	CM + IPTp + PBO + PMC
Imo	ngor_okpala	10.45	Moderate	CM + IPTp + PBO + PMC + Vac
Imo	njaba	9.93	Low	CM + IPTp + PBO + PMC
Imo	nkwerre	7.84	Low	CM + IPTp + PBO + PMC
Imo	nwangele	6.46	Low	CM + IPTp + PBO + PMC
Imo	obowo	6.97	Low	CM + IPTp + PBO + PMC
Imo	oguta	12.55	Moderate	CM + IPTp + PBO + PMC + Vac
Imo	ohaji_egbema	14.36	Moderate	CM + IPTp + PBO + PMC + Vac
Imo	okigwe	9.49	Low	CM + IPTp + PBO + PMC
Imo	orlu	7.76	Low	CM + IPTp + PBO + PMC
Imo	orsu	6.74	Low	CM + IPTp + PBO + PMC
Imo	oru_east	12.09	Moderate	CM + IPTp + PBO + PMC + Vac
Imo	oru_west	12.19	Moderate	CM + IPTp + PBO + PMC + Vac
Imo	owerri_municipal	5.57	Low	CM + IPTp + PBO + PMC
Imo	owerri_north	7.32	Low	CM + IPTp + PBO + PMC

Imo	owerri_west	10.74	Moderate	CM + IPTp + PBO + PMC + Vac
Imo	unuimo	9.1	Low	CM + IPTp + PBO + PMC
Jigawa	auyo	3.68	Low	CM + IPTp + Dual AI + SMC
Jigawa	babura	11.23	Moderate	CM + IPTp + Dual AI + SMC + Vac
Jigawa	biriniwa	4.12	Low	CM + IPTp + Dual AI + SMC
Jigawa	birni_kudu	18.28	Moderate	CM + IPTp + Dual AI + SMC + Vac
Jigawa	buji	17.76	Moderate	CM + IPTp + Dual AI + SMC + Vac
Jigawa	dutse	11.38	Moderate	CM + IPTp + Dual AI + SMC + Vac
Jigawa	gagarawa	5.51	Low	CM + IPTp + Dual AI + SMC
Jigawa	garki	9.36	Low	CM + IPTp + Dual AI + SMC
Jigawa	gumel	5.15	Low	CM + IPTp + Dual AI + SMC
Jigawa	guri	4.94	Low	CM + IPTp + Dual AI + SMC
Jigawa	gwaram	13.07	Moderate	CM + IPTp + Dual AI + SMC + Vac
Jigawa	gwiwa	12.04	Moderate	CM + IPTp + Dual AI + SMC + Vac
Jigawa	hadejia	1.85	Low	CM + IPTp + Dual AI + SMC
Jigawa	jahun	7.23	Low	CM + IPTp + Dual AI + SMC
Jigawa	kafin_hausa	5.06	Low	CM + IPTp + Dual AI + SMC
Jigawa	kaugama	5.7	Low	CM + IPTp + Dual AI + SMC
Jigawa	kazaure	14.64	Moderate	CM + IPTp + Dual AI + SMC + Vac
Jigawa	kiri_kasamma	3.94	Low	CM + IPTp + Dual AI + SMC
Jigawa	maigatari	7.67	Low	CM + IPTp + Dual AI + SMC
Jigawa	malam_madori	3.87	Low	CM + IPTp + Dual AI + SMC
Jigawa	miga	5.88	Low	CM + IPTp + Dual AI + SMC
Jigawa	ringim	8.73	Low	CM + IPTp + Dual AI + SMC
Jigawa	roni	14.49	Moderate	CM + IPTp + Dual AI + SMC + Vac
Jigawa	sule_tankarkar	8.66	Low	CM + IPTp + Dual AI + SMC
Jigawa	taura	3.66	Low	CM + IPTp + Dual AI + SMC
Jigawa	yankwashi	13.35	Moderate	CM + IPTp + Dual AI + SMC + Vac
Jigawa	kiyawa	20.29	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kaduna	birnin_gwari	11.63	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kaduna	chikun	11.35	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kaduna	giwa	10.69	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kaduna	igabi	17.87	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kaduna	ikara	8.07	Low	CM + IPTp + Dual AI + SMC
Kaduna	jaba	6.65	Low	CM + IPTp + Dual AI + SMC
Kaduna	jema_a	10.57	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kaduna	kachia	7.53	Low	CM + IPTp + Dual AI + SMC
Kaduna	kaduna_north	5.95	Low	CM + IPTp + Dual AI + SMC
Kaduna	kaduna_south	9.02	Low	CM + IPTp + Dual AI + SMC

Kaduna	kagarko	8.54	Low	CM + IPTp + Dual AI + SMC
Kaduna	kajuru	9.82	Low	CM + IPTp + Dual AI + SMC
Kaduna	kaura	8.89	Low	CM + IPTp + Dual AI + SMC
Kaduna	kauru	14.35	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kaduna	kubau	10.81	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kaduna	kudan	9.09	Low	CM + IPTp + Dual AI + SMC
Kaduna	lere	4.4	Low	CM + IPTp + Dual AI + SMC
Kaduna	markafi	7.41	Low	CM + IPTp + Dual AI + SMC
Kaduna	sabon_gari	9.48	Low	CM + IPTp + Dual AI + SMC
Kaduna	sanga	7.47	Low	CM + IPTp + Dual AI + SMC
Kaduna	soba	18.84	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kaduna	zango_kataf	6.75	Low	CM + IPTp + Dual AI + SMC
Kaduna	zaria	9.88	Low	CM + IPTp + Dual AI + SMC
Kano	ajingi	12.46	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	albasu	17.84	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	bagwai	24.54	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	bebeji	7.02	Low	CM + IPTp + Dual AI + SMC
Kano	bichi	15.36	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	bunkure	20.25	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	dala	2.63	Low	CM + IPTp + Dual AI + SMC
Kano	dambatta	14.99	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	dawakin_kudu	21.83	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	dawakin_tofa	15.88	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	doguwa	8.18	Low	CM + IPTp + Dual AI + SMC
Kano	fagge	4.23	Low	CM + IPTp + Dual AI + SMC
Kano	gabasawa	13.1	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	garko	18.58	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	garum_mallam	9.46	Low	CM + IPTp + Dual AI + SMC
Kano	gaya	14.33	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	gezawa	9.65	Low	CM + IPTp + Dual AI + SMC
Kano	gwale	1.6	Low	CM + IPTp + Dual AI + SMC
Kano	gwarzo	20.12	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	kabo	23.61	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	kano_municipal	1.83	Low	CM + IPTp + Dual AI + SMC
Kano	karaye	18.97	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	kibiya	16.08	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	kiru	12.17	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	kumbotso	7.69	Low	CM + IPTp + Dual AI + SMC
Kano	kunchi	16.48	Moderate	CM + IPTp + Dual AI + SMC + Vac

Kano	kura	16.84	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	madobi	19.99	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	makoda	15.82	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	minjibir	18.51	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	nasarawa_1	1.25	Low	CM + IPTp + Dual AI + SMC
Kano	rano	12.5	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	rimin_gado	21.07	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	rogo	9.71	Low	CM + IPTp + Dual AI + SMC
Kano	shanono	19.88	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	sumaila	19.02	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	takali	16.42	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	tarauni	2.44	Low	CM + IPTp + Dual AI + SMC
Kano	tofa	23.41	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	tsanyawa	13.55	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	tudun_wada	11.69	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	ungogo	8.72	Low	CM + IPTp + Dual AI + SMC
Kano	warawa	15.83	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kano	wudil	21.7	Moderate	CM + IPTp + Dual AI + SMC + Vac
Katsina	bakori	14.89	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Katsina	batagarawa	6.57	Low	CM + IPTp + PBO + SMC + iCCM
Katsina	batsari	11.4	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Katsina	baure	10.42	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Katsina	bindawa	12.83	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Katsina	charanchi	16.11	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Katsina	dan_musa	22.44	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Katsina	dandume	11.24	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Katsina	danja	8.62	Low	CM + IPTp + Dual AI + SMC + iCCM
Katsina	daura	7.99	Low	CM + IPTp + Dual AI + SMC + iCCM
Katsina	dutsi	13.25	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Katsina	dutsin_ma	12.74	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Katsina	faskari	15.29	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM

Katsina	funtua	10.94	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Katsina	ingawa	10.14	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Katsina	jibia	8.3	Low	CM + IPTp + Dual AI + SMC + iCCM
Katsina	kafur	15.13	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Katsina	kankara	15.85	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Katsina	kankia	16.34	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Katsina	katsina	3.64	Low	CM + IPTp + Dual AI + SMC + iCCM
Katsina	kurfi	13.86	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Katsina	kusada	13.69	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Katsina	mai_adua	8.2	Low	CM + IPTp + Dual AI + SMC + iCCM
Katsina	malumfashi	7.98	Low	CM + IPTp + PBO + SMC + iCCM
Katsina	mani	9.01	Low	CM + IPTp + Dual AI + SMC + iCCM
Katsina	mashi	10.61	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Katsina	matazuu	23.21	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Katsina	musawa	14.82	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Katsina	rimi	10.62	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Katsina	sabuwa	11.95	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Katsina	safana	9.23	Low	CM + IPTp + Dual AI + SMC + iCCM
Katsina	sandamu	18.28	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Katsina	zango	10.25	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Katsina	kaita	11.58	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Kebbi	aleiro	5.71	Low	CM + IPTp + PBO + SMC + iCCM
Kebbi	arewa_dandi	6.63	Low	CM + IPTp + PBO + SMC + iCCM
Kebbi	argungu	4.69	Low	CM + IPTp + Dual AI + SMC + iCCM
Kebbi	augie	6.01	Low	CM + IPTp + Dual AI + SMC + iCCM
Kebbi	bagudo	8.89	Low	CM + IPTp + Pyr + SMC + iCCM
Kebbi	birnin_kebbi	3.93	Low	CM + IPTp + Pyr + SMC + iCCM

Kebbi	bunza	3.27	Low	CM + IPTp + Dual AI + SMC + iCCM
Kebbi	dandi	5.04	Low	CM + IPTp + Pyr + SMC + iCCM
Kebbi	fakai	9.14	Low	CM + IPTp + Dual AI + SMC + iCCM
Kebbi	gwandu	15.23	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Kebbi	jega	5.62	Low	CM + IPTp + Dual AI + SMC + iCCM
Kebbi	kalgo	3.94	Low	CM + IPTp + Dual AI + SMC + iCCM
Kebbi	koko besse	8.34	Low	CM + IPTp + PBO + SMC + iCCM
Kebbi	maiyyama	6.07	Low	CM + IPTp + Dual AI + SMC + iCCM
Kebbi	ngaski	9.98	Low	CM + IPTp + PBO + SMC + iCCM
Kebbi	sakaba	12.09	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Kebbi	shanga	8.99	Low	CM + IPTp + Dual AI + SMC + iCCM
Kebbi	suru	6.23	Low	CM + IPTp + Dual AI + SMC + iCCM
Kebbi	wasagu danko	14.08	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Kebbi	yauri	9.67	Low	CM + IPTp + PBO + SMC + iCCM
Kebbi	zuru	8.64	Low	CM + IPTp + PBO + SMC + iCCM
Kogi	adavi	8.65	Low	CM + IPTp + PBO + SMC + iCCM
Kogi	ajaokuta	7.2	Low	CM + IPTp + PBO + SMC + iCCM
Kogi	ankpa	10.16	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Kogi	bassa_1	8.66	Low	CM + IPTp + PBO + SMC + iCCM
Kogi	dekina	5.47	Low	CM + IPTp + PBO + PMC + iCCM
Kogi	ibaji	5.53	Low	CM + IPTp + PBO + PMC + iCCM
Kogi	idah	3.39	Low	CM + IPTp + PBO + PMC + iCCM
Kogi	igalamela_odolu	5.24	Low	CM + IPTp + PBO + PMC + iCCM
Kogi	ijumu	10.64	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Kogi	kabba_bunu	9.24	Low	CM + IPTp + PBO + PMC + iCCM
Kogi	kogi	6.29	Low	CM + IPTp + PBO + SMC + iCCM
Kogi	lokoja	5.7	Low	CM + IPTp + PBO + SMC + iCCM
Kogi	mopa_muro	9.78	Low	CM + IPTp + PBO + PMC + iCCM
Kogi	ofu	5.99	Low	CM + IPTp + PBO + PMC + iCCM
Kogi	ogori_mangongo	8.63	Low	CM + IPTp + PBO + PMC + iCCM
Kogi	okehi	7.19	Low	CM + IPTp + PBO + SMC + iCCM
Kogi	okene	4.9	Low	CM + IPTp + PBO + PMC + iCCM
Kogi	olamabolo	12.27	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Kogi	omala	6.78	Low	CM + IPTp + PBO + SMC + iCCM

Kogi	yagba_east	6.52	Low	CM + IPTp + PBO + SMC + iCCM
Kogi	yagba_west	5.8	Low	CM + IPTp + PBO + SMC + iCCM
Kwara	asa	3.21	Low	CM + IPTp + Dual AI + SMC
Kwara	baruten	9.27	Low	CM + IPTp + Dual AI + SMC
Kwara	edu	6.98	Low	CM + IPTp + Dual AI + SMC
Kwara	ekiti	9.87	Low	CM + IPTp + Dual AI + PMC
Kwara	ifelodun_1	7.16	Low	CM + IPTp + Dual AI + SMC
Kwara	ilorin_east	4.06	Low	CM + IPTp + Dual AI + SMC
Kwara	ilorin_south	3.17	Low	CM + IPTp + Dual AI + SMC
Kwara	ilorin_west	2.72	Low	CM + IPTp + Dual AI + SMC
Kwara	irepodun_1	13.01	Moderate	CM + IPTp + Dual AI + PMC + Vac
Kwara	isin	10.15	Moderate	CM + IPTp + Dual AI + PMC + Vac
Kwara	kaiaama	9.79	Low	CM + IPTp + Dual AI + SMC
Kwara	moro	8.07	Low	CM + IPTp + Dual AI + SMC
Kwara	offa	3.8	Low	CM + IPTp + Dual AI + PMC
Kwara	oke_ero	11.52	Moderate	CM + IPTp + Dual AI + SMC + Vac
Kwara	oyun	7.04	Low	CM + IPTp + Dual AI + PMC
Kwara	pategi	4.05	Low	CM + IPTp + Dual AI + SMC
Lagos	agege	3.16	Low	CM + IPTp + PBO + PMC
Lagos	ajeromi_ifelodun	1.87	Low	CM + IPTp + PBO + PMC
Lagos	alimosho	5.17	Low	CM + IPTp + PBO + PMC
Lagos	amuwo_odofin	3.85	Low	CM + IPTp + PBO + PMC
Lagos	apapa	2.29	Low	CM + IPTp + PBO + PMC
Lagos	badagry	11.62	Moderate	CM + IPTp + PBO + PMC + Vac
Lagos	epe	8.68	Low	CM + IPTp + PBO + PMC
Lagos	eti_osa	2.9	Low	CM + IPTp + PBO + PMC
Lagos	ibeju_lekki	8.05	Low	CM + IPTp + PBO + PMC
Lagos	ifako_ijaye	2.6	Low	CM + IPTp + PBO + PMC
Lagos	ikeja	1.63	Low	CM + IPTp + PBO + PMC + LSM
Lagos	ikorodu	4.25	Low	CM + IPTp + PBO + PMC + LSM
Lagos	kosofe	2.98	Low	CM + IPTp + PBO + PMC
Lagos	lagos_island	1.47	Low	CM + IPTp + PBO + PMC
Lagos	lagos_mainland	2.12	Low	CM + IPTp + PBO + PMC
Lagos	mushin	1.29	Low	CM + IPTp + PBO + PMC
Lagos	ojo	7.56	Low	CM + IPTp + PBO + PMC
Lagos	oshodi_isolo	2.9	Low	CM + IPTp + PBO + PMC
Lagos	shomolu	1.56	Low	CM + IPTp + PBO + PMC
Lagos	surulere_1	1.15	Low	CM + IPTp + PBO + PMC
Nasarawa	akwanga	7.12	Low	CM + IPTp + PBO + SMC

Nasarawa	awe	4.97	Low	CM + IPTp + PBO + SMC
Nasarawa	doma	4.86	Low	CM + IPTp + PBO + SMC
Nasarawa	karu	12.77	Moderate	CM + IPTp + Dual AI + SMC + Vac
Nasarawa	keana	6.04	Low	CM + IPTp + Dual AI + SMC
Nasarawa	keffi	17.96	Moderate	CM + IPTp + Dual AI + SMC + Vac
Nasarawa	kokona	17.32	Moderate	CM + IPTp + Dual AI + SMC + Vac
Nasarawa	lafia	3.65	Low	CM + IPTp + PBO + SMC
Nasarawa	nasarawa_eggon	5.82	Low	CM + IPTp + Dual AI + SMC
Nasarawa	nasarawa_2	11.03	Moderate	CM + IPTp + Dual AI + SMC + Vac
Nasarawa	obi_2	3.05	Low	CM + IPTp + Dual AI + SMC
Nasarawa	toto	7.82	Low	CM + IPTp + Dual AI + SMC
Nasarawa	wamba	7.69	Low	CM + IPTp + Dual AI + SMC
Niger	agaie	4.2	Low	CM + IPTp + Dual AI + SMC + iCCM
Niger	agwara	9.77	Low	CM + IPTp + Dual AI + SMC + iCCM
Niger	bida	3.58	Low	CM + IPTp + Dual AI + SMC + iCCM
Niger	borgu	12.46	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Niger	bosso	5.17	Low	CM + IPTp + Dual AI + SMC + iCCM
Niger	chanchaga	2.18	Low	CM + IPTp + Dual AI + SMC + iCCM
Niger	edati	3.89	Low	CM + IPTp + Dual AI + SMC + iCCM
Niger	gbako	5.32	Low	CM + IPTp + Dual AI + SMC + iCCM
Niger	gurara	6.18	Low	CM + IPTp + Dual AI + SMC + iCCM
Niger	katcha	4.07	Low	CM + IPTp + Dual AI + SMC + iCCM
Niger	kontagora	8.28	Low	CM + IPTp + Dual AI + SMC + iCCM
Niger	lapai	4.84	Low	CM + IPTp + Dual AI + SMC + iCCM
Niger	lavun	10.45	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Niger	magama	11.9	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Niger	mariga	11.28	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Niger	mashegu	16.59	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Niger	mokwa	14.24	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Niger	muya	12.85	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Niger	pailoro	4.96	Low	CM + IPTp + Dual AI + SMC + iCCM
Niger	rafi	10.11	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM

Niger	rijau	7.86	Low	CM + IPTp + Dual AI + SMC + iCCM
Niger	shiroro	12.2	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Niger	suleja	5.48	Low	CM + IPTp + Dual AI + SMC + iCCM
Niger	tafa	6.86	Low	CM + IPTp + Dual AI + SMC + iCCM
Niger	wushishi	10.13	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Ogun	abeokuta_north	5.41	Low	CM + IPTp + Dual AI + PMC
Ogun	abeokuta_south	3.83	Low	CM + IPTp + Dual AI + PMC
Ogun	ado_odo_ota	9.27	Low	CM + IPTp + Dual AI + PMC
Ogun	egbado_north	11.81	Moderate	CM + IPTp + Dual AI + PMC + Vac
Ogun	egbado_south	13.62	Moderate	CM + IPTp + Dual AI + PMC + Vac
Ogun	ewekoro	8.61	Low	CM + IPTp + Dual AI + PMC
Ogun	ifo	7.34	Low	CM + IPTp + Dual AI + PMC
Ogun	ijebu_east	13.33	Moderate	CM + IPTp + Dual AI + PMC + Vac
Ogun	ijebu_north	11.47	Moderate	CM + IPTp + Dual AI + PMC + Vac
Ogun	ijebu_north_east	15.95	Moderate	CM + IPTp + Dual AI + PMC + Vac
Ogun	ijebu_ode	8.03	Low	CM + IPTp + Dual AI + PMC
Ogun	ikenne	8.5	Low	CM + IPTp + Dual AI + PMC
Ogun	imeko_afon	10.53	Moderate	CM + IPTp + Dual AI + PMC + Vac
Ogun	ipokia	13.43	Moderate	CM + IPTp + Dual AI + PMC + Vac
Ogun	obafemi_owode	7.4	Low	CM + IPTp + Dual AI + PMC
Ogun	odeda	7.75	Low	CM + IPTp + Dual AI + PMC
Ogun	odogbolu	10.74	Moderate	CM + IPTp + Dual AI + PMC + Vac
Ogun	ogun_waterside	12.23	Moderate	CM + IPTp + Dual AI + PMC + Vac
Ogun	remo_north	7.65	Low	CM + IPTp + Dual AI + PMC
Ogun	shagamu	6.42	Low	CM + IPTp + Dual AI + PMC
Ondo	akoko_north_east	11.46	Moderate	CM + IPTp + PBO + PMC + Vac
Ondo	akoko_north_west	11.08	Moderate	CM + IPTp + PBO + PMC + Vac
Ondo	akoko_south_east	5.83	Low	CM + IPTp + PBO + PMC
Ondo	akoko_south_west	8.39	Low	CM + IPTp + PBO + PMC
Ondo	akure_north	6.99	Low	CM + IPTp + PBO + PMC + LSM
Ondo	akure_south	4.86	Low	CM + IPTp + PBO + PMC
Ondo	ese_odo	19.33	Moderate	CM + IPTp + PBO + PMC + Vac
Ondo	idanre	11.74	Moderate	CM + IPTp + PBO + PMC + Vac
Ondo	ifedore	6.49	Low	CM + IPTp + PBO + PMC
Ondo	ilaje	16.97	Moderate	CM + IPTp + PBO + PMC + Vac
Ondo	ile_oluji_okeigbo	7.56	Low	CM + IPTp + PBO + PMC
Ondo	irele	12.85	Moderate	CM + IPTp + PBO + PMC + Vac

Ondo	odigbo	11.45	Moderate	CM + IPTp + PBO + PMC + Vac
Ondo	okitipupa	10.04	Moderate	CM + IPTp + PBO + PMC + Vac + LSM
Ondo	ondo_east	8.72	Low	CM + IPTp + PBO + PMC
Ondo	ondo_west	4.62	Low	CM + IPTp + PBO + PMC
Ondo	ose	13.43	Moderate	CM + IPTp + PBO + PMC + Vac
Ondo	owo	10.49	Moderate	CM + IPTp + PBO + PMC + Vac
Osun	aiyedade	15.97	Moderate	CM + IPTp + PBO + PMC + Vac
Osun	aiyedire	18.05	Moderate	CM + IPTp + PBO + PMC + Vac
Osun	atakumosa_east	11.47	Moderate	CM + IPTp + PBO + PMC + Vac
Osun	atakumosa_west	11.24	Moderate	CM + IPTp + PBO + PMC + Vac
Osun	boluwaduro	13.49	Moderate	CM + IPTp + PBO + PMC + Vac
Osun	boripe	9.55	Low	CM + IPTp + Dual AI + PMC
Osun	ede_north	10.01	Moderate	CM + IPTp + Dual AI + PMC + Vac
Osun	ede_south	8.17	Low	CM + IPTp + PBO + PMC
Osun	egbedore	9.09	Low	CM + IPTp + Dual AI + PMC
Osun	ejigbo	9.95	Low	CM + IPTp + PBO + PMC
Osun	ife_central	10.48	Moderate	CM + IPTp + PBO + PMC + Vac
Osun	ife_east	8.27	Low	CM + IPTp + PBO + PMC
Osun	ife_north	13.32	Moderate	CM + IPTp + PBO + PMC + Vac
Osun	ife_south	7.63	Low	CM + IPTp + PBO + PMC
Osun	ifedayo	22.36	Moderate	CM + IPTp + PBO + PMC + Vac
Osun	ifelodun_2	7.42	Low	CM + IPTp + Dual AI + PMC
Osun	ila	9.08	Low	CM + IPTp + PBO + PMC
Osun	ileshe_east	7.67	Low	CM + IPTp + PBO + PMC
Osun	ileshe_west	8.73	Low	CM + IPTp + PBO + PMC
Osun	irepodun_2	7.56	Low	CM + IPTp + PBO + PMC
Osun	irewole	8.6	Low	CM + IPTp + PBO + PMC
Osun	isokan	10.1	Moderate	CM + IPTp + PBO + PMC + Vac
Osun	iwo	22.76	Moderate	CM + IPTp + PBO + PMC + Vac
Osun	obokun	15.25	Moderate	CM + IPTp + PBO + PMC + Vac
Osun	odo_otin	12.51	Moderate	CM + IPTp + PBO + PMC + Vac
Osun	ola_oluwa	16.64	Moderate	CM + IPTp + PBO + PMC + Vac
Osun	olorunda	3.76	Low	CM + IPTp + PBO + PMC
Osun	oriade	12.75	Moderate	CM + IPTp + Dual AI + PMC + Vac
Osun	orolu	5.28	Low	CM + IPTp + PBO + PMC
Osun	osogbo	7.01	Low	CM + IPTp + Dual AI + PMC
Oyo	afijio	17.57	Moderate	CM + IPTp + PBO + PMC + Vac
Oyo	akinyele	11.62	Moderate	CM + IPTp + Dual AI + PMC + Vac

Oyo	atiba	10.45	Moderate	CM + IPTp + Dual AI + PMC + Vac
Oyo	atigbo	9.71	Low	CM + IPTp + PBO + PMC
Oyo	egbeda	8.35	Low	CM + IPTp + PBO + PMC
Oyo	ibadan_north	3.94	Low	CM + IPTp + PBO + PMC
Oyo	ibadan_north_east	7.74	Low	CM + IPTp + PBO + PMC
Oyo	ibadan_north_west	5.68	Low	CM + IPTp + PBO + PMC
Oyo	ibadan_south_east	7.37	Low	CM + IPTp + PBO + PMC
Oyo	ibadan_south_west	5.06	Low	CM + IPTp + PBO + PMC
Oyo	ibarapa_central	12.49	Moderate	CM + IPTp + PBO + PMC + Vac
Oyo	ibarapa_east	15.61	Moderate	CM + IPTp + PBO + PMC + Vac
Oyo	ibarapa_north	14.11	Moderate	CM + IPTp + Dual AI + PMC + Vac
Oyo	ido	8.98	Low	CM + IPTp + PBO + PMC
Oyo	irepo	8.28	Low	CM + IPTp + PBO + SMC
Oyo	iseyin	7.98	Low	CM + IPTp + PBO + PMC
Oyo	itesiwaju	10.84	Moderate	CM + IPTp + Dual AI + PMC + Vac
Oyo	iwajowa	12.75	Moderate	CM + IPTp + PBO + PMC + Vac
Oyo	kajola	9.14	Low	CM + IPTp + PBO + PMC
Oyo	lagelu	9.61	Low	CM + IPTp + PBO + PMC
Oyo	ogbomosho_north	2.5	Low	CM + IPTp + PBO + SMC
Oyo	ogbomosho_south	4	Low	CM + IPTp + PBO + PMC
Oyo	ogo_oluwa	8.93	Low	CM + IPTp + PBO + PMC
Oyo	olorunsogo	6	Low	CM + IPTp + PBO + SMC
Oyo	oluyole	12.7	Moderate	CM + IPTp + PBO + PMC + Vac
Oyo	ona_ara	8.83	Low	CM + IPTp + PBO + PMC
Oyo	orelope	7.5	Low	CM + IPTp + Dual AI + PMC
Oyo	ori_ire	5.5	Low	CM + IPTp + PBO + PMC
Oyo	oyo_east	9.5	Low	CM + IPTp + PBO + PMC
Oyo	oyo_west	8.78	Low	CM + IPTp + Pyr + PMC
Oyo	saki_east	7.03	Low	CM + IPTp + PBO + SMC
Oyo	saki_west	6.53	Low	CM + IPTp + Dual AI + SMC
Oyo	surulere_2	4.97	Low	CM + IPTp + Dual AI + PMC
Plateau	barikin_ladi	2.3	Low	CM + IPTp + PBO + SMC
Plateau	bassa_2	3.29	Low	CM + IPTp + Dual AI + SMC
Plateau	bokkos	3.05	Low	CM + IPTp + Dual AI + SMC
Plateau	jos_east	4.1	Low	CM + IPTp + Dual AI + SMC
Plateau	jos_north	1.39	Low	CM + IPTp + Dual AI + SMC

Plateau	josh_south	1.26	Low	CM + IPTp + Dual AI + SMC
Plateau	kanam	4.01	Low	CM + IPTp + Dual AI + SMC
Plateau	kanke	4.24	Low	CM + IPTp + Dual AI + SMC
Plateau	langtang_north	1.79	Low	CM + IPTp + Dual AI + SMC
Plateau	langtang_south	2.48	Low	CM + IPTp + PBO + SMC
Plateau	mangu	2.13	Low	CM + IPTp + Dual AI + SMC
Plateau	mikang	2.42	Low	CM + IPTp + PBO + SMC
Plateau	pankshin	2.96	Low	CM + IPTp + Dual AI + SMC
Plateau	qua_an_pan	2.3	Low	CM + IPTp + PBO + SMC
Plateau	riyom	4.79	Low	CM + IPTp + PBO + SMC
Plateau	shendam	1.94	Low	CM + IPTp + Dual AI + SMC
Plateau	wase	4.75	Low	CM + IPTp + PBO + SMC
Rivers	abua_odual	7.06	Low	CM + IPTp + PBO + PMC + iCCM
Rivers	ahoadan_east	12.6	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM + LSM
Rivers	ahoadan_west	8.74	Low	CM + IPTp + PBO + PMC + iCCM
Rivers	akuku_toru	9.28	Low	CM + IPTp + PBO + PMC + iCCM
Rivers	andoni	40.49	High	CM + IPTp + PBO + PMC + Vac + iCCM
Rivers	asari_toru	7.31	Low	CM + IPTp + PBO + PMC + iCCM
Rivers	bonny	28.18	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Rivers	degema	8.97	Low	CM + IPTp + PBO + PMC + iCCM
Rivers	eleme	5.47	Low	CM + IPTp + PBO + PMC + iCCM
Rivers	emohua	11.56	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Rivers	etche	17.33	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Rivers	gokana	20.34	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Rivers	ikwerre	15.01	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Rivers	khana	30.62	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Rivers	obia_akpor	8.25	Low	CM + IPTp + PBO + PMC + iCCM + LSM
Rivers	ogba_egbema_andoni	11.8	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Rivers	ogu_bolo	19.43	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Rivers	okrika	8.59	Low	CM + IPTp + PBO + PMC + iCCM

Rivers	omumma	15.16	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Rivers	opobo_nkoro	43.56	High	CM + IPTp + PBO + PMC + Vac + iCCM
Rivers	oyigbo	10.15	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Rivers	port_harcourt	5.44	Low	CM + IPTp + PBO + PMC
Rivers	tai	11.77	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Sokoto	binji	9.92	Low	CM + IPTp + PBO + SMC + iCCM
Sokoto	bodinga	6.98	Low	CM + IPTp + PBO + SMC + iCCM
Sokoto	dange_shnsi	5.33	Low	CM + IPTp + PBO + SMC + iCCM
Sokoto	gada	13.4	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Sokoto	gawabawa	11.5	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Sokoto	goronyo	15.38	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Sokoto	gudu	11.93	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Sokoto	illela	10.43	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Sokoto	isa	8.43	Low	CM + IPTp + PBO + SMC + iCCM
Sokoto	kebbe	14.94	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Sokoto	kware	8.56	Low	CM + IPTp + PBO + SMC + iCCM
Sokoto	rabah	14.25	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Sokoto	sabon_birni	11.16	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Sokoto	shagari	8.95	Low	CM + IPTp + Pyr + SMC + iCCM
Sokoto	silame	10.42	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Sokoto	sokoto_north	4.59	Low	CM + IPTp + Dual AI + SMC + iCCM
Sokoto	sokoto_south	2.07	Low	CM + IPTp + Dual AI + SMC + iCCM
Sokoto	tambuwal	15.73	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Sokoto	tangaza	13.01	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Sokoto	tureta	16.11	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Sokoto	wamako	6.02	Low	CM + IPTp + PBO + SMC + iCCM

Sokoto	wurno	8.88	Low	CM + IPTp + PBO + SMC + iCCM
Sokoto	yabo	7.23	Low	CM + IPTp + PBO + SMC + iCCM
Taraba	ardo_kola	13.1	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Taraba	bali	20.6	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Taraba	donga	10.53	Moderate	CM + IPTp + Dual AI + PMC + Vac + iCCM
Taraba	gashaka	21.59	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Taraba	gassol	9.1	Low	CM + IPTp + Dual AI + SMC + iCCM
Taraba	ibi	5.37	Low	CM + IPTp + PBO + SMC + iCCM
Taraba	jalingo	10.71	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Taraba	karin_lamido	8.41	Low	CM + IPTp + PBO + SMC + iCCM
Taraba	kurmi	28.99	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Taraba	lau	7.63	Low	CM + IPTp + PBO + SMC + iCCM
Taraba	sardauna	12.92	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Taraba	takum	9.66	Low	CM + IPTp + Dual AI + PMC + iCCM
Taraba	ussa	13.32	Moderate	CM + IPTp + PBO + PMC + Vac + iCCM
Taraba	wukari	4.07	Low	CM + IPTp + PBO + SMC + iCCM
Taraba	yorro	7.76	Low	CM + IPTp + PBO + SMC + iCCM
Taraba	zing	6.4	Low	CM + IPTp + PBO + SMC + iCCM
Yobe	bade	6.94	Low	CM + IPTp + Dual AI + SMC + iCCM
Yobe	bursari	9.44	Low	CM + IPTp + Dual AI + SMC + iCCM
Yobe	damaturu	8.48	Low	CM + IPTp + Dual AI + SMC + iCCM
Yobe	fika	10.78	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Yobe	fune	17.88	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Yobe	geidam	12.92	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Yobe	gujba	7.26	Low	CM + IPTp + PBO + SMC + iCCM
Yobe	gulani	14.68	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Yobe	jakusko	12.62	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Yobe	karasuwa	4.67	Low	CM + IPTp + PBO + SMC + iCCM
Yobe	machina	6.12	Low	CM + IPTp + PBO + SMC + iCCM

Yobe	nangere	10.92	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Yobe	nguru	2.7	Low	CM + IPTp + Dual AI + SMC + iCCM
Yobe	potiskum	9.93	Low	CM + IPTp + Dual AI + SMC + iCCM
Yobe	tarmua	15.07	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Yobe	yunusari	6.41	Low	CM + IPTp + PBO + SMC + iCCM
Yobe	yusufari	5.14	Low	CM + IPTp + PBO + SMC + iCCM
Zamfara	anka	19.3	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Zamfara	bakura	16.3	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Zamfara	birnin_magaji	29.15	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Zamfara	bukkuyum	16.76	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Zamfara	bungudu	21.9	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Zamfara	gummi	17.08	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Zamfara	gusau	19.59	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Zamfara	kaura_namoda	20.68	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Zamfara	maradun	14.82	Moderate	CM + IPTp + Dual AI + SMC + Vac + iCCM
Zamfara	maru	16.73	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM
Zamfara	shinkafi	8.47	Low	CM + IPTp + PBO + SMC + iCCM
Zamfara	talata_mafara	16.78	Moderate	CM + IPTp + Pyr + SMC + Vac + iCCM
Zamfara	tsafe	14.16	Moderate	CM + IPTp + Pyr + SMC + Vac + iCCM
Zamfara	zurmi	12.2	Moderate	CM + IPTp + PBO + SMC + Vac + iCCM

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- ⁴Federal Ministry of Women Affairs: National Gender Policy, 2021-2026.
- ⁵National Malaria Elimination Programme (NMEP): Malaria Programme Review (MPR) 2025.
- ⁶National Population Commission (2025): Nigeria Population Estimates.
- ⁷World Health Organization: World Malaria Report (WMR) 2024.
- ⁸World Bank: Poverty & Equity Brief; Nigeria (April 2025)
- ⁹National Bureau of Statistics (NBS): Nigeria Multidimensional Poverty Index 2022.
- ¹⁰National Population Commission (NPC). Nigeria Demographic and Health Survey (NDHS) 2023-2024.
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